AMA
AMERICAN MEDICAL ASSOCIATION

MEMBERSHIP MOVES MEDICINE™

November 2021 Special Meeting
of the AMA House of Delegates

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MEMORANDUM FROM THE SPEAKER OF THE HOUSE OF DELEGATES

• All Delegates, Alternate Delegates and others receiving this material are reminded that it refers only to items THAT MAY BE CONSIDERED by the House.

- **ALL ITEMS HAVE NOT YET BEEN REVIEWED BY THE RESOLUTIONS COMMITTEE FOR PRIORITY/URGENCY FOR THIS SPECIAL MEETING**

• No action has been taken on anything herein contained, and it is informational only.

• Only those items that have been acted on finally by the House can be considered official.

• REMINDER*: Only the Resolve portions of the resolutions are considered by the House of Delegates. The Whereas portions or preambles are informational and explanatory only.*

AMA
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UNDERSTANDING THE RECORDING OF AMERICAN MEDICAL ASSOCIATION POLICY

Current American Medical Association (AMA) policy is catalogued in PolicyFinder, an electronic database that is updated after each AMA House of Delegates (HOD) meeting and available online. Each policy is assigned to a topical or subject category. Those category headings are alphabetical, starting with "abortion" and running to "women"; the former topic was assigned the number 5, and "women" was assigned 525. Within a category, policies are assigned a 3 digit number, descending from 999, meaning that older policies will *generally* have higher numbers within a category (eg, 35.999 was initially adopted before 35.984). A policy number is not affected when it is modified, however, so a higher number may have been altered more recently than a lower number. Numbers are deleted and not reused when policies are rescinded.

AMA policy is further categorized into one of four types, indicated by a prefix:

- "H" – for statements that one would consider positional or philosophical on an issue
- "D" – for statements that direct some specific activity or action. There can be considerable overlap between H and D statements, with the assignment made on the basis of the core nature of the statement.
- "G" – for statements related to AMA governance
- "E" – for ethical opinions, which are the recommendations put forward in reports prepared by the Council on Ethical and Judicial Affairs and adopted by the AMA-HOD

AMA policy can be accessed at ama-assn.org/go/policyfinder.

The actions of the AMA-HOD in developing policy are recorded in the *Proceedings*, which are available online as well. Annotations at the end of each policy statement trace its development, from initial adoption through any changes. If based on a report, the annotation includes the following abbreviations:

BOT – Board of Trustees
CCB – Council on Constitution and Bylaws
CEJA – Council on Ethical and Judicial Affairs
CLRPD – Council on Long Range Planning and Development
CME – Council on Medical Education
CMS – Council on Medical Service
CSAPH – Council on Science and Public Health

If a resolution was involved, "Res" is indicated. The number of the report or resolution and meeting (A for Annual; I for Interim) and year (two digits) are also included (eg, BOT Rep. 1, A-14 or Res. 319, I-12).

AMA policy is recorded in the following categories, and any particular policy is recorded in only a single category.

5.000 Abortion	10.000 Accident Prevention/Unintentional Injuries
15.000 Accident Prevention: Motor Vehicles	20.000 Acquired Immunodeficiency Syndrome
25.000 Aging	30.000 Alcohol and Alcoholism
35.000 Allied Health Professions	40.000 Armed Forces
45.000 Aviation Medicine	50.000 Blood
55.000 Cancer	60.000 Children and Youth
65.000 Civil and Human Rights	70.000 Coding and Nomenclature
75.000 Contraception	80.000 Crime
85.000 Death and Vital Records	90.000 Disabled
95.000 Drug Abuse	100.000 Drugs
105.000 Drugs: Advertising	110.000 Drugs: Cost
115.000 Drugs: Labeling and Packaging	120.000 Drugs: Prescribing and Dispensing
125.000 Drugs: Substitution	130.000 Emergency Medical Services
135.000 Environmental Health	140.000 Ethics
145.000 Firearms: Safety and Regulation	150.000 Foods and Nutrition

155.000 Health Care Costs	160.000 Health Care Delivery
165.000 Health Care/System Reform	170.000 Health Education
175.000 Health Fraud	180.000 Health Insurance
185.000 Health Insurance: Benefits and Coverage	190.000 Health Insurance: Claim Forms and Claims Processing
195.000 Health Maintenance Organizations	200.000 Health Workforce
205.000 Health Planning	210.000 Home Health Services
215.000 Hospitals	220.000 Hospitals: Accreditation Standards
225.000 Hospitals: Medical Staff	230.000 Hospitals: Medical Staff - Credentialing and Privileges
235.000 Hospitals: Medical Staff - Organization	240.000 Hospitals: Reimbursement
245.000 Infant Health	250.000 International Health
255.000 International Medical Graduates	260.000 Laboratories
265.000 Legal Medicine	270.000 Legislation and Regulation
275.000 Licensure and Discipline	280.000 Long-Term Care
285.000 Managed Care	290.000 Medicaid and State Children's Health Insurance Programs
295.000 Medical Education	300.000 Medical Education: Continuing
305.000 Medical Education: Financing and Support	310.000 Medical Education: Graduate
315.000 Medical Records and Patient Privacy	320.000 Medical Review
330.000 Medicare	335.000 Medicare: Carrier Review
340.000 Medicare: PRO	345.000 Mental Health
350.000 Minorities	355.000 National Practitioner Data Bank
360.000 Nurses and Nursing	365.000 Occupational Health
370.000 Organ Donation and Transplantation	373.000 Patients
375.000 Peer Review	380.000 Physician Fees
383.000 Physician Negotiation	385.000 Physician Payment
390.000 Physician Payment: Medicare	400.000 Physician Payment: Medicare - RBRVS
405.000 Physicians	406.000 Physician-Specific Health Care Data
410.000 Practice Parameters	415.000 Preferred Provider Arrangements
420.000 Pregnancy and Childbirth	425.000 Preventive Medicine
430.000 Prisons	435.000 Professional Liability
440.000 Public Health	445.000 Public Relations
450.000 Quality of Care	455.000 Radiation and Radiology
460.000 Research	465.000 Rural Health
470.000 Sports and Physical Fitness	475.000 Surgery
478.000 Technology - Computer	480.000 Technology - Medical
485.000 Television	490.000 Tobacco Use, Prevention and Cessation
495.000 Tobacco Products	500.000 Tobacco: AMA Corporate Policies and Activities
505.000 Tobacco: Federal and International Policies	510.000 Veterans Medical Care
515.000 Violence and Abuse	520.000 War
525.000 Women	600.000 Governance: AMA House of Delegates
605.000 Governance: AMA Board of Trustees and Officers	610.000 Governance: Nominations, Elections, and Appointments
615.000 Governance: AMA Councils, Sections, and Committees	620.000 Governance: Federation of Medicine
625.000 Governance: Strategic Planning	630.000 Governance: AMA Administration and Programs
635.000 Governance: Membership	640.000 Governance: Advocacy and Political Action

LIST OF MATERIAL INCLUDED IN THIS HANDBOOK

NOVEMBER 2021 SPECIAL MEETING OF THE AMA HOUSE OF DELEGATES

Resolutions and reports have been collated by referral according to reference committee assignment. In the listing below, referral is indicated by letter in parenthesis following the title of the report. Resolutions have been numbered according to referrals (i.e., those referred to the Reference Committee on Amendments to Constitution and Bylaws begin with 001, Reference Committee B begins with 201, etc.).

The informational reports contain no recommendations and will be filed on Friday, November 12, unless a request is received for referral and consideration by a Reference Committee (similar to the use of a consent calendar).

1. Memorandum from the Speaker

2. Understanding the Recording of American Medical Association Policy

3. Declaration of Professional Responsibility - Medicine's Social Contract with Humanity

4. Delegate / Alternate Delegate Job Description, Roles and Responsibilities

5. Seating Chart

6. Official Call to the Officers and Members of the AMA
Listing of Delegates and Alternate Delegates
Officials of the Association and AMA Councils

7. Note on Order of Business

8. Listing of Resolutions (by sponsor)

9. Reference Committee Hearings

10. Reference Committee Members

11. Summary of Fiscal Notes

FOLLOWING COLLATED BY REFERRAL

12. Report(s) of the Board of Trustees - Bobby Mukkamala, MD, Chair

01 Racial Essentialism in Medical Education (Info. Report)
02 Policing Reform (B)
03 Redefining the AMA's Position on ACA and Healthcare Reform (Info. Report)
04 2021 AMA Advocacy Efforts (Info. Report)
05 Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment (Amendments to C&B)
06 Mitigating the Effects of Racism in Health Care: "Best Practices" (Info. Report)
07 Improving Clinical Algorithms: Moving Beyond Race and Ethnicity (Info. Report)
08 Improved Access and Coverage to Non-opioid Modalities to Address Pain (B)
09 Medical Marijuana License Safety (B)
10 Physician Access to Their Medical and Billing Records (B)

11 National Guidelines for Guardianship (Amendments to C&B)

12 Direct-to-Consumer Genetic Tests (B)

13 Study of Forced Organ Harvesting by China (Amendments to C&B)

14 Net Neutrality and Public Health (B)

15 Opposing Attorney Presence at and/or Recording of Independent Medical Examinations (Amendments to C&B)

16 Research Handling of De-Identified Patient Information (Amendments to C&B)

17 Distracted Driver Education and Advocacy (D)

18 Financial Protections for Doctors in Training (F)

19 Advocacy for Physicians with Disabilities (F)

13. Report(s) of the Council on Constitution and Bylaws - Pino D. Colone, MD, Chair

01 Further Action on Bylaw 7.5.2 (Amendments to C&B)

02 Rescission of Bylaws Related to Run-off Elections (Amendments to C&B)

03 AMA Women Physicians Section: Clarification of Bylaw Language (Amendments to C&B)

14. Report(s) of the Council on Ethical and Judicial Affairs - Alexander M. Rosenau, MD, Chair

01 Short-Term Medical Service Trips (Amendments to C&B)

02 Amendment to Opinions 1.2.11, "Ethical Innovation in Medical Practice"; 11.1.2, Physician Stewardship of Health Care Resources"; 11.2.1, "Professionalism in Health Care Systems"; and 1.1.6, "Quality" (Amendments to C&B)

15. Opinion(s) of the Council on Ethical and Judicial Affairs - Alexander M. Rosenau, MD, Chair

01 Amendment to Opinion 9.3.2, "Physician Responsibilities to Impaired Colleagues" (Info. Report)

16. Report(s) of the Council on Long Range Planning and Development - Clarence P. Chou, MD, Chair

01 Minority Affairs Section Five-Year Review (F)

02 Integrated Physician Practice Section - Five-Year Review (F)

17. Report(s) of the Council on Medical Education - Niranjan V. Rao, MD, Chair

01 Guiding Principles and Appropriate Criteria for Assessing the Competency of Late Career Physicians (C)

02 A Study to Evaluate Barriers to Medical Education for Trainees with Disabilities (C)

03 Rural Health Physician Workforce Disparities (C)

04 Medical Student Debt and Career Choice (C)

05 Investigation of Existing Application Barriers for Osteopathic Medical Students Applying for Away Rotation (C)

18. Report(s) of the Council on Medical Service - Asa C. Lockhart, MD, Chair

01 End-of-Life Care (A)

02 Access to Health Plan Information Regarding Lower-Cost Prescription Options (G)

03 Covering the Remaining Uninsured (A)

04 Financing of Home and Community-Based Services (G)

05 Integrating Care for Individuals Dually Eligible for Medicare and Medicaid (A)

19. Report(s) of the Council on Science and Public Health - Alexander Ding, MD, Chair

01 Drug Shortages: 2021 Update (Info. Report)

02 Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems (D)

03 Physician Involvement in State Regulations of Motor Vehicle Operation and/or Firearm Use by Individuals with Cognitive Deficits Due to Traumatic Brain Surgery (D)

04 Pharmacovigilance (E)

20. Report(s) of the HOD Committee on Compensation of the Officers - Steven Tolber, MD, Chair

01 Report of the House of Delegates Committee on the Compensation of the Officers (F)

21. Joint Report(s)

01 CMS/CSAPH Joint Report - Reducing Inequities and Improving Access to Insurance for Maternal Health Care (G)

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

01 Report of the Election Task Force (Amendments to C&B)

02 Establishing an Election Committee (Amendments to C&B)

23. Resolutions

001 Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers (Amendments to C&B)

002 Disaggregation of Race Data for Individuals of Middle Eastern and North African (MENA) Descent (Amendments to C&B)

003 Supporting the Study of Reparations as a Means to Reduce Racial Inequalities (Amendments to C&B)

004 Guidelines on Chaperones for Sensitive Exams (Amendments to C&B)

005 Combating Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism (Amendments to C&B)

006 Evaluating Scientific Journal Articles for Racial and Ethnic Bias (Amendments to C&B)

007 Exclusion of Race and Ethnicity in the First Sentence of Case Reports (Amendments to C&B)

008 Amendment to Truth and Transparency in Pregnancy Counseling Centers, H-420.954 (Amendments to C&B)

009 Banning the Practice of Virginity Testing (Amendments to C&B)

010 Improving the Health and Safety of Sex Workers (Amendments to C&B)

011 Expanding the Definition of Iatrogenic Infertility to Include Gender Affirming Interventions (Amendments to C&B)

012 Increased Recognition and Treatment of Eating Disorders in Minority Populations (Amendments to C&B)

013 Equal Access to Adoption for the LGBTQ Community (Amendments to C&B)

014 Reducing Disparities in HIV Incidence through Pre-Exposure Prophylaxis for HIV (Amendments to C&B)

015 Using X-Ray and Dental Records for Assessing Immigrant Age (Amendments to C&B)

016 Student-Centered Approaches for Reforming School Disciplinary Policies (Amendments to C&B)

017 Gender Equity and Female Physician Work Patterns During the Epidemic (Amendments to C&B)

018 Support for Safe and Equitable Access to Voting (Amendments to C&B)

019 Disaggregation of Demographic Data for Individuals of Middle Eastern and North African (MENA) Descent (Amendments to C&B)

020* Recognizing and Remedying "Structural Urbanism" Bias as a Factor in Rural Health Disparities (Amendments to C&B)

021* Free Speech and Civil Discourse in the American Medical Association (Amendments to C&B)

022* Prohibition of Racist Characterization Based on Personal Attributes (Amendments to C&B)

101 Standardized Coding for Telehealth Services (A)

102 Prevention of Hearing Loss-Associated-Cognitive-Impairment Through Earlier Recognition and Remediation (A)

103 Oral Healthcare Is Healthcare (A)

104 Improving Access to Vaccinations for Patients (A)

105 Fertility Preservation Insurance Coverage for Women in Medicine (A)

106 Reimbursement of School-Based Health Centers (A)

107 Expanding Medicaid Transportation to Include Healthy Grocery Destinations (A)

108 Medicaid and CHIP Coverage of Glucose Monitoring Devices for Patients with Diabetes (A)

109 Amending D-440.985, Health Care Payment for Undocumented Persons, to Study Methods to Increase Health Care Access for Undocumented Immigrants (A)

110 Caps on Insulin Co-Payments for Patients with Insurance (A)

111 Addressing Healthcare Accessibility for Current and Aged-Out Youth in the Foster Care System (A)

112 Expanding Coverage for and Access to Pulmonary Rehabilitation (A)

113 Supporting Medicare Drug Price Negotiation (A)

114 Medicare and Private Health Insurance for Hearing Aids (A)

115 Bundled Payments and Medically Necessary Care (A)

116 Recognizing the Need to Move Beyond Employer-Sponsored Health Insurance (A)

117 Implant-Associated Anaplastic Large Cell Lymphoma (A)

118 Expanding Site-of-Service Neutrality (A)

119* Bundling Physician Fees with Hospital Fees (A)

120* COBRA for College Students (A)

121* Medicaid Tax Benefits (A)

122* Increase Funding, Research and Education for Post-Intensive Care Syndrome (A)

201 Protection of Peer-Review Process (B)

202 RESOLUTION WITHDRAWN (B)

203 Poverty-Level Wages and Health (B)

204 Supporting Collection of Data on Medical Repatriation (B)

205 Reducing the Prevalence of Sexual Assault by Testing Sexual Assault Evidence Kits (B)

206 Updating Policy on Immigration Laws, Rules, Legislation, and Health Disparities to Better Address National Crises (B)

207 Authority to Grant Vaccine Exemptions (B)

208 Protections for Incarcerated Mothers in the Perinatal Period (B)

209 Increasing Access to Hygiene and Menstrual Products (B)

210 Advocating for the Amendment of Chronic Nuisance Ordinances (B)

211 Support for Mental Health Courts (B)

212 Sequestration (B)

213 Eliminating Unfunded or Unproven Mandates and Regulations (B)

214 Stakeholder Engagement in Medicare Administrative Contractor Policy (B)

215 Pharmacy Benefit Manager Reform as a State Legislative Priority (B)

216 Preserving Appropriate Physician Supervision of Midlevel Providers and Ensuring Patient Awareness of the Qualifications of Physicians vs. Midlevel Providers (B)

217 Studying Physician Supervision of Allied Health Professionals Outside of their Fields of Graduate Medical Education (B)

218 Physician Opposition to the Coordinated Effort by Corporations and Midlevel Providers to Undermine the Physician-Patient Relationship and Safe Quality Care (B)

219 The Impact of Midlevel Providers on Medical Education (B)

220 Gonad Shields: Regulatory and Legislation Advocacy to Oppose Routine Use (B)

221 Promoting Sustainability in Medicare Physician Payments (B)

222 Opposing Federal Preemption of State Licensing Laws and Scope-of-Practice Expansion Under the Ninth Amendment to Declaration Under the PREP Act (B)

223 Paying Physicians for Services According to the Physician Fee Schedule (B)

224 Improve Physician Payments (B)

225 End Budget Neutrality (B)

226 Addressing Adolescent Telehealth Confidentiality Concerns (B)

227 Medication for Opioid Use Disorder in Physician Health Programs (B)

228 Resentencing for Individuals Convicted of Marijuana-Based Offenses (B)

229* CMS Administrative Requirements (B)

230* Medicare Advantage Plan Mandates (B)

231* Prohibit Ghost Guns (B)

232* Ban the Gay/Trans (LGBTQ+) Panic Defense (B)

233* Insurers and Vertical Integration (B)

234* Permitting the Dispensing of Stock Medications for Post Discharge Patient Use and the Safe Use of Multi-dose Medications for Multiple Patients (B)

301 Equitable Reporting of USMLE Step 1 Scores (C)

302 University Land Grant Status in Medical School Admissions (C)

303 Decreasing Bias in Evaluations of Medical Student Performance (C)

304 Reducing Complexity in the Public Service Loan Forgiveness Program (C)

305 Increase Awareness Among Residency, Fellowship, and Academic Programs on the United States-Puerto Rico Relationship Status (C)

306 Support for Standardized Interpreter Training (C)

307 Support for Institutional Policies for Personal Days for Undergraduate Medical Students (C)

308 Modifying Eligibility Criteria for Association of American Medical Colleges' Financial Assistance Program (C)

309 Protecting Medical Student Access to Abortion Education and Training (C)

310 Resident and Fellow Access to Fertility Preservation (C)

311 Improving Access to Physician Health Programs for Physician Trainees (C)

312 Accountable Organizations to Resident and Fellow Trainees (C)

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

314 Updating Current Wellness Policies and Improving Implementation (C)

315 Reducing Overall Fees and Making Costs for Licensing, Exam Fees, Application Fees, etc. Equitable for IMGs (C)

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

317* Creating a More Accurate Accounting of Medical Education Financial Costs (C)

318* The Medical Student Match Mismatch (C)

401 Endorsement of Public Health Measures to End the COVID-19 Pandemic and Promotion of Research and Insurance Coverage to Define and Delimit the Emerging Issue of Post-Acute Covid Syndrome (D)

402 Expansion on Comprehensive Sexual Health Education (D)

403 Providing Reduced Parking Fees for Patients (D)

404 Increase Employment Services Funding for People with Disabilities (D)

405 Formal Transitional Care Program for Children and Youth with Special Health Care Needs (D)

406 Addressing Gaps in Patient and Provider Knowledge to Increase HPV Vaccine Uptake and Prevent HPV-Associated Oropharyngeal Cancer (D)

407 Traumatic Brain Injury and Access to Firearms (D)

408* Ensuring Affordability and Equity in COVID-19 Vaccine Boosters (D)

501 Ensuring Continued Access to Equitable Take-Home Methadone Treatment (E)

502 Advocating for Heat Exposure Protections for Outdoor Workers (E)

503 Marketing Guardrails for the "Over-Medicalization" of Cannabis Use (E)

504 Air Pollution and COVID: A Call to Tighten Regulatory Standards (E)

505 Representation of Dermatological Pathologies in Varying Skin Tones (E)

506 Enhancing Harm Reduction for People Who Use Drugs (E)

601 "Virtual Water Cooler" for our AMA (F)

602 Mitigating Environmental Contributors to Disease and Sustainability of AMA National Meetings (F)

603 Abolishment of the Resolution Committee (F)

604 The Critical Role of Physicians in the COVID-19 Pandemic (F)

605 Formalization of the Resolution Committee as a Standing Committee of the American Medical Association House of Delegates (F)

606 Increasing the Effectiveness of Online Reference Committee Testimony (F)

607 AMA Urges Health and Life Insurers to Divest From Investments in Fossil Fuels (F)

608 Fulfilling Medicine’s Social Contract with Humanity in the Face of the Climate Health Crisis (F)

609 Fulfilling Medicine's Social Contract with Humanity in the Face of the Climate Health Emergency (F)

610 Creation of Employed Physician Section (F)

611* September 11th as a National Holiday (F)

612* UN International Radionuclide Therapy Day Recognition (F)

613* Due Process at our AMA (F)

614* Insurance Industry Behaviors (F)

615* Employed Physicians (F)

616* Financial Impact and Fiscal Transparency of the American Medical Association Current Procedural Terminology System (F)

617* Together We are Stronger Marketing Campaign (F)

701 Coverage of Pregnancy-Associated Healthcare for 12 Months Postpartum for Uninsured Patients who are Ineligible for Medicaid (G)

702 System Wide Prior and Post-Authorization Delays and Effects on Patient Care Access (G)

703 Clear Statement Regarding the Use of CPT E/M Outpatient Visit Codes (G)

704 Expanding the AMA’s Study on the Economic Impact of COVID-19 (G)

705 Advocating for Program Stability in the Merit-Based Incentive Payment System (G)

706 Support for State Medical Record Retention Laws (G)

707* Fifteen Month Lab Standing Orders (G)
708* Insurance Coverage for Scalp Cooling (Cold Cap) Therapy (G)
709* Prior Authorization - CPT Codes for Fair Compensation (G)
710* Physician Burnout is an OSHA Issue (G)

* Contained in the Handbook Addendum

DECLARATION OF PROFESSIONAL RESPONSIBILITY: MEDICINE'S SOCIAL CONTRACT WITH HUMANITY

Preamble

Never in the history of human civilization has the well-being of each individual been so inextricably linked to that of every other. Plagues and pandemics respect no national borders in a world of global commerce and travel. Wars and acts of terrorism enlist innocents as combatants and mark civilians as targets. Advances in medical science and genetics, while promising great good, may also be harnessed as agents of evil. The unprecedented scope and immediacy of these universal challenges demand concerted action and response by all.

As physicians, we are bound in our response by a common heritage of caring for the sick and the suffering. Through the centuries, individual physicians have fulfilled this obligation by applying their skills and knowledge competently, selflessly and at times heroically. Today, our profession must reaffirm its historical commitment to combat natural and man-made assaults on the health and well-being of humankind. Only by acting together across geographic and ideological divides can we overcome such powerful threats. Humanity is our patient.

Declaration

We, the members of the world community of physicians, solemnly commit ourselves to:

1. Respect human life and the dignity of every individual.

2. Refrain from supporting or committing crimes against humanity and condemn all such acts.

3. Treat the sick and injured with competence and compassion and without prejudice.

4. Apply our knowledge and skills when needed, though doing so may put us at risk.

5. Protect the privacy and confidentiality of those for whom we care and breach that confidence only when keeping it would seriously threaten their health and safety or that of others.

6. Work freely with colleagues to discover, develop, and promote advances in medicine and public health that ameliorate suffering and contribute to human well-being.

7. Educate the public and polity about present and future threats to the health of humanity.

8. Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being.

9. Teach and mentor those who follow us for they are the future of our caring profession.

We make these promises solemnly, freely, and upon our personal and professional honor.

Adopted by the House of Delegates of the American Medical Association
in San Francisco, California on December 4, 2001

Delegate/Alternate Delegate Job Description, Roles and Responsibilities

At the 1999 Interim Meeting, the House of Delegates adopted as amended Recommendation 16 of the final report of the Special Advisory Committee to the Speaker of the House of Delegates. This recommendation included a job description and roles and responsibilities for delegates and alternate delegates. The description and roles and responsibilities were modified at the 2002 Annual Meeting by Recommendation 3 of the Joint Report of the Board of Trustees and Council on Long Range Planning and Development. The modified job description, qualifications, and responsibilities are listed below.

Delegates and Alternate Delegates should meet the following job description and roles and responsibilities:

Job Description and Roles and Responsibilities of AMA Delegates/Alternate Delegates

Members of the AMA House of Delegates serve as an important communications, policy, and membership link between the AMA and grassroots physicians. The delegate/alternate delegate is a key source of information on activities, programs, and policies of the AMA. The delegate/alternate delegate is also a direct contact for the individual member to communicate with and contribute to the formulation of AMA policy positions, the identification of situations that might be addressed through policy implementation efforts, and the implementation of AMA policies. Delegates and alternate delegates to the AMA are expected to foster a positive and useful two-way relationship between grassroots physicians and the AMA leadership. To fulfill these roles, AMA delegates and alternate delegates are expected to make themselves readily accessible to individual members by providing the AMA with their addresses, telephone numbers, and e-mail addresses so that the AMA can make the information accessible to individual members through the AMA web site and through other communication mechanisms. The qualifications and responsibilities of this role are as follows:

A. Qualifications
- AMA member.
- Elected or selected by the principal governing body or the membership of the sponsoring organization.
- The AMA encourages that at least one member of each delegation be involved in the governance of their sponsoring organization.

B. Responsibilities
- Regularly communicate AMA policy, information, activities, and programs to constituents so he/she will be recognized as the representative of the AMA.
- Relate constituent views and suggestions, particularly those related to implementation of AMA policy positions, to the appropriate AMA leadership, governing body, or executive staff.
- Advocate constituent views within the House of Delegates or other governance unit, including the executive staff.
- Attend and report highlights of House of Delegates meetings to constituents, for example, at hospital medical staff, county, state, and specialty society meetings.
- Serve as an advocate for patients to improve the health of the public and the health care system.
- Cultivate promising leaders for all levels of organized medicine and help them gain leadership positions.
- Actively recruit new AMA members and help retain current members.
- Participate in the AMA Membership Outreach Program.

NOVEMBER 2021 SPECIAL MEETING OF THE AMA HOUSE OF DELEGATES

SEATING CHART

Your speakers have determined that each participant at the Special Meeting may sit anywhere they wish so long as whomever is sitting near you doesn't object. This will be left to the discretion of the individuals with whom you must live.

To: Delegates and Alternate Delegates

From: Bruce A. Scott, MD, Speaker; and Lisa Bohman Egbert, MD, Vice Speaker

Date: Monday, September 13, 2021

Subject: N21 - Official Call to the November 2021 Special Meeting of the AMA House of Delegates

Pursuant to the actions of the American Medical Association (AMA) Board of Trustees (Board) previously communicated to you on August 27 and September 10, this notice will serve as the Official Call to convene a Special Meeting of the AMA House of Delegates (HOD) on November 12-16, 2021. The purpose of this meeting, as defined by the action of the Board, is to conduct **priority business of the Association.** This Special Meeting will be convened virtually on the same platforms, Lumi and Zoom, that were used at the November 2020 and June 2021 Special Meetings.

As previously communicated the schedule was developed to expand the time available for deliberation of business in reference committee hearings and House sessions. Reference committee hearings will again be held on Saturday and Sunday. The House will commence with the Opening Session at 7 pm Central Standard Time (CST), Friday, November 12 and convene again on Monday, November 15 at 10 am CST. We anticipate that we will utilize all of the scheduled time through Tuesday until our business is completed. **Note: We will NOT have a hard stop on Tuesday, November 16,** as there is no need for travel time, and this day should have already been cleared on your calendars.

BUSINESS OF THE HOUSE:

The inherent inefficiencies of a virtual meeting demand a prioritization of the business to be considered, and thus the Board motion specified that the purpose of the meeting is to conduct priority business. In keeping with this defined purpose, all delegates and delegations are strongly encouraged to submit only priority resolutions. Our councils and the Board have been asked to do the same. To facilitate the prioritization process, **resolutions MUST BE ACCOMPANIED by a statement of priority (not to exceed 250 words)**, and if submitting more than 1 resolution, **delegations MUST RANK their resolutions in order of priority**. Resolutions submitted without these required elements will not be accepted.

A Resolutions Committee will be convened to review all resolutions and make recommendations to the House regarding the priority of the resolutions. Your submitted prioritization statement and ranking will be considered by the Resolutions Committee as a factor in their recommendation to the House. The final determination of the business to be considered by the House at this Special Meeting will be decided by majority vote during the Opening Session of the House.

The *Prioritization Matrix* that was used for the J21 Special Meeting will again be utilized at this meeting. It is attached to this communication. Delegates considering submitting a resolution are encouraged to review this matrix. The detailed Prioritization Process is posted on the AMA website for review.

ONLINE FORUMS:

Online Forums will once again be open for comment on all submitted resolutions and reports. Your Speakers request that **all authors please present an opening comment regarding their resolutions/reports**. In addition, we ask that members comment not only on the merits of the proffered resolution/report, but also to the priority of the resolutions. Your Speakers strongly encourage the use

of the Online Forum to facilitate the live deliberations. As a reminder, there is no limit on debate via the Online Forum, however, there will be a limit at the live virtual hearing.

To encourage use of the Online Forums, reference committees will be instructed to give equal weight to testimony presented in the Online Forums to that presented at the live hearings.

REFERENCE COMMITTEES:
Reference committees are scheduled Saturday morning and afternoon and Sunday morning. To facilitate deliberation of as much business as possible, your Speakers have determined that we will once again use all 8 reference committees typically held at our Annual Meetings (CC&B, A-G). Reference committee reports will be posted as soon as available. In general, reference committee reports will be considered by the House in the order in which they become available for review. Saturday and Sunday late afternoon/evening and early morning Monday have been kept open on the schedule to allow for Delegations to consider the reports.

HOUSE OF DELEGATES SESSIONS:

The Opening Session of the House will be held Friday, November 12 at 7 pm CST. The House will consider reference committee reports beginning at 10 am CST Monday and continuing on Tuesday until all business has been completed. Please keep open Tuesday afternoon as we do not know when we will adjourn.

See preliminary schedule below for further details.

Your Speakers are sensitive to the fact that our schedule continues past sundown on Friday and on through Sunday. Delegates for whom this schedule potentially creates a conflict may wish to coordinate with their alternate delegates. Saturday and Sunday will include reference committees where participation is optional, and individuals are reminded of the opportunity to present testimony in the Online Forum which will be open for several weeks. If further accommodations are needed, please contact us at HOD@ama-assn.org.

HEALTH EQUITY FORUM:

A Health Equity Forum will be offered on Sunday afternoon, November 14. This program is under development by management and the Center for Health Equity. Further details will be forthcoming.

EMAIL ADDRESSES:

Although this notice is being sent both electronically and by postal mail, delivery delays and the need to expedite communication as we approach the upcoming meeting necessitate that we have correct email addresses for ALL members of the HOD, including alternate delegates and any other involved individuals. Email will once again be our primary method of sharing important information, including delegate credentials, with the House. In some cases this notice may have been sent to “spam” or been removed by a security filter. If you receive this notice by postal mail only, you need to confirm your email address and check your filters.

In addition, because delegation rosters may have changed since our June 2021 Special Meeting, **we remind delegation chairs and/or staff to confirm that all delegation members have received this communication electronically**. If you or a member of your delegation needs to correct or update their email address, please contact the HOD office at HOD@ama-assn.org immediately.

COMMITTEE VOLUNTEERS:

Your Speakers are seeking multiple volunteers for the Resolutions Committee, Rules and Credentials Committee, and reference committees. Those interested in serving on reference committees and particularly those interested in serving as a chair should be experienced in working via a virtual meeting format. Please submit a *"Committee Volunteer Form,"* which is attached to this call or can be downloaded from the Speaker's Page on the AMA site.

FINAL REMINDERS:

Please watch for further communication from us as details are finalized. As a reminder, notices regarding the upcoming November Special Meeting will have **N21** in the subject line (which is short for the November 2021 meeting of the AMA House of Delegates) and will be sent from ama.delegates@groups.ama-assn.org. Please add this address to your contact list.

The tentative schedule is listed below.

Your Speakers share your disappointment that circumstances have once again prevented us from meeting in person, but rest assured that plans are well underway to facilitate the policymaking role of our House of Delegates in a fair and deliberative fashion.

TENTATIVE SCHEDULE *(Central Standard Time)***:**

Wednesday, October 13:
Resolution Submission On Time Deadline
Societies whose meetings adjourn after Oct. 8 will have 7 days from their adjournment to submit their priority business but no later than noon Nov. 7
NOTE: Reports and resolutions will be posted to the Online Member Forum as soon as feasible.

Sunday, November 7, noon:
Deadline for supplemental resolution submission from the sections and late resolutions from the Federation ("Sunday Tote")

Friday, November 12, 7 pm:
HOD Opening Session
Ceremonial Opening
Speeches
Rules & Credentials Report
Resolutions Committee Final Report considered by HOD

Saturday, November 13:
9:00 am - Morning Reference Committee Hearings (3)
1:00 pm - Afternoon Reference Committee Hearings (3)

Sunday November 14:
9:00 am - Reference Committee Hearings (2)
1:00 pm - Health Equity Forum

<u>Monday November 15</u>:
10:00 am - Second Session of HOD presentation of reference committee reports
12:00-1:00 pm - AMPAC Capitol Club Luncheon

<u>Tuesday, November 16</u>:
9 am until completed - Final Session HOD

NOVEMBER 2021 MEETING OF THE AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Official Call to the Officers and Members of the American Medical Association to participate in the November 2021 Special Meeting of the AMA House of Delegates on November 12-16, 2021. The House of Delegates will convene at 7 p.m. (CT) on November 12, on a virtual platform.

STATE ASSOCIATION REPRESENTATION IN THE HOUSE OF DELEGATES

Alabama 4
Alaska 1
Arizona 5
Arkansas 3
California 33
Colorado 5
Connecticut 4
Delaware 1
District of Columbia 3
Florida 16
Georgia 6
Guam 1
Hawaii 2
Idaho 1
Illinois 12
Indiana 5
Iowa 4
Kansas 3
Kentucky 5
Louisiana 6
Maine 2
Maryland 5
Massachusetts 13
Michigan 13
Minnesota 5
Mississippi 3
Missouri 6
Montana 1
Nebraska 2
Nevada 2
New Hampshire 1
New Jersey 8
New Mexico 2
New York 22
North Carolina 6
North Dakota 1
Ohio 13
Oklahoma 4
Oregon 3
Pennsylvania 13
Puerto Rico 2
Rhode Island 2
South Carolina 5
South Dakota 2
Tennessee 5
Texas 20
Utah 2
Vermont 1
Virgin Islands 1
Virginia 8
Washington 5
West Virginia 2
Wisconsin 5
Wyoming 1

SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES

AMDA-The Society for Post-Acute and Long-Term Care Medicine 2
American Academy of Child and Adolescent Psychiatry 2
American Academy of Dermatology 4
American Academy of Family Physicians 16
American Academy of Hospice and Palliative Medicine 2
American Academy of Neurology 4
American Academy of Ophthalmology 4
American Academy of Orthopaedic Surgeons 5
American Academy of Otolaryngology-Head and Neck Surgery 3
American Academy of Pediatrics 5
American Academy of Physical Medicine and Rehabilitation 2
American Academy of Sleep Medicine 2
American Association of Clinical Endocrinologists 2
American Association of Gynecologic Laparoscopists 3
American Association of Neurological Surgeons 2
American Association of Neuromuscular & Electrodiagnostic Medicine 2
American College of Cardiology 7
American College of Chest Physicians (CHEST) 3
American College of Emergency Physicians 8
American College of Gastroenterology 2
American College of Obstetricians and Gynecologists 14
American College of Occupational and Environmental Medicine 2
American College of Physicians 34
American College of Radiology 8
American College of Rheumatology 2
American College of Surgeons 7
American Gastroenterological Association 2
American Geriatrics Society 2
American Institute of Ultrasound in Medicine 2
American Psychiatric Association 8
American Roentgen Ray Society 3
American Society for Clinical Pathology 3
American Society for Dermatologic Surgery 2
American Society for Gastrointestinal Endoscopy 2
American Society for Radiation Oncology 2
American Society for Reproductive Medicine 2
American Society of Addiction Medicine 2
American Society of Anesthesiologists 7
American Society of Breast Surgeons 2
American Society of Cataract and Refractive Surgery 2
American Society of Clinical Oncology 3
American Society of Echocardiography 2
American Society of Hematology 2
American Society of Interventional Pain Physicians 2
American Society of Nuclear Cardiology 2
American Society of Plastic Surgeons 2
American Society of Retina Specialists 2
American Thoracic Society 3
American Urological Association 2
Association of Military Surgeons of the United States 2
College of American Pathologists 4
Congress of Neurological Surgeons 2
Heart Rhythm Society 2
Infectious Diseases Society of America 2
North American Spine Society 2
Radiological Society of North America 3
Renal Physicians Association 2
Society for Vascular Surgery 2
Society of American Gastrointestinal Endoscopic Surgeons 2
Society of Critical Care Medicine 2
Society of Hospital Medicine 3
Society of Interventional Radiology 2
Society of Laparoscopic and Robotic Surgeons 2
Society of Thoracic Surgeons 2
The Endocrine Society 2
United States and Canadian Academy of Pathology 2

Remaining eligible national medical specialty societies (58) are entitled to one delegate each.

The Academic Physicians Section, Integrated Physician Practice Section, International Medical Graduates Section, Medical Student Section, Minority Affairs Section, Organized Medical Staff Section, Private Practice Physicians Section, Resident and Fellow Section, Senior Physicians Section, Women Physicians Section, Young Physicians Section, Army, Navy, Air Force, Public Health Service, Department of Veterans Affairs, Professional Interest Medical Associations, AMWA, AOA and NMA are entitled to one delegate each.

State Medical Associations	306
National Medical Specialty Societies	304
Professional Interest Medical Associations	3
Other National Societies (AMWA, AOA, NMA)	3
Medical Student Regional Delegates	27
Resident and Fellow Delegate Representatives	32
Sections	11
Services	5
Total Delegates	**691**

Gerald E. Harmon, MD
President

Bruce A. Scott, MD
Speaker, House of Delegates

Scott Ferguson, MD
Secretary

2021-2022

OFFICIALS OF THE ASSOCIATION

BOARD OF TRUSTEES (OFFICERS)

President - Gerald E. Harmon.....Pawleys Island, South Carolina
President-Elect -Jack Resneck..... San Rafael, California
Immediate Past President - Susan R. Bailey.....Fort Worth, Texas
Secretary - Scott Ferguson.....West Memphis, Arkansas
Speaker, House of Delegates - Bruce A. Scott ..... Louisville, Kentucky
Vice Speaker, House of Delegates - Lisa Bohman Egbert .....Kettering, Ohio

David H. Aizuss (2024)..... Encino, California
Madelyn E. Butler (2025)..... Tampa, Florida
Willarda V. Edwards (2024).....Baltimore, Maryland
Jesse M. Ehrenfeld (2022)..... Milwaukee, Wisconsin
Sandra Adamson Fryhofer (2022), *Chair-Elect*..... Atlanta, Georgia
Drayton Charles Harvey (2022).....Los Angeles, California
Pratistha Koirala (2023).....Danbury, Connecticut
Russell W.H. Kridel (2022).....Houston, Texas
Ilse R. Levin (2024) ..... Silver Spring, Maryland
Thomas J. Madejski (2024) .....Medina, New York
Mario E. Motta (2022) .....Salem, Massachusetts
Bobby Mukkamala (2025), *Chair*.....Flint, Michigan
Harris Pastides (2024) ..... Columbia, South Carolina
Michael Suk (2023) .....Danville, Pennsylvania
Willie Underwood, III (2023).....Buffalo, New York

COUNCILS OF THE AMA

COUNCIL ON CONSTITUTION AND BYLAWS
Pino D. Colone, Howell, Michigan, Chair (2024); Kevin C. Reilly, Sr., Elizabethtown, Kentucky, Vice-Chair (2022); Jerry P. Abraham, Los Angeles, California (2025); Patricia L. Austin, Alamo, California (2022); Mark N. Bair, Highland, Utah (2023); Mary Ann Contogiannis, Greensboro, North Carolina (2025); Christopher P. Libby, Anaheim, California (Resident) (2024); Michael J. Rigby, Madison, Wisconsin (Student) (2022).
Ex Officio, without vote: Bruce A. Scott, Louisville, Kentucky; Lisa Bohman Egbert, Kettering, Ohio.
Secretary: Janice Robertson, Chicago, Illinois.

COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS
Alexander M. Rosenau, Allentown, Pennsylvania, Chair (2022); Peter A. Schwartz, Reading, Pennsylvania, Vice-Chair (2023); Rebecca W. Brendel, Boston, Massachusetts (2026); David A. Fleming, Columbia, Missouri (2024); Jeremy A. Lazarus, Greenwood Village, Colorado (2025); Kelsey Mumford, Austin, Texas (Student) (2023)Larry E. Reaves, Fort Worth, Texas (2027); Daniel P. Sulmasy, Washington, DC (2028); Danish M. Zaidi, Winston-Salem, NC (Resident) (2027).
Secretary: Elliott Crigger, Chicago, Illinois.

COUNCIL ON LEGISLATION
Mary S. Carpenter, Winner, South Dakota, Chair (2022); Heather Ann Smith, Newport, Rhode Island, Vice Chair (2022); Vijaya L. Appareddy, Chattanooga, Tennessee (2022); Molly Benoit, Miami, Florida (Student) 2022; Maryanne C. Bombaugh, Falmouth, Massachusetts (2022); Brooke M. Buckley, Bloomfield Hills, Michigan (AMPAC Liaison) (2022); Gary W. Floyd, Keller, Texas (2022); Merrilee Aynes Gober, Atlanta, Georgia (Alliance Rep) (2022); Ross F. Goldberg, Scottsdale, Arizona (2022); Marilyn J. Heine, Dresher, Pennsylvania (2022); Tripti C. Kataria, Chicago, Illinois (2022); Amar H. Kelkar, Gainesville, Florida (Resident) (2022); Ann Rosemarie Stroink, Bloomington, Illinois (2022); Marta J. Van Beek, Iowa City, Iowa (2022).
Secretary: George Cox, Washington, District of Columbia.

COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT
Clarence P. Chou, Milwaukee, Wisconsin, Chair (2024); Edmond B. Cabbabe, St. Louis, Missouri, Vice Chair (2025); John H. Armstrong, Ocala, Florida (2025); Rijul Asri, Princeton, New Jersey (Student) (2022); Michelle A. Berger, Austin, Texas (2022); Jan M. Kief, Merritt Island, Florida (2023); G. Sealy Massingill, Fort Worth, Texas (2023); Benjamin D. Meyer, Seattle, Washington (Resident) (2022); Shannon Pryor, Chevy Chase, Maryland (2024); Gary D. Thal, Chicago, Illinois (2025).
Secretary: Susan Close, Chicago, Illinois.

COUNCIL ON MEDICAL EDUCATION
Niranjan V. Rao, Franklin Park, New Jersey, Chair (2022); John P. Williams, Gibsonia, Pennsylvania, Chair-Elect (2023); Sherri S. Baker, Edmond, Oklahoma (2025); Kelly J. Caverzagie, Omaha, Nebraska (2023); Sharon P. Douglas, Madison, Mississippi (2023); Louito C. Edje, Cincinnati, Ohio (2025); Robert B. Goldberg, Morristown, New Jersey (2025); Cynthia A. Jumper, Lubbock, Texas (2024); Rohan Khazanchi, Omaha, Nebraska (Student) (2022); Shannon M. Kilgore, Palo Alto, California (2023); David J. Savage, La Jolla, California (Resident) (2023); Krystal L. Tomei, Lyndhurst, Ohio (2025).
Secretary: Tanya Lopez, Chicago, Illinois.

COUNCIL ON MEDICAL SERVICE
Asa C. Lockhart, Tyler, Texas, Chair (2022); Lynn L. C. Jeffers, Camarillo, California, Chair-Elect (2024); Hussein A. Antar, Foxboro, Massachusetts (Student) (2022); Patrice Burgess, Boise, Idaho (2023); Alain A. Chaoui, Peabody, Massachusetts (2025); Steven L. Chen, San Diego, California (2024); Betty S. Chu, West Bloomfield, Michigan (2022); Alice Coombs, Richmond, Virginia (2023); Erick A. Eiting, New York, New York (2024); Stephen K. Epstein, Needham, Massachusetts (2022); Sheila Rege, Kennewick, Washington (2022); Megan L. Srinivas, Fort Dodge, Iowa (Resident) (2023).
Secretary: Val Carpenter, Chicago, Illinois.

COUNCIL ON SCIENCE AND PUBLIC HEALTH
Alexander Ding, Belmont, California, Chair (2024); Noel N. Deep, Antigo, Wisconsin, Chair-Elect (2023); Devin V. Bageac, Farmington, Connecticut (Student) (2022); John T. Carlo, Dallas, Texas (2025); Karen Dionesotes, Baltimore, Maryland (Resident) (2024); Kira A. Geraci-Ciardullo, Harrison, New York (2022); Mary E. LaPlante, Broadview Heights, Ohio (2025); Michael M. Miller, Madison, Wisconsin (2022); Tamaan K. Osbourne-Roberts, Denver, Colorado (2023); Padmini D. Ranasinghe, Baltimore, Maryland (2022); Corliss A. Varnum, Oswego, New York (2023); David J. Welsh, Batesville, Indiana (2024).
Secretary: Andrea Garcia, Chicago, Illinois.

AMERICAN MEDICAL ASSOCIATION POLITICAL ACTION COMMITTEE
Stephen A. Imbeau, Florence, South Carolina, Chair; Brooke M. Buckley, Bloomfield Hills, Michigan, Secretary; Elie C. Azrak, St. Louis, Missouri; Paul J. Carniol, Summit, New Jersey; Ricardo Correa, Phoenix, Arizona; Hart L. Edmonson, Seattle, Washington (Student); Benjamin Z. Galper, Potomac, Maryland; James L. Milam, Libertyville, Illinois; L. Elizabeth Peterson, Spokane, Washington; Stephen J. Rockower, Rockville, Maryland; Janice Tildon-Burton, Wilmington, Delaware; Anna L. Yap, Los Angeles, California (Resident).
Executive Director and Treasurer: Kevin Walker, Washington, District of Columbia.

EX OFFICIO MEMBERS OF THE HOUSE OF DELEGATES

The Former Presidents and Former Trustees of the Association, the Chairs of the Councils of the AMA and the current General Officers, with the exception of the Speaker and Vice Speaker of the House of Delegates, are ex officio, nonvoting members of the House of Delegates.

FORMER PRESIDENTS

David O. Barbe	2017-2018
Lonnie R. Bristow	1995-1996
Peter W. Carmel	2011-2012
Yank D. Coble, Jr.	2002-2003
Richard F. Corlin	2001-2002
Nancy W. Dickey	1998-1999
Andrew W. Gurman	2016-2017
Patrice A. Harris	2019-2020
J. Edward Hill	2005-2006
Ardis D. Hoven	2013-2014
Daniel H. Johnson, Jr.	1996-1997
Jeremy A. Lazarus	2012-2013
Robert E. McAfee	1994-1995
Barbara L. McAneny	2018-2019
Alan R. Nelson	1989-1990
John C. Nelson	2004-2005
Nancy H. Nielsen	2008-2009
Donald J. Palmisano	2003-2004
William G. Plested, III	2006-2007
Thomas R. Reardon	1999-2000
J. James Rohack	2009-2010
Randolph D. Smoak, Jr.	2000-2001
Steven J. Stack	2015-2016
Robert M. Wah	2014-2015
Cecil B. Wilson	2010-2011
Percy Wootton	1997-1998

FORMER TRUSTEES

Herman I. Abromowitz	1997-2005
Susan Hershberg Adelman	1998-2002
Kendall S. Allred	2008-2009
Raj S. Ambay	2009-2011
Joseph P. Annis	2006-2014
Grayson W. Armstrong	2019-2021
John H. Armstrong	2002-2006
Maya A. Babu	2013-2017
Timothy E. Baldwin	1987-1989
David O. Barbe	2009-2016
Regina M. Benjamin	1995-1998
Scott L. Bernstein	1991-1992
Stefano M. Bertozzi	1986-1988
David J. Brailer	1985-1986
Lonnie R. Bristow	1985-1994
Peter Carmel	2002-2010
Alice A. Chenault	1984-1985
Yank D. Coble	1994-2001
David S. Cockrum	1993-1994
MaryAnn Contogiannis	1989-1993
Malini Daniel	2012-2013
Christopher M. DeRienzo	2006-2008
Nancy W. Dickey	1989-1997
Alexander Ding	2011-2013
William A. Dolan	2007-2011
Timothy T. Flaherty	1994-2003
Melissa J. Garretson	1992-1993
Michael S. Goldrich	1993-1997
Julie K. Goonewardene	2012-2016
Andrew W. Gurman	2007-2015
Patrice A. Harris	2011-2018
Alan C. Hartford	1989-1990
William A. Hazel, Jr	2004-2009
Cyril M. Hetsko	2003-2011
Joseph M. Heyman	2002-2010
J. Edward Hill	1996-2004
Ardis D. Hoven	2005-2012
William E. Jacott	1989-1998
Hillary D. Johnson	2001-2002
Matthew D. Kagan	1999-2000
Christopher K. Kay	2008-2012
William E. Kobler	2012-2020
Edward L. Langston	2003-2011
Matthew C. Lawyer	2004-2005
Jeremy A. Lazarus	2005-2011
W. J. Lewis	1979-1984
Audrey J. Ludwig	1990-1991
Justin B. Mahida	2009-2010
Omar Z. Maniya	2016-2017
Robert E. McAfee	1984-1993
Barbara L. McAneny	2010-2017
William A. McDade	2016-2020
Mary Anne McCaffree	2008-2016
Joe T. McDonald	2005-2006
Samuel J. Mackenzie	2014-2015
Robert R. McMillan	2002-2008
Sandeep “Sunny” Mistry	2000-2001
Elizabeth Blake Murphy	2020-2021
Alan R. Nelson	1980-1988
John C. Nelson	1994-2003
Nancy H. Nielsen	2005-2007
Albert J. Osbahr, III	2011-2019
Donald J. Palmisano	1996-2002
Rebecca J. Patchin	1988-1989
Rebecca J. Patchin	2003-2011
Stephen R. Permut	2010-2018
Pamela Petersen-Crair	1996-1998
Dina Marie Pitta	2015-2016
William G. Plested, III	1998-2005
Stephen Pool	1995-1996
Liana Puscas	1999-2001
Thomas R. Reardon	1990-1998
Kevin C. Reilly	2003-2005
Ryan J. Ribeira	2013-2014
J. James Rohack	2001-2008
David A. Rosman	2002-2004
Samantha L. Rosman	2005-2009
Raymond Scalettar	1985-1994
Bruce A. Scott	1998-2002
Carl A. Sirio	2010-2018
Sarah Mae Smith	2019-2020
Randolph D. Smoak, Jr.	1992-1999
Steven J. Stack	2006-2014
Michael Suk	1994-1995
Andrew M. Thomas	1997-1999
Jeffrey A. Towson	1998-1999
Georgia A. Tuttle	2011-2019
Jordan M. VanLare	2011-2012
Robert M. Wah	2005-2013
Peter Y. Watson	2001-2003
Monica C. Wehby	2011-2013
Kevin W. Williams	2016-2020
Meredith C. Williams	2010-2011
Cecil B. Wilson	2002-2009
Percy Wootton	1991-1996

SPECIALTY AND SERVICE SOCIETY REPRESENTATIVES

(The following are not members of the House of Delegates but are representatives of the following societies which are represented in the SSS.)

Academy of Consultation Liaison Psychiatry ..... Lee Tynes, MD
American Academy of Addiction Psychiatry ..... Alena Balasanova, MD
American Academy of Emergency Medicine ..... Joseph Wood, MD, JD
American Association of Endocrine Surgeons ..... Dina Elaraj, MD
American Association of Hip and Knee Surgeons ..... Beau Kildow, MD
American College of Correctional Physicians ..... Charles Lee, MD
American College of Lifestyle Medicine ..... Ron Stout, MD
American Contact Dermatitis Society ..... Bruce Brod, MD
American Epilepsy Society ..... David M. Labiner, MD
American Society for Laser Medicine and Surgery ..... George Hruza, MD
American Society of Regional Anesthesia and Pain Medicine ..... David Provenzano, MD
American Venous Forum ..... Dan Monahan, MD
Americas Hernia Society ..... John Fischer, MD
Association of Academic Physiatrists ..... Prakash Jayabalan, MD, PhD
Association of Professors of Dermatology ..... Christopher R. Shea, MD
Korean American Medical Association ..... John Yun, MD
Outpatient Endovascular and Interventional Society ..... Eric Dippel, MD
Society for Cardiovascular Magnetic Resonance ..... Edward T. Martin, MD
Society of Gynecologic Oncologists ..... S. Diane Yamada, MD
Society of Pediatric Dermatology ..... Dawn Davis, MD

MEMBERS OF THE HOUSE OF DELEGATES SPECIAL MEETING - NOVEMBER 2021
The following is a list of delegates and alternate delegates to the House of Delegates as reported to the Executive Vice President

Medical Association of the State of Alabama

Delegate(s)

Jorge Alsip, Daphne AL

Steven P. Furr, Jackson AL

B Jerry Harrison, Haleyville AL

George C. Smith, Lineville AL

Alternate Delegate(s)

Harry Kuberg, Russelville AL

Alexis Mason, Tuscaloosa AL

John Meigs Jr, Brent AL

William Schneider, Huntsville AL

Regional Medical Student Alternate Delegate(s)

Megan Ward, Murfreesboro TN

Alaska State Medical Association

Delegate(s)

Alex Malter, Juneau AK

Alternate Delegate(s)

Rhene Merkouris, Anchorage AK

Arizona Medical Association

Delegate(s)

Daniel P. Aspery, Phoenix AZ

Veronica K. Dowling, Lakeside AZ

Gary R. Figge, Tucson AZ

Michael Hamant, Tucson AZ

M Zuhdi Jasser, Phoenix AZ

Alternate Delegate(s)

Timothy Fagan, Tucson AZ

Ross F. Goldberg, Scottsdale AZ

Jennifer Hartmark-Hill, Phoenix AZ

Jacquelyn Hoffman, Tucson AZ

Arizona Medical Association

Alternate Delegate(s)

Marc Leib, Phoenix AZ

Regional Medical Student Delegate(s)

Meera Kapadia, Chandler AZ

Regional Medical Student Alternate Delegate(s)

Avi Levy, Paradise Vly AZ

Arkansas Medical Society

Delegate(s)

Omar Atiq, Little Rock AR

Eugene Shelby, Little Rock AR

Alan Wilson, Monticello AR

Alternate Delegate(s)

Amy Cahill, White Hall AR

Stephen Magie, Conway AR

California Medical Association

Delegate(s)

Jerry P Abraham, Los Angeles CA

Barbara J. Arnold, Sacramento CA

Patricia L. Austin, Alamo CA

Dirk Stephen Baumann, Burlingame CA

Jeffrey Brackett, Ventura CA

Peter N. Bretan, Novato CA

Jacob Burns, Sacramento CA

J Brennan Cassidy, Newport Beach CA

Luther Cobb, Eureka CA

Maisha Draves, Fairfield CA

Kyle P. Edmonds, San Diego CA

Rachel Ekaireb, Sacramento CA

George Fouras, Los Angeles CA

California Medical Association

Delegate(s)

Dev A. GnanaDev, Upland CA

James T. Hay, Del Mar CA

Robert Hertzka, Rancho Santa Fe CA

Samuel Huang, Los Angeles CA

Vito Imbasciani, Los Angeles CA

Melissa Jones, Sacramento CA

Kermit Jones, Vacaville CA

Kim Lau, Davis CA

Edward Lee, Sacramento CA

Arthur N. Lurvey, Los Angeles CA

Michael Luszczak, Carmichael CA

Ramin Manshadi, Stockton CA

Robert J. Margolin, San Francisco CA

Theodore Mazer, Poway CA

Kelly McCue, Davis CA

Stephen Parodi, Oakland CA

Albert Ray, San Diego CA

Tatiana W. Spirtos, Redwood City CA

Holly Yang, San Diego CA

Paul Yost, Seal Beach CA

Alternate Delegate(s)

Raag Agrawal, Los Angeles CA

Alan Anzai, Sacramento CA

David Bazzo, San Diego CA

Lawrence Cheung, San Francisco CA

Jack Chou, Baldwin Park CA

James Cotter, Napa CA

Alexander Ding, Louisville KY

Suparna Dutta, Castro Valley CA

David Friscia, San Diego CA

California Medical Association

Alternate Delegate(s)

Anjalee Galion, Santa Ana CA

Jennifer Hone, Santa Barbara CA

Scott Richard Karlan, West Hollywood CA

Nikan Khatibi, Laguna Niguel CA

Jeff Klingman, Orinda CA

Mark H. Kogan, San Pablo CA

Man Kit Leung, San Francisco CA

Ashley McClure, Oakland CA

Sandra Mendez, Sacramento CA

Chang Na, Bakersfield CA

Richard Pan, Sacramento CA

Bing Pao, Escondido CA

Mihir Parikh, La Jolla CA

Damodara Rajasekhar, Apple Valley CA

Ryan J. Ribeira, Mountain View CA

Sion Roy, Torrance CA

Ashley Rubin, Sacramento CA

Rodolfo Saenz, Riverside CA

Lorin Scher, Sacramento CA

Seema Sidhu, Fremont CA

Sarah M. Smith, Anaheim CA

James J. Strebig, Irvine CA

Raymond Tsai, Lost Hills CA

Barbara Weissman, Pacifica CA

Resident and Fellow Sectional Delegate(s)

Trishna Narula, Los Altos CA

Daniel Udrea, Loma Linda CA

Sophia Yang, San Jose CA

Resident and Fellow Sectional Alternate Delegate(s)

Hunter Pattison, Sacramento CA

Current as of: 10/21/2021

California Medical Association

Regional Medical Student Delegate(s)
Russyan Mark Mabeza, Los Angeles CA

Regional Medical Student Alternate Delegate(s)
Vinita Shivakumar, Stanford CA

Colorado Medical Society

Delegate(s)
David Downs, Denver CO

Jan Kief, Merritt Island FL

A. "Lee" Morgan, Denver CO

Tamaan Osbourne-Roberts, Denver CO

Lynn Parry, Littleton CO

Alternate Delegate(s)
Carolynn Francavilla, Lakewood CO

Rachelle M. Klammer, Denver CO

Katie Lozano, Centennial CO

Brigitta J. Robinson, Centennial CO

Michael Volz, Englewood CO

Regional Medical Student Delegate(s)
Alysa Edwards, Colorado Springs CO

Connecticut State Medical Society

Delegate(s)
Michael L. Carius, Stratford CT

Katherine L. Harvey, Canton CT

Bollepalli Subbarao, Middletown CT

Theodore Zanker, Cheshire CT

Alternate Delegate(s)
Kathleen A. LaVorgna, Norwalk CT

Gwendolyn Moraski, West Simsbury CT

Stacy Taylor, New Hartford CT

Steven C. Thornquist, Bethany CT

Connecticut State Medical Society

Regional Medical Student Delegate(s)
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November 2021 Special Meeting

Note on Order of Business
(All Times are Central Standard Time)

FIRST SESSION, Friday, November 12, 7:00 pm

SECOND SESSION, Monday, November 15, 10:00 am

THIRD SESSION, Tuesday, November 16, 9:00 am until completed

N-21 Resolutions (by sponsor)

American Academy of Pediatrics

703 Clear Statement Regarding the Use of CPT E/M Outpatient Visit Codes

American Association of Public Health Physicians

607 AMA Urges Health and Life Insurers to Divest From Investments in Fossil Fuels

American College of Cardiology

202 RESOLUTION WITHDRAWN

American College of Rheumatology

214 Stakeholder Engagement in Medicare Administrative Contractor Policy
215 Pharmacy Benefit Manager Reform as a State Legislative Priority

American Thoracic Society

112 Expanding Coverage for and Access to Pulmonary Rehabilitation

Association for Clinical Oncology

212 Sequestration

California

113 Supporting Medicare Drug Price Negotiation
609 Fulfilling Medicine's Social Contract with Humanity in the Face of the Climate Health Emergency

Florida

224 Improve Physician Payments
225 End Budget Neutrality
610 Creation of Employed Physician Section

Illinois

234* Permitting the Dispensing of Stock Medications for Post Discharge Patient Use and the Safe Use of Multi-dose Medications for Multiple Patients
317* Creating a More Accurate Accounting of Medical Education Financial Costs

Iowa

020* Recognizing and Remedying "Structural Urbanism" Bias as a Factor in Rural Health Disparities

Louisiana

021* Free Speech and Civil Discourse in the American Medical Association
022* Prohibition of Racist Characterization Based on Personal Attributes
617* Together We are Stronger Marketing Campaign

Medical Student Section

001 Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers
002 Disaggregation of Race Data for Individuals of Middle Eastern and North African (MENA) Descent
003 Supporting the Study of Reparations as a Means to Reduce Racial Inequalities
004 Guidelines on Chaperones for Sensitive Exams
005 Combating Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism
006 Evaluating Scientific Journal Articles for Racial and Ethnic Bias
007 Exclusion of Race and Ethnicity in the First Sentence of Case Reports
008 Amendment to Truth and Transparency in Pregnancy Counseling Centers, H-420.954
009 Banning the Practice of Virginity Testing
010 Improving the Health and Safety of Sex Workers
011 Expanding the Definition of Iatrogenic Infertility to Include Gender Affirming Interventions
012 Increased Recognition and Treatment of Eating Disorders in Minority Populations
013 Equal Access to Adoption for the LGBTQ Community
014 Reducing Disparities in HIV Incidence through Pre-Exposure Prophylaxis for HIV
015 Using X-Ray and Dental Records for Assessing Immigrant Age
016 Student-Centered Approaches for Reforming School Disciplinary Policies
106 Reimbursement of School-Based Health Centers
107 Expanding Medicaid Transportation to Include Healthy Grocery Destinations
108 Medicaid and CHIP Coverage of Glucose Monitoring Devices for Patients with Diabetes
109 Amending D-440.985, Health Care Payment for Undocumented Persons, to Study Methods to Increase Health Care Access for Undocumented Immigrants
110 Caps on Insulin Co-Payments for Patients with Insurance
111 Addressing Healthcare Accessibility for Current and Aged-Out Youth in the Foster Care System
203 Poverty-Level Wages and Health
204 Supporting Collection of Data on Medical Repatriation
205 Reducing the Prevalence of Sexual Assault by Testing Sexual Assault Evidence Kits
206 Updating Policy on Immigration Laws, Rules, Legislation, and Health Disparities to Better Address National Crises
207 Authority to Grant Vaccine Exemptions
208 Protections for Incarcerated Mothers in the Perinatal Period
209 Increasing Access to Hygiene and Menstrual Products
210 Advocating for the Amendment of Chronic Nuisance Ordinances
211 Support for Mental Health Courts
301 Equitable Reporting of USMLE Step 1 Scores
302 University Land Grant Status in Medical School Admissions
303 Decreasing Bias in Evaluations of Medical Student Performance
304 Reducing Complexity in the Public Service Loan Forgiveness Program
305 Increase Awareness Among Residency, Fellowship, and Academic Programs on the United States-Puerto Rico Relationship Status
306 Support for Standardized Interpreter Training
307 Support for Institutional Policies for Personal Days for Undergraduate Medical Students
308 Modifying Eligibility Criteria for Association of American Medical Colleges' Financial Assistance Program
309 Protecting Medical Student Access to Abortion Education and Training
402 Expansion on Comprehensive Sexual Health Education
403 Providing Reduced Parking Fees for Patients
404 Increase Employment Services Funding for People with Disabilities
405 Formal Transitional Care Program for Children and Youth with Special Health Care Needs
505 Representation of Dermatological Pathologies in Varying Skin Tones
506 Enhancing Harm Reduction for People Who Use Drugs
602 Mitigating Environmental Contributors to Disease and Sustainability of AMA National Meetings
603 Abolishment of the Resolution Committee
701 Coverage of Pregnancy-Associated Healthcare for 12 Months Postpartum for Uninsured Patients who are Ineligible for Medicaid

Michigan

226 Addressing Adolescent Telehealth Confidentiality Concerns
227 Medication for Opioid Use Disorder in Physician Health Programs
228 Resentencing for Individuals Convicted of Marijuana-Based Offenses
616* Financial Impact and Fiscal Transparency of the American Medical Association Current Procedural Terminology System

Mississippi

613* Due Process at our AMA

New England

104 Improving Access to Vaccinations for Patients
504 Air Pollution and COVID: A Call to Tighten Regulatory Standards

New Jersey

614* Insurance Industry Behaviors

New Mexico

114 Medicare and Private Health Insurance for Hearing Aids

New York

119* Bundling Physician Fees with Hospital Fees
120* COBRA for College Students
121* Medicaid Tax Benefits
229* CMS Administrative Requirements
230* Medicare Advantage Plan Mandates
231* Prohibit Ghost Guns
232* Ban the Gay/Trans (LGBTQ+) Panic Defense
233* Insurers and Vertical Integration
316* Medical Education Debt Cancellation in the Face of a Physician Shortage During the COVID-19 Pandemic
408* Ensuring Affordability and Equity in COVID-19 Vaccine Boosters
611* September 11th as a National Holiday
612* UN International Radionuclide Therapy Day Recognition
707* Fifteen Month Lab Standing Orders
708* Insurance Coverage for Scalp Cooling (Cold Cap) Therapy
709* Prior Authorization - CPT Codes for Fair Compensation
710* Physician Burnout is an OSHA Issue

North Carolina

318* The Medical Student Match Mismatch

Ohio

115 Bundled Payments and Medically Necessary Care
213 Eliminating Unfunded or Unproven Mandates and Regulations
702 System Wide Prior and Post-Authorization Delays and Effects on Patient Care Access

Oklahoma

615* Employed Physicians

Resident and Fellow Section

018 Support for Safe and Equitable Access to Voting

019 Disaggregation of Demographic Data for Individuals of Middle Eastern and North African (MENA) Descent

116 Recognizing the Need to Move Beyond Employer-Sponsored Health Insurance

117 Implant-Associated Anaplastic Large Cell Lymphoma

216 Preserving Appropriate Physician Supervision of Midlevel Providers and Ensuring Patient Awareness of the Qualifications of Physicians vs. Midlevel Providers

217 Studying Physician Supervision of Allied Health Professionals Outside of their Fields of Graduate Medical Education

218 Physician Opposition to the Coordinated Effort by Corporations and Midlevel Providers to Undermine the Physician-Patient Relationship and Safe Quality Care

219 The Impact of Midlevel Providers on Medical Education

220 Gonad Shields: Regulatory and Legislation Advocacy to Oppose Routine Use

310 Resident and Fellow Access to Fertility Preservation

311 Improving Access to Physician Health Programs for Physician Trainees

312 Accountable Organizations to Resident and Fellow Trainees

313 Establishing Minimum Standards for Parental Leave During Graduate Medical Education Training

314 Updating Current Wellness Policies and Improving Implementation

315 Reducing Overall Fees and Making Costs for Licensing, Exam Fees, Application Fees, etc. Equitable for IMGs

406 Addressing Gaps in Patient and Provider Knowledge to Increase HPV Vaccine Uptake and Prevent HPV-Associated Oropharyngeal Cancer

407 Traumatic Brain Injury and Access to Firearms

608 Fulfilling Medicine's Social Contract with Humanity in the Face of the Climate Health Crisis

704 Expanding the AMA's Study on the Economic Impact of COVID-19

Senior Physicians Section

102 Prevention of Hearing Loss-Associated-Cognitive-Impairment Through Earlier Recognition and Remediation

103 Oral Healthcare Is Healthcare

401 Endorsement of Public Health Measures to End the COVID-19 Pandemic and Promotion of Research and Insurance Coverage to Define and Delimit the Emerging Issue of Post-Acute Covid Syndrome

601 "Virtual Water Cooler" for our AMA

Society of Critical Care Medicine

122* Increase Funding, Research and Education for Post-Intensive Care Syndrome

South Carolina

201 Protection of Peer-Review Process

Texas

118 Expanding Site-of-Service Neutrality

221 Promoting Sustainability in Medicare Physician Payments

222 Opposing Federal Preemption of State Licensing Laws and Scope-of-Practice Expansion Under the Ninth Amendment to Declaration Under the PREP Act

223 Paying Physicians for Services According to the Physician Fee Schedule

604 The Critical Role of Physicians in the COVID-19 Pandemic

605 Formalization of the Resolution Committee as a Standing Committee of the American Medical Association House of Delegates

606 Increasing the Effectiveness of Online Reference Committee Testimony

705 Advocating for Program Stability in the Merit-Based Incentive Payment System

706 Support for State Medical Record Retention Laws

Virginia

101 Standardized Coding for Telehealth Services

Washington

501 Ensuring Continued Access to Equitable Take-Home Methadone Treatment

502 Advocating for Heat Exposure Protections for Outdoor Workers

Women Physicians Section

017 Gender Equity and Female Physician Work Patterns During the Epidemic

105 Fertility Preservation Insurance Coverage for Women in Medicine

Young Physicians Section

503 Marketing Guardrails for the "Over-Medicalization" of Cannabis Use

** Contained in the Handbook Addendum*

Preliminary Reference Committee Schedule

NOTE: This schedule is preliminary and subject to change..

Saturday, November 13, 9 a.m. to 12:30 p.m.:

- Reference Committee A
- Reference Committee D
- Reference Committee F

Saturday, November 13, 1 p.m. to 4:30 p.m.:

- Reference Committee on Amendments to Constitution & Bylaws
- Reference Committee B
- Reference Committee C

Sunday, November 14, 9 a.m. to 12:30 p.m.:

- Reference Committee E
- Reference Committee G

REFERENCE COMMITTEES OF THE HOUSE OF DELEGATES
(November 2021 Special Meeting)

Reference Committee on Amendments to Constitution and Bylaws

Heidi Dunniway, MD, Indiana, Chair
Abhishek Dharan, Texas, Regional Medical Student
George A. Fouras, MD, California
Tate Hinkle, MD, American Academy of Family Physicians
Theodore Jones, MD, Michigan
Candace E. Keller, MD, American Society of Anesthesiologists
Robert Panton, MD, Illinois

Reference Committee A (Medical Service)

Peter C. Amadio, MD, American Association for Hand Surgery, Chair
Anjalee W. Galion, MD, California
Barbara Hummel, MD, Wisconsin
Rajadhar Reddy, Texas, Regional Medical Student
Ezequiel Silva, III, MD, Texas
Hugh Taylor, MD, American Academy of Family Physicians
Shannon Trotter, DO, Ohio

Reference Committee B (Legislation)

Michael Luszczak, DO, California, Chair
Michael A. DellaVecchia, MD, Pennsylvania
William Freeman, MD, Louisiana
Ryan Hall, MD, Florida
Nicole A. Henry-Dindial, MD, New Jersey
Bryan G. Johnson, MD, Texas
Janice Tildon-Burton, MD, Delaware

Reference Committee C (Medical Education)

Kimberly Templeton, MD, American Academy of Orthopaedic Surgeons, Chair
Daniel Dent, MD, American College of Surgeons
Betty M. Drees, MD, Missouri
Alysa Edwards, Colorado, Regional Medical Student
Douglas W. Martin, MD, Iowa
Debra Perina, MD, American College of Emergency Physicians
Kenath Shamir, MD, Massachusetts

Reference Committee D (Public Health)

Janet West, MD, American Academy of Family Physicians, Chair
Jack Gatti, Maryland, Regional Medical Student
Woody Jenkins, MD, Oklahoma
Sarah Marsicek, MD, American Academy of Pediatrics
Eddie Patton, Jr., MD, Texas
Donald Posner, MD, Louisiana
Donald J. Swikert, MD, Kentucky

Reference Committee E (Science and Technology)

E. Christopher Bush, MD, Michigan, Chair
Jessica Adkins, MD, Kentucky, Sectional Resident
Ricardo Correa, MD, American College of Physicians
Oluwasegun Paul Emenogu, Ohio, Regional Medical Student
Jeff Klingman, MD, California
David Teuscher, MD, American Academy of Orthopaedic Surgeons
Yasser Zeid, MD, Texas

Reference Committee F (AMA Finance; AMA Governance)

David J. Bensema, MD, Kentucky, Chair
Veronica K. Dowling, MD, Arizona
Cheryl Gibson Fountain, MD, American College of Obstetricians and Gynecologists
Stuart J. Glassman, MD, American Academy of Physical Medicine and Rehabilitation
Rebecca L. Johnson, MD, Florida
Shilpen A. Patel, MD, American Society for Radiation Oncology
William Reha, MD, Virginia

Reference Committee G (Medical Practice)

Alan Klitzke, MD, American College of Nuclear Medicine, Chair
Michael Hanak, MD, American Academy of Family Physicians
Niva Lubin-Johnson, MD, Illinois
Justin Magrath, Louisiana
Joshua Mammen, MD, International College of Surgeons - US Section
Ashok Patel,MD, Minnesota
Stephen J. Rockower, MD, Maryland

Committee on Rules and Credentials

Tripti C. Kataria, MD, American Society of Anesthesiologists, Chair
Patricia L. Austin, MD, California
Ariel Carpenter, MD, Kentucky, Sectional Resident
Dale M. Mandel, MD, Pennsylvania
Glen McClain, Ohio
Laurel Ries, MD, Minnesota
Jayesh B. Shah, MD, Texas

SUMMARY OF FISCAL NOTES (NOVEMBER 2021 SPECIAL MEETING)

BOT Report(s)

01 Racial Essentialism in Medical Education: Informational Report
02 Policing Reform: Modest
03 Redefining the AMA's Position on ACA and Healthcare Reform: Informational Report
04 2021 AMA Advocacy Efforts: Informational Report
05 Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment: Modest
06 Mitigating the Effects of Racism in Health Care: "Best Practices": Informational Report
07 Improving Clinical Algorithms: Moving Beyond Race and Ethnicity: Informational Report
08 Improved Access and Coverage to Non-opioid Modalities to Address Pain: Minimal
09 Medical Marijuana License Safety: Minimal
10 Physician Access to Their Medical and Billing Records: Minimal
11 National Guidelines for Guardianship: Minimal
12 Direct-to-Consumer Genetic Tests: Minimal
13 Study of Forced Organ Harvesting by China: Minimal
14 Net Neutrality and Public Health: Minimal
15 Opposing Attorney Presence at and/or Recording of Independent Medical Examinations: Minimal
16 Research Handling of De-Identified Patient Information: Minimal
17 Distracted Driver Education and Advocacy: Minimal
18 Financial Protections for Doctors in Training: Minimal
19 Advocacy for Physicians with Disabilities: Estimated cost of $30,000 to convene an advidory group and develop resources.

CC&B Report(s)

01 Further Action on Bylaw 7.5.2: Minimal
02 Rescission of Bylaws Related to Run-off Elections: Minimal
03 AMA Women Physicians Section: Clarification of Bylaw Language: Minimal

CEJA Opinion(s)

01 Amendment to Opinion 9.3.2, "Physician Responsibilities to Impaired Colleagues": Informational Report

CEJA Report(s)

01 Short-Term Medical Service Trips: Mimimal
02 Amendment to Opinions 1.2.11, "Ethical Innovation in Medical Practice"; 11.1.2, Physician Stewardship of Health Care Resources"; 11.2.1, "Professionalism in Health Care Systems"; and 1.1.6, "Quality": Minimal

CLRPD Report(s)

01 Minority Affairs Section Five-Year Review: Minimal
02 Integrated Physician Practice Section - Five-Year Review: Minimal

CME Report(s)

01 Guiding Principles and Appropriate Criteria for Assessing the Competency of Late Career Physicians: Minimal
02 A Study to Evaluate Barriers to Medical Education for Trainees with Disabilities: Modest
03 Rural Health Physician Workforce Disparities: Minimal

SUMMARY OF FISCAL NOTES (NOVEMBER 2021 SPECIAL MEETING)

CME Report(s)

04 Medical Student Debt and Career Choice: Minimal

05 Investigation of Existing Application Barriers for Osteopathic Medical Students Applying for Away Rotation: Minimal

CMS Report(s)

01 End-of-Life Care: Minimal

02 Access to Health Plan Information Regarding Lower-Cost Prescription Options: Modest

03 Covering the Remaining Uninsured: Minimal

04 Financing of Home and Community-Based Services: Minimal

05 Integrating Care for Individuals Dually Eligible for Medicare and Medicaid: Minimal

CSAPH Report(s)

01 Drug Shortages: 2021 Update: Informational Report

02 Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems: $650,000

03 Physician Involvement in State Regulations of Motor Vehicle Operation and/or Firearm Use by Individuals with Cognitive Deficits Due to Traumatic Brain Surgery: Minimal

04 Pharmacovigilance: Minimal

HOD Comm on Compensation of the Officers

01 Report of the House of Delegates Committee on the Compensation of the Officers: Estimated cost for July 1, 2021 to June 30, is a max of $37,500 if all Presidents and Officers use the allowance.

Joint Report(s)

01 CMS/CSAPH Joint Report - Reducing Inequities and Improving Access to Insurance for Maternal Health Care: Minimal

Report of the Speakers

01 Report of the Election Task Force: Minimal

02 Establishing an Election Committee: Minimal

Resolution(s)

001 Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers: Minimal

002 Disaggregation of Race Data for Individuals of Middle Eastern and North African (MENA) Descent: Moderate

003 Supporting the Study of Reparations as a Means to Reduce Racial Inequalities: Estimated cost to implement this resolution is $110,000. Estimate includes current and new staff costs.

004 Guidelines on Chaperones for Sensitive Exams: Minimal

005 Combating Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism: Minimal

006 Evaluating Scientific Journal Articles for Racial and Ethnic Bias: Minimal

007 Exclusion of Race and Ethnicity in the First Sentence of Case Reports: Modest

008 Amendment to Truth and Transparency in Pregnancy Counseling Centers, H-420.954: Minimal

009 Banning the Practice of Virginity Testing: Minimal

010 Improving the Health and Safety of Sex Workers: Modest

011 Expanding the Definition of Iatrogenic Infertility to Include Gender Affirming Interventions: Minimal

012 Increased Recognition and Treatment of Eating Disorders in Minority Populations: Minimal

013 Equal Access to Adoption for the LGBTQ Community: Minimal

SUMMARY OF FISCAL NOTES (NOVEMBER 2021 SPECIAL MEETING)

Resolution(s)

014 Reducing Disparities in HIV Incidence through Pre-Exposure Prophylaxis for HIV: Minimal
015 Using X-Ray and Dental Records for Assessing Immigrant Age: Minimal
016 Student-Centered Approaches for Reforming School Disciplinary Policies: Minimal
017 Gender Equity and Female Physician Work Patterns During the Epidemic: Minimal
018 Support for Safe and Equitable Access to Voting: Minimal
019 Disaggregation of Demographic Data for Individuals of Middle Eastern and North African (MENA) Descent: Modest
020* Recognizing and Remedying "Structural Urbanism" Bias as a Factor in Rural Health Disparities: Modest
021* Free Speech and Civil Discourse in the American Medical Association: Minimal
022* Prohibition of Racist Characterization Based on Personal Attributes: Minimal
101 Standardized Coding for Telehealth Services: Minimal
102 Prevention of Hearing Loss-Associated-Cognitive-Impairment Through Earlier Recognition and Remediation: Modest
103 Oral Healthcare Is Healthcare: Modest
104 Improving Access to Vaccinations for Patients: Modest
105 Fertility Preservation Insurance Coverage for Women in Medicine: Modest
106 Reimbursement of School-Based Health Centers: Minimal
107 Expanding Medicaid Transportation to Include Healthy Grocery Destinations: Modest
108 Medicaid and CHIP Coverage of Glucose Monitoring Devices for Patients with Diabetes: Modest
109 Amending D-440.985, Health Care Payment for Undocumented Persons, to Study Methods to Increase Health Care Access for Undocumented Immigrants: Minimal
110 Caps on Insulin Co-Payments for Patients with Insurance: Minimal
111 Addressing Healthcare Accessibility for Current and Aged-Out Youth in the Foster Care System: Minimal
112 Expanding Coverage for and Access to Pulmonary Rehabilitation: Modest
113 Supporting Medicare Drug Price Negotiation: Modest
114 Medicare and Private Health Insurance for Hearing Aids: Modest
115 Bundled Payments and Medically Necessary Care: Modest
116 Recognizing the Need to Move Beyond Employer-Sponsored Health Insurance: Minimal
117 Implant-Associated Anaplastic Large Cell Lymphoma: Minimal
118 Expanding Site-of-Service Neutrality: Modest
119* Bundling Physician Fees with Hospital Fees: Minimum
120* COBRA for College Students: Modest
121* Medicaid Tax Benefits: Modest
122* Increase Funding, Research and Education for Post-Intensive Care Syndrome: Modest
201 Protection of Peer-Review Process: Modest
202 RESOLUTION WITHDRAWN:
203 Poverty-Level Wages and Health: Mimimal
204 Supporting Collection of Data on Medical Repatriation: Modest
205 Reducing the Prevalence of Sexual Assault by Testing Sexual Assault Evidence Kits: Modest
206 Updating Policy on Immigration Laws, Rules, Legislation, and Health Disparities to Better Address National Crises: Minimal
207 Authority to Grant Vaccine Exemptions: Minimal
208 Protections for Incarcerated Mothers in the Perinatal Period: Minimal
209 Increasing Access to Hygiene and Menstrual Products: Modest

SUMMARY OF FISCAL NOTES (NOVEMBER 2021 SPECIAL MEETING)

Resolution(s)

210 Advocating for the Amendment of Chronic Nuisance Ordinances: Modest
211 Support for Mental Health Courts: Minimal
212 Sequestration: Modest
213 Eliminating Unfunded or Unproven Mandates and Regulations: Modest
214 Stakeholder Engagement in Medicare Administrative Contractor Policy: Modest
215 Pharmacy Benefit Manager Reform as a State Legislative Priority: Modest
216 Preserving Appropriate Physician Supervision of Midlevel Providers and Ensuring Patient Awareness of the Qualifications of Physicians vs. Midlevel Providers: Modest
217 Studying Physician Supervision of Allied Health Professionals Outside of their Fields of Graduate Medical Education: Estimated cost of $100,000 to staff and consultant expenses to conduct research, analysis and surveys and an analysis of results
218 Physician Opposition to the Coordinated Effort by Corporations and Midlevel Providers to Undermine the Physician-Patient Relationship and Safe Quality Care: Estimate $250,000 includes in house research and analysis, and consultants to research, analyze, survey and analysis of results
219 The Impact of Midlevel Providers on Medical Education: Estimate $52,000 includes outside consultants to conduct research and analysis.
220 Gonad Shields: Regulatory and Legislation Advocacy to Oppose Routine Use: Modest
221 Promoting Sustainability in Medicare Physician Payments: Modest
222 Opposing Federal Preemption of State Licensing Laws and Scope-of-Practice Expansion Under the Ninth Amendment to Declaration Under the PREP Act: Modest
223 Paying Physicians for Services According to the Physician Fee Schedule: Modest
224 Improve Physician Payments: Estimated cost to implement resolution is $240,000 which includes staff time, materials and postage.
225 End Budget Neutrality: Modest
226 Addressing Adolescent Telehealth Confidentiality Concerns: Minimal
227 Medication for Opioid Use Disorder in Physician Health Programs: Modest
228 Resentencing for Individuals Convicted of Marijuana-Based Offenses: Minimum
229* CMS Administrative Requirements: Modest
230* Medicare Advantage Plan Mandates: Modest
231* Prohibit Ghost Guns: Minimum
232* Ban the Gay/Trans (LGBTQ+) Panic Defense: Modest
233* Insurers and Vertical Integration: Modest
234* Permitting the Dispensing of Stock Medications for Post Discharge Patient Use and the Safe Use of Multi-dose Medications for Multiple Patients: Modest
301 Equitable Reporting of USMLE Step 1 Scores: Modest
302 University Land Grant Status in Medical School Admissions: Moderate
303 Decreasing Bias in Evaluations of Medical Student Performance: Modest
304 Reducing Complexity in the Public Service Loan Forgiveness Program: Modest
305 Increase Awareness Among Residency, Fellowship, and Academic Programs on the United States-Puerto Rico Relationship Status: Modest
306 Support for Standardized Interpreter Training: Moderate
307 Support for Institutional Policies for Personal Days for Undergraduate Medical Students: Minimal
308 Modifying Eligibility Criteria for Association of American Medical Colleges' Financial Assistance Program: Minimal
309 Protecting Medical Student Access to Abortion Education and Training: Minimal
310 Resident and Fellow Access to Fertility Preservation: Minimal
311 Improving Access to Physician Health Programs for Physician Trainees: Minimal
312 Accountable Organizations to Resident and Fellow Trainees: Modest
313 Establishing Minimum Standards for Parental Leave During Graduate Medical Education Training: Minimal

SUMMARY OF FISCAL NOTES (NOVEMBER 2021 SPECIAL MEETING)

Resolution(s)

314 Updating Current Wellness Policies and Improving Implementation: Modest

315 Reducing Overall Fees and Making Costs for Licensing, Exam Fees, Application Fees, etc. Equitable for IMGs: Minimal

316* Medical Education Debt Cancellation in the Face of a Physician Shortage During the COVID-19 Pandemic: Modest

317* Creating a More Accurate Accounting of Medical Education Financial Costs: Modest

318* The Medical Student Match Mismatch: Estimated $175,000 annually includes two new FTEs and existing staff costs.

401 Endorsement of Public Health Measures to End the COVID-19 Pandemic and Promotion of Research and Insurance Coverage to Define and Delimit the Emerging Issue of Post-Acute Covid Syndrome: Modest

402 Expansion on Comprehensive Sexual Health Education: Minimal

403 Providing Reduced Parking Fees for Patients: Modest

404 Increase Employment Services Funding for People with Disabilities: Minimal

405 Formal Transitional Care Program for Children and Youth with Special Health Care Needs: Minimal

406 Addressing Gaps in Patient and Provider Knowledge to Increase HPV Vaccine Uptake and Prevent HPV-Associated Oropharyngeal Cancer: Minimal

407 Traumatic Brain Injury and Access to Firearms: Minimal

408* Ensuring Affordability and Equity in COVID-19 Vaccine Boosters: Minimum

501 Ensuring Continued Access to Equitable Take-Home Methadone Treatment: Minimal

502 Advocating for Heat Exposure Protections for Outdoor Workers: Minimal

503 Marketing Guardrails for the "Over-Medicalization" of Cannabis Use: Minimal

504 Air Pollution and COVID: A Call to Tighten Regulatory Standards: Minimal

505 Representation of Dermatological Pathologies in Varying Skin Tones: Minimal

506 Enhancing Harm Reduction for People Who Use Drugs: Minimal

601 "Virtual Water Cooler" for our AMA: Minimal

602 Mitigating Environmental Contributors to Disease and Sustainability of AMA National Meetings: Multi-million dollar undertaking: consults to develop plan, project mgmt, purchase of carbon credits to offset areas where AMA may not be able to reduce emissions. Measuring and reporting on compliance will add to significant annual costs thereafter.

603 Abolishment of the Resolution Committee: Minimal

604 The Critical Role of Physicians in the COVID-19 Pandemic: Projects underway and included in current budgets. Throughout the COVID-19 pandemic our AMA has been implementing the directives outlined by this resolution and continued efforts to communicate the role of physicians and medical students as we emerge from the pandemic are embedded in our AMA operating budget.

605 Formalization of the Resolution Committee as a Standing Committee of the American Medical Association House of Delegates: Minimal

606 Increasing the Effectiveness of Online Reference Committee Testimony: Minimal

607 AMA Urges Health and Life Insurers to Divest From Investments in Fossil Fuels: Modest

608 Fulfilling Medicine’s Social Contract with Humanity in the Face of the Climate Health Crisis: $2M to est a crisis campaign to dist evidence based info on the relationship btwn climate change and human health, determine high yield adv and leadership opps for physicians, centralize effort towards environ justice and an equitable transition to net zero carbon society by 2050

609 Fulfilling Medicine's Social Contract with Humanity in the Face of the Climate Health Emergency: Moderate

610 Creation of Employed Physician Section: Modest

611* September 11th as a National Holiday: Minimal

612* UN International Radionuclide Therapy Day Recognition: Minimal

613* Due Process at our AMA: Minimal

614* Insurance Industry Behaviors: Estimated to cost approximately $300,000 annually derived from outsourcing to local counsels around the country.

615* Employed Physicians: Implementing components of this resolution are estimated to begin at approximately $720,000 annually. Further costs will be impacted by a myriad of variables, such as granting proportional representation to the Organized Medical Staff Section given the current ambiguity of defining an employed physician.

SUMMARY OF FISCAL NOTES (NOVEMBER 2021 SPECIAL MEETING)

Resolution(s)

616* Financial Impact and Fiscal Transparency of the American Medical Association Current Procedural Terminology System: Modest
617* Together We are Stronger Marketing Campaign: Minimal
701 Coverage of Pregnancy-Associated Healthcare for 12 Months Postpartum for Uninsured Patients who are Ineligible for Medicaid: Minimal
702 System Wide Prior and Post-Authorization Delays and Effects on Patient Care Access: Modest
703 Clear Statement Regarding the Use of CPT E/M Outpatient Visit Codes: Modest
704 Expanding the AMA's Study on the Economic Impact of COVID-19: Modest
705 Advocating for Program Stability in the Merit-Based Incentive Payment System: Modest
706 Support for State Medical Record Retention Laws: Modest
707* Fifteen Month Lab Standing Orders: Modest
708* Insurance Coverage for Scalp Cooling (Cold Cap) Therapy: Modest
709* Prior Authorization - CPT Codes for Fair Compensation: Minimal
710* Physician Burnout is an OSHA Issue: Modest

Minimal - less than $1,000
Modest - between $1,000 - $5,000
Moderate - between $5,000 - $10,000

*** Contained in Handbook Addendum**

Reference Committee on Amendments to Constitution and Bylaws

BOT Report(s)

05 Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment
11 National Guidelines for Guardianship
13 Study of Forced Organ Harvesting by China
15 Opposing Attorney Presence at and/or Recording of Independent Medical Examinations
16 Research Handling of De-Identified Patient Information

CC&B Report(s)

01 Further Action on Bylaw 7.5.2
02 Rescission of Bylaws Related to Run-off Elections
03 AMA Women Physicians Section: Clarification of Bylaw Language

CEJA Report(s)

01 Short-Term Medical Service Trips
02 Amendment to Opinions 1.2.11, "Ethical Innovation in Medical Practice"; 11.1.2, Physician Stewardship of Health Care Resources"; 11.2.1, "Professionalism in Health Care Systems"; and 1.1.6, "Quality"

Report of the Speakers

01 Report of the Election Task Force
02 Establishing an Election Committee

Resolution(s)

001 Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers
002 Disaggregation of Race Data for Individuals of Middle Eastern and North African (MENA) Descent
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021* Free Speech and Civil Discourse in the American Medical Association
022* Prohibition of Racist Characterization Based on Personal Attributes

* Contained in the Handbook Addendum

REPORT OF THE BOARD OF TRUSTEES

B of T Report 5-N-21

Subject: Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Policy G-600.067, "References to Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment," instructs the American Medical Association (AMA) to:

(1) undertake a study to identify all discrimination and harassment references in AMA policies and the code of ethics, noting when the language is consistent and when it is not;

(2) research language and terms used by other national organizations and the federal government in their policies on discrimination and harassment; and

(3) present the preliminary study results to the Minority Affairs Section, the Women's Physician Section, and the Advisory Committee on LGBTQ Issues to reach consensus on optimal language to protect vulnerable populations including racial and ethnic minorities, sexual and gender minorities, and women, from discrimination and harassment; and

(4) produce a report within 18 months with study results and recommendations.

BACKGROUND

Original Resolution 009-A-19 observes that while the "concept of protection against discrimination or harassment is not controversial . . . generally accepted, standard language for protected classes or groups does not exist among national organizations."

Federal law establishes a variety of characteristics as defining "protected classes": race; color; religion or creed; national origin or ancestry; sex, including gender, pregnancy, sexual orientation, and gender identity; age; physical or mental disability; veteran status; genetic information; citizenship; and military status. Relevant laws are as follows:

Title VII of the Civil Rights Act of 1964 (42 U.S.C. § 2000e) prohibits discrimination based on race, color, sex—including amendments by the Pregnancy Discrimination Act and Civil Rights Act of 1991, national origin, and religion. Title I and Title V of the Americans with Disabilities Act (42 U.S.C. §§ 12101-12113) prohibits discrimination based on disability—including amendments by the Civil Rights Act of 1991 and the Americans with Disabilities Act Amendments Act. The Rehabilitation Act (29 U.S.C. §§ 791, 793, 794, and 794a) prohibits discrimination based on disability in federal employment by employers with federal contracts or subcontracts that exceed $10,000 and by employers that receive federal funds. The Age Discrimination in Employment Act (29 U.S.C. §§ 621-634) prohibits discrimination based on ages 40 and over. The Genetic Information Nondiscrimination Act (42 U.S.C. § 2000ff)

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> prohibits discrimination based on genetic information. The Uniformed Services Employment and Reemployment Rights Act (38 U.S.C. § 4311) prohibits discrimination based on past, current, or prospective military service. Section 1981 of the Civil Rights Act of 1866 (42 U.S.C. § 1981) prohibits discrimination based on race, color, and ethnicity in contracts, including most employment arrangements. The Equal Pay Act (29 U.S.C. § 209(d)) prohibits sex-based wage discrimination against men or women performing substantially equal work in the same establishment. The Immigration Reform and Control Act (Pub. L. 99-603, 100 Stat. 3359 (1986)) prohibits citizenship discrimination, national origin discrimination by certain employers, and over-documentation in the employment eligibility verification process [PracticalLaw].

States may extend protections more broadly – for example, California protects individuals against discrimination on the basis of "marital status"; includes "childbirth, breastfeeding, and/or related medical conditions" within the protected category of "sex"; and explicitly prohibits discrimination on the basis of request for family care leave or for an employee's own serious medical condition [CA State Senate].

CURRENT AMA POLICY

A search of AMA's policy compendium (PolicyFinder) using the terms "discrimination" and "harassment" returned 73 results, covering AMA Bylaws and governance policy, the AMA *Code of Medical Ethics*, and directives and policies of the AMA House of Delegates. After eliminating duplicate entries and excluding policies that did not address discrimination on the basis of personal or practice characteristics the remaining 54 policies were reviewed for the characteristics they delineate (Appendix I).

Of these, 10 adopt at least four of the "protected classes" recognized in law. However, no two policies adopt precisely the same set of characteristics or express them in precisely the same language. Thus Bylaw 1.4 prohibits denying membership in AMA on the basis of sex, color, creed, race, religion, disability, ethnic origin, national origin, sexual orientation, gender identity, age, "or for any other reason unrelated to character, competence, ethics, professional status or professional activities." Opinion 9.5.4, "Civil Rights & Medical Professionals," in the *Code of Medical Ethics* enumerates a fundamentally similar, but nonetheless not identical set: race, color, religion, creed, ethnic affiliation, national origin, gender or gender identity, sexual orientation, age, family status, and disability, but uses the same language to qualify its guidance: "or for any other reason unrelated to character, competence, ethics, professional status, or professional activities."

H-140.837, "Policy on Conduct at AMA Meetings and Events," delineates yet a further, albeit related, set of characteristics: race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, marital status, citizenship "or otherwise." While H-65.965, "Support for Human Rights and Freedom," prohibits discrimination on the basis of "sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin or age" or "any other such reprehensible policies." H-310.919 opposes questioning residency or fellowship applicants about "marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion" as discriminatory, yet H-65.978, "Nondiscrimination Toward Residency Applicants," calls on the Accreditation Council for Graduate Medical Education to amend institutional requirements to prohibit discrimination based on the more limited set of age, sex, race, creed, national origin, gender identity and sexual orientation.

As Appendix I details, the remaining policies address discrimination in reference to fewer of the characteristics that define protected classes or to other characteristics entirely:

Characteristic	No. of Policies
Sex/gender (including gender identity)	8
National origin (more specifically, IMG status)	6
Genetic information	4
Disability	2
Race/ethnicity	1
Religion	1
Age	1
Other	14

The "other" characteristics set out in various policies included status as an international medical graduate; enrollment in a physician health program, osteopathic or allopathic training; and status as a living organ donor. Table 1 presents the specific choices made across AMA policies on discrimination.

POLICY OF OTHER ORGANIZATIONS

For purposes of comparison, publicly available policies or position statements relating to discrimination were retrieved for 27 organizations: four federal agencies, 13 major specialty societies in the AMA House of Delegates, and 10 academic institutions (Appendix II).

Not surprisingly, public statements of nondiscrimination by the Office for Civil Rights of the Department of Education, the Equal Employment Opportunity Commission (EEOC) of the Department of Labor, the Department of Health and Human Services, and the Office of Fair Housing and Equal Opportunity of the Department of Housing and Urban Development employ the protected classes as defined in federal law.

The federal protected classes form the foundation in policy and position statements reviewed from professional medical organizations. These policies nonetheless differ significantly in how finely they parse the universe of possible personal characteristics or social categories to identify those they deem most pertinent to nondiscrimination policy. Policy of the American Academy of Family Physicians, for example, recognizes not only "socioeconomic status" as a protected feature, but also "body habitus," while the American Heart Association condemns discrimination on the basis of zip code and primary language, as well as on traditional grounds for protection. The American Academy of Pediatrics (AAP) extends its policy to prohibit discrimination based on the patient's disability or "the disability of the patient's parent(s) or guardian(s)." Among the 18 characteristics set out in the statement on nondiscrimination of the American College of Emergency Physicians are socioeconomic status, immigration status, and language preference. Characteristics set out in policy of the American Academy of Hospice and Palliative Medicine include education, political opinion and professional experience.

Using various language, several policies extend protection to "any other characteristic prohibited by applicable federal, state, or local law" (American Urological Association). The National Association of Medical Examiners, in contrast, condemns discrimination based on delineated characteristics and "any other human condition or choice."

Table 1. AMA policies

	AMA Policies																															
categories/characteristics cited	B-1.4	9.5.4	H-140.837	H-295.955	H-295.865	D-185.981	H-310.919	H-65.965	H-295.989	8.5	H-180.990	H-310.976	H-525.998	H-525.984	H-65.961	H-60.919	H-255.986	H-255.978	H-255.988	4.1.3	7.3.7	H-315.983	-65.969	H-310.923	H-310.923	H-25.996	H-20.914	D-90.991 D-95.881	D-95.988	H-275.949	H-370.965
age	x	x	x	x	x	x	x	x	x																	x					
ancestry																															
appearance																															
body habitus																															
citizenship			x																												
color	x	x	x			x																									
creed	x	x							x																						
disability	x	x	x	x		x		x																			x				
education																															
ethnic origin	x	x		x	x			x																							
family status		x																													
gender		x						x		x	x	x			x																
gender identity	x	x	x	x	x	x		x	x							x															
gender expression																x				x											
genetic information																					x	x	x								
health/health status						x																									
immigration status																															
language preference																															
marital status			x		x		x																								
medical condition																										x					
military/veteran status																															
national origin	x	x	x			x	x	x	x																						
pregnancy																															
race	x	x	x	x	x	x	x	x	x															x							
religion	x	x	x	x	x		x	x																	x						
sex	x		x	x	x	x		x	x				x	x																	
sexual orientation	x	x	x	x	x	x	x	x								x															
social status or condition																															
socioeconomic status																															
other basis prohibited by law																															
other protected group/category/ characteristic																															
other personal category																															
other social category																															
other human condition or choice																															
other legally protected basis																															
other	x	x	x			x																									
affiliational preferences																															
country of education or origin																	x														
culture																															
degree of medical dependency						x																									
dependent status																															
drug abuse																													x		
employment status																															
expected length of life						x																									
future plans for marrige or children							x																								
international medical graduate																		x	x												
living donor status																															x
order of protection status																															
participation in a PHP																														x	
political opinion																															
present or predicted disability						x																									
professional experience/profession					x																										
quality of life						x																									
zip code																															

Like the medical professional society policies reviewed, sample policies of academic institutions that prohibit discrimination—among students, faculty, staff, and, where relevant, patients—are grounded in the protected classes of federal law, but also delineate a wider or more nuanced range of protected characteristics. For example, "order of protection status" and "unfavorable military discharge" (University of Illinois at Chicago); "genetic information or family medical history" (University of Alabama); "associational preferences" (University of Iowa Hospitals & Clinics); "serious medical condition" (University of New Mexico); "family status and responsibilities," "political affiliation," "matriculation," and "unemployed status" (Howard University). Vanderbilt University adopts "sexual orientation" as a protected characteristic but goes on to define it more specifically as "a person's self-identification as heterosexual, homosexual, bisexual, asexual, pansexual, or uncertain." In keeping with many others, policies sampled from academic institutions are often open ended" in that they specifically defer to "other protected classes" (or "any other legally protected basis" (University of Alabama).

Table 2 presents the specific choices made across the non-AMA policies reviewed.

THE GOAL OF A COMMON LANGUAGE

Several of the position statements reviewed were triggered by recent events and the impact of the COVID-19 pandemic. For example, the American College of Surgeons' statement indicates that it responds, at least in part, to "reports of racial and ethnic discrimination during the COVID-19 pandemic," and is offered as condemnation of such behavior. So too, the statement by the National Academy of Medical Examiners "strongly denounces injustice and racism in all its forms" as a prelude to condemning discrimination on the basis of characteristics the statement then enumerates.

Academic institutions have a clear duty to comply with federal nondiscrimination law, as policy of Vanderbilt University explicitly indicates. The University of Washington grounds its responsibility to provide "equality of opportunity and an environment that fosters respect for all members of the University community," on the fact that as an institution it is "established and maintained by the people of the state."

What the statements and policies reviewed demonstrate is that there is no single, agreed on way to speak to discrimination and promote nondiscrimination. In themselves, these materials offer no specific insight into why a particular set of characteristics was adopted or why particular language was used to express those characteristics.

Federal, state, and local law establish a baseline, identifying the minimum constellation of characteristics with respect to which discrimination should not be tolerated, based on the history of discrimination in the U.S. At the same time, policies among medical professional organizations, including those of the AMA, suggest that beyond that baseline it may be appropriate to focus nondiscrimination policy—and tailor the language used—to the salient issues of the context(s) in which policy is intended to apply. As statements of aspiration for conduct at all times and in all places, policies should be encompassing. As guides for action, they may need to be, and responsibly could be, more narrowly focused.

For example, in light of the distinctive responsibilities physicians and parents/guardians must negotiate in caring for pediatric patients, there is strong rationale for the AAP to oppose discrimination on the basis of the disability status of a patient's parent(s) or guardian(s). That insight perhaps should inform other health care contexts in which decision making involves multiple parties, but whether the disability status of participants should universally be specifically addressed in nondiscrimination policy is considerably less clear.

Table 2: Non-AMA policies

categories/characteristics cited	*Non-AMA Institutions/Organizations*																										
	ACEP	AAFP	AHA	AAHPM	AAO-HNS/F	AAP	ACS	AGS	AOA	ASCRS	SVS	AUA*	NAME	Dept Ed	EEOC	HHS	UIC	U-IA Hlth Care	Uchicago	Harvard College	Harvard Med School	Vanderbilt	U-WA	U-NM	U-AL	Howard
age	*	*		*	*	*	*			*	*			*	*	*	*	*	*	*	*	*	*	*	*		
ancestry	*					*											*			*	*			*			
appearance												*														*	
body habitus		*																									
citizenship	*																						*				
color	*	*			*			*	*		*	*		*	*	*	*	*	*	*	*	*	*	*	*	*	
creed	*								*									*		*	*		*				
disability	*	*		*	*	*		*	*	*	*	*		*	*	*	*	*	*	*	*	*	*	*	*	*	
education				*																							
ethnic origin	*	*	*	*		*	*					*	*						(*)			(*)		*			
gender		*		*		*	*	*			*	*												*		*	
gender identity		*		*	*	*		(*)	*			*			(*)		(*)	*	*	*	*	*	*	*	**	*	
gender expression					*	*						*											(*)	(*)		*	
genetic information										*					*		*	*	*			*	*	*	*	*	
health		*																									
immigration status	*					*																					
language preference	*		*																								
marital status					*	*											*						*	*		*	
medical condition	*																							*		*	
military/veteran status	*				*	*				*	*						*	*	*	*	*	*	*	*	*	*	
national origin	*	*		*	*	*		*	*	*				*	*	*	*	*	*	*	*	*	*	*	*	*	
pregnancy					(*)			*							(*)			*					*	*	*	*	
race	*	*	*	*	*	*		*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	
religion	*	*	*	*	*	*		*		*	*	*	*		*		*	*	*	*	*	*	*	*	*	*	
sex	*		*						*	*	*			*	*	*	*	*	*	*	*	*	*	*	*	*	
sexual orientation	*	*		*	*	*	*	(*)	*	*		*	*		(*)		*	*	*	*	*	*	*	*	*	*	
social status or condition	*																										
socioeconomic status	*	*	*	*																							
other basis prohibited by law					*					*																	
other protected group/ category/ characteristic											*	*							*	*	*						
other personal category			*																								
other social category			*																								
other human condition or choice													*														
other legally protected basis																									*		
other																		*									
affiliational preferences																		*									
family status/responsibilities																										*	
matriculaation																										*	
order of protection status																	*										
political opinion/affiliation				*																						*	
professional experience				*																							
unemployed status																										*	
zip code			*				*																				

The policies reviewed further suggest that how a nondiscrimination policy expresses or describes salient characteristics is also worthy of thoughtful consideration. The majority of documents in the current, admittedly limited sample, for example, most often refer simply to "disability," or in some instances "physical or mental disability," as a characteristic of concern. The University of Chicago, however, refers to "status as an individual with a disability," using "person-first language." AMA policy has elsewhere recommended the use of such language (H-440.821).

In some circumstances, "context sensitivity" of the sort evidenced in AAP's nondiscrimination policy might argue for more granular distinctions with respect to a protected characteristic, replacing the broadest designation of the relevant characteristic with a set of more nuanced features. Much as Vanderbilt University's policy offers secondary interpretation of the characteristic "sexual orientation" as a range of specific self-identifications. As, indeed, the policies reviewed suggest is the case in the emerging preference for "gender identity" coupled with "gender expression" over a monolithic—and increasingly ethically, scientifically, and socially problematic—characteristic of "gender."

Perhaps the most important consideration for any policy or position statement is the goal it is intended to serve. Arguably, as the nondiscrimination policy of the University of Iowa eloquently puts it, the goal is to prevent discrimination on the basis of any classification "that deprives the person of consideration as an individual." Seen through an equity lens, that means disrupting the historical chain of actions that have the effect of discriminating against, marginalizing, or minoritizing individuals on the basis of actual, perceived, or ascribed characteristics. Words do matter, but there is not necessarily one and only one vocabulary that can accomplish the goal.

These results were circulated to the Governing Councils of the Minority Affairs Section, Women Physicians Section, LTBTQ Advisory Committee, International Medical Graduate Section, and Senior Physicians Section. The wide variation in language used across policies of the AMA, other professional medical organizations, and health care institutions argues that further thoughtful reflection should be given to deciding what terms will best express AMA's commitment to equity and nondiscrimination across our policy compendium, as reflected in the recommendation that follows.

RECOMMENDATION

In keeping with these considerations, your Board of Trustees recommends that G-600.067, "Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment," be rescinded, the following be adopted, and the remainder of this report be filed:

1. That our AMA recommend preferred terminology for protected personal characteristics to be used in AMA policies and position statements. (Directive to Take Action)

Fiscal note: Less than $1,500

Appendix I: AMA Policies

AMA Bylaws & governance policy

B-1.4 Discrimination	Membership in the AMA or in any constituent association, national medical specialty society or professional interest medical association represented in the House of Delegates, shall not be denied or abridged **because of sex, color, creed, race, religion, disability, ethnic origin, national origin, sexual orientation, gender identity, age, or for any other reason unrelated to** character, competence, ethics, professional status or professional activities.
Cross-referenced by B-7.1 Resident/Fellow Section B-7.3 Medical Student Section	7.1.4.1 National Resident and Fellow Organizations. National resident and fellow organizations that meet the following criteria may be considered for representation in the Resident and Fellow Section Assembly: c. Membership in the organization must be available to all residents or fellows, **without discrimination**. 7.3.3.4.1 Criteria for Eligibility. National medical student organizations that meet the following criteria may be considered for representation in the Medical Student Section Business Meeting: c. Membership in the organization must be available to all medical students, **without discrimination**.
G-600.014 Constituent Associations G-600.020 Specialty Organizations	(1) The organization must not be in conflict with the Constitution and Bylaws of our AMA **with regard to discrimination in membership**;

AMA Code of Medical Ethics	
9.5.4 Civil Rights & Medical Professionals	Opportunities in medical society activities or membership, medical education and training, employment and remuneration, academic medicine and all other aspects of professional endeavors must not be denied to any physician or medical trainee because of **race, color, religion, creed, ethnic affiliation, national origin, gender or gender identity, sexual orientation, age, family status, or disability or for any other reason unrelated to character, competence, ethics, professional status, or professional activities.**

Directives and policies of the House of Delegates	
H-140.837 Policy on Conduct at AMA Meetings and Events	Harassment consists of unwelcome conduct whether verbal, physical or visual that denigrates or shows hostility or aversion toward an individual because of **his/her race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, marital status, citizenship or otherwise**, and that: (1) has the purpose or effect of creating an intimidating, hostile or offensive environment; (2) has the purpose or effect of unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any AMA Entity; or (3) otherwise adversely affects an individual's participation in such

	meetings or proceedings or, in the case of AMA staff, such individual's employment opportunities or tangible job benefits.
H-295.865 Discrimination Against Patients by Medical Students	Our AMA opposes the **refusal by medical students** to participate in the care of patients on the basis of the patient's **race, ethnicity, age, religion, ability, marital status, sexual orientation, sex, or gender identity.**
H-295.955 Teacher-Learner Relationship In Medical Education	Certain behaviors are inherently destructive to the teacher-learner relationship. Behaviors such as violence, sexual harassment, inappropriate discrimination based on personal characteristics must never be tolerated. Other behavior can also be inappropriate if the effect interferes with professional development. Behavior patterns such as making habitual demeaning or derogatory remarks, belittling comments or destructive criticism fall into this category. On the behavioral level, abuse may be operationally defined as behavior by medical school faculty, residents, or students which is consensually disapproved by society and by the academic community as either exploitive or punishing. Examples of inappropriate behavior are: physical punishment or physical threats; **sexual harassment; discrimination based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities;** repeated episodes of psychological punishment of a student by a particular superior (e.g., public humiliation, threats and intimidation, removal of privileges); grading used to punish a student rather than to evaluate objective performance; assigning tasks for punishment rather than educational purposes; requiring the performance of personal services; taking credit for another individual's work; intentional neglect or intentional lack of communication.
D-185.981 Addressing Discriminatory Health Plan Exclusions or Problematic Benefit Substitutions for Essential Health Benefits Under the Affordable Care Act	Our AMA will work with state medical societies to ensure that no health carrier or its designee may adopt or implement a benefit design that discriminates on the basis of **health status, race, color, national origin, disability, age, sex, gender identity, sexual orientation, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.**
H-310.919 Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process	Our AMA: 1. opposes questioning residency or fellowship applicants regarding **marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion**;

H-65.965 Support of Human Rights and Freedom	Our AMA: (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's **sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age**; (3) opposes any discrimination based on an individual's **sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies**;
H-65.978 Nondiscrimination in Responding to Terrorism	Our AMA: (2) opposes discrimination or acts of violence against any person on the basis of **religion, culture, nationality, or country of education or origin** in the nation's response to terrorism.
H-295.969 Nondiscrimination Toward Residency Applicants Cross-referenced by H-310.943, Closing of Residency Programs	Our AMA urges the Accreditation Council for Graduate Medical Education to amend its Institutional Requirements to read: "In assessing and selecting applicants for residency/fellowship programs, ACGME-accredited programs must not discriminate on the basis of **sex, age, race, creed, national origin, gender identity, or sexual orientation**."

Appendix II: Professional associations – universities – health centers

Professional Medical Associations	
American College of Emergency Physicians	The American College of Emergency Physicians (ACEP) acknowledges that implicit and explicit biases, attitudes, or stereotypes affect our understanding, actions, and decisions. These factors are further magnified in the emergency department where cognitive load, rapid and abbreviated interactions, and high stress can leave patients and staff vulnerable to pre-conceived notions and biases. In order to reduce biases and improve health equity, it is crucial to be mindful of their pervasiveness and to employ critical reflection, training, and education geared to address and disarm them. ACEP advocates for the respect and dignity of each individual, opposes all forms of discrimination and harassment, and supports anti-discrimination and anti-harassment practices protected by local, state, or federal law. Discrimination and harassment **may be based on, but are not limited to, an individual's race, age, religion, creed, color, ancestry, citizenship, national or ethnic origin, language preference, immigration status, disability, medical condition, military, or veteran status, social or socioeconomic status or condition, sex, gender identity or expression, or sexual orientation**.
American Academy of Family Physicians	Patient: The AAFP opposes all discrimination in any form, including but not limited to, **that on the basis of actual or perceived race, color, religion, gender, sexual orientation, gender identity, ethnic affiliation, health, age, disability, economic status, body habitus or national origin.** Physician: Equal Opportunity--The AAFP strongly supports the principle that hiring, credentialing and privileging decisions for physicians should be based solely on verifiable professional criteria.
American Heart Association American College of Cardiology	(1.4)1. Principles of Professionalism) Social justice. The medical profession must promote justice in the healthcare system, including the fair distribution of healthcare resources. Physicians should work actively to eliminate discrimination in health care, **whether based on race, sex, socioeconomic status, ethnicity, religion, or any other social Category.** (2.2) 4. The existence and **perpetuation of bias and structural racial, ethnic, sex, and other inequities** throughout the cardiovascular community must be recognized and acknowledged as a problem, and change must be embraced and incentivized as vital to mission. (2.4) 6. Clinicians should review their own practices at least once per year for possible differential treatment of patients by **race and ethnicity, zip code, and primary language**.

American Academy of Hospice and Palliative Medicine	Systemic racism undermines public health and poses a barrier to achieving our vision that all patients, families, and caregivers who need it will have access to high-quality hospice and palliative care. We have made the following pledges to achieve Diversity, Equity and Inclusion Build a community and field that is **diverse across many dimensions, including but not limited to age, gender, gender identity, ability, education, ethnicity, nationality, political opinion, professional experience, race, religion, sexual orientation, and socioeconomic status**.
American Academy of Otolaryngology—Head and Neck Surgery	The AAO-HNS/F is opposed to discrimination against people o**n the basis of, but not limited to, race, color, national origin, religion, sex (including pregnancy), age, sexual orientation, gender identity and expression, marital status, disability, veteran status, or any other basis prohibited by federal, state, or local law.** This applies to all aspects of medical practice and training, practice administration, and academic settings.
American Academy of Pediatrics	THE MISSION OF the American Academy of Pediatrics (AAP) is "to attain optimal physical, mental, and social health and well-being for all infants, children, adolescents and young adults."1 In support of this mission, therefore, the AAP is opposed to discrimination **in the care of any patient on the basis of race, ethnicity, ancestry, national origin, religion, gender, marital status, sexual orientation, gender identity or expression, age, veteran status, immigration status, or disability of the patient or patient's parent(s) or guardian(s)**. In addition, the AAP supports the right of pediatricians, pediatric medical subspecialists, pediatric surgical specialists, and other specialist physicians who care for pediatric patients in both educational and practice settings **to participate in the delivery of health care without discrimination on the basis of race, ethnicity, ancestry, national origin, religion, gender, marital status, sexual orientation, gender identity or expression, age, veteran status, immigration status, or disability.** Physicians with disabilities who maintain the ability to perform the essential functions of their jobs with or without "reasonable accommodation," as defined by the Americans with Disabilities Act (ADA),2 should not be hindered from participating in such activities.
American College of Surgeons	The American College of Surgeons (ACS) is aware of reports of racial and ethnic discrimination during the COVID-19 pandemic. Since this outbreak started, Asian members of both our own surgical community and the public at large continue to experience bias. We strongly condemn these actions. COVID-19 does not discriminate. It **affects all people, regardless of gender, race, ethnicity, age, sexual orientation, or geographic location.** Discrimination of any kind is antithetical to the mission of any health care professional. We were drawn to this profession to serve all patients.

	The ACS supports all health care personnel who provide essential services in our communities at this time and maintains that they should be able to continue to do so without the specter of hatred and violence resulting from xenophobia, racism, and bigotry. We also encourage you to discuss any discriminatory acts you witness at any time to your institution's leadership and to the ACS.
American Geriatrics Society	The American Geriatrics Society (AGS) opposes **discrimination against healthcare professionals or older people based on race, color, religion, gender (including gender identity, sexual orientation, and pregnancy), disability, age, or national origin.** We believe that such discriminatory practices can have a negative impact on public health, especially the health of older Americans and vulnerable older people. We oppose any federal order or legislation that unfairly singles out or targets health professionals and other members of the healthcare workforce because of race, color, religion, gender (including gender identity, sexual orientation, and pregnancy), disability, age, or national origin. Additionally, we oppose discrimination or disparate treatment of any kind in any healthcare setting because of race, color, religion, gender (including gender identity, sexual orientation, and pregnancy), disability, age, or national origin.
American Osteopathic Association Code of Ethics	**Section 3**. A physician-patient relationship must be founded on mutual trust, cooperation, and respect. The patient, therefore, must have complete freedom to choose her/his physician. The physician must have complete freedom to choose patients whom she/he will serve. However, the physician should not refuse to accept patients **for reasons of discrimination, including, but not limited to, the patient's race, creed, color, sex, national origin, sexual orientation, gender identity, or disability.** In emergencies, a physician should make her/his services available. Section 3 does not address a patient's discriminating against a physician based on the physician's race, creed, color, sex, national origin, sexual orientation, gender identity or disability; and a patient may express a desire to not be treated by a particular physician or by a physician with certain characteristics. Therefore, the AOA interprets section 3 of its code of ethics to permit but not require an osteopathic physician to treat a patient when the physician reasonably believes the patient is experiencing a life- or limb-threatening event, even though the patient may have previously expressed a desire to not be treated by a physician based on the physician's race, creed, color, sex, national origin, sexual orientation, gender identity or disability. (July 2014)
American Society of Colon and Rectal Surgeons	The American Society of Colon and Rectal Surgeons does not discriminate **on the basis of race, color, religion, national origin, sex, sexual orientation, age, genetics information, disability, status as a protected veteran, or an any other basis violative of law**.

Society for Vascular Surgery	The Society for Vascular Surgery® (SVS) is committed to providing a work environment in which all individuals are treated with respect and dignity. Harassment of any kind, including sexual harassment, is prohibited and will not be tolerated. The Society has zero tolerance of harassment of any kind by anyone, including managers, co-workers, members, vendors, clients, customers, or any other third party. Harassment consists of unwelcome conduct or behavior, whether verbal, physical, or visual, that is based on a person's protected status, including **sex, race, color, religion, national origin, age, gender, sexual orientation, physical or mental disability, military status, or any other protected group status**.
American Urological Association	The American Urological Association (AUA) and the Urology Care Foundation are committed to promoting a productive work environment that is free from discrimination, harassment or disruptive activity. As such, neither the AUA nor Urology Care Foundation will tolerate verbal or physical conduct by an employee, member, vendor or other that discriminates, harasses, disrupts or unreasonably interferes with another's work performance or creates an intimidating, hostile or offensive working environment. No form of discrimination or harassment will be tolerated **based on a person's age, race, color, religion, gender identity and expression, disability, sexual orientation or any other characteristic protected by applicable federal, state and local laws and ordinances.**
National Association of Medical Examiners	The National Association of Medical Examiners strongly denounces injustice and racism in all forms. Forensic pathologists are committed to truth, mutual respect for all, listening objectively and understanding between people. Historically, forensic pathologists have stood for truth in Attica, and denounced genocides and many other wrongs flamed by hate and discrimination. We publicly condemn racism, injustice, and discrimination of any kind. We are appalled at the deaths of George Floyd and others before him, murdered and missing indigenous women, attacks on LGBQT and any attack, injustice or discrimination **based on race, gender, ethnicity, sexuality, religious or spiritual beliefs, appearance or any other human condition or choice**. We stand united against these terrible injustices. As forensic pathologists and physicians, we are committed to the betterment of humanity, and respect for all people regardless of **race, gender, sexuality, ethnicity, religious affiliation, place of birth or economic standing**.

REPORT OF THE BOARD OF TRUSTEES

BOT Report 11-N-21

Subject: National Guidelines for Guardianship (Resolution 17-A-19)

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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At the 2019 Annual Meeting, the House of Delegates (HOD) referred Resolution 017-A-19, "National Guidelines for Guardianship" to the Board of Trustees for report. Resolution 017-A-19, introduced by the Medical Student Section, asked that our American Medical Association (AMA) collaborate with relevant stakeholders to advocate for federal creation and adoption of national standards for guardianship programs, appropriate program funding measures, and quality control measures.

The reference committee heard limited testimony related to this resolution. One speaker lauded the intent of the resolution but expressed concern regarding the complexity of the issue and the need for further study. Testimony was also heard characterizing the resolution as too non-specific in its request. The reference committee recommended that Resolution 017-A-19 be referred.

The resolution raises vital issues regarding adult guardianship and protection of the elderly. This report presents the current federal and state regulatory framework for laws governing guardianship proceedings, the existing funding and support for programs and education, investigations of suspected elder abuse, and the agencies, associations and commissions that champion these issues. This report analyzes the existing body of AMA policy and *Code of Medical Ethics* opinions and evaluates the adequacy of existing governmental and non-governmental initiatives.

DISCUSSION

The resolution focused on the need to assure accountability, safety and transparency in the guardianship process in order to reduce the potential for abuse. Jurisdiction over the guardianship process is within the purview of each state's court system and relevant state social services and administrative agencies. The obstacles for health care providers in seeking guidance in a patchwork of state laws are evident. However, numerous programs address these obstacles, and several are discussed here.

The "Uniform Adult Guardianship and Protective Proceedings Jurisdiction Act"

The most ambitious and effective effort to address the inconsistency in state guardianship laws has been undertaken by the National Conference of Commissioners on Uniform State Laws, also known as the Uniform Law Commission (the ULC). The ULC drafted the "Uniform Adult Guardianship and Protective Proceedings Jurisdiction Act" (the Act). Drafted and recommended by the ULC for enactment in all states, the Act has been adopted in 49 states.

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The Act provides states with non-partisan, well-conceived model legislation that brings consistency and stability to this critical area of state law. Jurisdiction of guardianship statutes requires clarity, and the Act addresses the problems of multiple jurisdictions, transfer across state lines, out of state recognition of proceedings and interstate enforcement. In addition, the Act facilitates monitoring of guardian relationships by requiring the court's ability to monitor the guardian as a criterion when adjudicating a guardianship matter. The Act also establishes registration procedures to aid in notification and monitoring of abuse, facilitates cross-border court communication and authorizes a court to order an investigation in another state. Not only does the Act provide a national standard for guardianship programs, it also serves to reduce elder abuse by facilitating improved court monitoring and enforcement guidelines.

The Department of Justice and the American Bar Association Commission on Law and Aging

In 2001, the U.S. Department of Justice (Justice Department) funded the American Bar Association's Commission on Law and Aging (the ABA Commission) to provide seed funding for a variety of initiatives. One such initiative was coordination of the development of Elder Abuse Fatality Review Teams (EAFRT). EAFRTs examine deaths of individuals that may be caused by or related to elder abuse for the purpose of identifying system gaps and improving victim services. Lessons learned from fatality review teams for child abuse and domestic violence victims have shown a positive impact in improving responses to victims. The Justice Department has further supported technical assistance to coordinate the development of EAFRTs and to publish an instruction manual for replication and implementation. With funding from the U.S. Administration on Aging, the ABA Commission subsequently funded additional EAFRTs through the National Center on Elder Abuse.

In 2017, the Justice Department awarded funding to the ABA Commission and several other organizations for numerous programs and research dedicated to the fight against elder abuse and financial exploitation. The funding has enabled the ABA Commission to build upon the foundational EAFRT model by expanding its initial capacity and evaluating the impact of EAFRTs on victim services. The ABA Commission is currently collaborating with the University of Texas Health Science Center to lead program evaluation activities, establish an expert panel, facilitate information sharing, develop conference presentations and webinars and disseminate products and findings and publish.

By illustration, the ABA Commission's accomplishments in guardianship issues just for the 2019 calendar year included online training for guardians, developing of an annual state guardianship legislative update, collaborating on numerous webinars on guardianship, and working on projects with state stakeholders in Oregon, Florida, and New York to drive changes in guardianship reform. In addition, the ABA Commission on Law and Aging supports a resource and research library providing comprehensive coverage of standards and guidelines for guardianship matters.

The "Elder Justice Act"

Enacted as part of the Patient Protection and Affordable Care Act, the Elder Justice Act (EJA) establishes national leadership in the Office of the Secretary of Health and Human Services in the form of an Elder Justice Coordinating Council and Advisory Board. This was the first piece of federal legislation passed to authorize a specific source of federal funds to address elder abuse, neglect and exploitation. The EJA authorizes grants to support improvements in Adult Protective Services, Long-Term Care Ombudsman programs, state survey agencies for Medicare and Medicaid, and grants for the establishment of forensic centers. The EJA also provides funding for

programs to promote elder justice through the enhancement of long-term care, and evaluation of elder justice programs.

AMA POLICY

AMA has an extensive body of policy addressing elder mistreatment, the health care costs of violence and abuse, and preventing, identifying and treating abuse. AMA Code of Ethics Opinion 8.10, "Preventing, Identifying and Treating Violence and Abuse," was issued in 2008 and most recently modified in 2017. The opinion informs of the physician's ethical obligation to take appropriate action to avert harm caused by violence and abuse. Physicians are charged with numerous responsibilities regarding diagnosing abuse, knowledge of community and health resources, prevention measures, familiarity with reporting obligations, advocating for training in medical education, providing leadership in raising awareness, and supporting research efforts in this area.

House of Delegates Policy H-515.961, "Elder Mistreatment," was last modified in 2018 and recognizes elder mistreatment as a pervasive public health issue that requires an organized effort from the medical community to improve recognition and treatment. The policy further advocates for collaboration between the medical team, social services, law enforcement, and the legal system to develop appropriate interventions and evaluation of those interventions. House of Delegates Policy D-515.984, "Health Care Costs of Violence and Abuse Across the Lifespan," also last modified in 2018, encourages various national agencies to continue to study, conduct research on the cost savings resulting from interventions and to increase funding for research on the impact and costs of elder mistreatment.

CONCLUSION

Your Board recognizes the concerns expressed by those who promulgated Resolution 017-A-19. However, we note that AMA has an established and comprehensive body of policy on the matter. Moreover, several federal initiatives address the resolution's core concerns. The Affordable Care Act, specifically, the Elder Justice Act, created federal leadership and established programs to promote elder justice. The Uniform Law Commission has enacted model guardianship legislation that has been adopted by 49 states. The American Bar Association Commission on Law and Aging has championed the cause for elder justice for forty years. The Department of Justice and other federal agencies provide funding, and numerous agencies, professional associations, academic medical centers and social service organizations continue to develop initiatives, and research outcomes and effectiveness.

RECOMMENDATIONS

Your Board of Trustees recommends that the following be adopted in lieu of Resolution 17-A-19, and the remainder of this report be filed:

1. That Opinion 8.10, "Preventing, Identifying and Treating Violence and Abuse;" H-515.961, "Elder Mistreatment;" and H-515-984, "Health Care Costs of Violence and Abuse Across the Lifespan," be reaffirmed. (Reaffirm HOD Policy)

2. That our AMA support initiatives by the American Bar Association Commission on Law and Aging and other associations and agencies of the federal government to address elder abuse and to ensure consistent protection of elders' rights in all states. (Directive to Take Action)

Fiscal Note:– Less than $1,000

AMA POLICY

E-8.10 Preventing, Identifying and Treating Violence and Abuse. All patients may be at risk for interpersonal violence and abuse, which may adversely affect their health or ability to adhere to medical recommendations. In light of their obligation to promote the well-being of patients, physicians have an ethical obligation to take appropriate action to avert the harms caused by violence and abuse. To protect patients' well-being, physicians individually should:
(a) Become familiar with:(i) how to detect violence or abuse, including cultural variations in response to abuse; (ii) community and health resources available to abused or vulnerable persons; (iii) public health measures that are effective in preventing violence and abuse;
(iv) legal requirements for reporting violence or abuse.
(b) Consider abuse as a possible factor in the presentation of medical complaints. (c) Routinely inquire about physical, sexual, and psychological abuse as part of the medical history. (d) Not allow diagnosis or treatment to be influenced by misconceptions about abuse, including beliefs that abuse is rare, does not occur in "normal" families, is a private matter best resolved without outside interference, or is caused by victims' own actions. (e) Treat the immediate symptoms and sequelae of violence and abuse and provide ongoing care for patients to address long-term consequences that may arise from being exposed to violence and abuse. (f) Discuss any suspicion of abuse sensitively with the patient, whether or not reporting is legally mandated, and direct the patient to appropriate community resources. (g) Report suspected violence and abuse in keeping with applicable requirements. Before doing so, physicians should: (i) inform patients about requirements to report; (ii) obtain the patient's informed consent when reporting is not required by law. Exceptions can be made if a physician reasonably believes that a patient's refusal to authorize reporting is coerced and therefore does not constitute a valid informed treatment decision. (h) Protect patient privacy when reporting by disclosing only the minimum necessary information. Collectively, physicians should:
(i) Advocate for comprehensive training in matters pertaining to violence and abuse across the continuum of professional education. (j) Provide leadership in raising awareness about the need to assess and identify signs of abuse, including advocating for guidelines and policies to reduce the volume of unidentified cases and help ensure that all patients are appropriately assessed. (k) Advocate for mechanisms to direct physicians to community or private resources that might be available to aid their patients. (l) Support research in the prevention of violence and abuse and collaborate with public health and community organizations to reduce violence and abuse.
(m) Advocate for change in mandatory reporting laws if evidence indicates that such reporting is not in the best interests of patients.

H-515.961 Elder Mistreatment
Our AMA recognizes: (1) elder mistreatment as a serious and pervasive public health problem that requires an organized effort from physicians and all medical professionals to improve the timely recognition and provision of clinical care in vulnerable elders who experience mistreatment; and (2) the importance of an interdisciplinary and collaborative approach to this issue, and encourage states to bring together teams with representatives from medicine, nursing, social work, adult protective services (APS), criminal and civil law, and law enforcement to develop appropriate interventions and evaluate their effectiveness.

D-515.984 Health Care Costs of Violence and Abuse Across the Lifespan.
1. Our AMA urges the National Academies of Sciences, Engineering, and Medicine to continue to study the impact and health care costs of violence and abuse across the lifespan. 2. Our AMA encourages the National Institutes of Health, the Agency for Healthcare Research and Quality, and the Centers for Disease Control and Prevention to conduct research on the cost savings resulting from health interventions on violence and abuse. 3. Our AMA encourages the appropriate federal agencies to increase funding for research on the impact and health care costs of elder mistreatment.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 13-N-21

Subject: Study of Forced Organ Harvesting by China

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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At the 2019 Interim Meeting, the American Medical Association House of Delegates adopted Policy D-370.981, "Study of Forced Organ Harvesting by China." The policy directs the AMA to "gather and study all information available and possible on the issue of forced organ harvesting by China and issue a report to our House of Delegates at the 2020 Annual Meeting."

The Board of Trustees assigned this report to the Office of International Relations. This report highlights evidence examined on organ transplantation practices in the People's Republic of China (PRC) and makes recommendations within the context of the AMA's strategy for involvement in international medical issues.

BACKGROUND

The American Medical Association has opined on organ transplantation practices in the PRC for more than a decade, primarily through its membership and active involvement in the World Medical Association (WMA). As early as 2007, a delegation from the WMA visited the Chinese Medical Association (ChMA) to further discuss ethical principles and to seek compliance with WMA ethical principles. The AMA has expressed its consistent support of WMA policy, including WMA's Resolution on Organ Donation in China. The resolution was first adopted in 2006 and reiterated in 2016 and calls upon the ChMA to cease the practice of using prisoners as organ donors. In 2015, the ChMA reported to the WMA that this practice had been prohibited by the PRC. In 2017, existing WMA policy on organ transplantation was modified to include paragraphs recommending collaboration with governments to ensure that appropriate safeguards are in place to enhance transparency and credibility in the organ transplantation process. At the last meeting of the WMA General Assembly in October 2019, the resolution on organ donation in China was once again submitted for review. The ChMA is now in the process of working with the Medical Ethics Committee of the WMA to revise and clarify this resolution and will formally report its progress to the WMA Council in April 2020.

AMA POLICY

AMA has extensive ethics and House policy on issues in organ procurement and transplantation:

- E-6.1.1, Transplantation of Organs from Living Donors
- E-6.1.2, Organ Donation after Cardiac Death
- E-6.2.1, Guidelines for Organ Transplantation
- E-9.7.3, Capital Punishment
- E-1.2.13, Medical Tourism

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- H-370.967, Ethical Procurement of Organs for Transplantation
- H-370.990, Transplantable Organs as a National Resource

DISCUSSION

There are credible but conflicting and largely anecdotal reports from different sources regarding current transplant practices in the PRC.[1] [2] In 2013, the National Health and Family Planning Commission of the PRC affirmed the government's commitment to aligning transplant practices with guiding principles from the World Health Organization (WHO)[3] and the Transplantation Society and International Society of Nephrology's Declaration of Istanbul.[4] The PRC signed a resolution specifically agreeing to end the practice of accepting organs from condemned prisoners, prohibiting organ trafficking and transplant tourism and strengthening transplant practice and oversight overall.[5]

It appears the development of ethical transplantation practices is a rapidly evolving process in the PRC. While many surgeons and hospitals may be adhering to new standards, there is likely a complex hybrid approach to transplantation includes those who adhere to ethical practices supported officially by the government, and those who may still be operating outside the parameters of international ethical standards.

Scarcity of knowledgeable, independent sources of information limit the transplant community's ability to assess transplant practices in the PRC. Neither the AMA nor the WMA can independently verify sources of transplanted organs or transplantation data, and persistent yet conflicting reports of ethical infractions make it nearly impossible to determine whether any claim of organ sources is indeed what it purports to be.

There is credible evidence to suggest that the PRC's efforts to reform its transplantation practices have not succeeded to the extent the government claims, and that abuses still occur:

- There is no built-in transparency for organ transplantation statistics in China. A detailed statistical analysis published by Israeli researchers in 2019[6] showed evidence of data manipulation in the organ transplant data sets that were publicly available. Based on available data, they concluded there is no way to definitively extrapolate either the source of organs used, or the total number of transplants performed per year. The study also found evidence that the authors believed indicates donors are being misclassified as "voluntary" when they are not.

- The PRC has relied heavily on organs from executed prisoners and not voluntary organ donors for source organs, a practice which was internationally condemned. The PRC claims to have stopped this practice. Government statistical information indicated a huge increase in voluntary donors, from 23% of organs procured in 2013 to 80% in 2014. The PRC states that voluntary organs then became the sole official organ source in 2015. However, it is not plausible that the country increased its volunteer donor rate from 23% of all organs procured to 100% in just two years. Gains of this magnitude would likely take many years.[7]

- Evidence has been presented[8] indicating that waiting times for organs are much shorter in the PRC than in the rest of the world, and often as little as two weeks. If accurate, this evidence supports that prisoners are still being used as organ donors, as there does not seem to be a satisfactory alternate explanation.

- China's history of human rights violations against its religious minorities is well-documented by multiple independent sources.[9] [10] [11] These violations make accusations of organ harvesting from among these minorities more credible.

While progress has likely been made in developing more humane and ethically acceptable transplantation practices in the PRC, the continued lack of transparency and availability of transplantation data hurts its standing in the international community and leads other countries to question claims that harvesting organs from prisoners has conclusively ceased.

CONCLUSIONS

The AMA has consistently supported ethical organ transplantation policy at the WMA, and specifically, in its interactions with the Chinese Medical Association. The AMA has strong policies to support our position.

Neither the WMA nor the AMA can independently verify either the sources of transplanted organs or transplantation data in the PRC.

Due in part to lack of transparent and readily available organ transplant data, doubts remain as to the success of the PRC's organ transplantation reforms, and there is credible evidence to suggest that abuses may still be taking place.

RECOMMENDATIONS

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

1. That our American Medical Association continue to engage the Chinese Medical Association and the transplant community in the People's Republic of China (PRC) through promotion and support of relevant activities and policies of the World Medical Association that relate to organ transplantation. (Directive to Take Action)

2. That our AMA, through its membership in the World Medical Association, continue to call for the PRC's compliance with internationally recognized organ transplantation standards, such as those of the World Health Organization, and for the PRC to make available externally verifiable data on organ transplantation. (Directive to Take Action)

3. That our AMA condemn the retrieval of organs for transplantation without the informed consent of the donor. (New HOD Policy)

4. That Policy D-370.981, "Study of Forced Organ Harvesting by China," be rescinded, having been accomplished by this report. (Rescind HOD Policy)

Fiscal Note: Less than $500.

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Additional references are available from the AMA Office of International Relations.

REPORT OF THE BOARD OF TRUSTEES

BOT Report 15-N-21

Subject: Opposing Attorney Presence at and/or Recording of Independent Medical Examinations
(Resolution 1-A-19)

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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At the 2019 Annual Meeting, the House of Delegates (HOD) referred Resolution 1-A-19, "Opposing Attorney Presence at and/or Recording of Independent Medical Examinations" to the Board of Trustees for report. Resolution 1-A-19, introduced by the Illinois Delegation, asked that our American Medical Association (AMA) amend by addition Policy H-365.981, "Workers' Compensation," to include language that opposes the ability of courts to compel recording and videotaping of, or allow a court reporter or an attorney to be present during the independent medical examination, as a condition precedent to allowing the physician's medical opinion in court.

The reference committee heard testimony in opposition to this resolution. Speakers opposing the resolution noted the variability of state laws addressing the recording or videotaping of, or attorney presence at independent medical examinations (IME) for the purpose of resolution of workers' compensation claims. Furthermore, the state specific nature of workers compensation statutes precludes prescribing a national workers' compensation guideline. Testimony supportive of adopting the resolution noted that the resolution is consistent with the ethical guidelines of our AMA and of other organizations, and the recording or presence of a third party is intrusive to a private medical exam. Given the diverse testimony regarding the resolution, the HOD referred Resolution 1-A-19.

This report considers the discordancy of existing state laws regarding the physician's role in IME and presents current AMA policy and *Code of Medical Ethics* opinions. This report analyzes the existing body of AMA policy on the IME in workers' compensation matters and the physician patient relationship and evaluates the consistency of the proposed resolution with existing policy and concludes with a recommendation for HOD action.

BACKGROUND

An IME is a physical examination conducted at the request of a third party, such as an employer or an insurance company. IMEs arise in the context of workers' compensation injury claims, although an IME may also be utilized in any personal injury claim or in employer mandated pre-employment or annual physical examinations. Our AMA Policy on workers' compensation (Policy H -365.981) was initially adopted in 1993 and was most recently modified in 2017 to reflect certain goals that had been met. In addition, a number of states allow for attorney presence during examinations pursuant to a showing of good cause, and/or with the consent of the patient.

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DISCUSSION

AMA Code of Ethics Opinion 1.1.1, *Patient-Physician Relationship*, describes the practice of medicine as a moral activity where the relationship between the physician and patient is based on trust. The opinion further addresses circumstances wherein a *limited* patient-physician relationship is created. One example of a limited patient-physician relationship is in the context of an IME. In keeping with ethics guidance, the IME creates a limited patient-physician relationship imposing a duty of care on the physician conducting the IME examination. While this relationship is subject to variable interpretations across the states, our AMA tasks the physician with responsibilities to both the employer or insurer and the patient.

AMA Code of Medical Ethics E-1.2.6, *Work Related & Independent Medical Examinations*, states that physicians who provide medical examinations at the request of employers or insurance companies face a conflict of duties. The physician has responsibilities to *both* the patient and the employer or third party. The core obligations of industry-employed physicians to their patients include disclosure of the nature of the relationship between the physician and the patient and the physician's departure from the traditional fiduciary role. The physician's ethical responsibility further obligates the physician to inform the patient about incidental findings discovered during the exam, and when appropriate, suggest follow-up care. If requested, the physician also provides reasonable assistance in securing follow-up care.

The integrity of the physician-patient relationship is paramount with long-standing and unequivocal policy support by our AMA. Recording equipment, or the presence of an attorney at an IME, interferes with and lends a degree of artificiality to the examination. The need for a confidential and open exchange between the patient and the examining physician is evident. Allowing a third party who has an interest in the outcome of the examination, or recording the examination, could inhibit and intimidate the patient from candid communication during the exam. The intrusion of counsel in the examining room thrusts the adversarial process into the examination room.

The states have an interest in maintaining the integrity of Workers Compensation claims processes. Numerous states have implemented recording requirements for IME and/or allow an attorney's presence during the exam. While one can recognize the state's interest in attempting to interject a method to document proof of the veracity of the IME, AMA policy is unequivocal on patient privacy and the sanctity of the patient-physician relationship. Furthermore, the claims process is not disadvantaged by the lack of a recording or attorney at the IME. The attorneys and the employer or insurer each receive a copy of the examining physician's written report and can request an additional IME. Most importantly, the attorneys have the opportunity to cross examine the physician in a deposition or at trial. Cross examination of an expert is the industry standard and best practice for obtaining evidence.

Your Board recognizes the concerns expressed by those who testified in opposition to adoption of the resolution. There are numerous state law approaches to the issue raised by Resolution 1-A-19. The state-specific nature of the laws precludes the prescribing of workers compensation guidelines. Your Board further acknowledges a state's legitimate reasons for recording or having an attorney present during an IME. However, your Board does not believe these considerations outweigh the sanctity of the patient-physician relationship, even in the more limited context of an IME, particularly given the availability of other documentation methods such as written reports and cross examination.

CONCLUSION

As noted in the preceding paragraph, testimony at the reference committee indicated that state laws may differ widely in how they deal with the issues that Resolution 1-A-19 raises, and testimony did not indicate that physicians in all states opposed the manner in which their state's law addressed those issues. Consequently, your Board does not recommend that our AMA adopt a blanket policy requiring your AMA to always oppose instances where a state law or proposed legislation permits the recording of an independent medical examination. Adopting such a blanket policy would obligate our AMA to oppose state laws and legislative proposals in cases where physicians in the state may not wish our AMA to oppose the law or proposal. Your Board recommends that your AMA oppose attorney presence and the recording of IMEs when asked to do so by a state medical association or national medical specialty society. This approach avoids committing our AMA to opposition where none has been requested by the state medical association, yet empowers your AMA to assist those state medical associations who wish to challenge laws or legislative proposals that the association believes unjustifiably intrude into the limited patient-physician relationship created in the context of an IME.

RECOMMENDATION

Your Board of Trustees recommends that the following recommendation be adopted in lieu of Resolution 1-A-19 and that the remainder of the report be filed.

> That, upon request of state medical associations and national medical specialty societies, our AMA will provide assistance and consultation in opposing the ability of courts to compel recording and videotaping of, or allow a court reporter or an attorney to be present during the independent medical examination, as a condition precedent to allowing the physician's medical opinion in court. (Directive to Take Action)

Fiscal Note: Less than $1,000

AMA POLICY

H-365.981, “Workers' Compensation”
Our AMA: (1) will promote the development of practice parameters, when appropriate, for use in the treatment of injured workers and encourages those experienced in the care of injured workers to participate in such development. (2) will investigate support for appropriate utilization review guidelines for referrals, appropriate procedures and tests, and ancillary services as a method of containing costs and curbing overutilization and fraud in the workers' compensation system. Any such utilization review should be based on open and consistent review criteria that are acceptable to and have been developed in concert with the medical profession. Physicians with background appropriate to the care under review should have the ultimate responsibility for determining quality and necessity of care. (3) encourages the use of the Guides to the Evaluation of Permanent Impairment. The correct use of the Guides can facilitate prompt dispute resolution by providing a single, scientifically developed, uniform, and objective means of evaluating medical impairment. (4) encourages physicians to participate in the development of workplace health and safety programs. Physician input into healthy lifestyle programs (the risks associated with alcohol and drug use, nutrition information, the benefits of exercise, for example) could be particularly helpful and appropriate. (5) encourages the use of uniform claim forms (CMS 1500, UB04), electronic billing (with appropriate mechanisms to protect the confidentiality of patient information), and familiar diagnostic coding guidelines (ICD-9-CM, CPT; ICD-10-CM, CPT), when appropriate, to facilitate prompt reporting and payment of workers' compensation claims. (6) will evaluate the concept of Independent Medical Examinations (IME) and make recommendations concerning IME's (i) effectiveness; (ii) process for identifying and credentialing independent medical examiners; and (iii) requirements for continuing medical education for examiners. (7) encourages state medical societies to support strong legislative efforts to prevent fraud in workers' compensation. (8) will continue to monitor and evaluate state and federal health system reform proposals which propose some form of 24-hour coverage.
(9) will continue to evaluate these and other medical care aspects of workers' compensation and make timely recommendations as appropriate. (10) will continue activities to develop a unified body of policy addressing the medical care issues associated with workers' compensation, disseminate information developed to date to the Federation and provide updates to the Federation as additional relevant information on workers' compensation becomes available.

E-1.1.1. Patient-Physician Relationships. The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. The relationship between a patient and a physician is based on trust, which gives rise to physicians’ ethical responsibility to place patients’ welfare above the physician’s own self-interest or obligations to others, to use sound medical judgment on patients’ behalf, and to advocate for their patients’ welfare.
A patient-physician relationship exists when a physician serves a patient’s medical needs. Generally, the relationship is entered into by mutual consent between physician and patient (or surrogate). However, in certain circumstances a limited patient-physician relationship may be created without the patient’s (or surrogate’s) explicit agreement. Such circumstances include:
(a) When a physician provides emergency care or provides care at the request of the patient’s treating physician. In these circumstances, the patient’s (or surrogate’s) agreement to the relationship is implicit.
(b) When a physician provides medically appropriate care for a prisoner under court order, in keeping with ethics guidance on court-initiated treatment.
(c) When a physician examines a patient in the context of an independent medical examination, in keeping with ethics guidance. In such situations, a limited patient-physician relationship exists.

E-1.2.6: Work Related & Independent Medical Examinations. Physicians who are employed by businesses or insurance companies, or who provide medical examinations within their realm of specialty as independent contractors, to assess individuals’ health or disability face a conflict of duties. They have responsibilities both to the patient and to the employer or third party. Such industry-employed physicians or independent medical examiners establish limited patient-physician relationships. Their relationships with patients are confined to the isolated examinations; they do not monitor patients’ health over time, treat them, or carry out many other duties fulfilled by physicians in the traditional fiduciary role. In keeping with their core obligations as

medical professionals, physicians who practice as industry- employed physicians or independent medical examiners should:
(a) Disclose the nature of the relationship with the employer or third party and that the physician is acting as an agent of the employer or third party before gathering health information from the patient.
(b) Explain that the physician's role in this context is to assess the patient's health or disability independently and objectively. The physician should further explain the differences between this practice and the traditional fiduciary role of a physician.
(c) Protect patients' personal health information in keeping with professional standards of confidentiality.
(d) Inform the patient about important incidental findings the physician discovers during the examination. When appropriate, the physician should suggest the patient seek care from a qualified physician and, if requested, provide reasonable assistance in securing follow-up care.

E-3.2.3 Industry Employed Physicians and Independent Medical Examiners. Physicians may obtain personal information about patients outside an ongoing patient-physician relationship. For example, physicians may assess an individual's health or disability on behalf of an employer, insurer, or other third party. Or they may obtain information in providing care specifically for a work-related illness or injury. In all these situations, physicians have a responsibility to protect the confidentiality of patient information. When conducting third-party assessments or treating work-related medical conditions, physicians may disclose information to a third party:
(a) With written or documented consent of the individual (or authorized surrogate); or
(b) As required by law, including workmen's compensation law where applicable.
When disclosing information to third parties, physicians should:
(c) Restrict disclosure to the minimum necessary information for the intended purpose.
(d) Ensure that individually identifying information is removed before releasing aggregate data or statistical health information about the pertinent population.

E- 3.2.1 Confidentiality. Patients need to be able to trust that physicians will protect information shared in confidence. They should feel free to fully disclose sensitive personal information to enable their physician to most effectively provide needed services. Physicians in turn have an ethical obligation to preserve the confidentiality of information gathered in association with the care of the patient. In general, patients are entitled to decide whether and to whom their personal health information is disclosed. However, specific consent is not required in all situations. When disclosing patients' personal health information, physicians should:
(a) Restrict disclosure to the minimum necessary information; and
(b) Notify the patient of the disclosure, when feasible.
Physicians may disclose personal health information without the specific consent of the patient (or authorized surrogate when the patient lacks decision-making capacity).
(c) To other health care personnel for purposes of providing care or for health care operations; or
(d) To appropriate authorities when disclosure is required by law.
(e) To other third parties situated to mitigate the threat when in the physician's judgment there is a reasonable probability that: (i) the patient will seriously harm him/herself; or (ii) the patient will inflict serious physical harm on an identifiable individual or individuals.
For any other disclosures, physicians should obtain the consent of the patient (or authorized surrogate) before disclosing personal health information.

REPORT 16 OF THE BOARD OF TRUSTEES (N-21)
Research Handling of De-Identified Patient Information
(Reference Committee on Amendments to Constitutions and Bylaws)

EXECUTIVE SUMMARY

At the 2019 Annual Meeting, BOT Report 26 was referred back for further study to address questions raised by delegates on whether the recommendations in the original report could impact registries established by medical specialties. In addition, since the 2019 Annual Meeting our AMA has identified new and emerging concerns about de-identified data being re-identified by entities for a variety of purposes.

Protected health information (PHI) includes many common identifiers (e.g., name, address, birth date, Social Security Number) that can be associated with patient health information. The HIPAA Privacy Rule sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. Security of PHI safeguards patients from the risk of their data being released or used in manners that could result in discrimination, stigmatization, or embarrassment. However, the use, sale, or distribution of de-identified patient data is not prohibited under HIPAA, since once PHI is de-identified in accordance with the HIPAA Privacy Rule, it is no longer considered PHI and, thus, may be used and disclosed by a covered entity or health information organization (HIO) for any purpose.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 16-N-21

Subject: Research Handling of De-Identified Patient Information

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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INTRODUCTION

At the 2018 Annual Meeting, Policy D-315.975, "Research Handling of De-Identified Patient Information," was adopted by the House of Delegates (HOD). This policy directs the American Medical Association (AMA) to study the handling of de-identified patient data and report the findings and recommendations to the HOD at the 2019 Annual Meeting. During the 2019 Annual Meeting of the HOD, Board of Trustees (Board) Report 26 and the recommendations included therein were discussed on the House floor. Specifically, mixed testimony was offered on recommendation two in the original report which recommended that our AMA support state-based efforts to protect patient privacy including a patient's right to know whether information is being disclosed or sold and to whom, as well as the right to opt out of the sale of their data. Significant testimony was received concerning the impact of that recommendation on registries, its application across inconsistent state laws, as well as on underserved populations. As a result, the HOD referred the report for further study. In addition, since the 2019 Annual Meeting our AMA has grown increasingly concerned that despite data aggregation and the removal of individually identifying characteristics protected health information, de-identified data can and is being re-identified by entities for a variety of purposes.

BACKGROUND

Health-related information collected during the course of clinical care has always been of great interest for a number of secondary use cases, including scientific research in the academic and commercial settings, public health studies, marketing for pharmaceutical and medical device companies, and a wide variety of other uses. More recently, a new and substantial interest has been raised from technology companies who seek to use patient data to build new clinical tools using machine learning and "big data." Clinical data is the topic of significant ethical guidance and regulation at both the state and federal levels, focused primarily on the appropriate use and handling of identifiable patient information. Little guidance exists, however, on the use of de-identified patient data.

A variety of entities, including provider organizations, clinical laboratories, and commercial entities such as personal genomics companies, may collect patient data intended for clinical use or to deliver genetics information, and then resell de-identified data to other entities for other purposes. Concerns arise in that when the data is de-identified, it is no longer considered PHI and therefore patient authorization or consent for use is not required and therefore not solicited—meaning that patients are not always aware how their data is being used.[1]

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In addition, there is both a real and perceived lack of transparency and regulation in how patients' data is being sold, distributed, or used outside of their direct health care. Risk of re-identification, which some studies have demonstrated to be possible through matching data to other publicly available data sources, is another issue related to the use of de-identified data. There are also concerns about access to such information sought for marketing purposes on behalf of commercial entities that have financial interests in physicians' treatment and/or prescribing behavior. In addition, the sale of de-identified data by clinicians and provider organizations may create a real or perceived conflict of interest, which could lead to a loss of patient confidence.

What is Protected Health Information

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides extensive protections for patient data that is considered protected health information (PHI).[2] PHI is information, including demographic information, which relates to an individual's past, present, or future physical or mental health or condition; the provision of health care to the individual; or the past, present, or future payment for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual.[3] It should be noted that HIPPA was developed in the era prior to the expansion of machine learning. PHI includes many common identifiers (e.g., name, address, birth date, Social Security Number) when they can be associated with the health information listed above. The HIPAA Privacy Rule sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization.[4] These safeguards help protect patients from the risk of their data being released or used in manners that could result in discrimination, stigmatization, or embarrassment.[5,6] Section 164.514(a) of the HIPAA Privacy Rule establishes standards for de-identifying PHI so individuals can no longer be identified by any portion of the data. The use, sale, or distribution of de-identified patient data is not prohibited under HIPAA, since once PHI is de-identified in accordance with the HIPAA Privacy Rule, it is no longer considered PHI and, thus, may be used and disclosed by a covered entity or health information organization (HIO) for any purpose otherwise allowed by law.[7]

In addition to regulation at the federal level, state lawmakers have exhibited a general trend toward establishing stricter guards on the use of patient data and the requirement for patient consent, some of which reflect standards set forth in the European Union's recent General Data Protection Regulation (GDPR).[8] States are increasingly considering and passing laws to protect consumer privacy as it relates to the use of their personal information. For example, California in June 2018 passed the California Consumer Privacy Act of 2018 (effective January 1, 2020), which protects consumers' rights to: (1) know what personal information a for-profit business has collected about them, where it was sourced from, what it is being used for, whether it is being disclosed or sold, and to whom it is being disclosed or sold; (2) "opt out" of allowing a business to sell their personal information to third parties; (3) have a business delete their personal information, with some exceptions; and (4) receive equal service and pricing from a business, even if they exercise their privacy rights under the Act.[9] California's law does not apply to information covered by HIPAA, de-identified personal data, or aggregate consumer data, however, as long as the de-identification measures meet the Act's strict standards.[10]

What is de-identified patient data?

45 CFR §164.514(a) of HIPAA states that "[h]ealth information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information." Removing identifiers from PHI mitigates privacy risks to individuals and thereby supports the secondary use of data for

comparative effectiveness studies, policy assessment, life sciences research, and other endeavors.[11] HIPAA requires that covered entities use one of two methods for de-identification: (1) a formal determination by a qualified expert (expert determination); or (2) the removal of specified individual identifiers and an absence of actual knowledge by the covered entity that residual information could be used to identify the individual (safe harbor).

The identifiers that must be removed from PHI in the safe harbor method include:[12]

- Names
- All geographic subdivisions smaller than a state, including street address, city, county, precinct, ZIP code, and their equivalent geocodes, except for the initial three digits of the ZIP code if, according to the current publicly available data from the Bureau of the Census:
    - The geographic unit formed by combining all ZIP codes with the same three initial digits contains more than 20,000 people; and
    - The initial three digits of a ZIP code for all such geographic units containing 20,000 or fewer people is changed to 000.
- All elements of dates (except year) for dates that are directly related to an individual, including birth date, admission date, discharge date, death date, and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older
- Telephone numbers
- Vehicle identifiers and serial numbers, including license plate numbers
- Fax numbers
- Device identifiers and serial numbers
- Email addresses
- Web URLs
- Social security numbers
- Internet Protocol addresses
- Medical record numbers
- Biometric identifiers, including finger and voice prints
- Health plan beneficiary numbers
- Full-face photographs and any comparable images
- Account numbers
- Any other unique identifying number, characteristic, or code, except as permitted
- Certificate/license numbers

How is de-identified data used?

De-identified data is used for research to derive information and knowledge about treatment and outcomes, as well as other patient care-related purposes. De-identified data is sourced, collected, and used by a variety of organizations, including health care provider organizations such as hospitals or academic medical centers, and commercial enterprises such as personal genomics and biotechnology companies as well as others that may not be directly related to patient care. Pharmaceutical manufacturers and retail pharmacies may also use de-identified health data to target their advertising. Health care providers use this data typically in research or the direct care of patient populations. Many stakeholders assert that de-identified data can help reduce costs of care, improve treatment options, and support public health initiatives.

Machine learning is a family of methods used by some health care and data solution organizations to help predict certain outcomes and better prepare for and treat patients identified to be at risk. Machine learning models establish predictive rules using vast amounts of computing power. The

more data a machine learning model has, the more complex the rules and the more accurate the predictions.[13] However, machine learning models are vulnerable to biases induced by data that does not adequately represent the patient population, such as data collected from only one institution or one geographic region. In order to develop clinical decision support tools that can be effectively used to treat the diverse patient populations in the United States, large amounts of data are required, and often data from many different providers across the country are required to avoid bias. The data are often sourced from de-identified patient records. Allscripts, for example, used 50 million de-identified patient records, and the application of an advanced machine learning algorithm, to "train" its systems and further improve its clinical decision support tools.[14] Organizations like Orion Health and Precision Driven Health are using datasets like these to generate machine learning aimed at improving health care decisions, and driving operational and cost efficiencies.[15,16] By combining multiple datasets, such as behavioral data, device use data, patient claim data and socioeconomic and geographic data, these organizations are developing advanced predictive analytics to further improve precision health care.[17] The data used for the purposes of data mining and honing machine learning algorithms are either sourced and used at the organizational level, or de-identified when used for external research, such as the analysis done by Allscripts. Data may be sourced via publicly available de-identified datasets, databases established through collaborative research agreements, or via the purchase of bulk de-identified data, on an exclusive or non-exclusive basis. Since this technology is relatively new in the health care space its implications for patient data are not well-studied. As augmented intelligence and advanced machine learning proliferate in the health care space, the value and number of potential uses of patient health data will inevitably increase. Stakeholders should be prepared for increasing concerns about related patient privacy and data security.

Commercial entities, such as personal genomics companies, are typically not subject to HIPAA's rules around privacy and de-identification. They may collect data from consumers and then subsequently sell the de-identified data to another entity for another purpose. For example, 23andMe, a genomics and biotech service, sells de-identified user data to pharmaceutical companies that use it to conduct research on various diseases. However, patients are not always aware how their data is being used in these types of scenarios.[18] For example, research using de-identified data may result in scientific knowledge that has commercial value. Proper consent for use and/or disclosure of commercial interest in this research is ideal but inconsistent, sometimes resulting in legal action against physicians or researchers.[19]

In addition, there is a lack of transparency and regulation in how patients' data is being sold, distributed, or used outside of their direct health care, both by entities subject to HIPAA and commercial actors. Risk of re-identification, which some studies have demonstrated to be possible through matching data to other publicly available data sources, is another issue related to the use of de-identified data. There are also concerns about access to such information that is sought for marketing purposes on behalf of commercial entities that have financial interests in physicians' treatment and/or prescribing behavior.

AMA POLICY

The AMA has multiple policies expressing its recognition of the importance of data privacy and protection of PHI, as well as policies expressing commitment to ensuring safe and appropriate use of de-identified data.

AMA Policy H-315.978, "Privacy and Confidentiality," states that where possible, informed consent should be obtained before personally identifiable health information is used for any purpose. However, in those situations where specific informed consent is not practical or possible,

either (1) the information should have identifying information stripped from it or (2) an objective, publicly accountable entity must determine that patient consent is not required after weighing the risks and benefits of the proposed use. Re-identification of personal health information should only occur with patient consent or with the approval of an objective, publicly accountable entity.

AMA Policy H-315.974, "Guiding Principles, Collection and Warehousing of Electronic Medical Record Information," expresses the AMA's commitment to advocating that physicians, as trusted stewards of PHI, should be the owners of all claims data, transactional data and de-identified aggregate data created, established and maintained by a physician practice, regardless of how and where such data is stored but specifically including any such data derived from a physician's medical records, electronic health records, or practice management system.

AMA Policy H-315.983, "Patient Privacy and Confidentiality," states that whenever possible, medical records should be de-identified for purposes of use for utilization review, panel credentialing, quality assurance, and peer review. This policy also states our AMA will 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, and that whenever possible, de-identified data should be used for these purposes. Policy H-315.983, posits that in the event of a sale or discontinuation of a medical practice, 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. This policy includes extensive language emphasizing the AMA's commitment to protecting PHI, and that it will 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 physician 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.

In AMA Policy H-315.975, "Police, Payer, and Government Access to Patient Health Information," the AMA commits to advocating for narrow and clearly defined bounds for the appropriate use of patient information by law enforcement, payers and government entities, for operations that cannot be reasonably undertaken with de-identified data. AMA Policy H-315.987, "Limiting Access to Medical Records," further defines who should and should not have access to this information.

The AMA's *Code of Medical Ethics* includes an opinion on "Access to Medical Records by Data Collection Companies." Opinion E-3.2.4 asserts that disclosing information to third parties for commercial purposes without consent undermines trust, violates principles of informed consent and confidentiality, and may harm the integrity of the patient-physician relationship. The opinion further expresses that physicians who wish to permit third-party access to specific patient information for commercial purposes should: (a) only provide data that has been de-identified, and (b) fully inform each patient whose record would be involved about the purpose(s) for which access would be granted. This opinion, with respect to requests for permission to allow access to or disclose a full medical record, prohibits disclosing identifiable information for commercial purposes without obtaining consent from the patient to do so.

The authors of Resolution 3-A-18, which established Policy D-315.975 and is the subject of this report, expressed particular concern that this *Code of Medical Ethics* Opinion may contradict itself in its emphasis on informing the patient of how their de-identified data will be used and the

subsequent emphasis on the importance of obtaining consent. The key difference between the two elements of the opinion lies in the description of the patient information being requested (specific, de-identified patient information vs. full medical record), thus our AMA does not agree that these statements are contradictory.

The resolutions authors also expressed that this Opinion may be in disharmony with the rules set forth in the HIPAA Privacy Rule, specifically stating that authorization, rather than consent, is sometimes mandated for the release of PHI when being requested for purposes not related to treatment, payment, or health care operations (TPO). Ethical Opinion E-3.2.4 was originally issued in 1994 and updated in 1998, prior to the enactment of the HIPAA Privacy Rule, yet provides an even higher standard than the Rule with respect to requirements for consent to disclose patient data, including data that has been de-identified. With respect to authorization requirements, Opinion E-3.2.4 does not include a statement about when authorization, rather than consent, is appropriate and/or required. Guidance provided in the Code of Medical Ethics is provided by standards of conduct that define the essentials of honorable behavior for the physician. They cover broad ethical principles and are not intended to align with law or specific regulations that may be legally enforceable. During a comprehensive eight-year modernization process that ended in 2017, the AMA *Code of Medical Ethics* was reviewed for relevance/timeliness of guidance, clarity, and consistency of guidance. Opinion E-3.2.4 was reorganized in this process, taking the HIPAA provisions into consideration during the process. Care was taken to ensure the Council on Ethical and Judicial Affairs was conservative in suggesting substantive change, doing so only where needed to ensure that guidance remains relevant in the face of changes in biomedical science and conditions of medical practice. No contradictions or points of discord with HIPAA were identified in that review. It is also worth noting that "authorization" and "consent" are frequently (and often incorrectly) conflated in the context of HIPAA.

DISCUSSION

Oversight of patient information

The use of de-identified patient data is not heavily regulated at the federal level. The HIPAA Privacy Rule does not restrict the use or disclosure of de-identified health information, since it is not considered PHI.[20,21] HIPAA permits secondary uses of de-identified data for purposes such as public health initiatives, research, law enforcement, and other public interest endeavors.[22, 23] In addition, commercial entities that sell or use de-identified data, such as biotech, "big data" companies such as Google and Amazon, and pharmaceutical companies, are not considered covered entities under HIPAA. Through their interactions with pharmacy benefit managers, pharmacies, payers, physicians and patients, however, they may be indirectly impacted by privacy rules and thus obliged to structure their transactions, projects, and internal data programs such that their partners that are covered entities or business associates thereof meet data privacy requirements under HIPAA and any other applicable standards.

Studies that use de-identified data are exempt from regulations that govern human subject research.[24,25] Entities that collect and use consumer data, such as pharmaceutical companies or academic institutions conducting research, should employ privacy protections in their practices, such as data security, reasonable collection limits, sound retention and disposal practices, and data accuracy to protect privacy, as guided in recommendations from the Federal Trade Commission (FTC).[26] For example, Harvard University, like many academic institutions receiving federal grants, implements strict policy to govern the collection, storage and use of research data, including PHI.[27] In addition to the enforcement of strict policy, all human subject research is subject to approval by the institution's Institutional Review Board (IRB). It is the responsibility of IRBs to

specify the security level for research projects they review and approve, obtain confirmation that the relevant security controls are being implemented and decide if the human subject must give consent or in the case of de-identified information, approve the research under an exempt status from obtaining the consent.

Human subject research conducted or supported by certain federal departments or agencies is governed by the Federal Policy for the Protection of Human Subjects ("Common Rule"). Revisions to the Common Rule in 2017 were adopted in response to shifts in science, technology, public engagement, and public expectations that have raised concerns about the limitations of the existing ethical framework in research.[28] The rapid pace of change in the availability, utility, and value of patient data, including PHI and de-identified data, will continue to necessitate regular reconsideration of the ethical oversight of patient data and how it is protected by researchers and other entities.

De-identified data and clinical data registries

Clinical data registries sponsored by entities such as national medical societies, or state or local health departments also collect and analyze data (including PHI) on treatment outcomes submitted by physicians, hospitals, and other types of health care providers related to a wide variety of medical procedures, diagnostic tests, and/or clinical conditions. Such registries use the data they collect to produce benchmarks or metrics that their participating health care providers can use to improve the quality of care they provide their patients. Registries also conduct (or work with others to conduct) research on the data they collect to enhance general knowledge about the safety and effectiveness of various medical procedures, diagnostic tests, treatments, and health care products. Other registries, such as public health databases, collect data on various population health events that may or may not involve medical treatment.

In 2018, the AMA reaffirmed Policy H-450.933, "Clinical Data Registries." This policy states, in part, that "[o]ur AMA encourages multi-stakeholder efforts to develop and fund clinical data registries for the purpose of facilitating quality improvements and research that result in better health care, improved population health, and lower costs;" … "[o]ur AMA supports flexibility in the development and implementation of clinical data registries;" and "[r]egistries and electronic health records should be interoperable, and should be capable of sharing and integrating information across registries and with other data sources in a HIPAA-compliant and confidential manner." As evident by the reaffirmation of the Clinical Data Registries policy in 2018, our AMA does not desire to hinder the efforts of these registries to facilitate quality improvements and research that result in better health care, improved population health, and lower costs.

Risks with the re-identification of de-identified data and general ethical concerns

There are significant ethical concerns about the disclosure and use of de-identified health data that are rooted in the risk of re-identification. Studies have shown that certain elements of patient records, although not exclusive or unique to individual patients, increase the risk of re-identification if not removed from individual-level data.[29,30] Elements such as gender, date of service, date of birth or zip code can potentially be linked back to other sources of data, such as voter registration lists, and could put the data at risk of re-identification.[31,32] Organizations that collect, store, transfer and distribute de-identified data should take steps to reduce this risk, such as replacing a specific date of birth or date of service with a year.

Additionally, studies assessing the risk of re-identification after attempts to de-identify the data have found that just a few attributes are often enough to render the likelihood of correct re-

identification very high. Our AMA policy is clear that the re-identification of personal health information should only occur with patient consent or with the approval of an objective, publicly accountable entity. Furthermore, since our initial Board report was presented during A-19, new studies and legal challenges have emerged that provide additional insight, and by extension raise additional concerns, about the increasing ability of entities (especially those with augmented intelligence (AI) capabilities) to re-identify de-identified patient data.[33,34,35] Our AMA believes that corporate entities have a responsibility and an obligation to ensure that technical safeguards are being used to prevent the re-identification of de-identified patient data.

In addition to risk of re-identification, there are general ethical concerns with the availability and use of patient health data, even if it is de-identified, without explicit authorization from patients. For example, pharmaceutical companies may use de-identified data to target marketing or advertising efforts to specific physicians, therefore influencing treatment plans for patient populations with specific diseases or conditions. Accountable Care Organizations (ACOs), as business associates of the ACO participants or a covered entity, may use de-identified data to analyze quality measures, population risk scores and patient behaviors.[36] Other for-profit entities may use de-identified data for the development of new technology or clinical innovations. These sales of patient records for profit by provider organizations may raise concerns from the public that providers have an ulterior motive for collecting their data during clinical encounters. There are also studies demonstrating that for-profit entities selling de-identified information gleaned from consumer-facing mobile health applications (apps) frequently are in violation of the apps' stated privacy policies.[37] In addition, patient record licensing contracts with exclusive rights may raise questions about the appropriate stewardship of patient data, as such exclusive contracts may be seen to benefit specific licensees at the expense of others, rather than enabling research and product development across the entire marketplace. However, one can imagine limited scenarios where a registry may choose to license de-identified data sets to commercial entities, with or without some degree of exclusivity, and yet maintain proper safeguards that require entities to ensure the data is not re-identified so the data can be used to further medical research.

Consent and authorization

Issues that arise in the potential risks of patient data use can be mitigated by proactively obtaining appropriate authorization or informed consent from patients for the use of their data. In the context of HIPAA, these issues primarily apply to PHI and not de-identified data. The HIPAA Privacy Rule permits, but does not require, a covered entity voluntarily to obtain patient consent for uses and disclosures of PHI for TPO. Covered entities that decide to obtain consent have complete discretion to design a process that best suits their needs. By contrast, an authorization is required by the Privacy Rule for most uses and disclosures of PHI not otherwise allowed by the Rule. Where the Privacy Rule requires patient authorization, voluntary consent is not sufficient to permit a use or disclosure of PHI. An authorization is a detailed document that gives covered entities permission to use PHI for specified purposes (e.g., sale of PHI or use of PHI to conduct marketing activities) or to disclose PHI to a third party specified by the individual. An authorization must include a number of elements, including a description of the PHI to be used and disclosed, the person authorized to make the use or disclosure, the person to whom the covered entity may make the disclosure, an expiration date, and, in some cases, the purpose for which the information may be used or disclosed.[38]

PHI may be used and disclosed for research without an authorization in limited circumstances: (1) under a waiver of the authorization requirement; (2) as a limited data set with a data use agreement; (3) preparatory to research; and (4) for research on decedents' information. Limited data sets exclude 16 categories of direct identifiers, rather than the 18 identifiers removed in de-

identified data. The information in a limited data set is considered PHI and its use or disclosure requires a data use agreement between the covered entity and the entity that will receive or use the data.

Standards and guidance

ONC publishes the "Guide to Privacy and Security of Electronic Health Information" to help physicians, other health care providers and practices work to comply with federal requirements in collecting, storing and using patients' data.[39]

In addition to the policy set by the AMA and the guidance provided in the AMA *Code of Medical Ethics*, other physician and health care organizations provide guidelines and standards on the use of de-identified patient data. For example, the American Academy of Family Physicians published a "Data Stewardship" policy that facilitates the appropriate collection, storage, transmission, analysis, and reporting of de-identified patient data.[40] This policy includes guidance on establishing and maintaining a proper patient and physician consent process, as well as the appropriate use of data by third parties and policies that establish requirements for third-party use.

The American College of Physicians (ACP) policy encourages clinical entities and physicians to publish electronically their policies and procedures for sharing patient data and ensuring privacy. ACP's policy also states that in keeping with HIPAA, patients should know what information exists about them, its purpose, who can access and use it, and where it resides. While ACP supports the use of appropriately de-identified patient data for socially important activities, such as population health efforts and retrospective research, it does recommend tighter controls on the risks of re-identification of de-identified data.[41]

CONCLUSION

Access to de-identified patient data is important for the future of health care. Its benefits to the field of research have significant implications for our ability to make progress in refining the practice of medicine, reducing health care costs, reducing and preventing chronic disease, identifying cures for deadly conditions, and much more. In practice-level interventions, de-identified data can help practice administrators recognize patterns and gaps in processes and treatment plans across clinicians. Although the use of de-identified patient data can contribute to the continuum of improvement that is much needed across health care, its use comes with significant risks in the area of re-identifying patient data. The use of patient data is rapidly evolving, and our AMA must remain vigilant to ensure patient data is being used properly, that appropriate safeguards are instituted to ensure risks are mitigated, and that, where patient consent is required or warranted, it is meaningful.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) reaffirm Policies H-315.975, "Police, Payer, and Government Access to Patient Health Information," H-315.978, "Privacy and Confidentiality," and H-315.987, "Limiting Access to Medical Records." (Reaffirm HOD Policy)

2. That our AMA adopt a technical change to Policy H-315.974, "Guiding Principles, Collection and Warehousing of Electronic Medical Record Information," by addition as follows: (Modify Current HOD Policy)

   Policy H-315.974, "Guiding Principles, Collection and Warehousing of Electronic Medical Record Information"
   Our AMA expressly advocates for physician ownership of all claims data, transactional data and de-identified <u>and/or</u> aggregate data created, established and maintained by a physician practice, regardless of how and where such data is stored but specifically including any such data derived from a physician's medical records, electronic health records, or practice management system, while preserving the principle that physicians act as trusted stewards of Protected Health Information.

3. That our AMA support efforts to promote transparency in the use of de-identified patient data and to protect patient privacy by developing methods of, and technologies for, de-identification of patient information that reduce the risk of re-identification of such information. (New HOD Policy)

4. That our Council on Ethical and Judicial Affairs consider re-examining existing guidance relevant to the confidentiality of patient information, striving to preserve the benefits of widespread use of de-identified patient data for purposes of promoting quality improvement, research, and public health while mitigating the risks of re-identification of such data. (Directive to Take Action)

5. That Policy D-315.975, "Research Handling of De-Identified Patient Information," be rescinded, as having been fulfilled by this report. (Rescind HOD Policy)

Fiscal note: Less than $500

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REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 1-N-21

Subject: Further Action on Bylaw 7.5.2

Presented by: Pino Colone, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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At the June 2021 meeting of the AMA House of Delegates, the House adopted two reports from the Council on Constitution and Bylaws related to eligibility for the Young Physicians Section. CCB Report 3-JUN-21 provided language to clarify original Bylaw 7.5.2 as follows:

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

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

7.5.2 Cessation of Eligibility of Governing Council Members. If any Governing Council member ceases to meet the membership requirements of Bylaw 7.5.1 prior to the expiration of the term for which elected, the term of such member shall terminate and the position shall be declared vacant. If any member's term would terminate prior to the conclusion of an Annual Meeting, such member shall be permitted to serve in office until the conclusion of the Annual Meeting in the calendar year in which such member ceases to meet the membership requirements of Bylaw 7.5.1, as long as the member remains an active physician member of the AMA.

7.5.2.1 The chair position is a three-year commitment and divided into the roles of chair-elect, chair, and immediate past chair. The young physician must meet the requirements of Bylaws 7.5.1 and 7.5.2 through the end of the chair role, or 2nd year. The immediate past chair shall be permitted to complete the term of office even if unable to continue to meet all of the requirements of Bylaw 7.5.1, as long as the physician remains an active physician member of the AMA.

In consultation with the Young Physicians Section, CCB issued Report 5-JUN-21, which further amended the language of 7.5.2 as follows, and which also was adopted by the House:

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

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7.5.2 Cessation of Eligibility of Governing Council Members. If any Governing Council member ceases to meet the membership requirements of Bylaw 7.5.1 prior to the expiration of the term for which elected, the term of such member shall terminate and the position shall be declared vacant. If any member's term would terminate prior to the conclusion of an Annual Meeting, such member shall be permitted to serve in office until the conclusion of the Annual Meeting following that when ~~in which~~ such member ceases to meet the membership requirements of Bylaw 7.5.1, as long as the member remains an active physician member of the AMA.

7.5.2.1 The chair position is a three-year commitment and divided into the roles of chair-elect, chair, and immediate past chair. The young physician must meet the requirements of Bylaws 7.5.1 and 7.5.2 when elected as chair-elect ~~through the end of the chair role, or 2nd year~~. The chair-elect, chair and immediate past chair shall be granted membership in the Section and be permitted to complete the term of office even if unable to continue to meet all of the requirements of Bylaw 7.5.1, as long as the physician remains an active physician member of the AMA.

In reconciling the language of the two reports for PolicyFinder and the July 2021 update of the AMA Bylaws, it was discovered that that the words "in the calendar year" of 7.5.2 were inadvertently omitted from CCB Report 5-JUN-21. While elimination of these words was the goal of the YPS and CCB, because the words were not shown as stricken the words remain in the July 2021 Bylaws.

The Council has prepared this report to present the appropriate bylaw amendment by deletion to ensure that the AMA Constitution and Bylaws remains an accurate document. The Council confirmed with the Young Physicians Section that deletion of these words was the intent of both groups.

RECOMMENDATIONS

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

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

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

7.5.2 Cessation of Eligibility of Governing Council Members. If any Governing Council member ceases to meet the membership requirements of Bylaw 7.5.1 prior to the expiration of the term for which elected, the term of such member shall terminate and the position shall be declared vacant. If any member's term would terminate prior to the conclusion of an Annual Meeting, such member shall be permitted to serve in office until the conclusion of the Annual Meeting ~~in the calendar year~~ following that

when such member ceases to meet the membership requirements of Bylaw 7.5.1, as long as the member remains an active physician member of the AMA.

7.5.2.1 The chair position is a three-year commitment and divided into the roles of chair-elect, chair, and immediate past chair. The young physician must meet the requirements of Bylaws 7.5.1 and 7.5.2 when elected as chair-elect. The chair-elect, chair and immediate past chair shall be granted membership in the Section and be permitted to complete the term of office even if unable to continue to meet all of the requirements of Bylaw 7.5.1, as long as the physician remains an active physician member of the AMA.

(Modify Bylaws)

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 2-N-21

Subject: Rescission of Bylaws Related to Run-off Elections

Presented by: Pino Colone, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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At the June 2021 meeting of the AMA House of Delegates, the House adopted Recommendation 30 of Speakers Report 2, "Report of the Election Task Force," recommending that Bylaws 3.4.2.2 and 6.8.1.5 be rescinded. Rescission of these bylaw provisions and implementation of G-610.030, whereby voting for all elected positions including runoffs will be conducted electronically during an Election Session, encourages candidates to announce their candidacy early, adds transparency to AMA elections, results in more contested elections, allows delegations the opportunity to vet candidates for newly opened positions, and eliminates the distraction from policy discussion that occurs with the prior "pop-up" process as G-610.030 eliminates "pop-ups."

The Council has prepared this report to present the appropriate bylaw amendments for House action.

RECOMMENDATIONS

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

3.4.2 Method of Election. Where there is no contest, a majority vote without ballot shall elect. All other elections shall be by ballot.

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

[Subsequent bylaw provisions will be renumbered accordingly.]

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6.8 Election - Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, and Council on Science and Public Health.

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

(Modify Bylaws)

RELEVANT AMA POLICY

G-610.030, Election Process. AMA guidelines on the election process are as follows: (1) AMA elections will be held on Tuesday at each Annual Meeting; (2) Voting for all elected positions including runoffs will be conducted electronically during an Election Session to be arranged by the Speaker; (3) All delegates eligible to vote must be seated within the House at the time appointed to cast their electronic votes; and (4) The final vote count of all secret ballots of the House of Delegates shall be made public and part of the official proceedings of the House.

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 3-N-21

Subject: AMA Women Physicians Section: Clarification of Bylaw Language

Presented by: Pino Colone, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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At the June 2021 meeting, the Council submitted a report at the request of the Women Physicians Section to clarify the membership of the Women Physicians Section (WPS). CCB Report 2, "AMA Women Physicians Section: Clarification of Bylaw Language," proposed bylaw amendments to specify that all female physician and medical student members of the AMA as identified in the AMA Masterfile would automatically be considered WPS members in contrast to existing bylaw language that declares them "eligible" for WPS membership. Existing bylaw language also states that "other active AMA members who express an interest in women's issues shall be eligible for WPS membership." The Council's proposed language was consistent with the Internal Operating Procedures of the WPS review by the Council and approved by the Board.

Reference committee testimony on CCB Report supported the automatic inclusion of female physicians and medical students as WPS members, but some concerns arose about the need for gender-neutral language that ensured equal access to the WPS regardless of gender identity. The reference committee proposed alternative language as follows: "All physicians and medical students who are active members of the AMA and identify as female shall be members of the Women Physicians Section. Other active members of the AMA who express an interest in women's issues shall be eligible to join the section." The House did not accept the amended language offered by the reference committee and the report was referred back.

BACKGROUND

The Council has investigated how various AMA databases categorize gender to better understand the process of gender self-identification and implications for WPS membership. The Council learned that the AMA Masterfile is used to identify gender (male, female or unknown) for purposes of section participation. The Masterfile, established in 1906, derives its basic information for U.S. allopathic students and physicians from the Association of American Medical Colleges (AAMC) and their work with Liaison Committee on Medical Education (LCME) accredited medical schools.

When an individual enters an LCME accredited medical school, the AMA creates a record for that individual. The initial record created with AAMC matriculation data includes legal name, date of birth, birthplace, legal residence, gender (male or female), and training institution.[1] Specifically, gender information is self-reported by the individual on their medical school application. International medical graduates (IMGs) are identified upon entry into an ACGME-accredited post-graduate residency training program or when they obtain a license in a US licensing jurisdiction.

[1] Per Policy D-630.972, our AMA continues to work with the AAMC to collect race/ethnicity information through the student matriculation file and the GME census including automating the integration of this information into the Masterfile.

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U.S. osteopathic students and physicians are entered after verifying enrollment in or graduation from an accredited osteopathic medical school. Gender is provided, where available, by the school as part of the verification process. As a physician's training and career develop, additional information, such as licensure, residencies, fellowships, board certification and recertification, and type of practice, is added to their record. Records are continuously updated through extensive data collection and verification efforts. The Masterfile not only serves as a primary resource for professional medical organizations, universities and medical schools, research institutions, governmental agencies and other health-related groups, but its use is fundamental to the AMA's mission to strengthen the medical profession and ensure quality health care for the American public.

In 2018, AMA established a separate database to collect and maintain information on gender identity and sexual orientation in response to the adoption of Policy G-635.125, "AMA Membership Demographics." Submission of information to the Sexual Orientation Gender Identity (SOGI) database is completely voluntary and confidential. To protect confidentiality, these data are only provided in aggregate for the AMA to better understand its membership demographics and are not made available at the physician level for any purpose. As of August 2021, approximately 35,000 physicians have chosen to provide this information via the AMA Account Management Center.

Updates to the AMA Physician Masterfile can be submitted electronically through the AMA Account Management Center, or the Online Data Collection Center at https://login.ama-assn.org/account/login. Updates can also be mailed or faxed to the AMA, Division of Health Solutions Data Management, Attn: Data Verification Unit, AMA Plaza, 330 N. Wabash Ave., Suite 39300, Chicago, Illinois 60611, (312) 464-5759, (312) 464-4880 (Fax). Physicians can also update information on their Masterfile record by contacting the AMA Member Service Center at 800-262-3211 (available Monday through Friday from 8:00 AM until 5:00 PM CT).

While the Council supports the desire of WPS to allow those physicians who self-identify as female to be enrolled automatically as WPS members based on either Masterfile or SOGI data, that cannot currently be accomplished without violating the confidentiality under which these data were collected. The only way to ensure that the WPS offers equal access to the section regardless of gender identity would be to make the WPS an opt-in section, which likely would significantly diminish its membership numbers and impact.

The Council on Constitution and Bylaws presents this report for House action.

RECOMMENDATIONS

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

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

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

Fiscal Note: Less than $500

RELEVANT AMA POLICY

G-635.125, AMA Membership Demographics
1. Stratified demographics of our AMA membership will be reported annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty.
2. Our AMA will immediately release to each state medical and specialty society, on request, the names, category and demographics of all AMA members of that state and specialty.
3. Our AMA will develop and implement a plan with input from the Advisory Committee on LGBTQ Issues to expand demographics collected about our members to include both sexual orientation and gender identity information, which may be given voluntarily by members and will be handled in a confidential manner.

D-630.972, AMA Race/Ethnicity Data
Our American Medical Association will continue to work with the Association of American Medical Colleges to collect race/ethnicity information through the student matriculation file and the GME census including automating the integration of this information into the Masterfile.

H-65.9671, Conforming Sex and Gender Designation on Government IDs and Other Documents
1. Our AMA supports every individual's right to determine their gender identity and sex designation on government documents and other forms of government identification.
2. Our AMA supports policies that allow for a sex designation or change of designation on all government IDs to reflect an individual's gender identity, as reported by the individual and without need for verification by a medical professional.
3. Our AMA supports policies that include an undesignated or nonbinary gender option for government records and forms of government-issued identification, which would be in addition to "male" and "female."
4. Our AMA supports efforts to ensure that the sex designation on an individual's government-issued documents and identification does not hinder access to medically appropriate care or other social services in accordance with that individual's needs.
5. Our AMA will advocate for the removal of sex as a legal designation on the public portion of the birth certificate, recognizing that information on an individual's sex designation at birth will still be submitted through the U.S. Standard Certificate of Live Birth for medical, public health, and statistical use only.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 1-N-21

Subject: Short-term Medical Service Trips

Presented by: Alexander M. Rosenau, DO, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Short-term medical service trips, which send physicians and physicians in training from wealthier countries to provide care in resource-limited settings abroad for a period of days or weeks, have emerged as a prominent strategy for addressing global health inequities. They also provide training and educational opportunities, thus offering benefit both to the communities that host them and the medical professionals and trainees who volunteer their time and clinical skills. At the same time, short-term medical service trips pose challenges for everyone involved. Volunteers, sponsors, and hosts must jointly prioritize activities to meet agreed-on goals; navigate day-to-day collaboration across differences of culture, language, and history; and fairly allocate host and team resources in the local setting.

This report by the Council on Ethical and Judicial Affairs (CEJA) explores the phenomenon of short-term medical service trips and offers guidance for physicians and physicians in training to help them address the ethical challenges they face in providing clinical care in resource-limited settings abroad.

THE APPEAL OF SERVING ABROAD

Just how many clinicians volunteer to provide medical care in resource-limited settings abroad is difficult to estimate, but the number is large. By one estimate, in the U.S. some 21% of the nearly 3 billion dollars' worth of volunteer hours spent in international efforts in 2007 were medically related [1]. For trainees, in January 2015 the Consortium of Universities for Global Health identified more than 180 websites relating to global health opportunities [2]. The Association of American Medical Colleges found that among students who graduated in 2017–2018 between 25% and 31% reported having had some "global health experience" during medical school [3].

A variety of reasons motivate physicians and trainees to volunteer for service trips. For many, compelling motivations include the opportunities such trips offer to help address health inequities, to improve their diagnostic and technical skills as clinicians, or to explore global health as a topic of study [1]. Service trips can also serve less lofty goals of building one's resume and improving one's professional prospects, gaining the esteem of peers and family, or simply enjoying international travel [1].

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*Reports of the Council on Ethical and Judicial Affairs are assigned to the Reference Committee on Amendments to Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

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A NOTE ON TERMINOLOGY

The literature is replete with different terms for the activity of traveling abroad to provide medical care on a volunteer basis, including "short-term medical volunteerism" [4], "short-term medical missions" [5], "short-term medical service trips" [6,7], "short-term experience in global health" [8,9], "global health field experience" [10], "global health experience," and "international health experience"[1]. Each has merit as a term of art.

The Council on Ethical and Judicial Affairs prefers "short-term medical service trips." In the council's view, this term is clear, concrete, concise, and does not lend itself to multiple interpretations and possible misunderstanding. Importantly, it succinctly captures the features of these activities that are most salient from the perspective of professional ethics in medicine: their limited duration and their orientation toward service.

MEDICAL SERVICE IN RESOURCE-LIMITED SETTINGS

Traditionally, short-term medical service trips focused on providing clinical care as a charitable activity, not infrequently under the auspices of faith-based institutions, whose primary goal was to address unmet medical needs [9]. Increasingly, such trips focus on the broader goal of improving the health and well-being of host communities [8]. Many now also offer training opportunities for medical students and residents [8,9,10]. Ideally, short-term medical service trips are part of larger, long-term efforts to build capacity in health care systems being visited, and ultimately to reduce global health disparities [8,9].

The medical needs of host communities differ from those of volunteers' home countries—volunteers may encounter patients with medical conditions volunteers have not seen before, or who present at more advanced stages of disease, or are complicated by "conditions, such as severe malnutrition, for which medical volunteers may have limited experience" [6]. At the same time, available treatment options may include medications or tools with which volunteers are not familiar.

By definition, short-term medical service trips take place in contexts of scarce resources. The communities they serve are "victims of social, economic, or environmental factors" who have limited access to health care [6], and often lack access to food, and economic and political power as well and "may feel unable to say no to charity in any form offered" [9]. Moreover, short-term medical service trips take place under the long shadow of colonialism, including medicine's role [11], and have been critiqued as perpetuating the colonial legacy of racism, exploitation, and dependency [9,12,13].

ETHICAL RESPONSIBILITIES IN SHORT-TERM MEDICAL SERVICE TRIPS

These realities define fundamental ethical responsibilities not only for those who volunteer, but equally for the individuals and organizations that sponsor short-term medical service trips. Emerging guidelines identify duties to maximize and enhance good clinical outcomes, to promote justice and sustainability, to minimize burdens on host communities, and to respect persons and local cultures [1,8, 9,10].

Promoting Justice & Sustainability

If short-term medical service trips are to achieve their primary goal of improving the health of local host communities, they must commit not simply to addressing immediate, concrete needs, but to helping the community build its own capacity to provide health care. To that end, the near and longer-term goals of trips should be set in collaboration with the host community, not determined in advance solely by the interests or intent of trip sponsors and participants [8,6]. Trips should seek to balance community priorities with the training interests and abilities of participants [9], but in the first instance benefits should be those desired by the host community [8]. Likewise, interventions must be acceptable to the community [8].

Volunteers and sponsors involved with short-term medical service trips have a responsibility to ask how they can best use a trip's limited time and material resources to promote the long-term goal of developing local capacity. Will the trip train local health care providers? Build local infrastructure? Empower the community [6]? Ideally, a short-term medical service trip will be part of a collaboratively planned longer-term and evolving engagement with the host community [6,9].

Minimizing Potential for Harms & Burdens in Host Communities

Just as focusing on the overarching goal of promoting justice and sustainability is foundational to ethically sound short-term medical service trips, so too is identifying and minimizing the burdens such trips could place on the intended beneficiaries.

Beyond lodging, food, and other direct costs of short-term medical service trips, which are usually reimbursed to host communities [8], such trips can place indirect, less material burdens on local communities. Physicians, trainees, and others who organize or participate in short-term medical service trips should be alert to possible unintended consequences that can undermine the value of a trip to both hosts and participants. Trips should not detract from or place significant burdens on local clinicians and resources, particularly in ways that negatively affect patients, jeopardize sustainability, or disrupt relationships between trainees and their home institutions [8,10]. For example, donations of medical supplies can address immediate need, but at the same time create burdens for the local health care system and jeopardize development by the local community of effective solutions to long-term supply problems [6].

Negotiating beforehand how visiting health care professionals will be expected to interact with the host community and the boundaries of the team's mission, skill, and training can surface possible impacts and allow them to be addressed before the team is in the field. Likewise, selecting team members whose skills and experience map to the needs and expectations of the host community can help minimize disruptive effects on local practice [10]. Advance preparation should include developing a plan to monitor and address ongoing costs and benefits to patients and host communities and institutions, including local trainees (when the trip includes providing training for the host community), once the team is in the field [10].

Respecting Persons & Cultures

Physicians and trainees who participate in short-term medical service trips face a host of challenges. Some of them are practical—resource limitations, unfamiliar medical needs, living conditions outside their experience, among many others. Some challenges are more philosophical, especially the challenge of navigating language(s) and norms they may never have encountered before, or not encountered with the same immediacy [1,8]. Striking a balance between Western medicine's understanding of the professional commitment to respect for persons and the

expectations of host communities rooted in other histories, traditions, and social structures calls for a level of discernment, sensitivity, and humility that may more often be seen as the skill set of an ethnographer than a clinician.

Individuals who travel abroad to provide medical care in resource-limited settings should be aware that the interactions they will have in the field will inevitably be cross-cultural. They should seek to become broadly knowledgeable about the communities in which they will work, such as the primary language(s) in which encounters will occur; predominant local "explanatory models" of health and illness; local expectations for how health care professionals behave toward patients and toward one another; and salient economic, political, and social dynamics. Volunteers should take advantage of resources that can help them begin to cultivate the "cultural sensitivity" they will need to provide safe, respectful, patient-centered care in the context of the specific host community [6,9,10].

Individuals do not bear this responsibility alone, of course. Organizations and institutions that sponsor short-term medical service trips have a responsibility to make appropriate orientation and training available to volunteers before they depart [10], in addition to working with host communities to put in place appropriate services, such as interpreters or local mentors, to support volunteers in the field.

The ethical obligation to respect the individual patients they serve and their host communities' cultural and social traditions does *not* obligate physicians and trainees "to violate fundamental personal values, standards of medical care or ethical practice, or the law" [8]. Volunteers will be challenged, rather, to negotiate compromises that preserve in some reasonable measure the values of both parties whenever possible [14]. Volunteers should be allowed to decline to participate in activities that violate deeply held personal beliefs, but they should reflect long and carefully before reaching such a decision [15].

GETTING INTO THE FIELD

To fulfill these fundamental ethical responsibilities, moreover, requires meeting other obligations with respect to organizing and carrying out short-term medical service trips. Specifically, sponsoring organizations and institutions have an obligation to ensure thoughtful, diligent preparation to promote a trip's overall goals, including appropriately preparing volunteers for the field experience. Physicians and trainees, for their part, have an obligation to choose thoughtfully those programs with which they affiliate themselves [1,8,9,10].

Prepare Diligently

Guidelines from the American College of Physicians recognize that "predeparture preparation is itself an ethical obligation" [8,cf. 1]. Defining the goal(s) of a short-term medical service trip in collaboration with the host community helps to clarify what material resources will be needed in the field, and thus anticipate and minimize logistic burdens the trip may pose. Collaborative planning can similarly identify what clinical skills volunteers should be expected to bring to the effort, for example, and what activities they should be assigned, or whether local mentors are needed or desirable and how such relationships will be coordinated [10].

Importantly, thoughtful preparation includes determining what nonclinical skills and experience volunteers should have to contribute to the overall success of the service opportunity. For example, a primary goal of supporting capacity building in the local community calls for participants who

have "training and/or familiarity with principles of international development, social determinants of health, and public health systems" [9].

Adequately preparing physicians and trainees for short-term medical service trips encompasses planning with respect to issues of personal safety, vaccinations, unique personal health needs, travel, malpractice insurance, and local credentialing requirements [6]. Equally important, to contribute effectively and minimize "culture shock" and distress, volunteers need a basic understanding of the context in which they will be working [1,6]. Without expecting them to become experts in local culture, volunteers should have access to resources that will orient them to the language(s), traditions, norms, and expectations of the host community, not simply to the resource and clinical challenges they are likely to face. Volunteers should have sufficient knowledge to conduct themselves appropriately in the field setting, whether that is in how they dress, how they address or interact with different members of the community, or how they carry out their clinical responsibilities [6]. And they need to know whom they can turn to for guidance in the moment.

Preparation should also include explicit attention to the possibility that volunteers will encounter ethical dilemmas. Working in unfamiliar cultural settings and health care systems poses the real possibility for physicians and trainees that they will encounter situations in which they "are unable to act in ways that are consistent with ethics and their professional values" or "feel complicit in a moral wrong" [8]. Having strategies in place to address dilemmas when they arise and to debrief after the fact can help mitigate the impact of such experiences. In cases of irreducible conflict with local norms, volunteers may withdraw from care of an individual patient or from the mission after careful consideration of the effect withdrawing will have on the patient, the medical team, and the mission overall, in keeping with ethics guidance on the exercise of conscience.

Choose Thoughtfully

Individual physicians and trainees who volunteer for short-term medical service trips are not in a position to directly influence how such programs are organized or carried out. They can, however, by preference choose to participate in activities carried out by organizations that fulfill the ethical responsibilities discussed above [8,9,10]. Volunteers can select organizations and programs that demonstrate commitment to long-term, community-led efforts to build and sustain local health care resources over programs that provide episodic, stop-gap medical interventions, which can promote dependence on the cycle of foreign charitable assistance rather than development of local infrastructure [9].

Measure & Share Meaningful Outcomes

Organizations that sponsor short-term medical service trips have a responsibility to monitor and evaluate the effectiveness of their programs, [8,6,9]. The measures used to evaluate program outcomes should be appropriate to the program's goals as defined proactively in collaboration with the host community [8]; for example, some have suggested quality-adjusted life years (QALYs) [16]. Prospective participants should affiliate themselves with programs that demonstrate effectiveness in providing outcomes meaningful to the population they serve, rather than simple measures of process such as number of procedures performed [6]. Developing meaningful outcome measures will require thoughtful reflection on the knowledge and skills needed to address the specific situation of the community or communities being served and on what preparations are essential to maximize health benefits and avoid undue harm.

RECOMMENDATION

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

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

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

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

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

(b) Seek to proactively identify and minimize burdens the trip may place on the host community, including not only direct, material costs of hosting volunteers, but on possible disruptive effects the presence of volunteers could have for local practice and practitioners as well. Sponsors and participants should ensure that team members practice only within their skill sets and experience, and that resources are available to support the success of the trip, including arranging for local mentors, translation services, and volunteers' personal health needs as appropriate.

(c) Seek to become broadly knowledgeable about the communities in which they will work and take advantage of resources to begin to cultivate the "cultural sensitivity" they will need to provide safe, respectful, patient-centered care in the context of the specific host community. Members of the volunteer medical team are expected to uphold the ethics standards of their profession and volunteers should insist that strategies are in place to address ethical dilemmas as they arise. In cases of irreducible conflict with local norms, volunteers may withdraw from care of an individual patient or from the mission after careful consideration of the effect that will have on the patient, the medical team, and the mission overall, in keeping with ethics guidance on the exercise of conscience.

Sponsors of short-term medical service trips should:

(d) Ensure that resources needed to meet the defined goals of the trip will be in place, particularly resources that cannot be assured locally.

(e) Proactively define appropriate roles and permissible range of practice for members of the volunteer team, including the training, experience, and oversight of team members required to provide acceptable safe, high-quality care in the host setting. Team members should practice only within the limits of their training and skills in keeping with the professional standards of the sponsor's country.

(f) Put in place a mechanism to collect data on success in meeting collaboratively defined goals for the trip in keeping with recognized standards for the conduct of health services research and quality improvement activities in the sponsor's country.

(New HOD/CEJA Policy)

Fiscal Note: Less than $500

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 2-N-21

Subject: Amendments to Opinions 1.2.11, "Ethical Innovation in Medical Practice"; 11.1.2, "Physician Stewardship of Health Care Resources"; 11.2.1, "Professionalism in Health Care Systems"; and 1.1.6, "Quality"

Presented by: Alexander M. Rosenau, DO, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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As the Council on Ethical and Judicial Affairs noted in its recent informational report on augmented intelligence (AI) in medicine:

> AI systems represent the latest in a long history of innovations in medicine. Like many new technologies before them, AI-based innovations challenge how physicians practice and how they interact with patients at the same time that these innovations offer promises to promote medicine's Quadruple Aim of enhancing patient experience, improving population health, reducing cost, and improving the work life of health care professionals [1].

At the same time, several characteristics distinguish AI-enabled innovations from other innovations in medicine in important ways. The data-driven machine-learning algorithms that drive clinical AI systems have the potential to replicate bias in the data sets on which they are built and exacerbate inequities in quality of care and patient outcomes. The most powerful, and useful, models are "black boxes" that have the capacity to evolve outside of human observation and independent of human control. Moreover, the design, development, deployment, and oversight diffuse accountability over multiple stakeholders who have differing forms of expertise, understandings of professionalism, and diverging goals.

Published analyses of ethical challenges presented by AI in multiple domains have converged around a core set of goals [2,3,4]:

- Protecting the privacy of data subjects and the confidentiality of personal information
- Ensuring that AI systems are safe for their intended use(s)
- Designing systems of accountability that are sensitive to the roles different stakeholders play in the design, deployment, performance, and outcomes of AI systems
- Maximizing the transparency and explainability of AI systems
- Promoting justice and fairness in the implementation and outcomes of AI systems
- Maintaining meaningful human control of AI technologies
- Accommodating human agency in AI-supported decision making/the use of AI

Realizing these goals for any AI system, in medicine or other domains, will be challenging. As the Gradient Institute notes in its report, Practical Challenge for Ethical AI, AI systems "possess no

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* * Reports of the Council on Ethical and Judicial Affairs are assigned to the reference committee on Amendments to Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

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intrinsic moral awareness or social context with which to understand the consequences of their actions. To build ethical AI systems, designers must meet the technical challenge of explicitly integrating moral considerations into the objectives, data and constraints that govern how AI systems make decisions" [5]. Developers must devise mathematical expressions for concepts such as "fairness" and "justice" and specify acceptable balances among competing objectives that will enable an algorithm to approximate human moral reasoning. They must design systems in ways that will align the consequences of the system's actions with the ethical motivation for deploying the system. And oversight must meaningfully address "the problem of many hands" in ascribing responsibility with respect to AI systems [6].

GUIDANCE IN THE AMA CODE OF MEDICAL ETHICS

Policies adopted by the AMA House of Delegates address issues of thoughtful AI design (H-480.940, "Augmented Intelligence in Health Care") and matters of oversight, payment and coverage, and liability (H-480.939). Policy H-295.857 addresses issues of AI in relation to medical education. AMA has further developed a framework for trustworthy AI in medicine that speaks broadly to the primacy of ethics, evidence, and equity as guiding considerations for the design and deployment of AI systems in health care and the interplay of responsibilities among multiple stakeholders [7].

The introduction of AI systems in medicine touches on multiple issues of ethics that are currently addressed in the AMA *Code of Medical Ethics*. These include quality of care, innovation in medical practice, stewardship of health care resources, and professionalism in health care systems, as well as privacy.

The *Code* grounds the professional ethical responsibilities of physicians in medicine's fundamental commitment of fidelity to patients. As Opinion 1.1.1 notes:

> The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for patients' welfare.

From the perspective of professional ethics, securing this commitment should equally inform medicine's response to emerging AI-enabled tools for clinical care and health care operations.

Guidance in Opinion 1.2.11, "Ethical Innovation in Medical Practice," calls on individuals who design and deploy innovations to ensure that they uphold the commitment to fidelity by serving the goals of medicine as a priority. It directs innovators to ensure that their work is scientifically well grounded and prioritizes the interests of patients over the interests of other stakeholders. Opinion 1.2.11 further recognizes that ensuring ethical practice in the design and introduction of innovations does not, indeed cannot, rest with physicians alone; health care institutions and the profession have significant responsibilities to uphold medicine's defining commitment to patients.

Opinion 11.2.1, "Professionalism in Health Care Systems," defines the responsibilities of leaders in health care systems to promote physician professionalism and to ensure that mechanisms adopted to influence physician decision making are "designed in keeping with sound principles and solid scientific evidence," deployed fairly so that they "do not disadvantage identifiable populations of patients or physicians or exacerbate health care disparities." It similarly recognizes that institutional

leaders should ensure that when these mechanisms are deployed they are monitored to identify and respond to the effects they have on patient care.

Individual physicians, and the institutions within in which they practice, have a responsibility to be prudent stewards of the shared societal resources entrusted to them, addressed in Opinion 11.1.2, "Physician Stewardship of Health Care Resources." Even as they prioritize the needs and welfare of their individual patients, physicians have a responsibility to promote public health and access to care. They fulfill that responsibility by choosing the course of action that will achieve the individual patient's goals for care in the least resource intensive way feasible.

Finally, as Opinion 1.1.6, "Quality," directs, all physicians share a responsibility for promoting and providing care that is "safe, effective, patient centered, timely, efficient, and equitable." This should be understood to include a responsibility to adopt AI systems that have been demonstrated to improve quality of care and patients' experience of care.

For the most part, individual physicians will be consumers of AI systems developed by others. As individual end users, physicians cannot reasonably be expected to have the requisite expertise or opportunity to evaluate AI systems. They must rely on their institutions, or the vendors from whom they purchase AI systems, to ensure that those systems are trustworthy.

Nonetheless, physicians do have an important role to play in promoting fair, responsible use of well-designed AI systems in keeping with responsibilities already delineated in the AMA *Code of Medical Ethics* noted above. Their voice must be heard in helping to hold other stakeholders accountable for ensuring that AI systems, like other tools, support the goals and values that define the medical profession and to which individual practitioners are held. CEJA Report 4-JUN-21 outlines the kinds of assurances physicians should be able to expect from their institutions when a given AI system is proposed or implemented.

CONCLUSION

AI systems are already a fact of life in medicine and other domains; it would be naïve to imagine there will not be further rapid evolution of these technologies. Fidelity to patients requires that physicians recognize the ways in which AI systems can improve outcomes for their patients and the community and enhance their own practices. They should be willing to be reflective, critical consumers of well-designed AI systems, recognizing both the potential benefits and the potential downsides of using AI-enable tools to deliver clinical care or organize their practices.

The fact that existing guidance in the AMA *Code of Medical Ethics* already addresses fundamental issues of concern noted above, coupled with the pace and scope of continuing evolution of AI technologies, the council concludes that developing guidance specifically addressing augmented intelligence in health care is not the most effective response. Rather, the council believes that amending existing guidance to more clearly encompass AI will best serve physicians and the patients they care for.

As the council noted in CEJA Report 4-JUN-21, the implications of AI technologies, and more specifically, the exploitation of "big data" to drive improvements in health care, carries significant implications for patient privacy and confidentiality that warrant separate consideration. The council intends to address those implications separately in future deliberations.

RECOMMENDATION

In light of the foregoing, the Council on Ethical and Judicial Affairs recommend that Opinion 1.2.11, "Ethically Sound Innovation in Medical Practice"; Opinion 11.2.1, "Professionalism in Health Care Systems"; Opinion 11.1.2, "Physician Stewardship of Health Care Resources"; and Opinion 1.1.6, "Quality," be amended as follows and the remainder of this report be filed:

1. Opinion 1.2.11, Ethically Sound Innovation in Clinical Practice

Innovation in medicine can span a wide range of activities. ~~From~~ It encompasses not only improving an existing intervention, ~~to introducing an innovation in one's own clinical practice for the first time, to~~ using an existing intervention in a novel way, or translating knowledge from one clinical context into another but also developing or implementing new technologies to enhance diagnosis, treatment, and health care operations. Innovation shares features with both research and patient care, but it is distinct from both.

When physicians participate in developing and disseminating innovative practices, they act in accord with professional responsibilities to advance medical knowledge, improve quality of care, and promote the well-being of individual patients and the larger community. Similarly, these responsibilities are honored when physicians enhance their own practices by expanding the range of tools, techniques, ~~and~~ or interventions they ~~offer to patients~~ employ in providing care.

Individually, physicians who are involved in designing, developing, disseminating, or adopting innovative modalities should:

(a) Innovate on the basis of sound scientific evidence and appropriate clinical expertise.

(b) Seek input from colleagues or other medical professionals in advance or as early as possible in the course of innovation.

(c) Design innovations so as to minimize risks to individual patients and maximize the likelihood of application and benefit for populations of patients.

(d) Be sensitive to the cost implications of innovation.

(e) Be aware of influences that may drive the creation and adoption of innovative practices for reasons other than patient or public benefit.

When they offer existing innovative diagnostic or therapeutic services to individual patients, physicians must:

(f) Base recommendations on patients' medical needs.

(g) Refrain from offering such services until they have acquired appropriate knowledge and skills.

(h) Recognize that in this context informed decision making requires the physician to disclose:

(i) how a recommended diagnostic or therapeutic service differs from the standard therapeutic approach if one exists;

(ii) why the physician is recommending the innovative modality;

(iii) what the known or anticipated risks, benefits, and burdens of the recommended therapy and alternatives are;

(iv) what experience the professional community in general and the physician individually has had to date with the innovative therapy;

(v) what conflicts of interest the physician may have with respect to the recommended therapy.

(i) Discontinue any innovative therapies that are not benefiting the patient.

(j) Be transparent and share findings from their use of innovative therapies with peers in some manner. To promote patient safety and quality, physicians should share both immediate or delayed positive and negative outcomes.

To promote responsible innovation, health care institutions and the medical profession should:

(k) Ensure that innovative practices or technologies that are made available to physicians meet the highest standards for scientifically sound design and clinical value.

(~~k~~l) Require that physicians who adopt ~~innovative treatment or diagnostic techniques~~ innovations into their practice have ~~appropriate~~ relevant knowledge and skills.

(~~l~~m) Provide meaningful professional oversight of innovation in patient care.

(~~m~~n) Encourage physician-innovators to collect and share information about the resources needed to implement their ~~innovative therapies~~ innovations safely, effectively, and equitably.

2. Opinion 11.2.1, Professionalism in Health Care Systems

Containing costs, promoting high-quality care for all patients, and sustaining physician professionalism are important goals. Models for financing and organizing the delivery of health care services often aim to promote patient safety and to improve quality and efficiency. However, they can also pose ethical challenges for physicians that could undermine the trust essential to patient-physician relationships.

Payment models and financial incentives can create conflicts of interest among patients, health care organizations, and physicians. They can encourage undertreatment and overtreatment, as well as dictate goals that are not individualized for the particular patient.

Structures that influence where and by whom care is delivered—such as accountable care organizations, group practices, health maintenance organizations, and other entities that may emerge in the future—can affect patients' choices, the patient-physician relationship, and physicians' relationships with fellow health care professionals.

Formularies, clinical practice guidelines, decision support tools that rely on augmented intelligence, and other ~~tools~~ mechanisms intended to influence decision making, may impinge

on physicians' exercise of professional judgment and ability to advocate effectively for their patients, depending on how they are designed and implemented.

Physicians in leadership positions within health care organizations and the profession should ~~ensure that practices for financing and organizing the delivery of care~~:

(a) Ensure that decisions to implement practices or tools for organizing the delivery of care ~~A~~are transparent and reflect input from key stakeholders, including physicians and patients.

~~(b) Reflect input from key stakeholders, including physicians and patients~~.

(~~e~~b) Recognize that over reliance on financial incentives or other tools to influence clinical decision making may undermine physician professionalism.

(~~d~~c) Ensure ~~ethically acceptable incentives~~ that all such tools:

(i) are designed in keeping with sound principles and solid scientific evidence.

a. Financial incentives should be based on appropriate comparison groups and cost data and adjusted to reflect complexity, case mix, and other factors that affect physician practice profiles.

b. Practice guidelines, formularies, and ~~other~~ similar tools should be based on best available evidence and developed in keeping with ethics guidance.

c. Clinical prediction models, decision support tools, and similar tools such as those that rely on AI technology must rest on the highest-quality data and be independently validated in relevantly similar populations of patients and care settings.

(ii) are implemented fairly and do not disadvantage identifiable populations of patients or physicians or exacerbate health care disparities;

(iii) are implemented in conjunction with the infrastructure and resources needed to support high-value care and physician professionalism;

(iv) mitigate possible conflicts between physicians' financial interests and patient interests by minimizing the financial impact of patient care decisions and the overall financial risk for individual physicians.

(~~e~~d)Encourage, rather than discourage, physicians (and others) to:

(i) provide care for patients with difficult to manage medical conditions;

(ii) practice at their full capacity, but not beyond.

(~~f~~e) Recognize physicians' primary obligation to their patients by enabling physicians to respond to the unique needs of individual patients and providing avenues for meaningful appeal and advocacy on behalf of patients.

(~~g~~f) ~~Are~~ Ensure that the use of financial incentives and other tools is routinely monitored to:

(i) identify and address adverse consequences;

(ii) identify and encourage dissemination of positive outcomes.

All physicians should:

(~~h~~g) Hold physician-leaders accountable to meeting conditions for professionalism in health care systems.

(~~i~~h) Advocate for changes ~~in health care payment and delivery models~~ how the delivery of care is organized to promote access to high-quality care for all patients.

3. Opinion 11.1.2, Physician Stewardship of Health Care Resources

Physicians' primary ethical obligation is to promote the well-being of individual patients. Physicians also have a long-recognized obligation to patients in general to promote public health and access to care. This obligation requires physicians to be prudent stewards of the shared societal resources with which they are entrusted. Managing health care resources responsibly for the benefit of all patients is compatible with physicians' primary obligation to serve the interests of individual patients.

To fulfill their obligation to be prudent stewards of health care resources, physicians should:

(a) Base recommendations and decisions on patients' medical needs.

(b) Use scientifically grounded evidence to inform professional decisions when available.

(c) Help patients articulate their health care goals and help patients and their families form realistic expectations about whether a particular intervention is likely to achieve those goals.

(d) Endorse recommendations that offer reasonable likelihood of achieving the patient's health care goals.

(e) Use technologies that have been demonstrated to meaningfully improve clinical outcomes to ~~C~~choose the course of action that requires fewer resources when alternative courses of action offer similar likelihood and degree of anticipated benefit compared to anticipated harm for the individual patient but require different levels of resources.

(f) Be transparent about alternatives, including disclosing when resource constraints play a role in decision making.

(g) Participate in efforts to resolve persistent disagreement about whether a costly intervention is worthwhile, which may include consulting other physicians, an ethics committee, or other appropriate resource.

Physicians are in a unique position to affect health care spending. But individual physicians alone cannot and should not be expected to address the systemic challenges of wisely managing health care resources. Medicine as a profession must create conditions for practice that make it feasible for individual physicians to be prudent stewards by:

(h) Encouraging health care administrators and organizations to make cost data transparent (including cost accounting methodologies) so that physicians can exercise well-informed stewardship.

(i) Advocating that health care organizations make available well-validated technologies to enhance diagnosis, treatment planning, and prognosis and support equitable, prudent use of health care resources.

(~~i~~j) Ensuring that physicians have the training they need to be informed about health care costs and how their decisions affect resource utilization and overall health care spending.

(~~j~~k) Advocating for policy changes, such as medical liability reform, that promote professional judgment and address systemic barriers that impede responsible stewardship.

4. Opinion 1.1.6, Quality

As professionals dedicated to promoting the well-being of patients, physicians individually and collectively share the obligation to ensure that the care patients receive is safe, effective, patient centered, timely, efficient, and equitable.

While responsibility for quality of care does not rest solely with physicians, their role is essential. Individually and collectively, physicians should actively engage in efforts to improve the quality of health care by:

(a) Keeping current with best care practices and maintaining professional competence.

(b) Holding themselves accountable to patients, families, and fellow health care professionals for communicating effectively and coordinating care appropriately.

(c) Using new technologies and innovations that have been demonstrated to improve patient outcomes and experience of care, in keeping with ethics guidance on innovation in clinical practice and stewardship of health care resources.

(~~c~~d) Monitoring the quality of care they deliver as individual practitioners—e.g., through personal case review and critical self-reflection, peer review, and use of other quality improvement tools.

(Modify HOD/CEJA policy)

Fiscal Note: Less than $500

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REPORT OF THE SPEAKERS

Speakers' Report 1-N-21

Subject: Report of the Election Task Force
(Recommendation 16, Speakers' Report 2-JUN-21)

Presented by: Bruce A. Scott, MD, Speaker; and Lisa Bohman Egbert, MD, Vice Speaker

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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At the June 2021 Special Meeting, the report of the Election Task Force (Speakers' Report 2) substantially revised the rules regarding nominations and elections. (See the updated policy in the appendix.) The following recommendation, dealing with interviews, was referred with a request for more detail.

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

Testimony was generally supportive of continuing the option of virtual interviews and most of the details provided in the recommendation, but concerns were expressed regarding the lack of specificity of the interview time period. Such matters as excessive demands on candidates, time zone differences between interviewers and interviewees, and interference with clinical duties underlay the referral. This report provides recommendations for the conduct of virtual interviews, proposing limits and expectations for fairness.

BACKGROUND

Interviews are generally regarded as the best tool by which to measure candidates and select those for whom one will vote. As both the 2020 and 2021 Annual Meetings were cancelled due to COVID, the speakers recorded interviews with candidates and made them available through the AMA website. The speakers also laid out rules to facilitate virtual interviews with candidates that were conducted by various caucuses and delegations.

The virtual interviews were viewed favorably and not simply as substitutes for the in-person interviews typically conducted during the Annual Meeting. The Task Force report recommended continuation of the virtual interviews as an option even after return to in-person meetings, and

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comments during this past June's special meeting supported the use of virtual interviews by delegations provided a standard set of rules could be implemented.

PROPOSALS FOR VIRTUAL INTERVIEWS

The Task Force had proposed that all interviews by a delegation or caucus for a given office be conducted by the same means: either in-person (onsite at the Annual Meeting) or virtually, before arriving in Chicago for the Annual Meeting. This was done in the interest of fairness, and as no comments were heard on this topic, the recommendation will be retained. Delegations and caucuses should continue to be allowed to select the method of interviews that best suits their needs.

During testimony at the June 2021 Special Meeting concerns were raised regarding the days and times during which virtual interviews may be conducted. The referred recommendation stated that virtual interviews would be conducted "during a period of time to be determined by the Speaker." Comments were heard that virtual interviews conducted before the June 2020 and June 2021 Special Meetings were spread over too long a period of time, that the dates were not known in advance and that some interview times interfered with clinical duties particularly for those in the Pacific and Eastern time zones. To address these concerns your speakers recommend a defined, relatively short window of dates for virtual interviews and interview times to be scheduled outside regular clinical hours. Meanwhile in-person interviews at the meeting will continue to be an option.

To allow candidates and delegations to plan, a specific window of dates should be defined. Both candidates and interviewers expressed a preference for interview dates relatively close to the opening of the Annual Meeting including the option of weekend interviews. Interviews should not be conducted the week immediately preceding the meeting which is typically busy with other responsibilities, including section and council meetings along with travel. Therefore, the window for virtual interviews is recommended to begin on the Friday evening of the second weekend immediately preceding the scheduled opening session of the House of Delegates meeting at which elections will take place and end on the Sunday evening of the weekend immediately preceding the meeting. Virtual interviews may only be scheduled during this defined period, beginning 15 days before and ending six days before the meeting opens. This window includes two weekends and six weeknights.[1] Should a planned in-person meeting be cancelled, the window could open a week earlier, effectively doubling the time available for interviews. Discretion should be granted to the speaker to address special situations such as this.

To avoid interfering with candidates' professional responsibilities, especially patient care and related clinical duties, interviews conducted on a weeknight (ie, Monday through Friday) must be scheduled between 5 pm and 10 pm based on the candidate's (ie, the person being interviewed) local time. Interviews conducted on weekends must be scheduled between 8 am and 10 pm based on the candidate's local time. Recognizing that physicians often have clinical duties outside of regular business hours, candidates and interviewers are encouraged to be flexible in scheduling interviews. Other times outside of these hours must be acceptable to both parties. Caucuses and delegations scheduling interviews for candidates within the parameters above are not obligated to offer alternatives but are encouraged to do so if possible. Candidates are encouraged to make themselves available for these interview windows to the extent possible but are entitled to decline any interview request.

[1] For example, the 2021 Annual Meeting was scheduled to begin on Saturday, June 12, which means the interviewing window would have run from the evening of Friday, May 28 through Sunday, June 6.

The Office of House of Delegates Affairs compiles candidate contact information, including that for the candidate's campaign team. The information will be provided to groups wishing to interview candidates. Groups wishing to conduct interviews must designate their interviewing coordinator and provide the individual's contact information to the Office of House of Delegates Affairs. This list will then be shared with all declared candidates. It is incumbent on the candidates to schedule their individual interviews. The Office of House of Delegates Affairs will continue to create an interview schedule for officer candidates in opposed races for those regional caucuses and sections electing to interview in-person.

Policy G-610.020 sets clear guardrails around announcements of candidacy, meaning candidate contact information will be available well before the interviewing window opens. While interviews may not be conducted outside the window, interviewers will be allowed to contact candidates to set up interviews any time after the publication of the election manual, typically in mid-April.

Other relevant elements for interviews

The referred language includes additional elements that merit discussion, namely the format and platform used, the recording of interviews, and the sharing of those recordings. None of these items drew criticism at June's meeting.

A foundational concept for the Task Force was to provide a level playing field for all candidates. Seeking to ensure fairness, the Task Force recommended that all candidates for a given office be interviewed using the same format, so all candidates for a given office must be interviewed either in-person or virtually. Interviewers are free to use either modality, with candidates for some offices interviewed online and candidates for other offices interviewed onsite, but the chosen modality applies to all candidates for a given office. To be clear, an interviewing group is also free to use only virtual or only in-person interviews for all candidates. All virtual interviews for a given office must also be conducted on the same or similar platform, for example, all audio only or by video with audio. The choice of platform to be used should be confirmed when an interview is arranged; flexibility to accommodate availability of specific platforms (Teams, Zoom, etc.) is encouraged.

Recognizing that delegations have a special relationship with their own members who may be candidates, the Task Force proposed an exception to the requirement to interview all candidates for a particular office. This exception allows the interviewing group to meet with a candidate who is a member of their group without interviewing other candidates for the same office. No objections were raised during testimony, and this exception is recommended to be retained.

Questions have been raised regarding what constitutes an interview and what does not. This arises from the fact that some campaigns request informal opportunities for their candidate to "stop by and introduce themselves" at a delegation or caucus meeting. This often evolves into a spontaneous interview which may not be offered to the other candidates in the same race or may occur when the same delegation has already conducted their interviews for that race. Your speakers believe further clarification is in order. For clarity, any appearance by a candidate before an organized meeting of a caucus or delegation, other than their own, would be considered an interview and fall under the rules for interviews as recommended below.

Notwithstanding various state laws that allow one party to record an interaction, the Task Force favored full transparency for these interviews and recommended that an interview be recorded only with the full knowledge and agreement of the candidate. No instances in which a candidate declined to be recorded have been reported, but nonetheless, the choice to be recorded should lie

with the interviewee / candidate. In those cases where the interview is recorded, it may not be shared outside the group—whether a caucus or a delegation—that conducted the interview.

Late announcing candidates

Under the newly adopted election rules (G-610.020, ¶4) candidates are officially announced by the Office of House of Delegates Affairs at defined times. Individuals may make an independent announcement of candidacy only after active campaigning is allowed. As previously specified in the referred recommendation, groups conducting interviews with candidates for a given office are required to offer an interview to all individuals that have officially announced their candidacy at the time the group's interview schedule is finalized. Interviewing groups may, but are not required to, interview late announcing candidates. Should an interview be offered to the late candidate, all other announced candidates for the same office (even those previously interviewed) must be afforded the same opportunity. Offering a late announced candidate an opportunity to interview at a different time (perhaps closer to the election) or in a different format (in-person at the meeting itself) could be perceived as an unfair advantage. While our rules continue to allow for late announcements of candidacy, up to and including nomination at the opening session of the House, given the opportunities to announce one's candidacy in advance, late announcements should be extremely rare and should not provide an advantage to such candidates. Thus, the focus of this recommendation is on fairness for all candidates by encouraging transparency and facilitating full vetting of candidates and should be retained.

TECHNICAL CORRECTION TO POLICY G-610.020

While dealing with the election rules, your speakers have become aware of the need for a correction to language that was adopted in June. The rules previously required candidates to complete a conflict of interest (COI) disclosure before election, and that part of the policy was reaffirmed. Language in a different recommendation adopted in June would require individuals submitting an announcement of candidacy to include "their conflict of interest statement" along with the announcement. Insofar as the COI disclosure is collected in the year of the election and is not necessary for an announcement, that language should be stricken from paragraph 4 of the policy.

RECOMMENDATIONS

This report from your speakers spells out the expectations for interviews, particularly virtual interviews, conducted with those seeking election to leadership positions within our AMA. It is recommended that Policy G-610.020 be amended by addition and deletion to read as follows and the remainder of this report be filed. [Note: Paragraph numbers will be editorially corrected as required.]

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

…

(11) The Speaker's Office will coordinate the scheduling of candidate interviews for general officer positions (Trustees, President-Elect, Speaker and Vice Speaker). Groups wishing to conduct interviews must designate their interviewing coordinator and provide the individual's contact information to the Office of House of Delegates Affairs. The Speaker's Office will collect contact information for groups wishing to conduct interviews as well as for candidates and their campaign teams and will provide the information as requested.

(12) Interviews conducted with current candidates must comply with the following rules:

a. Interviews may be arranged between the parties once active campaigning is allowed.

b. Groups conducting interviews with candidates for a given office must offer an interview to all individuals that have officially announced their candidacy at the time the group's interview schedule is finalized.

i. A group may meet with a candidate who is a member of their group without interviewing other candidates for the same office.

ii. Interviewing groups may, but are not required to, interview late announcing candidates. Should an interview be offered to a late candidate, all other announced candidates for the same office (even those previously interviewed) must be afforded the same opportunity.

iii. Any appearance by a candidate before an organized meeting of a caucus or delegation, other than their own, will be considered an interview and fall under the rules for interviews.

c. Groups may elect to conduct interviews virtually or in-person, but not both. All interviews for an office must be conducted using the same format and platform.

d. In-person interviews may be conducted between Friday and Monday of the meeting at which elections will take place.

e. Virtual interviews are subject to the following constraints:

i. Interviews may be conducted only during a window beginning on the Friday evening two weekends prior to the scheduled Opening Session of the House of Delegates meeting at which elections will take place and must be concluded by the Sunday evening one week before the scheduled Opening Session of the House.

ii. Interviews conducted on weeknights must be scheduled between 5 pm and 10 pm or on weekends between 8 am and 10 pm based on the candidate's local time, unless another mutually acceptable time outside these hours is arranged.

iii. Caucuses and delegations scheduling interviews for candidates within the parameters above are not obligated to offer alternatives but are encouraged to do so if possible.

f. Recording of interviews is allowed only with the knowledge and consent of the candidate.

g. Recordings of interviews may be shared only among members of the group conducting the interview.

h. A candidate is free to decline any interview request.

i. In consultation with the Election Committee, the Speaker, or where the Speaker is in a contested election, the Vice Speaker, may issue special rules for interviews to address unexpected situations.

Fiscal Note: Less than $500 to update policy

APPENDIX A – Policy G-610.020, Rules for AMA Elections

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

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

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

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

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

(6) If a potential newly opened position on the Board or a specified council does not open but there are other open positions for the same council or the Board, an election will proceed for the existing open seats. Candidates will be offered the opportunity to withdraw their nomination prior to the vote. If there are no scheduled open seats on the Board or specified council for which a potential newly opened position is announced and if the potential newly opened position does not open (i.e., the individual with the unexpired term is not elected to the office they sought), no election for the position will be held. In the event that a prior election results in a newly opened position without a nominated candidate or more positions are open than nominated candidates, the unfilled position/s would remain unfilled until the next Annual Meeting.

(7) The AMA Office of House of Delegates Affairs will provide an opportunity for all announced candidates to submit material to the HOD office which will then be sent electronically by the HOD Office in a single communication to all delegates and alternates. Parameters regarding content and deadlines for submission will be established by the Speaker and communicated to all announced candidates.

(8) Our AMA believes that: (a) specialty society candidates for AMA House of Delegates elected offices should be listed in the pre-election materials available to the House as the representative of that society and

not by the state in which the candidate resides; (b) elected specialty society members should be identified in that capacity while serving their term of office; and (c) nothing in the above recommendations should preclude formal co-endorsement by any state delegation of the national specialty society candidate, if that state delegation should so choose.

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

(10) Active campaigning for AMA elective office may not begin until the Board of Trustees, after its April meeting, announces the candidates for council seats. Active campaigning includes mass outreach activities directed to all or a significant portion of the members of the House of Delegates and communicated by or on behalf of the candidate. If in the judgment of the Speaker of the House of Delegates circumstances warrant an earlier date by which campaigns may formally begin, the Speaker shall communicate the earlier date to all known candidates.

(11) The Speaker's Office will coordinate the scheduling of candidate interviews for general officer positions (Trustees, President-Elect, Speaker and Vice Speaker).

(12) Every state and specialty society delegation is encouraged to participate in a regional caucus, for the purposes of candidate review activities.

(13) Campaign memorabilia may not be distributed in the Not for Official Business (NFOB) bag.

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

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

(16) Campaign expenditures and activities should be limited to reasonable levels necessary for adequate candidate exposure to the delegates. Campaign memorabilia and giveaways that include a candidate's name or likeness may not be distributed at any time.

(17) Campaign stickers, pins, buttons and similar campaign materials are disallowed. This rule will not apply for pins for AMPAC, the AMA Foundation, specialty societies, state and regional delegations and health related causes that do not include any candidate identifier. These pins should be small, not worn on the badge and distributed only to members of the designated group. General distribution of any pin, button or sticker is disallowed.

(18) At any AMA meeting convened prior to the time period for active campaigning, campaign-related expenditures and activities shall be discouraged. Large campaign receptions, luncheons, other formal campaign activities and the distribution of campaign literature and gifts are prohibited. It is permissible for candidates seeking election to engage in individual outreach meant to familiarize others with a candidate's opinions and positions on issues.

(19) Candidates for AMA office should not attend meetings of state medical societies unless officially invited and could accept reimbursement of travel expenses by the state society in accordance with the policies of the society.

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

(21) A state, specialty society, caucus, coalition, etc. may contribute to more than one party. However, a candidate may be featured at only one party, which includes: (a) being present in a receiving line, OR (b) appearing by name or in a picture on a poster or notice in or outside of the party venue. At these events, alcohol may be served only on a cash or no-host bar basis.

(22) Displays of campaign posters, signs, and literature in public areas of the hotel in which Annual Meetings are held are prohibited because they detract from the dignity of the position being sought and are unsightly. Campaign posters may be displayed at a single campaign reception at which the candidate is featured. No campaign literature shall be distributed in the House of Delegates and no mass outreach electronic messages shall be transmitted after the opening session of the House of Delegates.

(23) At the Opening Session of the Annual Meeting, officer candidates in a contested election will give a two-minute self-nominating speech, with the order of speeches determined by lot. No speeches for unopposed candidates will be given, except for president-elect. When there is no contest for president-elect, the candidate will ask a delegate to place his or her name in nomination, and the election will then be by acclamation. When there are two or more candidates for the office of president-elect, a two-minute nomination speech will be given by a delegate. In addition, the Speaker of the House of Delegates will schedule a debate in front of the AMA-HOD to be conducted by rules established by the Speaker or, in the event of a conflict, the Vice Speaker.

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

REPORT OF THE SPEAKERS

Speakers' Report 2-N-21

Subject: Establishing an Election Committee

Presented by: Bruce A. Scott, MD, Speaker; and Lisa Bohman Egbert, MD, Vice Speaker

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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At the June 2021 Special Meeting (J21), the House of Delegates (HOD) adopted the following recommendation as part of the report of the Election Task Force (Speakers' Report 2):

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

The recommendation is recorded as Paragraph 5 in Policy D-610.998, "Directives from the Election Task Force."

The Speakers determined that the term of each committee member should run from June to June, starting and ending with the adjournment of the HOD meeting, and initial appointments, including the chair, have been made. The seven members of the Committee are delegates or alternate delegates and have agreed to refrain from active participation in election campaigns through the following June, when their (initial) appointments will have concluded. Current members will be eligible for reappointment and other individuals willing to serve on the Committee are invited to complete the application form on the Speakers' page for positions that will begin in mid-2022.

Members of the Committee are listed in Appendix A. All were selected from among members of the House that submitted an application to serve. Appointments were made to cross the geographic regions and broad specialties represented in our House. The selected individuals have extensive experience with campaigns. Among those selected are past presidents of 4 state medical associations and 2 specialty societies, plus two past state medical association speakers in addition to past members of an AMA Council and Section Governing Councils. As part of their commitment, they have also agreed that all complaints and the ensuing discussions, deliberations, and votes will be kept confidential. Only those complaints that are verified and reported to the House will be shared, and then the Speaker will report to the House only the relevant aspects of the matter. The Committee might be likened to the peer review process. (See below for the complaint process.)

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In addition, Paragraph 6 of the same policy adopted at J21 reads as follows:

> The Speaker in consultation with the Election Committee will consider a more defined process for complaint reporting, validation, resolution, and potential penalties. This process will be presented to the House for approval.

This report is in response to Paragraph 6.

COMMITTEE ACTIVITIES AND PROPOSALS

The Committee convened by conference call to address the matters that had been assigned. Each is discussed below.

Complaint reporting

Long established policy (Policy G-610.020 [1]) states that the Speakers "are responsible for overall administration of our AMA elections." The Committee recommends that complaints continue to be submitted through the Speaker or Vice Speaker. Should either or both have a perceived conflict, complaints may be directed to our AMA's General Counsel. Counsel will then work with the Committee chair and/or the Speaker or Vice Speaker, depending on the nature and extent of the conflict. AMA's General Counsel can be reached through the Member Service Center or the HOD Office. Members of the Committee will not accept complaints directly and members of the House should not bring complaints to them or attempt to discuss campaign related concerns with individual members.

Complaints should generally be based on first-hand information because the necessary information is unlikely to otherwise be available. A complaint will need to include the following details:

- The name of the person(s) thought to have violated the rules
- The date of the alleged violation and the location if relevant
- The specific violation being alleged (i.e., the way the rules were violated)
- The materials, if any, that violate the rules; original materials are preferred over copies. Where necessary, arrangements for collection of these materials will be made.

Some discussion was had regarding the development of a list of potential rules violations and associated penalties, it quickly was recognized that this list would be limitless, necessarily qualified by nuance or exceptions. Furthermore, application of rigid penalties that do not take into account such nuances, would unnecessarily constrain the committee and potentially disenfranchise members of our House with whom rests the ultimate decision regarding verified infractions. Rather, the Committee recommends that they be allowed flexibility to consider the circumstances surrounding reported violations and to determine the appropriate corrective action. To ensure consistency and fairness over time, a history of the details of each verified offense and the ensuing penalty will be retained by the Office of General Counsel.

Inquiries about rules should also be directed to the Speakers. They have long interpreted AMA's election rules, and in fact, the annual election manual further elucidates the campaign rules. In this light some complaints could prove unfounded simply because of a misunderstanding of the rules. More importantly, consistency in explaining the rules is requisite, and the Speakers are familiar with both historical issues and current practice. In addition, questions sometimes arise for which the answer should be widely disseminated, and the Speakers have the ability and tools to share the information. Even-handedness in administering the elections is a hallmark of our processes.

Validation

Upon receiving a complaint, the Speaker will consult with the Committee chair to form a subcommittee of three members to investigate the allegation. The subcommittee members will be selected to avoid conflicts (e.g., being part of the same delegation as the alleged violator). Using necessary discretion, the subcommittee shall investigate the complaint and will report to the full Committee whether the complaint is founded. When necessary, the Office of General Counsel or the HOD Office will assist.

Following the subcommittee's evaluation, the full Committee will meet as soon as practical but generally within 2 weeks, to hear the subcommittee's report, determine whether a violation has occurred, and establish appropriate next steps. Committee members with a conflict of interest will be expected to recuse themselves from the vote, although they may participate in any discussion that precedes the decision. These internal deliberations are confidential, and details will not be shared. The Speakers are ex officio members of the Committee, without vote except as necessary to break a tie within the Committee, when one of them may vote.

Resolution and potential penalties

Historically, the only formal penalty for a campaign violation was for the Speaker to announce to the House before the election that a violation had occurred by naming the violator and the violation. These announcements thankfully have been rare, but when such an announcement has been made, it is noted that the candidate subsequently lost the election.

The Committee believes the House should continue to be the final arbiter when violations are deemed to be significant; thus, the Speaker announcing a violation to the House will remain a penalty which the Committee may impose. At the same time the Committee may believe that this penalty is excessive for some violations. The Committee should consider mitigating circumstances such as inadvertent breaches and technical or typographical errors. The Committee should also consider when during the year the violation occurs, the likely advantage sought or gained by the action in question, and who committed the violation. Consequently, the Committee recommends that it be given discretion to determine appropriate resolution of a validated complaint. In many circumstances resolution may be accomplished by corrective action, short of announcement to the House.

No exhaustive list of situations is possible, but three principles would seem to capture relevant aspects of violations:

- The more remote in time the violation occurs, the less the need to declare a violation, and conversely, the nearer the election, the greater the need for an announcement by the Speaker.

  It seems likely that a violation, particularly a violation that is perceived to be serious, will become generally known if it occurs well before the election. At the same time, awareness of a violation on the eve of the election has little chance of propagating and may warrant an announcement.

- The greater the advantage sought or gained, the more the need for a public announcement.

  Some subjectivity is apparent in this principle, but the Committee believes that both the motivation and the benefit of the violating activity need to be addressed. An inadvertent

violation that greatly advantages a candidate is more serious than the same inadvertent violation that for some reason handicaps the candidate.

- The greater the culpability of the candidate, the greater the need for an announcement to the House.

  Under AMA's election rules, the candidate is responsible for all campaign activities, including those carried out by the candidate's supporters. While it would be unwise to simply ignore a violation committed by a naïve supporter (or group), the role of the candidate her- or himself certainly needs to be considered. In the same way "plausible deniability" alone will not absolve the candidate, though it may decrease the likelihood of Speaker pronouncements.

As noted above, announcing the Committee's conclusion to the House that a violation has occurred should remain an option, but the Committee also favors availability of other options whereby relatively minor infractions may be easily and quickly remedied without being reported to the House. This may also be appropriate in those cases where the violation and corrective action is readily apparent without formal announcement. For example, Paragraph 15 of the rules (Policy G-610.020) requires candidates using electronic communications to "include a simple mechanism to allow recipients to opt out of receiving future [emails]." A candidate failing to provide the "simple mechanism" could easily correct the violation by sending another communication apologizing and adding the opt out, which would be apparent to all recipients, meaning that reporting the violation to the House would be of little need. For another example, a misstatement in an interview or on campaign materials could be subsequently corrected by the candidate by notification to those that received the misinformation.

Where a confirmed violation is deemed by the Election Committee to require a report to the House, the Speaker would report pertinent details, including any corrective action undertaken by the candidate, that are deemed appropriate for the HOD to consider. A notice to the House, separate from a meeting, could be provided when appropriate. For example, such notice could be included with the Speakers' planned announcements of candidates (see Policy G-610.020 [3]), which would allow the House to assess the gravity of the violation but also provide the violator with the opportunity to respond to concerns. Violations that occur once the Annual Meeting has convened, if determined by the Committee to be significant, would be announced during a session of the HOD.

CONCLUSION

The final recommendation of Speakers' Report 2 (Report of the Election Task Force) adopted at the J21 Special Meeting (Policy D-610.998) provides for a review of the reforms related to our election processes. The Election Committee itself and these recommendations will be subject to this review. Our tradition of professionalism and collegiality should result in few violations of our campaign principles and rules necessitating invoking the process detailed here. The Election Committee has recommended a process that draws upon our traditions, provides appropriate flexibility without undue complexity, and yet maintains the integrity of our elections. Accordingly, your Election Committee asks that the following recommendations be approved for use in the upcoming open campaign season and that the Committee be allowed to continue to monitor our election processes with further recommendations in the future as needed.

RECOMMENDATIONS

It is recommended that the following recommendations be adopted and the remainder of the report be filed.

1. A Campaign Complaint Reporting, Validation, and Resolution Process shall be established as follows:

   Campaign violation complaints should be directed to the Speaker, the Vice Speaker, or the AMA General Counsel and should include the following details:

   - The name of the person(s) thought to have violated the rules
   - The date of the alleged violation and the location if relevant
   - The specific violation being alleged (i.e., the way the rules were violated)
   - The materials, if any, that violate the rules; original materials are preferred over copies. Where necessary, arrangements for collection of these materials will be made.

   Campaign violation complaints will be investigated by the Election Committee, which will determine penalties for validated complaints as appropriate. Penalties may include an announcement of the violation by the Speaker to the House. (New HOD Policy)

2. The Election Committee will review the Campaign Complaint Reporting, Validation, and Resolution Process as implemented and make further recommendations to the House as necessary. (Directive to Take Action)

3. Policy D-610.998, Paragraph 6 be rescinded. (Rescind HOD Policy)

Fiscal Note: Less than $500 to update policy. Costs for the Committee's operation, minimal.

Appendix A – Members of the Election Committee

The following delegates and alternate delegates were selected for the initial election committee from among those who submitted applications. All have agreed to not be a candidate or to be directly involved in a campaign and will not seek reappointment for any year in which the individual intends to be a candidate or directly involved in a campaign:

- Lynda Young, MD, Chair, Delegate, Massachusetts Medical Society (pediatrics)
- Michael DellaVecchia, MD, PhD, Delegate, Pennsylvania Medical Society (ophthalmology)
- John Flores, MD, Delegate, Texas Medical Association (internal medicine)
- George Hruza, MD, Alternate Delegate, Missouri State Medical Association (dermatology)
- Josh Lesko, MD, Sectional Resident and Fellow Delegate (Medical Society of Virginia; emergency medicine)
- Ted Mazer, MD, Delegate, California Medical Association (otolaryngology)
- Nancy Mueller, MD, Delegate, Medical Society of New Jersey (neurology)

The Speakers serve ex officio, without vote, except to break ties.

Appendix B - Policies Relevant to this Report

D-610.998, Directives from the Election Task Force

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

Campaign literature
2. An AMA Candidates' Page will be created on the AMA website or other appropriate website to allow each candidate the opportunity to post campaign materials. Parameters for the site will be established by the Speaker and communicated to candidates.

Interviews
3. The Speakers are encouraged to continue recorded virtual interviews of announced candidates in contested races, to be posted on the AMA website.

Voting Process and Election Session
4. The Speaker is encouraged to consider means to reduce the time spent during the HOD meeting on personal points by candidates after election results are announced, including collecting written personal points from candidates to be shared electronically with the House after the meeting or imposing time limits on such comments.

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

6. The Speaker in consultation with the Election Committee will consider a more defined process for complaint reporting, validation, resolution, and potential penalties This process will be presented to the House for approval.

Review of Implementation
7. After an interval of 2 years a review of our election process, including the adopted Recommendations from this report, be conducted by the Speaker and, at the Speaker's discretion the appointment of another election task force, with a report back to the House.

Policy G-610.020, Rules for AMA Elections

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

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

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

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

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

(6) If a potential newly opened position on the Board or a specified council does not open but there are other open positions for the same council or the Board, an election will proceed for the existing open seats. Candidates will be offered the opportunity to withdraw their nomination prior to the vote. If there are no scheduled open seats on the Board or specified council for which a potential newly opened position is announced and if the potential newly opened position does not open (i.e., the individual with the unexpired term is not elected to the office they sought), no election for the position will be held. In the event that a prior

election results in a newly opened position without a nominated candidate or more positions are open than nominated candidates, the unfilled position/s would remain unfilled until the next Annual Meeting.

(7) The AMA Office of House of Delegates Affairs will provide an opportunity for all announced candidates to submit material to the HOD office which will then be sent electronically by the HOD Office in a single communication to all delegates and alternates. Parameters regarding content and deadlines for submission will be established by the Speaker and communicated to all announced candidates.

(8) Our AMA believes that: (a) specialty society candidates for AMA House of Delegates elected offices should be listed in the pre-election materials available to the House as the representative of that society and not by the state in which the candidate resides; (b) elected specialty society members should be identified in that capacity while serving their term of office; and (c) nothing in the above recommendations should preclude formal co-endorsement by any state delegation of the national specialty society candidate, if that state delegation should so choose.

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

(10) Active campaigning for AMA elective office may not begin until the Board of Trustees, after its April meeting, announces the candidates for council seats. Active campaigning includes mass outreach activities directed to all or a significant portion of the members of the House of Delegates and communicated by or on behalf of the candidate. If in the judgment of the Speaker of the House of Delegates circumstances warrant an earlier date by which campaigns may formally begin, the Speaker shall communicate the earlier date to all known candidates.

(11) The Speaker's Office will coordinate the scheduling of candidate interviews for general officer positions (Trustees, President-Elect, Speaker and Vice Speaker).

(12) Every state and specialty society delegation is encouraged to participate in a regional caucus, for the purposes of candidate review activities.

(13) Campaign memorabilia may not be distributed in the Not for Official Business (NFOB) bag.

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

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

(16) Campaign expenditures and activities should be limited to reasonable levels necessary for adequate candidate exposure to the delegates. Campaign memorabilia and giveaways that include a candidate's name or likeness may not be distributed at any time.

(17) Campaign stickers, pins, buttons and similar campaign materials are disallowed. This rule will not apply for pins for AMPAC, the AMA Foundation, specialty societies, state and regional delegations and health related causes that do not include any candidate identifier. These pins should be small, not worn on the badge and distributed only to members of the designated group. General distribution of any pin, button or sticker is disallowed.

(18) At any AMA meeting convened prior to the time period for active campaigning, campaign-related expenditures and activities shall be discouraged. Large campaign receptions, luncheons, other formal campaign activities and the distribution of campaign literature and gifts are prohibited. It is permissible for candidates seeking election to engage in individual outreach meant to familiarize others with a candidate's opinions and positions on issues.

(19) Candidates for AMA office should not attend meetings of state medical societies unless officially invited and could accept reimbursement of travel expenses by the state society in accordance with the policies of the society.

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

(21) A state, specialty society, caucus, coalition, etc. may contribute to more than one party. However, a candidate may be featured at only one party, which includes: (a) being present in a receiving line, OR (b) appearing by name or in a picture on a poster or notice in or outside of the party venue. At these events, alcohol may be served only on a cash or no-host bar basis.

(22) Displays of campaign posters, signs, and literature in public areas of the hotel in which Annual Meetings are held are prohibited because they detract from the dignity of the position being sought and are unsightly. Campaign posters may be displayed at a single campaign reception at which the candidate is featured. No campaign literature shall be distributed in the House of Delegates and no mass outreach electronic messages shall be transmitted after the opening session of the House of Delegates.

(23) At the Opening Session of the Annual Meeting, officer candidates in a contested election will give a two-minute self-nominating speech, with the order of speeches determined by lot. No speeches for unopposed candidates will be given, except for president-elect. When there is no contest for president-elect, the candidate will ask a delegate to place his or her name in nomination, and the election will then be by acclamation. When there are two or more candidates for the office of president-elect, a two-minute nomination speech will be given by a delegate. In addition, the Speaker of the House of Delegates will schedule a debate in front of the AMA-HOD to be conducted by rules established by the Speaker or, in the event of a conflict, the Vice Speaker.

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 001
(N-21)

Introduced by: Medical Student Section

Subject: Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, Correctional facilities, which include prisons and jails, are facilities that house people who have been accused and/or convicted of a crime[1]; and

Whereas, Detention centers refer to facilities that hold undocumented immigrants, refugees, people awaiting trial or sentence, or young offenders for short periods of time[2]; and

Whereas, Solitary confinement is the physical and social isolation of an incarcerated individual confined to a cell for 22-24 hours per day, routinely used as a punishment for disciplinary violations in correctional facilities and detention centers[3]; and

Whereas, Solitary confinement is used as punishment for minor nonviolent infractions, such as not standing up for headcount or not returning a food tray[3,4]; and

Whereas, Recent whistleblower accounts describe the use of solitary confinement as a means of reprisal for reporting unsafe and unsanitary conditions[5,6]; and

Whereas, Solitary confinement is distinguished from medical isolation and quarantine because solitary confinement is used punitively while medical isolation is used to reduce the spread of infectious disease[7]; and

Whereas, Solitary confinement consists of extended lengths of social separation, sensory deprivation, and the revocation of prison privileges, while medical isolation is a temporary measure overseen by medical professionals who treat prisoners with compassion and provide prisoners resources to aid their recovery[7]; and

Whereas, In the United States, approximately 4.5% of incarcerated individuals, or around 60,000 people, currently reside in some form of solitary confinement[8]; and

Whereas, A year in solitary confinement costs three times as much per prisoner, or an average of $75,000 per prisoner per year[9]; and

Whereas, Individuals in solitary confinement often suffer from sensory deprivation and are offered few or no educational, vocational, or rehabilitative programs[10]; and

Whereas, Chronic social isolation stress, as perpetuated by solitary confinement, is associated with a higher risk of cognitive deterioration, learning deficits, anxiety, depression, post-traumatic stress disorder, and psychosomatic behavior changes[11-13]; and

Whereas, There is a strong association between solitary confinement and self-harm, for instance, one *JAMA* study found persons that held in solitary confinement had a 78% higher suicide rate within the first year after release and another study analyzing over 240,000 incarcerations found that prisoners who experienced solitary confinement accounted for over 50% of self-harm incidents despite accounting for only 7.3% of prison admissions[4,13,14]; and

Whereas, Individuals who spend time in solitary confinement are 127% more likely to die of an opioid overdose in the first two weeks after release and 24% more likely to die from any cause in the first year after release, even after controlling for potential confounding factors, including substance use and mental health disorders[14]; and

Whereas, Formerly incarcerated individuals who spend time in solitary confinement have a higher overall 5-year mortality those who do not[15]; and

Whereas, A United States Department of Justice study indicates that inmates with mental illnesses are more likely to be put in solitary confinement and that solitary confinement further exacerbates their mental illnesses[16]; and

Whereas, Solitary confinement increases the likeliness of episodes of psychosis and long-term neurobiological consequences, increasing mentally ill prisoners' need for psychiatric services[12,13]; and

Whereas, Prisoners who spend any amount of time in solitary confinement have higher rates of homelessness and unemployment after release, in part due to the lasting psychological stress of confinement[17]; and

Whereas, Spending any amount of time in solitary confinement is associated with two times the risk of being reincarcerated within two weeks of release and other studies found a 10-25% increased overall risk of recidivism[14,18-20]; and

Whereas, Parolees released from solitary confinement commit new crimes in their community 35% more than parolees released from the general prison population, threatening community safety[19]; and

Whereas, Transitioning prisoners from solitary confinement to the general prison population prior to release reduces recidivism rates[20]; and

Whereas, A 2018 nationwide survey of correctional facilities found that, in most jurisdictions, certain racial minorities are disproportionately more likely to be placed in solitary confinement while white prisoners are 14% less likely to be placed in solitary confinement[8]; and

Whereas, A study of over 100,000 prisoners found that the odds that gay and bisexual men will be placed in solitary confinement are 80% greater than heterosexual men and the odds are 190% greater that lesbian and bisexual women will be placed in solitary confinement than heterosexual women[21]; and

Whereas, The United Nations and The International Convention on the Rights of the Child prohibit the solitary confinement of anyone under the age of 18[22,23]; and

Whereas, In 2015 the United Nations General Assembly adopted "The Standard Minimum Rules for the Treatment of Prisoners," also known as the "Mandela Rules," which condemn the use of solitary confinement for prisoners with mental or physical disabilities when their conditions would be exacerbated by such measures[23]; and

Whereas, The same rules call for the prohibition of prolonged solitary confinement, longer than 15 days, because it is "cruel, inhuman or degrading treatment or punishment"[23]; and

Whereas, The Mandela Rules further state that "solitary confinement shall be used only in exceptional cases as a last resort, for as short a time as possible and subject to independent review"[23]; and

Whereas, Solitary confinement is a risk for self-harm and predisposes to a multitude of physical and psychological health issues, and should be considered cruel and unusual punishment and a human rights violation[24]; and

Whereas, At least some United States correctional facilities have managed to reform and reduce their use of solitary confinement in order to better respect the dignity and human rights of inmates while still maintaining the safety of correctional officers and inmates in jails and prisons[18]; and

Whereas, In Colorado, state prisons have reduced their use of solitary confinement by 85% without any other interventions and have seen a concurrent drop in the rate of prisoner on staff violence[18]; and

Whereas, In Mississippi, when correctional facilities reduced their solitary confinement population, violent incidents also dropped by nearly 70%[19]; and

Whereas, A 2015 study found that placing male inmates who were violent in solitary confinement did not effectively deter or alter the probability, timing, or development of future misconduct or violence[25]; and

Whereas, Some correctional facilities have created special units to protect vulnerable groups together with similar access to privileges and programs available to the general population without using solitary confinement as a means of protection[18]; and

Whereas, Alternatives to solitary confinement exist for individuals with mental illness and for sexual minorities, such as the Clinical Alternative to Punitive Segregation (CAPS) unit in New York City[26]; and

Whereas, AMA policy H-60.922 opposes the use of solitary confinement of juveniles for disciplinary purposes in correctional facilities; therefore be it

RESOLVED, That American Medical Association Policy H-430.983, "Reducing the Use of Restrictive Housing in Prisoners with Mental Illness," be amended by addition and deletion to read as follows:

~~Reducing~~ Opposing the Use of Restrictive Housing ~~in~~ for Prisoners ~~with Mental Illness~~
H-430.983
Our AMA will: (1) ~~support limiting~~ oppose the use of solitary confinement of any length~~, with rare exceptions,~~ for incarcerated persons ~~with mental illness~~, in ~~adult~~ correctional facilities and detention centers, except for medical isolation or to protect individuals who are actively being harmed or will be immediately harmed by a physically violent individual, in which cases confinement may be used for as short a time as possible; ~~and~~ (2) while solitary confinement practices are still in place, support efforts to ensure that the mental and physical health of all individuals placed in solitary confinement are regularly monitored by health professionals; and (3) encourage appropriate stakeholders to develop and implement safe, humane, and ethical alternatives to solitary confinement for incarcerated persons in all correctional facilities.~~; and (3) encourage appropriate stakeholders to develop and implement alternatives to solitary confinement for incarcerated persons in all correctional facilities.~~ (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Our AMA has increasingly recognized the priority and urgency of addressing health injustices. The mental health detriments of solitary confinement are well-documented and openly opposed by international groups as a form of cruel and unusual punishment. As this resolution demonstrates, humane alternatives are available to ensure safety and prevent violence. Using solitary confinement is actively harmful to the future of these individuals once they are released and has a detrimental effect on later attempts to reduce recidivism rates. Our delegation has worked to solicit review from advocacy and staff to ensure the issue is timely, addresses a gap in policy, and without substantial concerns on feasibility or actionability, and therefore would ask the House to take timely action on behalf of an incredibly vulnerable population.

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RELEVANT AMA POLICY

Reducing the Use of Restrictive Housing in Prisoners with Mental Illness H-430.983

Our AMA will: (1) support limiting the use of solitary confinement of any length, with rare exceptions, for incarcerated persons with mental illness, in adult correctional facilities; (2) support efforts to ensure that the mental and physical health of all individuals placed in solitary confinement are regularly monitored by health professionals; and (3) encourage appropriate stakeholders to develop and implement alternatives to solitary confinement for incarcerated persons in all correctional facilities.
Res. 412, A-18.

Solitary Confinement of Juveniles in Legal Custody H-60.922

Our AMA: (1) opposes the use of solitary confinement in juvenile correction facilities except for extraordinary circumstances when a juvenile is at acute risk of harm to self or others; (2) opposes the use of solitary confinement of juveniles for disciplinary purposes in correctional facilities; and

(3) supports that isolation of juveniles for clinical or therapeutic purposes must be conducted under the supervision of a physician.
Res. 3, I-14; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: Res. 917, I-16.

Discriminatory Policies that Create Inequities in Health Care H-65.963
Our AMA will: (1) speak against policies that are discriminatory and create even greater health disparities in medicine; and (2) be a voice for our most vulnerable populations, including sexual, gender, racial and ethnic minorities, who will suffer the most under such policies, further widening the gaps that exist in health and wellness in our nation.
Res. 001, A-18.

Support of Human Rights and Freedom H-65.965
Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.
CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17.

Human Rights and Health Professionals H-65.981
The AMA opposes torture in any country for any reason; urges appropriate support for victims of torture; condemns the persecution of physicians and other health care personnel who treat torture victims.
Sub. Res. 615, A-97; Reaffirmed: Sub. Res. 12, A-04; Reaffirmed: Sub. Res. 10, A-05; Reaffirmed: CEJA Rep. 5, A-15.

Human Rights H-65.997
Our AMA endorses the World Medical Association's Declaration of Tokyo which are guidelines for medical doctors concerning torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment.
BOT Rep. M, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Sub. Res. 12, A-04; Reaffirmed: CEJA Rep. 8, A-14.

Appropriate Placement of Transgender Prisoners H-430.982
1. Our AMA supports the ability of transgender prisoners to be placed in facilities, if they so choose, that are reflective of their affirmed gender status, regardless of the prisoner’s genitalia, chromosomal make-up, hormonal treatment, or non-, pre-, or post-operative status.
2. Our AMA supports that the facilities housing transgender prisoners shall not be a form of administrative segregation or solitary confinement.
BOT Rep. 24, A-18.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 002
(N-21)

Introduced by: Medical Student Section

Subject: Disaggregation of Race Data for Individuals of Middle Eastern and North African (MENA) Descent

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, The American Association of Physical Anthropologists believes that "race does not
2 have its roots in biological reality, but… has become a social reality that structures societies
3 and how we experience the world. In this regard, race is real, as is racism, and both have real
4 biological consequences";[1] and
5
6 Whereas, People of Middle Eastern and North African (MENA) descent are not recognized as
7 belonging to a unique, independent racial category in the U.S. Census data, and instead they
8 are aggregated under "White";[2] and
9
10 Whereas, MENA designation is not included in the National Institute of Health's racial
11 categories, and thus is not required to be considered in any federally-funded research;[3] and
12
13 Whereas, MENA is not included as a race category routinely collected in survey and
14 demographic data in the U.S.;[4,5] and
15
16 Whereas, There are discrepancies in estimates of the total MENA population across the US due
17 to lack of a racial identifier; [2,5] and
18
19 Whereas, There lack of a racial identifier for MENA populations has limited research on this
20 population in the US to ethnic enclaves, which may not be reflective of the community as a
21 whole;[4,6] and
22
23 Whereas, Americans of MENA descent disproportionately constitute recent immigrants to the
24 U.S., share a set of cultural norms, and face marginalization and discrimination;[4,5,6,7.8,9] and
25
26 Whereas, To the knowledge of the authors there has never been a prospective study examining
27 the health needs of MENA communities in the U.S.;[4] and
28
29 Whereas, Genetic disorders and familial inherited cancers occur at a higher frequency in some
30 MENA populations due to higher rates of consanguineous marriages, most commonly with first
31 cousins;[10] and
32
33 Whereas, Discrimination against MENA populations in the U.S. increased dramatically after
34 September 11th, 2001, including increased harassment, violence, and targeted hate crimes that
35 have resulted in worsening health outcomes in this population;[6,11,12] and

Whereas, Classifying MENA populations as “White” has led to their “cultural invisibility” and perpetuates a cycle of undocumented health disparities that affects funding for health-related research, targeting of effective and personalized healthcare, and prevents patient-centered care and engagement;[4,5,6,10,13] and

Whereas, Including a race identifier for MENA populations on all medical records will increase the representation and visibility of the population, and increase the research and attention to the medical and public health needs of this community;[4,5,6,14] and

Whereas, Despite analysis issued by the U.S. Census Bureau in 2017 that “it is optimal to use a dedicated ‘Middle Eastern or North African’ response category,” the Census Bureau declined to include a MENA identifier in the 2020 Census;[15] and

Whereas, Our AMA had supported the addition of MENA as a “distinct reporting category” in a 2016 letter to the Chief Statistician at the Office of Management and Budget, but has not publicly engaged on this issue since then and does not list “MENA” as a race option on AMA demographics forms;[16] and

Whereas, The U.S. Census is used to direct federal resources, funding, and research, making it vitally important in the promotion of medicine and public health, and the Census has acknowledged that its inaccuracies in collection of race data act as a barrier to its utility and accuracy;[17] and

Whereas, Our AMA “recognizes that race is a social construct and is distinct from ethnicity, genetic ancestry, or biology” (H-65.953); and

Whereas, Separating the demographic identifier as MENA will allow for the disaggregation of data in order to appropriately target research, preventive measures, and healthcare engagement; therefore be it

RESOLVED, That our American Medical Association add “Middle Eastern/North African (MENA)” as a separate race category on all AMA demographics forms (Directive to Take Action); and be it further

RESOLVED, That our AMA work with relevant stakeholders to promote the inclusion of “Middle Eastern/North African (MENA)” as a separate race category on all surveys conducted by the U.S. Census Bureau, and for all federally funded research using race categories (Directive to Take Action); and be it further

RESOLVED, That our AMA work with relevant stakeholders to promote the inclusion of “Middle Eastern/North African (MENA)” as a separate race category on all medical school and residency demographics forms. (Directive to Take Action)

Fiscal Note: Moderate - between $5,000 - $10,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Since the fall of Afghanistan to the Taliban, more than 100,000 Afghan refugees are expected to arrive in the US. Over 4 million people in America of Middle Eastern and North African (MENA) descent are currently identified as "White" by the US Census Bureau, creating an invisible minority. This leaves MENA populations to choose between misidentifying their race or being forced to check off "Other", as many have done on AMA forms and at every level of the medical system. As our AMA and society at large moves to rectify the systemic racism and marginalization facing many communities, it is time for us to speak out for thousands of our MENA colleagues and millions of patients.

It is imperative that we act on this today, so we can create a more inclusive environment for every MENA individual in this nation. Any delay in consideration means another year with millions of patients marginalized, health disparities missed, and AMA members feeling excluded. Every year we wait is $675 billion in misallocated federal and state funds, all distributed based on the annual American Community Survey conducted by the Census Bureau.

This is a resolution that fills a clear gap in AMA and federal policy. In 2017, the Census Bureau agreed to include "MENA" as a separate race on the 2020 Census, only to backtrack in 2018 and has not commented on the issue since then. If adopted, this policy could help alleviate a glaring disparity in medical training, medical practice, and research.

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RELEVANT AMA POLICY

Disaggregation of Demographic Data Within Ethnic Groups H-350.954

1. Our AMA supports the disaggregation of demographic data regarding: (a) Asian-Americans and Pacific Islanders in order to reveal the within-group disparities that exist in health outcomes and representation in medicine; and (b) ethnic groups in order to reveal the within-group disparities that exist in health outcomes and representation in medicine.
2. Our AMA: (a) will advocate for restoration of webpages on the Asian American and Pacific Islander (AAPI) initiative (similar to those from prior administrations) that specifically address disaggregation of health outcomes related to AAPI data; (b) supports the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in health outcomes; (c) supports the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in representation in medicine, including but not limited to leadership positions in academic medicine; and (d) will report back at the 2020 Annual Meeting on the issue of disaggregation of data regarding AAPIs (and other ethnic subgroups) with regards to the ethnic subgroup disparities that exist in health outcomes and representation in medicine, including leadership positions in academic medicine.

Res. 001, I-17, Appended: Res. 403, A-19

Accurate Collection of Preferred Language and Disaggregated Race and Ethnicity to Characterize Health Disparities H-315.963

Our AMA encourages the Office of the National Coordinator for Health Information Technology (ONC) to expand their data collection requirements, such that electronic health record (EHR) vendors include options for disaggregated coding of race, ethnicity and preferred language.

Res. 03, I-19

Racism as a Public Health Threat H-65.952

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

Res. 5, I-20

Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice H-65.953

1. Our AMA recognizes that race is a social construct and is distinct from ethnicity, genetic ancestry, or biology.
2. Our AMA supports ending the practice of using race as a proxy for biology or genetics in medical education, research, and clinical practice.
3. Our AMA encourages undergraduate medical education, graduate medical education, and continuing medical education programs to recognize the harmful effects of presenting race as biology in medical education and that they work to mitigate these effects through curriculum change that: (a) demonstrates

how the category “race” can influence health outcomes; (b) that supports race as a social construct and not a biological determinant and (c) presents race within a socio-ecological model of individual, community and society to explain how racism and systemic oppression result in racial health disparities.
4. Our AMA recommends that clinicians and researchers focus on genetics and biology, the experience of racism, and social determinants of health, and not race, when describing risk factors for disease.
Res. 11, I-20

Racial Essentialism in Medicine D-350.981
1. Our AMA recognizes that the false conflation of race with inherent biological or genetic traits leads to inadequate examination of true underlying disease risk factors, which exacerbates existing health inequities.
2. Our AMA encourages characterizing race as a social construct, rather than an inherent biological trait, and recognizes that when race is described as a risk factor, it is more likely to be a proxy for influences including structural racism than a proxy for genetics.
3. Our AMA will collaborate with the AAMC, AACOM, NBME, NBOME, ACGME and other appropriate stakeholders, including minority physician organizations and content experts, to identify and address aspects of medical education and board examinations which may perpetuate teachings, assessments, and practices that reinforce institutional and structural racism.
4. Our AMA will collaborate with appropriate stakeholders and content experts to develop recommendations on how to interpret or improve clinical algorithms that currently include race-based correction factors.
5. Our AMA will support research that promotes anti-racist strategies to mitigate algorithmic bias in medicine.
Res. 10, I-20

Health Plan Initiatives Addressing Social Determinants of Health H-165.822
Our AMA:
1. recognizing that social determinants of health encompass more than health care, encourages new and continued partnerships among all levels of government, the private sector, philanthropic organizations, and community- and faith-based organizations to address non-medical, yet critical health needs and the underlying social determinants of health;
2. supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs;
3. encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health, including through such mechanisms as professional development and other training;
4. supports mechanisms, including the establishment of incentives, to improve the acquisition of data related to social determinants of health, while minimizing burdens on patients and physicians;
5. supports research to determine how best to integrate and finance non-medical services as part of health insurance benefit design, and the impact of covering non-medical benefits on health care and societal costs; and
6. encourages coverage pilots to test the impacts of addressing certain non-medical, yet critical health needs, for which sufficient data and evidence are not available, on health outcomes and health care costs.
CMS Rep. 7, I-20

Protecting the Integrity of Public Health Data Collection H-440.817
Our AMA will advocate: (1) for the inclusion of demographic data inclusive of sexual orientation and gender identity in national and state surveys, surveillance systems, and health registries; including but not limited to the Current Population Survey, United States Census, National Survey of Older Americans Act Participants, all-payer claims databases; and (2) against the removal of demographic data inclusive of sexual orientation and gender identity in national and state surveys, surveillance systems, and health registries without plans for updating measures of such demographic data.
Res. 002, I-18

Maintaining Validity and Comprehensiveness of U.S. Census Data H-350.952
Our AMA will support adequate funding for the U.S. Census to assure accurate and relevant data is collected and disseminated.
Res. 221, A-18

Race and Ethnicity as Variables in Medical Research H-460.924
Our AMA policy is that: (1) race and ethnicity are valuable research variables when used and interpreted appropriately;
(2) health data be collected on patients, by race and ethnicity, in hospitals, managed care organizations, independent practice associations, and other large insurance organizations;
(3) physicians recognize that race and ethnicity are conceptually distinct;
(4) our AMA supports research into the use of methodologies that allow for multiple racial and ethnic self-designations by research participants;
(5) our AMA encourages investigators to recognize the limitations of all current methods for classifying race and ethnic groups in all medical studies by stating explicitly how race and/or ethnic taxonomies were developed or selected;
(6) our AMA encourages appropriate organizations to apply the results from studies of race-ethnicity and health to the planning and evaluation of health services; and
(7) our AMA continues to monitor developments in the field of racial and ethnic classification so that it can assist physicians in interpreting these findings and their implications for health care for patients.
CSA Rep. 11, A-98 Appended: Res. 509, A-01 Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed: CEJA Report 01, A-21

Accuracy in Racial, Ethnic, Lingual and Religious Designations in Medical Records H-315.996
Our AMA advocates precision without regulatory requirement or mandatory reporting of racial, ethnic, preferred language and religious designations in medical records, with information obtained from the patient, always respecting the personal privacy and communication preferences of the patient.
Res. 4, I-83 Reaffirmed: CLRPD Rep. 1, I-93 Reaffirmed: CSA Rep. 8, A-05 Modified: CSAPH Rep. 1, A-15 Modified: Res. 03, I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 003
(N-21)

Introduced by: Medical Student Section

Subject: Supporting the Study of Reparations as a Means to Reduce Racial Inequalities

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, Many healthcare disparities that exist today can be attributed to exploitative structural policies targeting minorities, especially the Black community, including disproportionate rates of incarceration,[5–7] residential segregation,[8] and unfair labor and employment policies; [1–4] and

Whereas, Toxic stresses of racism, incarceration, community violence, and low socioeconomic status are shown to increase the likelihood of social/emotional/cognitive impairment, high-risk behavior[10], disease, and early death in minority children[9, 11,12]; and

Whereas, The racial wealth gap in the United States has increased dramatically, as households with Black children hold just one cent for every dollar held by households with non-Hispanic White children as of 2016[13,14]; and

Whereas, Income has been shown to be positively correlated with life expectancy, increased access to care, and improved health outcomes[15,16]; and

Whereas, Effects of Jim Crow era policies throughout time have severely hindered access to education and job opportunities, which are correlated with positive health outcomes, for the African American community[17,18,19,20]; and

Whereas, The United States has never created a commission to formally study the health, economic or social impacts of slavery and the Jim Crow era on African Americans and the resolution of those injustices through the context of reparations[14,21]; and

Whereas, Reparations, encompassing a broad variety of public aid including but not limited to direct compensation, special education and job training, and community support for descendants of slaves, have been discussed as a means to support the marginalized Black community and end multi-generational poverty and its associated racial inequities[21]; and

Whereas, In 2015, Chicago became the first city in the United States to propose reparations for victims of police torture and brutality, in a measure including $5.5 million in direct compensation, free college education to survivors, a formal apology from the city, and education on police torture in public schools[22]; and

Whereas, Reparations are designed to promote intergenerational wealth amongst affected communities, which in turn will increase the health outcomes of these communities; and

Whereas, Legislators have unsuccessfully introduced House Resolution 40: “Commission to Study Reparation Proposals for African Americans Act,” which asked for a study of reparations, into Congress every year since 1989[14,21,23]; and

Whereas, Individual cities and states including in California, Illinois, and North Carolina among others, are now beginning to adopt policies acknowledging a need for reparations to address racial disparities resulting in adverse health outcomes[23–25]; and

Whereas, Countries such as South Africa, which developed a Truth and Reconciliation Commission to address its history of apartheid, and France, which approved over $60 million in 2014 to be allocated to Holocaust survivors and their descendants, have implemented reparations successfully in the past[26,27]; and

Whereas, The United Nations and many of its member nations have created commissions repeatedly calling for reparations in the United States and for lawmakers to pass HR 40 or similar legislation[28-30]; and

Whereas, Reparations may serve as an avenue to alleviate some of the health, educational, and economic disparities faced by the US Black population[14,30,31]; and

Whereas, The Black community is severely underrepresented in medicine, due to many societal barriers for success and the closure of all but two predominantly Black medical schools after the 1910 publication of the Flexner Report[31]; and

Whereas, The AMA historically refused to establish a policy of nondiscrimination or take action against AMA-affiliated state and local medical associations that openly practiced racial exclusion in their memberships[32,33]; and

Whereas, AMA President-Emeritus Dr. Ronald Davis issued an apology on behalf of the AMA for its past wrongs and pushed the AMA towards continually addressing health disparities alongside all public health and health care stakeholders[33]; therefore be it

RESOLVED, That our American Medical Association study potential mechanisms of national economic reparations that could improve inequities associated with institutionalized, systematic racism and report back to the House of Delegates (Directive to Take Action); and be it further

RESOLVED, That our AMA study the potential adoption of a policy of reparations by the AMA to support the African American community currently interfacing with, practicing within, and entering the medical field and report back to the House of Delegates (Directive to Take Action); and be it further

RESOLVED, That our AMA support federal legislation that facilitates the study of reparations. (Directive to Take Action)

Fiscal Note: Estimated cost to implement resolution is $110,000.

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

This resolution is timely with pending legislative discussions in Congress. Over the past years, our AMA has begun a movement attempting to redress our decades-long contributions to medical racism. This resolution is urgent, as it asks our AMA to support a Congressional commission to make recommendations on reparations, for which federal legislation has already been introduced (HR 40, the Commission to Study and Develop Reparation Proposals for African Americans Act), making now an ideal time for the AMA to act. This resolution also asks the AMA to study mechanisms of economic and healthcare reparations, a necessary, vital next step if the AMA truly intends to advance racial justice in medicine. This resolution gives our AMA the opportunity to lend a powerful voice, at an extremely timely and important juncture, towards true health equity through the study of the feasibility of reparations and their potential to contribute to undoing the deep health disparities that hold our nation back.

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RELEVANT AMA POLICY

Support of Human Rights and Freedom H-65.965

Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.
CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17

AMA Initiatives Regarding Minorities H-350.971

The House of Delegates commends the leaders of our AMA and the National Medical Association for having established a successful, mutually rewarding liaison and urges that this relationship be expanded in all areas of mutual interest and concern. Our AMA will develop publications, assessment tools, and a survey instrument to assist physicians and the federation with minority issues. The AMA will continue to strengthen relationships with minority physician organizations, will communicate its policies on the health care needs of minorities, and will monitor and report on progress being made to address racial and ethnic disparities in care. It is the policy of our AMA to establish a mechanism to facilitate the development and implementation of a comprehensive, long-range, coordinated strategy to address issues and concerns affecting minorities, including minority health, minority medical education, and minority membership in the AMA. Such an effort should include the following components: (1) Development, coordination, and strengthening of AMA resources devoted to minority health

issues and recruitment of minorities into medicine; (2) Increased awareness and representation of minority physician perspectives in the Association's policy development, advocacy, and scientific activities; (3) Collection, dissemination, and analysis of data on minority physicians and medical students, including AMA membership status, and on the health status of minorities; (4) Response to inquiries and concerns of minority physicians and medical students; and (5) Outreach to minority physicians and minority medical students on issues involving minority health status, medical education, and participation in organized medicine.
CLRPD Rep. 3, I-98; CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 01, A-20

Improving the Health of Black and Minority Populations H-350.972
Our AMA supports: (1) A greater emphasis on minority access to health care and increased health promotion and disease prevention activities designed to reduce the occurrence of illnesses that are highly prevalent among disadvantaged minorities. (2) Authorization for the Office of Minority Health to coordinate federal efforts to better understand and reduce the incidence of illness among U.S. minority Americans as recommended in the 1985 Report to the Secretary's Task Force on Black and Minority Health. (3) Advising our AMA representatives to the LCME to request data collection on medical school curricula concerning the health needs of minorities. (4) The promotion of health education through schools and community organizations aimed at teaching skills of health care system access, health promotion, disease prevention, and early diagnosis.
CLRPD Rep. 3, I-98; Reaffirmation: A-01; Modified: CSAPH Rep. 1, A-11; Reaffirmed: CEJA Rep. 1, A-21

Racial and Ethnic Disparities in Health Care H-350.974
1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.
2. The AMA emphasizes three approaches that it believes should be given high priority:
A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.
B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.
C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities
3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.

4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.
CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep. 1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 3, A-21

Reducing Racial and Ethnic Disparities in Health Care D-350.995
Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations:
(1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.
(2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.
(3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities.
BOT Rep. 4, A-03; Reaffirmation: A-11; Reaffirmation: A-16; Reaffirmed: CMS Rep. 10, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 004
(N-21)

Introduced by: Medical Student Section

Subject: Guidelines on Chaperones for Sensitive Exams

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, Estimates indicate that almost 11 percent of provider misconduct reports are sexual in nature[1]; and

Whereas, Rigorous published studies conclude that we lack sufficient information on malpractice to accurately establish the rates and types of physician misconduct[2]; and

Whereas, The presence of medical chaperones is a common practice during sensitive exams for patients[3,4]; and

Whereas, Physicians can be reported for alleged misconduct that never occurred, but is difficult to disprove without witnesses[5]; and

Whereas, University of Michigan policy states that “A chaperone’s presence may also provide protection to health professionals against unfounded allegations of improper behavior, and a health professional should be able to request a chaperone for any examination or procedure”[6]; and

Whereas, A study investigating whether medical chaperones affect patient satisfaction had results indicating that 61% of adolescent patients preferred to be offered a chaperone[3,4]; and

Whereas, American College of Obstetricians and Gynecologists (ACOG) recommends, in part, accommodating patient requests for a chaperone, regardless of the physician's gender[7]; and

Whereas, The American College of Physicians Ethics Manual states that “in general, the more intimate the examination, the more the physician is encouraged to offer the presence of a chaperone.”[8]; and

Whereas, Pediatric patients, disabled patients, patients with judgement-altering health conditions, patients who lack the capacity to give informed consent, are unable to protect themself from abuse, neglect or exploitation, and patients who lack momentary capacity are vulnerable to potential misconduct and may be unable to request a chaperone; and

Whereas, Some institutions require formally trained chaperones, including 7 states implementing legal mandates for the presence of medical chaperones during sensitive physical exams[9-13]; and

Whereas, Requiring a chaperone for every single sensitive exam may place a greater burden on staff and increase health care costs, and thus should not be institutionally mandated for every exam; and

Whereas, Patients may not want an extra person present for sensitive examinations due to the private nature of such examinations, and thus an opt-in/opt-out policy is more preferable to a fully mandated policy[14]; and

Whereas, Documentation of patient interaction has been shown to decrease rates of litigation ruled against providers[15]; and

Whereas, Patients may be uncomfortable requesting a chaperone when the provider asks themselves due to intimidation or fear of undermining the trust in the patient-provider relationship, and a study found that 54% of patients preferred to have the nurse ask about chaperone preference rather than the physician [5]; and

Whereas, Chaperones may feel uncertain or concerned about intervening during an inappropriate exam or reporting potential misconduct, especially if they are hierarchically inferior to the provider, calling for a need for educating chaperones on proper conduct[13]; and

Whereas, AMA policy states any authorized member of the health care team can serve as a medical chaperone as long as there are clear expectations to uphold professional standards of privacy and confidentiality, failing to address potential discomfort a chaperone may have in reporting egregious behavior during exams; and

Whereas, There have been instances of litigation when patient declined a chaperone during an exam[16]; and

Whereas, Physicians may feel uncomfortable performing sensitive exams on patients without a chaperone due to fear of litigation or discomfort with patient conduct during an exam; and

Whereas, American Association of Family Physicians Policy suggests that providers should not allow the process of ensuring that an exam is chaperoned to interfere with appropriate and timely patient care and clinical judgment; and

Whereas, AMA and ACOG policy have extensive protection guidelines for patients, but do not include guidelines to protect physicians[17]; therefore be it

RESOLVED, That our American Medical Association ask the Council on Ethical and Judicial Affairs to consider amending E-1.2.4, “Use of Chaperones in Code of Medical Ethics,” to ensure that it is most in line with the current best practices and potentially considers the following topics: a) opt-out chaperones for breast, genital, and rectal exams; b) documentation surrounding the use or not-use of chaperones; c) use of chaperones for patients without capacity; and d) asking patients’ consent regarding the gender of the chaperons and attempting to accommodate that preference as able. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Sensitive physical examinations provoke anxiety in patients and providers alike. With increasing concerns in recent years over sexual harassment and misconduct, more attention has been paid to the importance of chaperones for sensitive exams and for correct provider use and understanding of these chaperones. Given this increased attention and recent high-publicity problematic actions (for example, Larry Nassar's horrific treatment of generations of U.S. gymnasts), we believe our AMA Council on Ethical and Judicial Affairs should revisit the sections pertaining to these topics in the AMA's Code of Ethics. We believe this is a timely, important, and relevant ask.

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RELEVANT AMA POLICY

1.2.4 Use of Chaperones

Efforts to provide a comfortable and considerate atmosphere for the patient and the physician are part of respecting patients' dignity. These efforts may include providing appropriate gowns, private facilities for undressing, sensitive use of draping, and clearly explaining various components of the physical examination. They also include having chaperones available. Having chaperones present can also help prevent misunderstandings between patient and physician.

Physicians should:

(a) Adopt a policy that patients are free to request a chaperone and ensure that the policy is communicated to patients.

(b) Always honor a patient's request to have a chaperone.
(c) Have an authorized member of the health care team serve as a chaperone. Physicians should establish clear expectations that chaperones will uphold professional standards of privacy and confidentiality.
(d) In general, use a chaperone even when a patient's trusted companion is present.
(e) Provide opportunity for private conversation with the patient without the chaperone present. Physicians should minimize inquiries or history taking of a sensitive nature during a chaperoned examination.
Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 005
(N-21)

Introduced by: Medical Student Section

Subject: Combating Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, Natural hair can be defined as a hair texture that is tightly coiled or tightly curled as
2 well as hairstyles that include locs, cornrows, twists, braids, Bantu knots, fades, Afros, and/or
3 the right to keep hair in an uncut or untrimmed manner [1]; and
4
5 Whereas, Cultural headwear refers to head or hair coverings (i.e. hijabs, turbans) worn for
6 cultural purposes and serves as a way to express values of a demographic group or particular
7 society for religious, spiritual, or gender identification [2]; and
8
9 Whereas, Discrimination and/or restrictions targeting hairstyles and/or headwear are proxies for
10 racial, ethnic, and/or religious discrimination since hair textures and styles, along with cultural
11 headwear, are phenotypic features used in categorizing race, ethnicity, and/or religious
12 association [3-6]; and
13
14 Whereas, Title VII of the 1964 Civil Rights Act states it is unlawful for employers to discriminate
15 against any individual based on an "... individual's race, color, religion, sex, or national origin,"
16 and section 703(a) of Title VII mentions prohibiting not only intentional discrimination, but also
17 unintentional discrimination on the enumerated proscribed ground [7]; and
18
19 Whereas, Appearance guidelines, in the form of "race-neutral" grooming policies, used as part
20 of medical professionalism standards tend to be euro-centric and penalize those with non-euro-
21 centric phenotypical features and/or culture [8,9]; and
22
23 Whereas, In 2019, the State of California and New York City passed laws to address hair
24 discrimination within the workplace through the CROWN Act (SB 188) and the NYC
25 Commission on Human Rights Legal Enforcement Guidance on Race Discrimination on the
26 Basis of Hair [1,3]; and
27
28 Whereas, United States Armed Forces have repealed several bans on natural hair and cultural
29 headwear in the workplace (Army Regulation 670-1, Section 3-2) [10]; and
30
31 Whereas, Qualitative analysis of minority resident physicians has revealed the additional
32 challenges to embracing their racial identities in a professional setting results in less job
33 satisfaction and more susceptibility to burnout [11]; and
34
35 Whereas, Studies show "a positive association between physician-patient racial/ethnic
36 concordance and patients' receiving preventive care, being satisfied with their care overall..." [12];
37 and

Whereas, The AMA has policies (H-295.955, H-310.919, H-310.923, D-255.982, D-350.984) focused on combating racial, ethnic, and religious discrimination in medicine, but fails to include discrimination against natural hair and cultural headwear as a form of racial, ethnic, and religious discrimination; therefore be it

RESOLVED, That our American Medical Association recognize that discrimination against natural hair/hairstyles and cultural headwear is a form of racial, ethnic and/or religious discrimination (New HOD Policy); and be it further

RESOLVED, That our AMA oppose discrimination against individuals based on their hair or cultural headwear in health care settings (New HOD Policy); and be it further

RESOLVED, That our AMA acknowledge the acceptance of natural hair/hairstyles and cultural headwear as crucial to professionalism in the standards for the health care workplace (New HOD Policy); and be it further

RESOLVED, That our AMA encourage medical schools, residency and fellowship programs, and medical employers to create policies to oppose discrimination based on hairstyle and cultural headwear in the interview process, medical education, and the workplace. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Current AMA and federal policies do not recognize guidelines that discriminate against natural hairstyles and cultural headwear as workplace discrimination. However, targeted hairstyles and/or headwear are known proxies for racial, ethnic, religious, and/or sexual minority groups and thereby should be protected by Title VII of The Civil Rights Act. This issue is especially relevant for students, residents, and young physicians, who feel pressure to spend their already scarce time and money to change their appearance to fit the mold of Eurocentric “professional” appearances. This issue has been and continues to be urgent because it is causing hardship and increasing burnout in students and physicians from marginalized groups, who already bear a disproportionately high burden of stress and increased burnout.

To date, 12 states and the American Academy of Pediatrics have passed laws and policies related to *Creat(ing) A Respectful and Open World for Natural Hair (CROWN)*. Within medical schools, residencies, and hospital settings, professionalism guidelines are euro-centric and penalize non-euro-centric phenotypic features being displayed in the healthcare setting, leading to decreased job satisfaction and increased burnout for already marginalized and underrepresented groups**.** Our AMA has a long and shameful history of participating in and perpetuating racial discrimination; this resolution gives our organization the opportunity to be a leader in setting standards that will make healthcare more welcoming and open to all.

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RELEVANT AMA POLICY

Principles for Advancing Gender Equity in Medicine H-65.961

Our AMA:
1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender);
2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;
3. endorses the principle of equal opportunity of employment and practice in the medical field;
4. affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;
5. acknowledges that mentorship and sponsorship are integral components of one's career advancement, and encourages physicians to engage in such activities;
6. declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;
7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;
8. affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and
9. affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas.

Our AMA encourages: (1) state and specialty societies, academic medical centers, medical schools, hospitals, group practices and other physician employers to adopt the AMA Principles for Advancing Gender Equity in Medicine; and (2) academic medical centers, medical schools, hospitals, group practices and other physician employers to: (a) adopt policies that prohibit harassment, discrimination and retaliation; (b) provide anti-harassment training; and (c) prescribe disciplinary and/or corrective action should violation of such policies occur.
BOT Rep. 27, A-19

Support of Human Rights and Freedom H-65.965

Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public

health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.
CCB/CLRPD Rep. 3, A-14,Reaffirmed in lieu of: Res. 001, I-16,Reaffirmation: A-17

Teacher-Learner Relationship In Medical Education H-295.955
The AMA recommends that each medical education institution have a widely disseminated policy that: (1) sets forth the expected standards of behavior of the teacher and the learner; (2) delineates procedures for dealing with breaches of that standard, including: (a) avenues for complaints, (b) procedures for investigation, (c) protection and confidentiality, (d) sanctions; and (3) outlines a mechanism for prevention and education. The AMA urges all medical education programs to regard the following Code of Behavior as a guide in developing standards of behavior for both teachers and learners in their own institutions, with appropriate provisions for grievance procedures, investigative methods, and maintenance of confidentiality.

CODE OF BEHAVIOR
The teacher-learner relationship should be based on mutual trust, respect, and responsibility. This relationship should be carried out in a professional manner, in a learning environment that places strong focus on education, high quality patient care, and ethical conduct.

A number of factors place demand on medical school faculty to devote a greater proportion of their time to revenue-generating activity. Greater severity of illness among inpatients also places heavy demands on residents and fellows. In the face of sometimes conflicting demands on their time, educators must work to preserve the priority of education and place appropriate emphasis on the critical role of teacher.
In the teacher-learner relationship, each party has certain legitimate expectations of the other. For example, the learner can expect that the teacher will provide instruction, guidance, inspiration, and leadership in learning. The teacher expects the learner to make an appropriate professional investment of energy and intellect to acquire the knowledge and skills necessary to become an effective physician. Both parties can expect the other to prepare appropriately for the educational interaction and to discharge their responsibilities in the educational relationship with unfailing honesty.
Certain behaviors are inherently destructive to the teacher-learner relationship. Behaviors such as violence, sexual harassment, inappropriate discrimination based on personal characteristics must never be tolerated. Other behavior can also be inappropriate if the effect interferes with professional development. Behavior patterns such as making habitual demeaning or derogatory remarks, belittling comments or destructive criticism fall into this category. On the behavioral level, abuse may be operationally defined as behavior by medical school faculty, residents, or students which is consensually disapproved by society and by the academic community as either exploitive or punishing. Examples of inappropriate behavior are: physical punishment or physical threats; sexual harassment; discrimination based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; repeated episodes of psychological punishment of a student by a particular superior (e.g., public humiliation, threats and intimidation, removal of privileges); grading used to punish a student rather than to evaluate objective performance; assigning tasks for punishment rather than educational purposes; requiring the performance of personal services; taking credit for another individual's work; intentional neglect or intentional lack of communication.
On the institutional level, abuse may be defined as policies, regulations, or procedures that are socially disapproved as a violation of individuals' rights. Examples of institutional abuse are: policies, regulations, or procedures that are discriminatory based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; and requiring individuals to perform unpleasant tasks that are entirely irrelevant to their education as physicians.

While criticism is part of the learning process, in order to be effective and constructive, it should be handled in a way to promote learning. Negative feedback is generally more useful when delivered in a private setting that fosters discussion and behavior modification. Feedback should focus on behavior rather than personal characteristics and should avoid pejorative labeling. Because people's opinions will differ on whether specific behavior is acceptable, teaching programs should encourage discussion and exchange among teacher and learner to promote effective educational strategies. People in the teaching role (including faculty, residents, and students) need guidance to carry out their educational responsibilities effectively.
Medical schools are urged to develop innovative ways of preparing students for their roles as educators of other students as well as patients.
BOT Rep. ZZ, I-90,Reaffirmed by CME Rep. 9, A-98,Reaffirmed: CME Rep. 2, I-99,Modified: BOT Rep. 11, A-07,Reaffirmed: CME Rep. 9, A-13; Reaffirmed: BOT Rep. 9, I-20

Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process H-310.919
Our AMA:
1. opposes questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion;
2. 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 marital and dependent status, future plans for marriage or children, sexual orientation, age, race, national origin, and religion during the residency and fellowship application process;
3. will continue to support efforts to enhance racial and ethnic diversity in medicine. Information regarding race and ethnicity may be voluntarily provided by residency and fellowship applicants;
4. encourages the Association of American Medical Colleges (AAMC) and its Electronic Residency Application Service (ERAS) Advisory Committee to develop steps to minimize bias in the ERAS and the residency training selection process; and
5. will advocate that modifications in the ERAS Residency Application to minimize bias consider the effects these changes may have on efforts to increase diversity in residency programs.
Res. 307, A-09, Appended: Res. 955, I-17

Eliminating Religious Discrimination from Residency Programs H-310.923
Our AMA encourages residency programs to: (1) make an effort to accommodate residents' religious holidays and observances, provided that patient care and the rights of other residents are not compromised; and (2) explicitly inform applicants and entrants about their policies and procedures related to accommodation for religious holidays and observances.
CME Rep. 10, A-06, Reaffirmed: CME Rep. 01, A-16

Reducing Discrimination in the Practice of Medicine and Health Care Education D-350.984
Our AMA will pursue avenues to collaborate with the American Public Health Association's National Campaign Against Racism in those areas where AMA's current activities align with the campaign.
BOT Action in response to referred for decision: Res. 602, I-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 006
(N-21)

Introduced by: Medical Student Section

Subject: Evaluating Scientific Journal Articles for Racial and Ethnic Bias

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, Race is a self-identified social construct that results in differential treatment of groups that leads to social inequity on people's health[1,2]; and

Whereas, According to the U.S. Census 2020 Bureau, ethnicity refers to an individual's self-identification of their origin or descent, "roots," heritage, or place where the individual or their parents or ancestors were born[3]; and

Whereas, Our AMA recognizes that race and ethnicity are conceptually distinct (H-460.924); and

Whereas, In practice, race and ethnicity are often inappropriately used interchangeably as demonstrated across the United States where the terms "Latino/a/x, Hispanic, Spanish and Chicano/a/x" have been used interchangeably with race in case report[4-7]; and

Whereas, Racial and ethnic categories are dependent on self-identification and self-reporting of origin and cultural heritage, constructs which can change over time[8,9]; and

Whereas, Racial and ethnic classification is highly inconsistent in literature, and evidence-based consensus is necessary for optimal use of self-identified race as well as geographical ancestry[10]; and

Whereas, In 2017, our AMA recognized assumptions attributed to race and ethnicity can contribute to the inequitable treatment of patients as it relates to evidence-based medicine[11]; and

Whereas, A current review examining ten studies and over 1.5 million participants demonstrated an association between ethnic minorities including Black, Hispanic, South Asian, Southeast Asian, and Chinese, and greater wait time for medical care for chest pain in the emergency department[12]; and

Whereas, In a study of 4.2 million Medicare beneficiaries who utilized home health services in 2015, there was substantial variation between states in administrative data misclassification of self-identified Hispanic, Asian American/Pacific Islander, and American Indian/Alaska Native beneficiaries[13]; and

Whereas, In a systematic analysis of race/ethnicity and GERD, it was found that only 25 of the 62 studies provided complete descriptions of their study populations[14]; and

Whereas, Conclusions drawn from past interpretations of race and ethnicity have been found to be inconsistent with current understanding of race and ethnicity[15]; and

Whereas, The use of race as a correction factor in the calculation of estimated glomerular filtration (eGFR) has been shown to be unnecessary and less precise than biological measures and has led to irreproducible results[16]; and

Whereas, The race correction factor in eGFR may lead to a delayed referral to a specialist or transplantation and worse outcomes in black patients[16]; and

Whereas, Race correction factors are still commonplace in cardiology, nephrology, urology, and obstetrics even though many were developed under the belief that race is a useful proxy for biology[16-18]; and

Whereas, Past literature has incorrectly favored a genetic explanation for the difference in birth outcomes between African American and white women[4]; and

Whereas, Current literature states that environmental factors play a greater role in explaining the greater risk of infant mortality in black women[19]; and

Whereas, It was seen that the rates of low birth weight and very low birth weight babies among sub-Saharan African-born Black women was less than that of U.S.-born black women and approximated those of U.S. born white women, suggesting no significant genetic basis to race differences[4]; and

Whereas, Our AMA Board of Trustees on June 7th, 2020 recognized racism as an urgent threat to public health and resolved to work towards dismantling racist and discriminatory practices across all of healthcare care[20]; and

Whereas, Our AMA states that “race and ethnicity are valuable research variables when used and interpreted appropriately” (H-460.924); and

Whereas, Our AMA “continues to monitor developments in the field of racial and ethnic classification so that it can assist physicians in interpreting these findings and their implications for health care for patients” (H-460.924); and

Whereas, The tools for the evaluation of research integrity exist to determine the strength of their validity and limits of their bias, however lack similar tools to evaluate racial and ethnic bias[21]; therefore be it

RESOLVED, That our American Medical Association support major journal publishers issuing guidelines for interpreting previous research which define race and ethnicity by outdated means; (New HOD Policy) and be it further

RESOLVED, That our AMA support major journal publishers implementing a screening method for future research submission concerning the incorrect use of race and ethnicity. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

The current momentum toward addressing racial and ethnic discrimination and inequities has been particularly important in medicine and medical research. These fields have a long and shameful history of racism, which is especially evident in the ways in which race and ethnicity are improperly used in scientific journal articles. Our AMA witnessed this firsthand during a recent incident with a JAMA podcast. The episode's misunderstanding of race and racism were extremely harmful and revealed how far medicine and science still have to go to undo the medical racism that has been taught and learned in these systems. Our AMA has already established policy discerning that race and ethnicity are distinct social categories. It is in the jurisdiction of our AMA to support scientific data that correctly aligns with the related but distinct nature of these words. The resolved clauses of this resolution are supported by H-350.974, specifically "Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Our AMA supports the use of evidence-based guidelines to promote the consistency and equity in care and has further recognized the importance of health justice toward providing the best care for all. This resolution provides a timely and important next step in ensuring that the research that guides our medical practice is accurate and usable to healthcare generations to come.

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RELEVANT AMA POLICY:

Code of Medical Ethics 7.1.5

Biomedical and health research is intended to advance medical knowledge to benefit future patients. To achieve those goals physicians who are involved in such research maintain the highest standards of professionalism and scientific integrity.

Physicians with oversight responsibilities in biomedical or health research have a responsibility to ensure that allegations of scientific misconduct are addressed promptly and fairly. They should ensure that procedures to resolve such allegations:

(a) Do not damage science.
(b) Resolve charges expeditiously.
(c) Treat all parties fairly and justly. Review procedures should be sensitive to parties' reputations and vulnerabilities.
(d) Maintain the integrity of the process. Real or perceived conflicts of interest must be avoided.

(e) Maintain accurate and thorough documentation throughout the process.
(f) Maintain the highest degree of confidentiality.
(g) Take appropriate action to discharge responsibilities to all individuals involved, as well as to the public, research sponsors, the scientific literature, and the scientific community.
Issued: 2016

Code of Medical Ethics Opinion 8.5

Stereotypes, prejudice, or bias based on gender expectations and other arbitrary evaluations of any individual can manifest in a variety of subtle ways. Differences in treatment that are not directly related to differences in individual patients' clinical needs or preferences constitute inappropriate variations in health care. Such variations may contribute to health outcomes that are considerably worse in members of some populations than those of members of majority populations.

This represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics.

To fulfill this professional obligation in their individual practices physicians should:

(a) Provide care that meets patient needs and respects patient preferences.
(b) Avoid stereotyping patients.
(c) Examine their own practices to ensure that inappropriate considerations about race, gender identify, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment.
(d) Work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients.
(e) Encourage shared decision making.
(f) Cultivate effective communication and trust by seeking to better understand factors that can influence patients' health care decisions, such as cultural traditions, health beliefs and health

literacy, language or other barriers to communication and fears or misperceptions about the health care system.
The medical profession has an ethical responsibility to:
(g) Help increase awareness of health care disparities.
(h) Strive to increase the diversity of the physician workforce as a step toward reducing health care disparities.
(i) Support research that examines health care disparities, including research on the unique health needs of all genders, ethnic groups, and medically disadvantaged populations, and the development of quality measures and resources to help reduce disparities.
Issued: 2016

Racial and Ethnic Disparities in Health Care, H-350.974
1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.
2. The AMA emphasizes three approaches that it believes should be given high priority:
A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.
B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.
C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities
3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.
4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.
CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep. 1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 3, A-21

Reducing Discrimination in the Practice of Medicine and Health Care Education, D-350.984
Our AMA will pursue avenues to collaborate with the American Public Health Association's National Campaign Against Racism in those areas where AMA's current activities align with the campaign.
BOT Action in response to referred for decision: Res. 602, I-15

Improving the Health of Black and Minority Populations, H-350.972
Our AMA supports:
(1) A greater emphasis on minority access to health care and increased health promotion and disease prevention activities designed to reduce the occurrence of illnesses that are highly prevalent among disadvantaged minorities.
(2) Authorization for the Office of Minority Health to coordinate federal efforts to better understand and reduce the incidence of illness among U.S. minority Americans as recommended in the 1985 Report to the Secretary's Task Force on Black and Minority Health.
(3) Advising our AMA representatives to the LCME to request data collection on medical school curricula concerning the health needs of minorities.
(4) The promotion of health education through schools and community organizations aimed at teaching skills of health care system access, health promotion, disease prevention, and early diagnosis.
CLRPD Rep. 3, I-98; Reaffirmation: A-01; Modified: CSAPH Rep. 1, A-11; Reaffirmed: CEJA Rep. 1, A-21

Reducing Racial and Ethnic Disparities in Health Care, D-350.995
Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations:
(1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.
(2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.
(3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities.
BOT Rep. 4, A-03; Reaffirmation: A-11; Reaffirmation: A-16; Reaffirmed: CMS Rep. 10, A-19

Strategies for Eliminating Minority Health Care Disparities, D-350.996
Our American Medical Association will continue to identify and incorporate strategies specific to the elimination of minority health care disparities in its ongoing advocacy and public health efforts, as appropriate.
Res. 731, I-02; Modified: CCB/CLRPD Rep. 4, A-12

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 007
(N-21)

Introduced by: Medical Student Section

Subject: Exclusion of Race and Ethnicity in the First Sentence of Case Reports

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, Patients of color often have worse healthcare outcomes than White patients,
2 particularly noticeable in the decreased life expectancies for Black and Indigenous patients[1,2];
3 and
4
5 Whereas, Non-Hispanic White patients report lower satisfaction with their doctors, and patients
6 of color routinely report worse treatment and experiencing bias and racism when accessing
7 care[1,3]; and
8
9 Whereas, Medical racism has been present throughout history and its legacy continues to
10 unfold today, manifesting as unethical experiments and substandard, unnecessary, or incorrect
11 treatments being given to minoritized racial groups historically and continuing to be discovered
12 even today[4,5]; and
13
14 Whereas, The perpetuation of racial bias begins early in preclinical medical education, such as
15 when race is taught to be a biological factor or a substitute for education, income, or genetics,
16 which also deeply harms medical trainees from minoritized communities by perpetuating the
17 belief that their race makes them biologically different, unusual, or inferior [6,7]; and
18
19 Whereas, A common example is that Black race is often used as a proxy for sickle cell trait or
20 disease, ignoring that sickle cell genetics can and do occur in people of any race, leading to
21 missed diagnoses in some individuals and also opening the possibility of “premature closure” in
22 diagnoses of Black patients experiencing symptoms that are similar to sickle cell but are
23 occurring due to a different pathological process[7,8]; and
24
25 Whereas, Analyses of lecture slides and clinical vignettes used in medical education have found
26 that race or ethnicity is often presented as a biological risk factor or linked to certain behaviors,
27 without addressing social context or history[9-11]; and
28
29 Whereas, During training, medical students learn to use race as a heuristic in preclinical exams
30 and on standardized licensing examinations, with a study of first- and second-year medical
31 students finding that all participants believed that if race was used in a board-style question, it
32 was likely relevant to answering the question correctly[12-14]; and
33
34 Whereas, A 2017 study of common USMLE Step 1 preparation material found that of 2,011
35 questions, 455 (20.6%) referred to race or ethnicity in the question stem, answer, or educational
36 objective, with 412 cases (90.5%) only mentioning it as a descriptor without a stated educational
37 objective, while the other 43 cases (9.45%) made race or ethnicity central to the case[15]; and

Whereas, It has been argued, including in the *AMA Journal of Ethics*, that race should (a) be obtained as directly identified by the patient themselves and (b) be recorded in the social history, rather than the first line in a case presentation, to help decrease the possibility of race being inappropriately used as a proxy while still recording this social factor as identified by the patient so that important social impacts like the patient's experiences with discrimination and racism can still be understood[10,16-18]; and

Whereas, The AMA has committed to recognizing and addressing the harmful effects of racism in medicine, medical training, and medical research (H-65.952, H-65.953, D-350.984, H-165.822, D-350.981); therefore be it

RESOLVED, That our American Medical Association encourage curriculum and clinical practice that omits race and/or ethnicity from the first sentence of case reports and other medical documentation (New HOD Policy); and be it further

RESOLVED, That our AMA encourages the maintenance of race and ethnicity in other relevant sections of case reports and other medical documentation. (New HOD Policy)

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

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Our AMA has finally begun to take earnest action to actively address the long and shameful history of racism in medicine. The reach of racism in medicine is broad and deep, and many long-accepted medical practices have been found to perpetuate racism and subsequently changed. One practice in need of changing is that of including a patient's race in the initial description of that patient. Race has been included at the beginning of case reports, case presentations, clinical vignettes, lecture slides, standardized test questions, morbidity, and mortality reports, and more. This practice teaches students and reinforces for physicians the use of race as a biological factor or a heuristic for social, cultural, or behavioral traits. Besides being discriminatory and stereotypical, this practice has been shown to be inaccurate, to result in worse outcomes for patients, and to cause psychological harm to physicians and students of minoritized races.

Our AMA has made a commitment to changing the course of medical racism and medical discrimination. It is vital that we continue to address and eliminate the way racism permeates medical practices. This resolution offers a concrete, tangible, and necessary next step in this process.

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RELEVANT AMA POLICY

Racism as a Public Health Threat H-65.952

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

Res. 5, I-20

Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice H-65.953

1. Our AMA recognizes that race is a social construct and is distinct from ethnicity, genetic ancestry, or biology.
2. Our AMA supports ending the practice of using race as a proxy for biology or genetics in medical education, research, and clinical practice.
3. Our AMA encourages undergraduate medical education, graduate medical education, and continuing medical education programs to recognize the harmful effects of presenting race as biology in medical education and that they work to mitigate these effects through curriculum change that: (a) demonstrates how the category "race" can influence health outcomes; (b) that supports race as a social construct and not a biological determinant and (c) presents race within a socio-ecological

model of individual, community and society to explain how racism and systemic oppression result in racial health disparities.
4. Our AMA recommends that clinicians and researchers focus on genetics and biology, the experience of racism, and social determinants of health, and not race, when describing risk factors for disease.
Res. 11, I-20

Reducing Discrimination in the Practice of Medicine and Healthcare Education D-350.984
Our AMA will pursue avenues to collaborate with the American Public Health Association's National Campaign Against Racism in those areas where AMA's current activities align with the campaign.
BOT action in response to referred for decision, Res. 602, I-15

Health Plan Initiatives Addressing Social Determinants of Health H-165.822
Our AMA:
1. recognizing that social determinants of health encompass more than health care, encourages new and continued partnerships among all levels of government, the private sector, philanthropic organizations, and community- and faith-based organizations to address non-medical, yet critical health needs and the underlying social determinants of health;
2. supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs;
3. encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health, including through such mechanisms as professional development and other training;
4. supports mechanisms, including the establishment of incentives, to improve the acquisition of data related to social determinants of health, while minimizing burdens on patients and physicians;
5. supports research to determine how best to integrate and finance non-medical services as part of health insurance benefit design, and the impact of covering non-medical benefits on health care and societal costs; and
6. encourages coverage pilots to test the impacts of addressing certain non-medical, yet critical health needs, for which sufficient data and evidence are not available, on health outcomes and health care costs.
CME Rep. 7, I-20

Racial Essentialism in Medicine D-350.981
1. Our AMA recognizes that the false conflation of race with inherent biological or genetic traits leads to inadequate examination of true underlying disease risk factors, which exacerbates existing health inequities.
2. Our AMA encourages characterizing race as a social construct, rather than an inherent biological trait, and recognizes that when race is described as a risk factor, it is more likely to be a proxy for influences including structural racism than a proxy for genetics.
3. Our AMA will collaborate with the AAMC, AACOM, NBME, NBOME, ACGME and other appropriate stakeholders, including minority physician organizations and content experts, to identify and address aspects of medical education and board examinations which may perpetuate teachings, assessments, and practices that reinforce institutional and structural racism.
4. Our AMA will collaborate with appropriate stakeholders and content experts to develop recommendations on how to interpret or improve clinical algorithms that currently include race-based correction factors.
5. Our AMA will support research that promotes antiracist strategies to mitigate algorithmic bias in medicine.
Res. 10, I-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 008
(N-21)

Introduced by: Medical Student Section

Subject: Amendment to Truth and Transparency in Pregnancy Counseling Centers, H-420.954

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, Pregnancy Counseling Centers, also referred to as Crisis Pregnancy Centers (CPC)
2 or Pregnancy Resource Centers (PRC), are defined as non-medical entities whose aim is to
3 dissuade women from seeking legal abortion to terminate pregnancy[1]; and
4
5 Whereas, Pregnancy Counseling Centers are intentionally advertised as comprehensive
6 medical facilities with licensed clinical professionals despite offering only select services,
7 providing misinformation regarding abortion and contraception, and being largely staffed by
8 volunteers instead of licensed care providers[2,3]; and
9
10 Whereas, A majority of unintended pregnancies that occur in the United States affect vulnerable
11 populations like minority and low-income women, which are the target population pursued by
12 Pregnancy Counseling Centers[4]; and
13
14 Whereas, Our AMA submitted an amicus brief to the U.S. Supreme Court in the case titled
15 *National Institute of Family and Life Advocates (NIFLA) v. Becerra* case, in support of
16 California's 2016 Reproductive Freedom, Accountability, Comprehensive Care and
17 Transparency (FACT) Act on the basis of "medical ethics and a patient's right to informed
18 consent"; and
19
20 Whereas, California's FACT Act would have required all licensed medical facilities to publicly
21 post information about affordable abortion and contraception services offered on their premises
22 and required all unlicensed CPCs to disclose that they were not licensed medical clinics[5-7]; and
23
24 Whereas, The public health repercussions that these entities pose by influencing women's
25 reproductive health decisions is well established by putting women at greater risk when they are
26 interrupted from seeking abortions in a timely manner, therefore subjecting them to the
27 increased risk associated with late term abortions or unsafe abortions[8]; and
28
29 Whereas, Pregnancy Counseling Centers perpetuate decreased prenatal care, substance
30 abuse, preterm births, and increased incidence of negative physical and mental outcomes of
31 babies that are born to women with unintended pregnancies[8]; and
32
33 Whereas, Our AMA recognizes the unethical practices utilized by Pregnancy Counseling
34 Centers, such as providing misleading and false information that falls outside of medical
35 standards, in the *Journal of Medical Ethics*[9]; and
36
37 Whereas, These practices can cause women to miss abortion law cutoffs, receive dangerous
38 late-stage abortions, and obstruct general access to abortion, all of which violate the ethical
39 standards of beneficence, respect for autonomy, nonmaleficence, and justice[9]; and

Whereas, Pregnancy Counseling Centers often use federal funds from programs like Temporary Assistance for Needy Families (TANF), Title V abstinence education funding programs and Title X family planning funding programs to fund their clinic's services despite only offering a limited, and often incomplete, number of services[10, 11]; and

Whereas, Pregnancy Counseling Centers can be funded by anti-choice organizations despite not disclosing this connection, such as profits made by "Choose Life" license plates which fund Pregnancy Counseling Centers in 32 states[12]; and

Whereas, A report from the National Abortion Rights Action League (NARAL) estimates that as of 2015, $60 million in federal abstinence and marriage promotion funds have gone to Pregnancy Counseling Centers, at least 23 states have laws supporting Pregnancy Counseling Centers, 11 states fund Pregnancy Counseling Centers directly, and 20 states refer women to Pregnancy Counseling Centers [13, 14]; and

Whereas, A survey of 254 websites that identify individual Pregnancy Counseling Centers revealed only 85 contained information on male condoms or sexually transmitted infections (STIs), and of these 85, 63.5% discouraged condom use by providing negative facts about condoms, 44.7% stated marriage is protective against STIs, and 91.8% showed pictures or videos of youth on their homepage to target younger populations[15]; and

Whereas, Pregnancy Counseling Centers strategically place ads aimed at pregnant women on search engine results, billboards, and buses near abortion clinics with abortion-related terms while hiding their agenda to dissuade women from seeking legal abortions[16]; and

Whereas, Within Pregnancy Counseling Centers staff often use manipulative and deceitful tactics to dissuade women from seeking legal abortion such as wearing white coats although they hold no medical training, failing to disclose they are not a medical facility, expressing judgement to clients about their decisions to pursue abortion or contraception, offering ultrasound services for purpose of using fetal images to dissuade women from abortion, and providing false information on the links between abortion and adverse mental health sequelae, breast cancer, and future infertility[16,17]; and

Whereas, Pregnancy Counseling Centers do not charge for services and are often not licensed medical practices, therefore they are not held to the same state consumer protection statutes and consumer protection regulations that medical practices must abide by[9]; therefore be it

RESOLVED, That our American Medical Association amend Policy H-420.954, "Truth and Transparency in Pregnancy Counseling Centers," by addition and deletion to read as follows, to further strengthen our AMA policy against the dissemination of purposely incomplete or deceptive information intended to mislead patients and the utilization of state and federal funds for potentially biased services provided by pregnancy counseling centers:

Truth and Transparency in Pregnancy Counseling Centers H-420.954

1. Our AMA ~~supports~~ advocates that any entity offering crisis pregnancy services disclose information on site, in its advertising; and before any services are provided concerning medical services, contraception, termination of pregnancy or referral for such services, adoption options or referral for such services that it does and does not provide, as well as fully disclose any financial, political, or religious associations which such entities may have;

2. Our AMA discourages the use of marketing, counseling, or coercion (by physical, emotional, or financial means) by any agency offering crisis pregnancy services that aim to discourage or interfere with a pregnant woman's pursuit of any medical services for the care of her unplanned pregnancy;

3. Our AMA advocates that any entity providing medical or health services to pregnant women that markets medical or any clinical services abide by licensing requirements and have the appropriate qualified licensed personnel to do so and abide by federal health information privacy laws, and additionally disclose their level of compliance to such requirements and laws to patients receiving services;

4. Our AMA opposes the utilization of state and federal funding to finance such entities offering crisis pregnancy services, which do not provide statistically validated evidence-based medical information and care to pregnant women. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

This resolution addresses a timely issue with long-term impact that aligns with the priorities for this meeting. It is made urgent given the restrictions on physicians' abilities to provide abortions in multiple states, and the criminalization of these physicians providing their patients' healthcare.

Research shows that the issues surrounding pregnancy crisis centers (PCCs) and their coercive tactics have been continually worsening for an already vulnerable population. With the onset of the pandemic, many states placed last-minute, restrictive abortion bans, claiming these procedures were "non-essential", and thus countless women in vulnerable positions are forced to leave their states to seek timely and legal abortions. The AMA, as America's physicians' advocacy body, should prioritize this resolution to allow for this long-overdue healthcare reform that has only been exacerbated from the strain of the pandemic. The resolution aligns with the AMA's focus on combating racial discrimination, since women of color are more at risk for coercion from PCCs and are frequently targeted by these centers. PCCs and their advertisements are purposefully placed in low-income communities with large minority populations. It is more important now than ever before to ensure that these entities do not further impede minority women from receiving their necessary care. Women's health was under constant siege, even before the pandemic. During COVID-19, the PCC presence is becoming more pronounced and unfortunately the only option available to many women. Pregnancy does not stop for a pandemic, and neither should our efforts to protect and provide proper care for vulnerable women.

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RELEVANT AMA POLICY

Truth and Transparency in Pregnancy Counseling Centers H-420.954
1. Our AMA supports that any entity offering crisis pregnancy services disclose information on site, in its advertising, and before any services are provided concerning the medical services, contraception, termination of pregnancy or referral for such services, adoption options or referral for such services that it provides; and be it further
2. Our AMA advocates that any entity providing medical or health services to pregnant women that markets medical or any clinical services abide by licensing requirements and have the appropriate qualified licensed personnel to do so and abide by federal health information privacy laws.
Res. 7, I-11; Reaffirmed: CEJA Rep. 1, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 009
(N-21)

Introduced by: Medical Student Section

Subject: Banning the Practice of Virginity Testing

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, A “virginity exam” or “virginity test” is defined as an exam to assess the hymen for tears and inspect the vaginal walls and introitus for laxity for the purpose of determining whether a female has ever had sexual intercourse[1]; and

Whereas, “Virginity testing” differs from female genital mutilation in that female genital mutilation involves either partial or full removal of or otherwise injuring external female genitalia and “virginity exams” do not[15]; and

Whereas, “Virginity testing” is a complex, culturally mediated practice which may be seen in some patient populations and may be poorly understood by U.S. clinicians[2]; and

Whereas, A survey conducted by The American College of Obstetricians and Gynecologists showed that 10% of obstetrician/gynecologists in the United States have been asked to perform “virginity testing,” and 34.5% of these physicians fulfilled these requests[2,17]; and

Whereas, U.S. physicians who perform requested “virginity tests” report not knowing why they are performing the test, and almost none of them ask the patient or family why the test is being requested[2, 13, 14]; and

Whereas, Little guidance has been published for clinicians who encounter requests for “virginity testing” in the clinical settings, and physicians who are asked to perform “virginity testing” report feeling they are not properly equipped to respond to these requests[2, 13, 14]; and

Whereas, “Virginity testing” is an extremely invasive procedure that is often performed under coercion from a third party, such as family or spouses, and/or without patient consent, and by itself confers no physical, mental, or emotional health benefit to the patient undergoing the exam[1,2, 7]; and

Whereas, “Virginity exams” may be physically harmful to the examinee as these exams may lead to hymenal damage, bleeding, or infection[3]; and

Whereas, Many anatomic variants of the hymen exist, including congenital abnormalities, natural changes in a woman’s lifespan, and injury resulting from non-sexual activities, and sexual intercourse or assault may not result in identifiable changes to hymenal tissue, thus “virginity exams” cannot reliably predict virginity status[1,3,4,5,6,7]; and

Whereas, The Independent Forensic Expert Group has stated that “virginity testing” is inherently discriminatory because it correlates intercourse with immorality or criminal deviance and can only be performed on female-typical anatomy[3]; and

Whereas, “Virginity exams” have been shown to have negative psychological consequences on the examinee including but not limited to lower self-confidence, depression, and suicidal ideation, as well as lifelong effects such as post-traumatic stress disorder and anxiety[1,2,3]; and

Whereas, There have been reported instances of “virginity exam” results leading to patient self-harm, murder, and physical violence against examinees[1,3]; and

Whereas, In 2018, the World Health Organization and the United Nations publicly called for an end to the practice of “virginity testing,” as it is a violation of human rights on the basis of gender discrimination, inhumane treatment and punishment, and violation of privacy[2,8]; and

Whereas, The American College of Obstetricians and Gynecologists supports efforts to eliminate the practice of “virginity testing” on the grounds of its medical invalidity and adverse effects to the examinee[12]; and

Whereas, A recent article in *BMJ Global Health* describes recommendations on educating and counseling patients about the lack of reliability and the possible harms of “virginity testing” through training community members, reading materials, and inclusion in other reproductive health discussion[2]; and

Whereas, The California Assembly (AB 1909) and the New York State Assembly (A08742) and Senate (S06879) have already introduced bills to prevent doctors from performing or supervising a “virginity examination”[9,10,11]; and

Whereas, Our AMA has policies that promote trauma-informed care that avoids re-traumatizing patients and recognizes the effect of trauma on patients (H-515.952); and

Whereas, The AMA Code of Ethics (5.5 and 8.5) recognizes that “Physicians should only recommend and provide interventions that are medically appropriate--i.e., scientifically grounded” as well as that gender disparities in health care can stem from arbitrary evaluations that are not directly related to a patient’s clinical needs; therefore be it

RESOLVED, That our American Medical Association advocate for the elimination of the practice of virginity testing exams, physical exams purported to assess virginity (Directive to Take Action); and be it further

RESOLVED, That our AMA support culturally-sensitive counseling by health professionals to educate patients and family members about the negative effects and inaccuracy of virginity testing and where needed, referral for further psychosocial support (New HOD Policy); and be it further

RESOLVED, That our AMA support efforts to educate medical students and physicians about the continued existence of the practice of virginity testing and its detrimental effects on patients. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

This resolution seeks to end the psychologically and physically dangerous practice of virginity testing. This practice recently came to the attention of the public when American rapper T.I. stated he regularly brings his daughter in for these exams. These tests have no scientific, medical, or legal validity, and they have shown to have harmful repercussions for the patients on which they are performed. Despite this, it is legal in all 50 states and there are no consequences for providers who perform such exams. Several institutions, such as ACOG and the United Nations, have already made statements supporting the elimination of this practice. Our delegation has already passed resolutions protecting women's rights, such as banning the practice of female genital mutilation, and this resolution would strengthen protections for this population. Women's medical rights have been particularly under attack in recent times, and this resolution poses an impactful, tangible way our AMA can take a stand for this group.

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RELEVANT AMA POLICY

H-525.980 Expansion of AMA Policy of Female Genital Mutilation

Our AMA: (1) condemns the practice of female genital mutilation (FGM); (2) considers FGM a form of child abuse; (3) supports legislation to eliminate the performance of female genital mutilation in the United States and to protect young girls and women at risk of undergoing the procedure; (4) supports that physicians who are requested to perform genital mutilation on a patient provide culturally sensitive counseling to educate the patient and her family members about the negative health consequences of the procedure, and discourage them from having the procedure performed. Where possible, physicians should refer the patient to social support

groups that can help them cope with societal mores; (5) will work to ensure that medical students, residents, and practicing physicians are made aware of the continued practice and existence of FGM in the United States, its physical effects on patients, and any requirements for reporting FGM; and (6) is in opposition to the practice of female genital mutilation by any physician or licensed practitioner in the United States.
CSA Rep. 5, I-94; Res. 513, A-96; Reaffirmed: CSAPH Rep. 3, A-06; Modified: Res. 9, A-12; Reaffirmed: BOT Rep. 15, A-17

H-60.938 Adolescent Sexual Activity
Our AMA (a) endorses the joint position "Protecting Adolescents: Ensuring Access to Care and Reporting Sexual Activity and Abuse"; and
(b) supports the following principles for consideration in development of public policy:
- (i) Sexual activity and sexual abuse are not synonymous and that many adolescents have consensual sexual relationships;
- (ii) It is critical that adolescents who are sexually active receive appropriate confidential health care and screening;
- (iii) Open and confidential communication between the health professional and adolescent patient, together with careful clinical assessment, can identify the majority of sexual abuse cases;
- (iv) Physicians and other health care professionals must know their state laws and report cases of sexual abuse to the proper authority in accordance with those laws, after discussion with the adolescent and/or parent as appropriate;
- (v) Federal and state laws should support physicians and other health care professionals in their role in providing confidential health care to their adolescent patients; and
- (vi) Federal and state laws should affirm the authority of physicians and other health care professionals to exercise appropriate clinical judgment in reporting cases of sexual activity.
Res. 825, I-04; Modified: CSAPH Rep. 1, A-14

H-515.952 Adverse Childhood Experiences and Trauma Informed Care
1. Our AMA recognizes trauma-informed care as a practice that recognizes the widespread impact of trauma on patients, identifies the signs and symptoms of trauma, and treats patients by fully integrating knowledge about trauma into policies, procedures, and practices and seeking to avoid re-traumatization.
2. Our AMA supports:
a. evidence-based primary prevention strategies for Adverse Childhood Experiences (ACEs);
b. evidence-based trauma-informed care in all medical settings that focuses on the prevention of poor health and life outcomes after ACEs or other trauma at any time in life occurs;
c. efforts for data collection, research, and evaluation of cost-effective ACEs screening tools without additional burden for physicians.
d. efforts to educate physicians about the facilitators, barriers and best practices for providers implementing ACEs screening and trauma-informed care approaches into a clinical setting; and
e. funding for schools, behavioral and mental health services, professional groups, community, and government agencies to support patients with ACEs or trauma at any time in life; and
f. increased screening for ACEs in medical settings, in recognition of the intersectionality of ACEs with significant increased risk for suicide, negative substance use-related outcomes including overdose, and a multitude of downstream negative health outcomes.
3. Our AMA supports the inclusion of ACEs and trauma-informed care into undergraduate and graduate medical education curricula.
Res. 504, A-19; Appended: CSAPH Rep. 3, A-21

E-5.5 Medically Ineffective Interventions

At times patients (or their surrogates) request interventions that the physician judges not to be medically appropriate. Such requests are particularly challenging when the patient is terminally ill or suffers from an acute condition with an uncertain prognosis and therapeutic options range from aggressive, potentially burdensome life-extending intervention to comfort measures only. Requests for interventions that are not medically appropriate challenge the physician to balance obligations to respect patient autonomy and not to abandon the patient with obligations to be compassionate, yet candid, and to preserve the integrity of medical judgment.

Physicians should only recommend and provide interventions that are medically appropriate—i.e., scientifically grounded—and that reflect the physician's considered medical judgment about the risks and likely benefits of available options in light of the patient's goals for care. Physicians are not required to offer or to provide interventions that, in their best medical judgment, cannot reasonably be expected to yield the intended clinical benefit or achieve agreed-on goals for care. Respecting patient autonomy does not mean that patients should receive specific interventions simply because they (or their surrogates) request them.

Many health care institutions have promoted policies regarding so-called "futile" care. However, physicians must remember that it is not possible to offer a single, universal definition of futility." The meaning of the term "futile" depends on the values and goals of a particular patient in specific clinical circumstances.

As clinicians, when a patient (or surrogate on behalf of a patient who lacks decision-making capacity) request care that the physician or other members of the health care team judge not to be medically appropriate, physicians should:

(a) Discuss with the patient the individual's goals for care, including desired quality of life, and seek to clarify misunderstandings. Include the patient's surrogate in the conversation if possible, even when the patient retains decision-making capacity.

(b) Reassure the patient (and/or surrogate) that medically appropriate interventions, including appropriate symptom management, will be provided unless the patient declines particular interventions (or the surrogate does so on behalf of a patient who lacks capacity).

(c) Negotiate a mutually agreed-on plan of care consistent with the patient's goals and with sound clinical judgment.

(d) Seek assistance from an ethics committee or other appropriate institutional resource if the patient (or surrogate) continues to request care that the physician judges not to be medically appropriate, respecting the patient's right to appeal when review does not support the request.

(e) Seek to transfer care to another physician or another institution willing to provide the desired care in the rare event that disagreement cannot be resolved through available mechanisms, in keeping with ethics guidance. If transfer is not possible, the physician is under no ethical obligation to offer the intervention.

As leaders within their institutions, physicians should encourage the development of institutional policy that:

(f) Acknowledges the need to make context sensitive judgments about care for individual patients.

(g) Supports physicians in exercising their best professional judgment.

(h) Takes into account community and institutional standards for care.

(i) Uses scientifically sound measures of function or outcome.

(j) Ensures consistency and due process in the event of disagreement over whether an intervention should be provided.

8.5 Disparities in Health Care

Stereotypes, prejudice, or bias based on gender expectations and other arbitrary evaluations of any individual can manifest in a variety of subtle ways. Differences in treatment that are not directly related to differences in individual patients' clinical needs or preferences constitute inappropriate variations in health care. Such variations may contribute to health outcomes that

are considerably worse in members of some populations than those of members of majority populations.

This represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics.

To fulfill this professional obligation in their individual practices physicians should:

(a) Provide care that meets patient needs and respects patient preferences.

(b) Avoid stereotyping patients.

(c) Examine their own practices to ensure that inappropriate considerations about race, gender identify, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment.

(d) Work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients.

(e) Encourage shared decision making.

(f) Cultivate effective communication and trust by seeking to better understand factors that can influence patients' health care decisions, such as cultural traditions, health beliefs and health literacy, language or other barriers to communication and fears or misperceptions about the health care system.

The medical profession has an ethical responsibility to:

(g) Help increase awareness of health care disparities.

(h) Strive to increase the diversity of the physician workforce as a step toward reducing health care disparities.

(i) Support research that examines health care disparities, including research on the unique health needs of all genders, ethnic groups, and medically disadvantaged populations, and the development of quality measures and resources to help reduce disparities.

Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 010
(N-21)

Introduced by: Medical Student Section

Subject: Improving the Health and Safety of Sex Workers

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, Sex work entails the provision of sexual services for money or goods, while sex trafficking is defined as the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act[1-3]; and

Whereas, Survival sex is the exchange of sexual activity for basic necessities such as shelter, food, or money; survival sex is considered a subset of “sex work” since it does not involve the force, fraud, or explicit coercion defined in sex trafficking[4]; and

Whereas, Consent is defined by the federal government as a freely given agreement to the conduct at issue by a competent person, and consent is not constituted by lack of verbal or physical resistance[5-7]; and

Whereas, Coercive sex—in the setting of economic, substance-related, or social vulnerability—often problematically falls under the term “consensual” sex work; thus, consent in the realm of sex work falls on a spectrum, rather than a binary definition[5-7]; and

Whereas, Globally, the three major policy approaches to sex trade regulation are (1) criminalization, (2) full and partial decriminalization, and (3) legalization, and the US primarily uses criminalization; and

Whereas, Criminalization of the selling of sex is associated with higher prevalence of unsafe practices, such as not using condoms, higher rates of sexually transmitted infections (STIs), lower likelihood of seeking healthcare for illness or injury related to sex work, and greater likelihood of violence and rape of the individuals selling sex[8-17]; and

Whereas, Criminalization of the selling of sex is associated with higher rates of sexual harassment, rape, and violence perpetrated by police against people selling sex[17-20]; and

Whereas, In a study on the mental health of legal and illegal sex workers, illegal sex workers were four times more likely to report mental health issues, possibly due to increased risks that come with illegal sex work such as assault and arrest[21]; and

Whereas, Because sex work is criminalized in the United States, many sex workers struggle to obtain health insurance, leading to the majority being uninsured and paying out of pocket for healthcare[22]; and

Whereas, A systematic review of the literature estimates that 15-20% of men in the United States have paid for sex at least once[23]; and

Whereas, Surveys showing up to 37% of buyers believe that if they pay for sex, the sex worker is obligated to do anything they ask, and 19% admitting to having committed rape[24-27]; and

Whereas, In 2019, nearly 27,000 people, many of whom were parents, were arrested for prostitution and commercial vices in the United States, putting their children at an increased risk for depression, anxiety, antisocial behavior, drug use, and cognitive delays[28,29]; and

Whereas, Individuals who sell sex for survival are often those from among the most vulnerable communities, such as undocumented immigrants, minority racial and ethnic populations, the economically marginalized, homeless or runaway youth, homeless populations in general and especially homeless LGBTQ+ populations, and transgender people[20,30-39]; and

Whereas, In a nationwide study, 12% of trans women reported earning income through sex work, with higher rates among trans women of color, with 77% of these women reported intimate partner violence, 72% reported sexual assault, and 86% reported police harassment[20]; and

Whereas, The World Health Organization, UNFPA, UNAIDS, the Global Network of Sex Work Projects, Amnesty International, and Human Rights Watch all recommend decriminalizing consensual sex work to improve access to health care for high risk populations, with the WHO specifying that decriminalization would help reduce HIV incidence[17,40,41]; and

Whereas, The Equality Model, in which the selling of sex is decriminalized, while buying sex, acting as a third-party profiteer, and brothel-owning are criminalized, is the most widely-followed system of partial decriminalization and is employed in Sweden, Norway, Iceland, France, Ireland, Northern Ireland, Canada, and Israel[42]; and

Whereas, In the Equality Model, people currently selling sex are offered voluntary participation in social services, and people found to be buying sex are offered voluntary participation programs to help them stop buying sex[42]; and

Whereas, Partial decriminalization strategies such as the Equality Model are associated with a markedly lower rate of human trafficking, while full decriminalization and legalization are associated with increases in human trafficking to meet the increased demand for commercial sex, as well as increases in organized crime[42-44]; and

Whereas, Transition from criminalization to the decriminalization of the sale of sex in the Equality Model in Sweden was shown to lower demand and overall rates of prostitution, led to a comparatively lower number of persons trafficked compared to surrounding nations using other policy systems[42,45,46]; and

Whereas, An article in the AMA *Journal of Ethics* suggested the Equality Model, to be the most effective and ethical approach to addressing the issue of sex work and human rights violations[47]; and

Whereas, Among the various systems of prostitution policy, only the Equality Model has resulted in net decreases of human trafficking, violence against sex workers, and STI rates among the general population; therefore be it

RESOLVED, That our American Medical Association recognize the adverse health outcomes of criminalizing consensual sex work (New HOD Policy); and be it further

RESOLVED, That our AMA: 1) support legislation that decriminalizes individuals who offer sex in return for money or goods; 2) oppose legislation that decriminalizes sex buying and brothel keeping; and 3) support the expungement of criminal records of those previously convicted of sex work, including trafficking survivors (New HOD Policy); and be it further

RESOLVED, That our AMA support research on the long-term health, including mental health, impacts of decriminalization of the sex trade. (New HOD Policy)

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

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

National and global disasters tend to lead to increases in human rights abuses and worsening circumstances for society's most vulnerable. Individuals who sell sex are often among the most vulnerable and marginalized members of society. As the voice of America's physicians, it is the AMA's duty to lead in protecting the most vulnerable. This resolution aims to allow the AMA to lead in recognizing the immense harms that the criminalization of people who sell sex causes to those people, their dependents, and the public's health. Research has demonstrated the positive impacts of decriminalizing the selling of sex while retaining criminalization of buying. Clearly, the selling of sex, in the same vein as drug use and abortion, has counterintuitive solutions that result in a better world for especially vulnerable patients.

Our AMA has been leading the charge with evidence-based solutions to many controversial issues in the past decades, and we believe that sex work is next. We urge this resolution's consideration and look forward to seeing the AMA join the WHO, UNFPA, UNAIDS, and many countries in improving the lives of many marginalized individuals, who have been particularly impacted by the pandemic.

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RELEVANT AMA POLICY

Commercial Exploitation and Human Trafficking of Minors H-60.912
Our AMA supports the development of laws and policies that utilize a public health framework to address the commercial sexual exploitation and sex trafficking of minors by promoting care and services for victims instead of arrest and prosecution.
Res. 009, A-17

Promoting Compassionate Care and Alternatives for Individuals Who Exchange Sex for Money or Goods H-515.958
Our AMA supports efforts to offer opportunities for a safe exit from the exchange of sex for money or goods if individuals choose to do so, and supports access to compassionate care and "best practices". Our American Medical Association also supports legislation for programs that provide alternatives and resources for individuals who exchange sex for money or goods, and offer alternatives for those arrested on related charges rather than penalize them through criminal conviction and incarceration.
Res. 14, A-15; Modified: Res. 003, I-17

HIV/AIDS as a Global Public Health Priority H-20.922
In view of the urgent need to curtail the transmission of HIV infection in every segment of the population, our AMA:
(1) Strongly urges, as a public health priority, that federal agencies (in cooperation with medical and public health associations and state governments) develop and implement effective programs and strategies for the prevention and control of the HIV/AIDS epidemic;
(2) Supports adequate public and private funding for all aspects of the HIV/AIDS epidemic, including research, education, and patient care for the full spectrum of the disease. Public and private sector prevention and care efforts should be proportionate to the best available statistics on HIV incidence and prevalence rates;
(3) Will join national and international campaigns for the prevention of HIV disease and care of persons with this disease;
(4) Encourages cooperative efforts between state and local health agencies, with involvement of state and local medical societies, in the planning and delivery of state and community efforts directed at HIV testing, counseling, prevention, and care;
(5) Encourages community-centered HIV/AIDS prevention planning and programs as essential complements to less targeted media communication efforts;
(6) In coordination with appropriate medical specialty societies, supports addressing the special issues of heterosexual HIV infection, the role of intravenous drugs and HIV infection in women, and initiatives to prevent the spread of HIV infection through the exchange of sex for money or goods;
(7) Supports working with concerned groups to establish appropriate and uniform policies for neonates, school children, and pregnant adolescents with HIV/AIDS and AIDS-related conditions;
(8) Supports increased availability of anti-retroviral drugs and drugs to prevent active tuberculosis infection to countries where HIV/AIDS is pandemic; and
(9) Supports programs raising physician awareness of the benefits of early treatment of HIV and

of "treatment as prevention," and the need for linkage of newly HIV-positive persons to clinical care and partner services.
CSA Rep. 4, A-03; Reaffirmed: Res. 725, I-03; Reaffirmed: Res. 907, I-08; Reaffirmation: I-11; Appended: Res. 516, A-13; Reaffirmation: I-13; Reaffirmed: Res. 916, I-16; Modified: Res. 003, I-17

Global HIV/AIDS Prevention H-20.898
Our AMA supports continued funding efforts to address the global AIDS epidemic and disease prevention worldwide, without mandates determining what proportion of funding must be designated to treatment of HIV/AIDS, abstinence or be-faithful funding directives or grantee pledges of opposition to the exchange of sex for money or goods.
Res. 439, A-08; Modified: Res. 003, I-17

Physicians Response to Victims of Human Trafficking H-65.966
1. Our AMA encourages its Member Groups and Sections, as well as the Federation of Medicine, to raise awareness about human trafficking and inform physicians about the resources available to aid them in identifying and serving victims of human trafficking. Physicians should be aware of the definition of human trafficking and of resources available to help them identify and address the needs of victims.
The US Department of State defines human trafficking as an activity in which someone obtains or holds a person in compelled service. The term covers forced labor and forced child labor, sex trafficking, including child sex trafficking, debt bondage, and child soldiers, among other forms of enslavement. Although it's difficult to know just how extensive the problem of human trafficking is, it's estimated that hundreds of thousands of individuals may be trafficked every year worldwide, the majority of whom are women and/or children.
The Polaris Project -
In addition to offering services directly to victims of trafficking through offices in Washington, DC and New Jersey and advocating for state and federal policy, the Polaris Project:
- Operates a 24-hour National Human Trafficking Hotline
- Maintains the National Human Trafficking Resource Center, which provides
a. An assessment tool for health care professionals
b. Online training in recognizing and responding to human trafficking in a health care context
c. Speakers and materials for in-person training
d. Links to local resources across the country
The Rescue & Restore Campaign -
The Department of Health and Human Services is designated under the Trafficking Victims Protection Act to assist victims of trafficking. Administered through the Office of Refugee Settlement, the Department's Rescue & Restore campaign provides tools for law enforcement personnel, social service organizations, and health care professionals.
2. Our AMA will help encourage the education of physicians about human trafficking and how to report cases of suspected human trafficking to appropriate authorities to provide a conduit to resources to address the victim's medical, legal and social needs.
BOT Rep. 20, A-13; Appended: Res. 313, A-15

Human Trafficking / Slavery Awareness D-170.992
Our AMA will study the awareness and effectiveness of physician education regarding the recognition and reporting of human trafficking and slavery.
Res. 015, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 011
(N-21)

Introduced by: Medical Student Section

Subject: Expanding the Definition of Iatrogenic Infertility to Include Gender Affirming Interventions

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, The World Health Organization has unequivocally defined infertility as a disease state and a cause of disability[1]; and

Whereas, Gender-affirming hormone therapy (GAHT) includes testosterone therapy for transgender men, which can suppress ovulation, and estrogen therapy for transgender women, which can lead to impaired spermatogenesis and testicular atrophy[2,3]; and

Whereas, Gender-affirming surgery (GAS) for transwomen can include hysterectomy and oophorectomy, which results in permanent sterility[2,3]; and

Whereas, The 2015 U.S. Transgender Survey of almost 28,000 people revealed that 49% of respondents had received GAHT and 25% had undergone some form of GAS[4]; and

Whereas, The World Professional Association for Transgender Health (WPATH), the Endocrine Society, and the American Society for Reproductive Medicine (ASRM) all recommend that transgender individuals receive counseling regarding potential loss of fertility and future reproductive options before initiating GAHT or undergoing GAS[5–7]; and

Whereas, As outlined in a recent AMA/GLMA issue brief, Section 1557 of the Affordable Care Act created protections barring insurance discrimination based on sexual orientation and gender identity, although the current Administration has declined to defend this regulation and has been deferential to states[8–10]; and

Whereas, Employers and states that have implemented coverage of transition-related services have demonstrated minimal or no costs with vast immaterial/societal benefits[10,11]; and

Whereas, Despite clear expert recommendations, anti-discrimination laws, and evidence of economic benefit, it is still difficult for transgender patients to obtain insurance coverage for gender-affirming care, fertility counseling, and gamete preservation[3,4,12]; and

Whereas, As of 2020, 17 states have infertility coverage mandates for private insurers, with specific requirements determined on a state-by-state basis[12,13]; and

Whereas, Seven states (Rhode Island, Connecticut, Delaware, Illinois, New Hampshire, New York, and Maryland) specify mandated coverage for iatrogenic infertility, but language around qualifying diagnoses is variable between states[12,13]; and

Whereas, “Iatrogenic infertility” has been defined in state legislation as impairment of fertility caused by surgery, radiation, chemotherapy, or other medically necessary treatment affecting reproductive organs or processes[12]; and

Whereas, GLMA policy and WPATH Standards of Care support that GAHT and GAS are medically necessary treatments for gender dysphoria, and our AMA supports coverage of medically necessary treatments for gender dysphoria as recommended by the patient’s physician (H-185.950)[7,14]; and

Whereas, Our AMA supports the right to seek fertility preservation services for members of the transgender and non-binary community seeking gender-affirming hormone therapy or surgery, but does not currently address insurance coverage for these services (H-65.956); and

Whereas, Our AMA will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility is “caused directly or indirectly by necessary medical treatments as determined by a licensed physician” (H-185.990); and

Whereas, As legislation around coverage of fertility preservation continues to evolve, it is imperative that equitable insurance coverage for transgender patients is ensured; therefore be it

RESOLVED, That our American Medical Association amend Policy H-185.990, “Infertility and Fertility Preservation Insurance Coverage,” by addition to read as follows:

Infertility and Fertility Preservation Insurance Coverage H-185.990
It is the policy of the AMA that (1) Our AMA encourages third party payer health insurance carriers to make available insurance benefits 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<u>; and (3) Our AMA encourages the inclusion of impaired fertility as a consequence of gender-affirming hormone therapy and gender-affirming surgery within legislative definitions of iatrogenic infertility.</u> (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA amend Policy H-185.950, “Removing Financial Barriers to Care for Transgender Patients,” by addition to read as follows:

Removing Financial Barriers to Care for Transgender Patients H-185.950
Our AMA supports public and private health insurance coverage for <u>medically necessary</u> treatment of gender dysphoria as recommended by the patient’s physician<u>, including gender-affirming hormone therapy and gender-affirming surgery</u>. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Gender-affirming therapy, including gender-affirming hormone therapy and gender-affirming surgery, is vital to the physical and mental health of patients experiencing gender dysphoria. It is a necessary medical treatment, and any resulting complications should be considered iatrogenic. Our AMA supports payment for iatrogenic infertility (H185.990) and rights for gamete preservation for members of transgender and non-binary communities (H-65.956). However, patients who undergo gender-affirming therapy and have the complication of iatrogenic infertility are often denied coverage for fertility therapy. This resolution is a critical step to correcting this problem and eliminating discrimination against the LGTBQ+ community. The transgender and non-binary communities have suffered immensely this past year physically--due to increased occurrences of hate crimes--and emotionally---due to a record-setting amount of anti-LGTBQ legislation passed in 2021. The AMA has made recent commitments to advocate for health equity and justice, including the release of our Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity, and this resolution represents an important step in furthering our advocacy in the health equity space.

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RELEVANT AMA POLICY

Right for Gamete Preservation Therapies H-65.956

It is the policy of the AMA that (1): Fertility preservation services are recognized by our AMA as an option for the members of the transgender and non-binary community who wish to preserve future fertility through gamete preservation prior to undergoing gender affirming medical or surgical therapies; and (2) Our AMA supports the right of transgender or non-binary individuals

to seek gamete preservation therapies.
Res. 005, A-19

Infertility and Fertility Preservation Insurance Coverage H-185.990
1. Our AMA encourages third party payer health insurance carriers to make available insurance benefits 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.
Res. 150, A-88 Reaffirmed: Sunset Report, I-98Reaffirmed: CMS Rep. 4, A-08Appended: Res. 114, A-13Modified: Res. 809, I-14

Sexual Orientation and/or Gender Identity as Health Insurance Criteria H-180.980
The AMA opposes the denial of health insurance on the basis of sexual orientation or gender identity.
Res. 178, A-88; Reaffirmed: Sub. Res. 101, I-97; Reaffirmed: CMS Rep. 9, A-07; Modified: BOT Rep. 11, A-07; Reaffirmed: CMS Rep. 01, A-17

Removing Financial Barriers to Care for Transgender Patients H-185.950
Our AMA supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician.
Res. 122 A-08; Modified: Res. 05, A-16

Infertility Benefits for Veterans H-510.984
The AMA (1) Our AMA supports lifting the congressional ban on the Department of Veterans Affairs (VA) from covering in vitro fertilization (IVF) costs for veterans who have become infertile due to service-related injuries; (2) Our AMA encourages interested stakeholders to collaborate in lifting the congressional ban on the VA from covering IVF costs for veterans who have become infertile due to service-related injuries; (3) Our AMA encourages the Department of Defense (DOD) to offer service members fertility counseling and information on relevant health care benefits provided through TRICARE and the VA at pre-deployment and during the medical discharge process; (4) Our AMA supports efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address infertility due to service-related injuries; and (5) Our AMA supports additional research to better understand whether higher rates of infertility in servicewomen may be linked to military service, and which approaches might reduce the burden of infertility among service women.
CMS Rep. 01, I-16; Appended: Res. 513, A-19

Storage & Use of Human Embryos- Ethics 4.2.5
Embryos created during cycles of in vitro fertilization (IVF) that are not intended for immediate transfer are often frozen for future use. The primary goal is to minimize risk and burden by minimizing the number of cycles of ovarian stimulation and egg retrieval that an IVF patient undergoes. While embryos are usually frozen with the expectation that they will be used for reproductive purposes by the prospective parent(s) for whom they were created, frozen embryos may also offer hope to other prospective parent(s) who would otherwise not be able to have a child. Frozen embryos also offer the prospect of advancing scientific knowledge when made available for research purposes. In all of these possible scenarios, ethical concerns arise

regarding who has authority to make decisions about stored embryos and what kinds of choices they may ethically make. Decision-making authority with respect to stored embryos varies depending on the relationships between the prospective rearing parent(s) and any individual(s) who may provide gametes. At stake are individuals' interests in procreating. When gametes are provided by the prospective rearing parent(s) or a known donor, physicians who provide clinical services that include creation and storage of embryos have an ethical responsibility to proactively discuss with the parties whether, when, and under what circumstances stored embryos may be:
(a) Used by a surviving party for purposes of reproduction in the event of the death of a partner or gamete donor.
(b) Made available to other patients for purposes of reproduction.
(c) Made available to investigators for research purposes, in keeping with ethics guidance and on the understanding that embryo(s) used for research will not subsequently be used for reproduction.
(d) Allowed to thaw and deteriorate.
(e) Otherwise disposed of.
Under no circumstances should physicians participate in the sale of stored embryos
Issued: 2016

Assisted Reproductive Technology- Ethics 4.2.1
Assisted reproduction offers hope to patients who want children but are unable to have a child without medical assistance. In many cases, patients who seek assistance have been repeatedly frustrated in their attempts to have a child and are psychologically very vulnerable. Patients whose health insurance does not cover assisted reproductive services may also be financially vulnerable. Candor and respect are thus essential for ethical practice. "Assisted reproductive technology" is understood as all treatments or procedures that include the handling of human oocytes or embryos. It encompasses an increasingly complex range of interventions—such as therapeutic donor insemination, ovarian stimulation, ova and sperm retrieval, in vitro fertilization, gamete intrafallopian transfer—and may involve multiple participants. Physicians should increase their awareness of infertility treatments and options for their patients. Physicians who offer assisted reproductive services should:
(a) Value the well-being of the patient and potential offspring as paramount.
(b) Ensure that all advertising for services and promotional materials are accurate and not misleading.
(c) Provide patients with all of the information they need to make an informed decision, including investigational techniques to be used (if any); risks, benefits, and limitations of treatment options and alternatives, for the patient and potential offspring; accurate, clinic-specific success rates; and costs.
(d) Provide patients with psychological assessment, support and counseling or a referral to such services.
(e) Base fees on the value of the service provided. Physicians may enter into agreements with patients to refund all or a portion of fees if the patient does not conceive where such agreements are legally permitted.
(f) Not discriminate against patients who have difficult-to-treat conditions, whose infertility has multiple causes, or on the basis of race, socioeconomic status, or sexual orientation or gender identity.
(g) Participate in the development of peer-established guidelines and self-regulation.blished guidelines and self-regulation.
Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 012
(N-21)

Introduced by: Medical Student Section

Subject: Increased Recognition and Treatment of Eating Disorders in Minority Populations

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, The DSM-V defines a binge-eating episode as "eating, in a discrete period of time, an amount of food that is definitely larger than most people would eat in a similar period of time under similar circumstances"[1]; and

Whereas, The DSM-V defines the essential feature of binge-eating disorder (BED) as "recurrent episodes [of] binge eating that must occur, on average, at least once per week for 3 months"[1]; and

Whereas, Binge eating disorder is the most prevalent eating disorder in the United States with a lifetime prevalence of 2.8%[2]; and

Whereas, Recent evidence has shown significant differences in the prevalence of binge-eating symptoms in non-Hispanic White populations and non-Hispanic Black populations[3]; and

Whereas, Rates of obesity, body satisfaction, and depression vary among ethnic groups causing heterogeneity in the prevalence of eating disorders within these groups[4,5]; and

Whereas, Some studies suggest that the increased risk of disordered eating in ethnic minority adolescents may result from higher levels of stress due to minority status[6]; and

Whereas, It has been further suggested that among these adolescents, physical appearance is viewed as a source of social capital, increasing their risk for engaging in unhealthy eating behaviors as a means of changing their appearance[6]; and

Whereas, Research has shown that men and ethnic/racial minorities are significantly less likely to seek help for binge eating disorders than women or non-Hispanic White people[7]; and

Whereas, Studies have documented lower rates of treatment for eating disorders among some specific diverse populations due to differences in clinical presentation, differences in help-seeking patterns, and clinician error or bias[8-10]; and

Whereas, Recent evidence from a study of Latina and Asian American women has shown that "acculturative stress," the adjustment and internal conflict that often occur as an individual attempts to resolve cultural differences, may contribute to disordered eating[11]; and

Whereas, A recent overview of Cochrane systematic reviews has shown that of all studied psychosocial interventions, the cognitive behavioral approach was most effective for binge-eating disorder, bulimia, nervosa, and night eating syndrome[15]; and

Whereas, For example, a qualitative study has shown that culturally adapted Cognitive Behavioral Therapy (CBT)-guided self-help has been well received and is a feasible treatment for Mexican American women with binge-eating disorder[14]; and

Whereas, Research suggests culturally sensitive CBT is both feasible and efficacious[12,13]; and

Whereas, Binge-eating is the most prominent presentation of eating disorders, particularly in minority populations, but is not specified in current AMA policy despite less prevalent presentations such as weight restriction being specified; therefore be it

RESOLVED, That our American Medical Association amend Policy H-150.965, "Eating Disorders," by addition to read as follows in order to support increased recognition of disordered eating behaviors in minority populations and culturally appropriate interventions:

> H-150.965 – EATING DISORDERS
> The AMA (1) adopts the position that overemphasis of bodily thinness is as deleterious to one's physical and mental health as obesity; (2) asks its members to help their patients avoid obsessions with dieting and to develop balanced, individualized approaches to finding the body weight that is best for each of them; (3) encourages training of all school-based physicians, counselors, coaches, trainers, teachers and nurses to recognize unhealthy eating, <u>binge-eating</u>, dieting, and weight restrictive behaviors in adolescents and to offer education and appropriate referral of adolescents and their families for <u>culturally-informed</u> interventional counseling; and (4) participates in this effort by consulting with appropriate and <u>culturally informed</u> educational and counseling materials pertaining to unhealthy eating, <u>binge-eating</u>, dieting, and weight restrictive behaviors. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

The COVID-19 pandemic has had immense impacts on mental health, with mental health providers seeing enormous increases in demand for their services. During the pandemic, as well, we as a national and international community have had to face the massive impact of racial discrimination and mistreatment of people of marginalized racial groups. Medicine has particularly faced a reckoning, as the pandemic made and continues to make it abundantly clear that treatment of illnesses may differ solely based upon the race of the patient, and medical problems more that more profoundly affect some social, racial, or cultural groups are given less attention and less priority by the medical community. This is especially notable in the treatment of eating disorders, in which people from different cultures have been found to experience disordered eating differently, and people from certain cultural backgrounds have been shown to be less likely to receive appropriate treatment due to a lack of culturally appropriate care. Further, binge-eating disorder is the most prevalent eating disorder in the U.S., but it is left out of our AMA's policy considerations.

This resolution is important because it allows our AMA to make a small change policy change with a large impact, allowing us to recognize the importance of binge-eating disorder in a time of great mental health distress, and allowing us to address cultural and racial inequities in a time when medicine is having a reckoning with its own history of inexcusably unequal treatment.

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RELEVANT AMA POLICY

Eating Disorders H-150.965

The AMA (1) adopts the position that overemphasis of bodily thinness is as deleterious to one's physical and mental health as is obesity; (2) asks its members to help their patients avoid obsessions with dieting and to develop balanced, individualized approaches to finding the body weight that is best for each of them; (3) encourages training of all school-based physicians, counselors, coaches, trainers, teachers and nurses to recognize unhealthy eating, dieting, and weight restrictive behaviors in adolescents and to offer education and appropriate referral of adolescents and their families for interventional counseling; and (4) participates in this effort by consulting with appropriate specialty societies and by assisting in the dissemination of appropriate educational and counseling materials pertaining to unhealthy eating, dieting, and weight restrictive behaviors.
Res. 417, A-92, Appended: Res. 503, A-98, Modified and Reaffirmed: CSAPH Rep. 2, A-08, Reaffirmed: CSAPH Rep. 1, A-18

Eating Disorders and Promotion of Healthy Body Image H-150.928

Our AMA supports increased funding for research on the epidemiology, etiology, diagnosis, prevention, and treatment of eating disorders, including research on the effectiveness of school-based primary prevention programs for pre-adolescent children and their parents, in order to prevent the onset of eating disorders and other behaviors associated with a negative body image.
CSAPH Rep. 1, A-17

Increasing Detection of Mental Illness and Encouraging Education D-345.994

1. Our AMA will work with: (A) mental health organizations, state, specialty, and local medical societies and public health groups to encourage patients to discuss mental health

concerns with their physicians; and (B) the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for preschool through high school students, as well as for their parents, caregivers and teachers.
2. Our AMA will encourage the National Institute of Mental Health and local health departments to examine national and regional variations in psychiatric illnesses among immigrant, minority, and refugee populations in order to increase access to care and appropriate treatment.
Res. 412, A-06, Appended: Res. 907, I-12, Reaffirmed in lieu of: Res 001, A-16

Access to Mental Health Services H-345.981
Our AMA advocates the following steps to remove barriers that keep Americans from seeking and obtaining treatment for mental illness:
(1) reducing the stigma of mental illness by dispelling myths and providing accurate knowledge to ensure a more informed public; (2) improving public awareness of effective treatment for mental illness; (3) ensuring the supply of psychiatrists and other well trained mental health professionals, especially in rural areas and those serving children and adolescents; (4) tailoring diagnosis and treatment of mental illness to age, gender, race, culture and other characteristics that shape a person's identity; (5) facilitating entry into treatment by first-line contacts recognizing mental illness, and making proper referrals and/or to addressing problems effectively themselves; and (6) reducing financial barriers to treatment.
CMS Rep. 9, A-01, Reaffirmation: A-11, Reaffirmed: CMS Rep. 7, A-11, Reaffirmed: BOT action in response to referred for decision Res. 403, A-12, Reaffirmed in lieu of: Res. 804, I-13, Reaffirmed in lieu of: Res. 808, I-14, Reaffirmed: Res. 503, A-17, Reaffirmation: A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 013
(N-21)

Introduced by: Medical Student Section

Subject: Equal Access to Adoption for the LGBTQ Community

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, Current federal qualifications for adoption, according to U.S. Citizenship and Immigration Services (USCIS) are as follows:

1. You must be a U.S. Citizen.
2. If you are unmarried, you must be at least 25 years old.
3. If you are married, you must jointly adopt the child (even if you are separated but not divorced), and your spouse must also be either a U.S. citizen or in legal status in the United States.
4. You must meet certain requirements that will determine your suitability as a prospective adoptive parent, including criminal background checks, fingerprinting, and a home study[1]; and

Whereas, The federal government currently allocates funding for adoption and foster care to states, which independently manage federal funds and have differing statutes concerning eligibility to adopt or place a child up for adoption[2-4.]; and

Whereas, Independent state-licensed child welfare agencies are contracted by each state to provide foster care or adoption services[5]; and

Whereas, The American Bar Association recently adopted a resolution in 2019 criticizing how "state-sanctioned discrimination against LGBT individuals who wish to raise children has dramatically increased in recent years"[6-7]; and

Whereas, Eleven states currently permit state-licensed welfare agencies to refuse placement of children with LGBTQ individuals and same-sex couples and fourteen additional states lack explicit protection for LGBTQ individuals concerning adoption rights[5]; and

Whereas, In fiscal year 2018 alone, the need for adoption was evident as there were 437,283 total children in the U.S. foster care system with 125,422 children waiting to be adopted[8]; and

Whereas, According to 2019 Adoption and Foster Care Analysis and Reporting System (AFCARS) data, 58% or 143,572 children spent over 12 months in foster care before leaving the system[8]; and

Whereas, The longer a child is in foster care, the more likely that child is to move from one foster placement to another, and the greater the risk that child experiences adverse childhood events (ACEs), which may result in lasting negative social and emotional consequences[9]; and

Whereas, Per evaluation with the Child Behavior Checklist (CBCL), children who enter foster care with no known internal or external problems show an increase in “total problem behavior” in direct correlation with their number of placements[10-12]; and

Whereas, Frequent placement changes result in difficulty forming secure attachments with foster parents, low self-esteem, and a negative relationship with academic growth[10-12]; and

Whereas, Per the Centers for Disease Control and Prevention, “Creating and sustaining safe, stable, nurturing relationships and environments for all children and families can prevent ACEs and help all children reach their full potential”[13]; and

Whereas, Recent social science literature supports that children living with same-sex parents have equivalent outcomes compared to children with different-sex parents[14]; and

Whereas, Estimates from the 2010 U.S. Census suggest there are nearly 650,000 same-sex couples living in the U.S., and same-sex couples are five times (10% vs 2%) more likely to adopt children under age 18 compared to different sex couples[15-16]; and

Whereas, Current AMA Policy H-60.959 calls for the “comprehensive and evidence-based care that addresses the specific health care needs of children in foster care” and supports the "best interest of the child" as the most important criterion determining custody, placement, and adoption of children;” and

Whereas, AMA policy H-60.940 supports the rights of a non-married partner to adopt the child of their co-parenting partner but does not adequately address adoption rights of LGBTQ individuals nor their limited eligibility or access to adoption, allowing for potential harm towards children by narrowing the pool of qualified foster and adoptive homes; therefore be it

RESOLVED, That our American Medical Association advocate for equal access to adoption services for LGBTQ individuals who meet federal criteria for adoption regardless of gender identity or sexual orientation (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage allocation of government funding to licensed child welfare agencies that offer adoption services to all individuals or couples including those with LGBTQ identity. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

This resolution addresses equal access to adoption for the LGBTQ community, a topic which is especially timely given the myriad of anti-LGBTQ+ legislation being passed or considered around the country. It is imperative that our AMA continue to decrease the stigma and discrimination not only for those children who have yet to be adopted, but for the innumerable children parented by same-sex couples today. Moreover, there is also a vital function of a more equitable and available adoption process for same sex couples. By expanding the federal requirements for non-discrimination in relation to same sex parents, great strides could be made in addressing the epidemic of LGBTQ youth homelessness. Furthermore, the Supreme Court recently heard arguments on this very topic, experts believe the Supreme Court is likely to rule in favor of the Catholic adoption agency and thus against LGBTQ+ same sex parents/couples. This resolution is thus urgent, time-sensitive, and a priority, and our AMA should act now to protect the rights and wellbeing of children and of LGBTQ+ parents and families.

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RELEVANT AMA POLICY

Uniformity of State Adoption and Child Custody Laws H-60.959

The AMA urges: (1) state medical societies to support the adoption of a Uniform Adoption Act that places the best interest of the child as the most important criteria; (2) the National

Conference of Commissioners on Uniform State Laws to include mandatory pre-consent counseling for birth parents as part of its proposed Uniform Adoption Act; and (3) state medical societies to support adoption of child custody statutes that place the "best interest of the child" as the most important criterion determining custody, placement, and adoption of children.
Sub. Res. 219, I-93Reaffirmed: BOT Rep. 28, A-03Reaffirmed: BOT Rep. 28, A-13

Addressing Healthcare Needs of Children in Foster Care H-60.910
Our AMA advocates for comprehensive and evidence-based care that addresses the specific health care needs of children in foster care.
Res. 907, I-17

Partner Co-Adoption H-60.940
Our AMA will support legislative and other efforts to allow the adoption of a child by the non-married partner who functions as a second parent or co-parent to that child.
Res. 204, A-04; Modified: CSAPH Rep. 1, A-14

Health Care disparities in Same-Sex Partner Households H-65.973
Our American Medical Association: (1) recognizes that denying civil marriage based on sexual orientation is discriminatory and imposes harmful stigma on gay and lesbian individuals and couples and their families; (2) recognizes that exclusion from civil marriage contributes to health care disparities affecting same-sex households; (3) will work to reduce health care disparities among members of same-sex households including minor children; and (4) will support measures providing same-sex households with the same rights and privileges to health care, health insurance, and survivor benefits, as afforded opposite-sex households.
CSAPH Rep. 1, I-09; BOT Action in response to referred for decision; Res. 918, I-09; Reaffirmed in lieu of Res. 918, I-09; BOT Rep. 15, A-11; Reaffirmed in lieu of Res. 209, A-12

Adoption H-420.973
It is the policy of the AMA to (1) support the provision of adoption information as an option to unintended pregnancies; and (2) support and encourage the counseling of women with unintended pregnancies as to the option of adoption.
Res. 146, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Support of Human Rights and Freedom H-65.965
Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.
CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 014
(N-21)

Introduced by: Medical Student Section

Subject: Reducing Disparities in HIV Incidence through Pre-Exposure Prophylaxis (PrEP) for HIV

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, Sexual identity is fluid and can be defined on a spectrum, ranging from exclusively
2 homosexual behavior to exclusively heterosexual behavior[1]; and
3
4 Whereas, According to the U.S. National Survey of Family Growth, 17.4% of women and 6.2%
5 of men aged 18-44 report any same-sex sexual behavior at any time in their life, despite only
6 6.8% of women and 3.9% of men aged 18-44 report being homosexual, gay, lesbian, or
7 bisexual[2]; and
8
9 Whereas, Patients' reported sexual behavior and orientation is not always consistent with actual
10 sexual behavior as patients may not be willing to report their sexual histories accurately[2]; and
11
12 Whereas, In 2017, 30% of new HIV diagnoses in the United States were not attributed to the
13 men who have sex with men (MSM) demographic[3]; and
14
15 Whereas, From 2010-2016, African American heterosexual women accounted for the second
16 highest incidence of HIV infection after MSM[4]; and
17
18 Whereas, Black men who have sex with men and women (MSMW) have been hypothesized to
19 be the "bridge" through which HIV has been transmitted to black heterosexual men and women[5-
20 6]; and
21
22 Whereas, Several studies have shown that African American MSMW may challenge targeted
23 HIV prevention approaches that focus explicitly on sexual orientation since this population may
24 not identify as gay or bisexual and is therefore unlikely to participate in programs that prioritize
25 gay community affiliation as foundations for HIV prevention[5-6]; and
26
27 Whereas, In 2017, the African American population and Hispanic population collectively
28 accounted for 69% of HIV diagnoses, despite comprising only 31% of the U.S. population[3]; and
29
30 Whereas, A report from the CDC concluded that increasing HIV prevention services among
31 heterosexuals at increased risk is important, especially among racial and ethnic groups
32 disproportionately affected by HIV infection, such as blacks and Hispanics/Latinos[7]; and
33
34 Whereas, In 2019, the United States Preventive Services Task Force (USPSTF) recommended
35 with an "A" rating that clinicians offer HIV pre-exposure prophylaxis (PrEP) to persons who are
36 at high risk of HIV acquisition as an evidence-based primary prevention because PrEP reduces
37 the risk of sexual transmission of HIV by about 99% when taken daily[8-9]; and

Whereas, While there are over 77,000 PrEP users in the United States, over 1.1 million additional individuals would benefit from being on it[10-13]; and

Whereas, Sixty-nine percent of the individuals that could benefit from PrEP are Black or Hispanic, yet these individuals comprise only 4% of the individuals who are prescribed it[11-12]; and

Whereas, PrEP uptake does not reflect the general distribution of the HIV epidemic in the United States, as people of color and women bear a high HIV burden, but have a disproportionately limited uptake[14]; and

Whereas, Only 28% of primary care physicians are comfortable with prescribing PrEP, with the most frequently cited barrier to prescribing it being lack of knowledge[15-16]; and

Whereas, A 2018 study showed that medical students were unable to identify individuals at highest risk of HIV acquisition and recommend PrEP accordingly[17]; and

Whereas, Educational interventions targeted at primary care physicians that focus on HIV epidemiology, an introduction to PrEP and appropriate candidates, an overview of how to prescribe PrEP, as well as recommendations on sexual-history taking have all been shown to increase rates of PrEP prescribing when clinically indicated[16]; and

Whereas, Regardless of the patient's current stated sexual behavior, routine primary care office visits are comprised of a comprehensive discussion of sexual health, sexual activity, sexuality, contraception, and prevention of sexually transmitted infections/diseases (STIs), beginning as early as age 11[18-19]; and

Whereas, It is considered a best practice in primary care settings to educate patients about all the available options for preventing STIs, especially in sexually active adolescents and in adults at increased risk for STIs[18-19]; and

Whereas, PrEP is considered to be an option for the prevention of HIV infection in seronegative individuals at high risk of HIV acquisition, yet it is not routinely discussed with patients[8,15]; and

Whereas, A study found that the strongest factor influencing PrEP uptake among majority non-white heterosexual individuals at high risk of HIV, a group with disproportionately low PrEP uptake, was suggestion to initiate PrEP by a healthcare provider[14]; and

Whereas, AMA policies H-180.944 "Plan for Continued Progress Toward Health Equity" and H-350.974 "Racial and Ethnic Disparities in Health Care" has named the elimination of racial and ethnic disparities in health care "an issue of highest priority" as they are a "barrier to effective medical diagnosis and treatment"; and

Whereas, H-350.974 calls on the importance of "evidence-based guidelines to promote the consistency and equity of care for all persons" and "supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations"; and

Whereas, No existing AMA policy explicitly acknowledges the disparities that exist in HIV prevention and treatment nor proposes a specific intervention to reduce such disparities; therefore be it

RESOLVED, That our American Medical Association amend Policy H-20.895 “Pre-Exposure Prophylaxis (PrEP) for HIV,” by addition to read as follows:

Pre-Exposure Prophylaxis (PrEP) for HIV, H-20.895

1. Our AMA will educate physicians, physicians-in-training, and the public about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines.
2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances.
3. Our AMA supports the removal of insurance barriers for PrEP such as prior authorization, mandatory consultation with an infectious disease specialist and other barriers that are not clinically relevant.
4. Our AMA advocates that individuals not be denied any insurance on the basis of PrEP use.
5. Our AMA encourages the discussion of and education about PrEP during routine sexual health counseling, regardless of a patient’s current reported sexual behaviors. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

This resolution is pivotal if the U.S. wishes to reach or even come close to its set goal of eliminating HIV in our country by 2030. The HIV/AIDS pandemic has continued unabated and even increased during the COVID-19 pandemic. HIV researchers and infectious diseases physicians have predicted that the decreased availability of HIV treatment during the COVID-19 pandemic may set back our progress against HIV by multiple years. HIV most profoundly affects marginalized communities, and these communities are also the most likely to have barriers to access to preventive measures, especially PrEP.

This resolution aims to reduce existing disparities through universal PrEP counseling. Universal PrEP counseling would work to address the stark underutilization of PrEP by many vulnerable populations, including Black heterosexual women and queer and trans people of color. While recent years have seen significant uptake by white and wealthier members of the LGBTQ+ community, true improvement in the health of our community as a whole and addressal of the health disparities within our community requires increased PrEP knowledge and use among queer and trans people, people of color, and low-income LGBTQ+ individuals. This resolution represents a way to use patient-centered care to address an urgent and rapidly growing problem: with proper, universal counseling around preventive measures against a chronic condition with high prevalence and morbidity, patients can make their own informed decisions about what the best preventive practice looks like for their own sexual practices and their own lives.

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RELEVANT AMA POLICY

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.
2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk

for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.
3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.
4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.
CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8, I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmation: A-12; Modified: Res. 08, A-16; Modified: Res. 903, I-17; Modified: Res. 904, I-17; Res. 16, A-18; Reaffirmed: CSAPH Rep. 01, I-18.

Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) Health Issues in Medical Education H-295.878
Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues related to sexual orientation and gender identity; and (3) encourages medical education accreditation bodies to both continue to encourage and periodically reassess education on health issues related to sexual orientation and gender identity in the basic science, clinical care, and cultural competency curricula in undergraduate and graduate medical education.
Res. 323, A-05; Modified in lieu of Res. 906, I-10; Reaffirmation: A-11; Reaffirmation: A-12; Reaffirmation: A-16; Modified: Res. 16, A-18; Modified: Res. 302, I-19

Improving the Health of Black and Minority Populations H-350.972
Our AMA supports:
1. A greater emphasis on minority access to health care and increased health promotion and disease prevention activities designed to reduce the occurrence of illnesses that are highly prevalent among disadvantaged minorities.
2. Authorization for the Office of Minority Health to coordinate federal efforts to better understand and reduce the incidence of illness among U.S. minority Americans as recommended in the 1985 Report to the Secretary's Task Force on Black and Minority Health.
3. Advising our AMA representatives to the LCME to request data collection on medical school curricula concerning the health needs of minorities.
4. The promotion of health education through schools and community organizations aimed at teaching skills of health care system access, health promotion, disease prevention, and early diagnosis.
CLRPD Rep. 3, I-98; Reaffirmation: A-01; Modified: CSAPH Rep. 1, A-11; Reaffirmed: CEJA Rep. 1, A-21

Plan for Continued Progress Toward Health Equity H-180.944
Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.
BOT Rep. 33, A-18

Racial and Ethnic Disparities in Health Care H-350.974
1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.
2. The AMA emphasizes three approaches that it believes should be given high priority:
a. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.
b. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.
c. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision-making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities
3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.
4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.
CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep. 1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 3, A-21

Pre-Exposure Prophylaxis (PrEP) for HIV H-20.895
1. Our AMA will educate physicians and the public about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines.
2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances.
3. Our AMA supports the removal of insurance barriers for PrEP such as prior authorization, mandatory consultation with an infectious disease specialist and other barriers that are not clinically relevant.
4. Our AMA advocates that individuals not be denied any insurance on the basis of PrEP use.
Res. 106, A-16; Modified: Res. 916, I-16; Appended: Res. 101, A-17

Support of a National HIV/AIDS Strategy H-20.896

1. Our AMA supports the creation of a National HIV/AIDS strategy and will work with relevant stakeholders to update and implement the National HIV/AIDS strategy.
2. Our AMA supports and will strongly advocate for the funding of plans to end the HIV epidemic that focus on: (a) diagnosing individuals with HIV infection as early as possible; (b) treating HIV infection to achieve sustained viral suppression; (c) preventing at-risk individuals from acquiring HIV infection, including through the use of pre-exposure prophylaxis; and (d) rapidly detecting and responding to emerging clusters of HIV infection to prevent transmission.

Sub Res. 425, A-09; Modified: CSAPH Rep. 01, A-19; Appended: Res. 413, A-19.

HIV/AIDS Education and Training H-20.904

(1) Public Information and Awareness Campaigns

Our AMA:

a) Supports development and implementation of HIV/AIDS health education programs in the United States by encouraging federal and state governments through policy statements and recommendations to take a stronger leadership role in ensuring interagency cooperation, private sector involvement, and the dispensing of funds based on real and measurable needs. This includes development and implementation of language- and culture-specific education programs and materials to inform minorities of risk behaviors associated with HIV infection.

b) Our AMA urges the communications industry, government officials, and the health care communities together to design and direct efforts for more effective and better targeted public awareness and information programs about HIV disease prevention through various public media, especially for those persons at increased risk of HIV infection;

c) Encourages education of patients and the public about the limited risks of iatrogenic HIV transmission. Such education should include information about the route of transmission, the effectiveness of universal precautions, and the efforts of organized medicine to ensure that patient risk remains immeasurably small. This program should include public and health care worker education as appropriate and methods to manage patient concern about HIV transmission in medical settings. Statements on HIV disease, including efficacy of experimental therapies, should be based only on current scientific and medical studies;

d) Encourages and will assist physicians in providing accurate and current information on the prevention and treatment of HIV infection for their patients and communities;

e) Encourages religious organizations and social service organizations to implement HIV/AIDS education programs for those they serve.

(2) HIV/AIDS Education in Schools

Our AMA:

a) Endorses the education of elementary, secondary, and college students regarding basic knowledge of HIV infection, modes of transmission, and recommended risk reduction strategies;

b) Supports efforts to obtain adequate funding from local, state, and national sources for the development and implementation of HIV educational programs as part of comprehensive health education in the schools.

(3) Education and Training Initiatives for Practicing Physicians and Other Health Care Workers

Our AMA supports continued efforts to work with other medical organizations, public health officials, universities, and others to foster the development and/or enhancement of programs to provide comprehensive information and training for primary care physicians, other front-line health workers (specifically including those in addiction treatment and community health centers and correctional facilities), and auxiliaries focusing on basic knowledge of HIV infection, modes of transmission, and recommended risk reduction strategies.

CSA Rep. 4, A-03; Appended: Res. 516, A-06; Modified: CSAPH 01, A-16; Reaffirmed: Res. 916, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 015
(N-21)

Introduced by: Medical Student Section

Subject: Using X-Ray and Dental Records for Assessing Immigrant Age

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, Skeletal and dental maturity are assessed from hand-wrist radiographs and dental x-rays, which together are compared to growth charts to determine the age of an individual[1]; and

Whereas, Estimated chronological age determined from growth charts, hand-wrist radiographs, and dental x-rays may not correlate with the true chronological age of an individual due to population and geography-specific factors, including nutritional intake, environmental exposure, and genetics to such an extent that the Centers for Disease Control and Prevention (CDC) recommends against using hand-wrist radiographs to determine the age of refugees[1-5]; and

Whereas, International records highlight the wide variety in growth charts utilized country to country, in part due to different genetics, nutrition, medical conditions, and environmental exposures[6,7,8]; and

Whereas, The Department of Homeland Security (DHS) and the Department of Health and Human Services (HHS) will request new skeletal and dental x-ray imaging to establish the age of an individual crossing the border[9]; and

Whereas, According to Food and Drug Administration recommendations, performing x-rays on children comes with greater risk of radiation-related illness and should only be used to answer a clinical question or to guide treatment[10]; and

Whereas, The DHS handbook, in collaboration with the Office of Refugee Resettlement , which is part of HHS, states that medical images may be used only when no other means of verifying chronological age exist[9,11]; and

Whereas, The DHS handbook states that acceptable documentation to verify chronological age can include official government-issued documents such as a birth certificate, other governmental records, a baptismal certificate, school records, medical records, or other objective documentation with a date of birth listed[9]; and

Whereas, If the immigrant/refugee does not have their birth certificate, the DHS handbook states that affirmative steps should be taken to contact the refugee's home country's relevant record keeping department to verify their birth date[9]; and

Whereas, The DHS handbook directs immigration officers to accept statements by the person in question, their family members, other people who know the person as verifying evidence[9]; and

Whereas, As part of the 2009 Appropriations Bill, Congress stated its concern that Immigration and Customs Enforcement (ICE) had not stopped using fallible bone and dental forensics for child age determination and has since decreased their use of age determination exams [12,13]; and

Whereas, In 2018, ICE decreased the number of age determination exams it used to less than 50; meanwhile, HHS increased its utilization of the exams for those in the care of the ORR to almost 700, almost double the number granted to both agencies in each of the prior two years[13]; and

Whereas, Minors who are incorrectly classified as adults due to dental and x-ray imaging are held in adult detention centers while waiting for their cases to be heard and therefore are not held in the least restrictive setting, in violation of the federal government's promise to do so in the Flores Agreement and further restricting their rights [14]; and

Whereas, Attorneys representing minors report that their clients' supporting documentation was not used and were instead placed in adult detention centers solely based on x-ray images for months until federal judges ruled that ICE and HHS could not classify their immigrant clients as adults based solely on imaging[15]; and

Whereas, As an example, one 19-year-old woman immigrating to the U.S. on a fiancée visa was incorrectly deemed a minor based on dental and hand-wrist radiographs and was not released to her aunt, resulting in her involuntary detainment in a shelter for minors for 14 months[16]; and

Whereas, Existing AMA policy H-65.958 states that the AMA will advocate for the healthcare services provided to minor immigrants, both in detention and those held at border patrol stations; and

Whereas, Existing AMA policy H-315.966 states that the AMA supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented; therefore be it

RESOLVED, That our American Medical Association support discontinuation of the use of non-medically necessary dental and bone forensics to assess an immigrant's age. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

The COVID-19 pandemic has revealed some of the great inequities faced by immigrants and refugees, especially immigrant and refugee children, seeking safety in the U.S. This resolution addresses a specific healthcare problem that pediatric migrants and refugees face when crossing our borders. Dental and bone X-rays are often used inappropriately in determining an immigrant person's age, which physicians have said is inaccurate and could result in inaccurate treatment of the children. Further, physicians and researchers have raised alarms that this is a harmful practice that subjects children to the unnecessary use of medical imaging, unnecessarily increasing their radiation exposure. As the voice of America's physicians, our AMA should prioritize protections for particularly vulnerable and marginalized members in our society, including immigrants and refugees and especially children, during this ongoing pandemic. This resolution calls for timely action taken on behalf of an incredibly vulnerable population and thus asks the House's consideration.

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RELEVANT AMA POLICY

Opposing Office of Refugee Resettlement's Use of Medical and Psychiatric Records for Evidence in Immigration Court H-65.958

Our AMA will: (1) advocate that healthcare services provided to minors in immigrant detention and border patrol stations focus solely on the health and well-being of the children; and (2)

condemn the use of confidential medical and psychological records and social work case files as evidence in immigration courts without patient consent.
Res. 013, A-19

HIV, Immigration, and Travel Restrictions H-20.901
Our AMA recommends that: (1) decisions on testing and exclusion of immigrants to the United States be made only by the U.S. Public Health Service, based on the best available medical, scientific, and public health information; (2) non- immigrant travel into the United States not be restricted because of HIV status; and (3) confidential medical information, such as HIV status, not be indicated on a passport or visa document without a valid medical purpose.
CSA Rep. 4, A-03 Modified: Res. 2, I-10 Modified: Res. 254, A-18

Patient and Physician Rights Regarding Immigration Status H-315.966
Our AMA supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented.
Res. 018, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 016
(N-21)

Introduced by: Medical Student Section

Subject: Student-Centered Approaches for Reforming School Disciplinary Policies

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, School-related arrests and juvenile justice referrals have been associated with school disengagements, lower graduation rates, increased dropout rates, and increased involvement in the school-to-prison pipeline[1, 2]; and

Whereas, School-related arrests and juvenile justice referrals disproportionately target Black students, Latinx students, male students, and students with physical or mental disabilities[3, 4, 5]; and

Whereas, Research on the effectiveness of school resource officer programs is limited, and fails to make a strong case for harsh discipline programs that include referral to law enforcement[6]; and

Whereas, School-based mental health efforts have been successful in identifying those in need of mental health services, bolstering academic functioning, and improving patterns of behavior[7]; and

Whereas, Educators, nurses, and counselors can play a key role in fostering protective environments for children and identifying students who may need additional support, in contrast to school resource officers[8, 9]; and

Whereas, School-based mental health professionals report ever-increasing workloads and responsibilities that include disciplinary roles[10, 11]; and

Whereas, Students report feeling hesitant to approach counselors to discuss academic, mental health, or social issues because they do not feel that their disclosure will be kept private, possibly affecting their academic or conduct standing[12]; and

Whereas, The American School Counselor Association urges that “school counselors maintain non-threatening relationships with students to best promote student achievement and development” and states that school counselors are neither “disciplinarians” or “enforcement agent[s] for the school”[13]; and

Whereas, The National Association of School Nurses states that school nurses should facilitate an “environment that values connecting students, families, and the community in positive engagement” characterized by “safety and trust where students are aware that caring, trained adults are present and equipped to take action on their behalf”[14]; and

Whereas, Positive Behavior Interventions and Supports (PBIS) is an evidence-based implementation framework focusing on prevention and intervention strategies that support the academic, social, emotional, and behavioral competence of students at all levels of education[15]; and

Whereas, PBIS promotes prevention of student misbehavior by having students experience "predictable instructional consequences for problem behavior without inadvertent rewarding" while educators provide "clear and predictable consequences for problem behavior and following up with constructive support to reduce the probability of future problem behavior"[15]; and

Whereas, PBIS was shown in a group randomized controlled effectiveness trial of 12,344 elementary students to reduce concentration and behavioral problems, and increase social-emotional functioning and prosocial behavior[16]; and

Whereas, PBIS implementation has been linked to positive outcomes in attendance, behavior, and academics while decreasing office discipline referrals, in-school suspensions, and out-of-school suspensions[17, 18]; and

Whereas, Mental Health America and the American Academy of Pediatrics have recognized the detrimental effects of “zero tolerance” policies and have advocated for school wide PBIS as an alternative[19, 20]; and

Whereas, AMA policy H-60.919 includes support for “school discipline policies that permit reasonable discretion and consideration of mitigating circumstances when determining punishments,” but is largely focused on determination of punishment rather than prevention of misbehavior; and

Whereas, AMA policy H-60.991 establishes the role of school-based health programs and AMA policy H-60.902 addresses the need for policy ensuring proper qualification and training for school resource officers, but do not delineate if or how school-based health professionals should participate in school disciplinary roles; therefore be it

RESOLVED, That our American Medical Association support evidence-based frameworks in K-12 schools that focus on school-wide prevention and intervention strategies for student misbehavior (New HOD Policy); and be it further

RESOLVED, That our AMA support the inclusion of school-based mental health professionals in the student discipline process. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

This resolution addresses an important policy gap by expanding on current policies concerning school discipline. This issue is particularly urgent and timely as schools are transitioning back to in-person attendance after more than a year of virtual learning. We ask the AMA to work with education stakeholders to determine appropriate roles for mental-health professionals in schools, with particular respect to disciplinary processes. Children are returning from a year at home, under the constant threat of a dangerous disease, when many likely lost family members; children will undoubtedly find themselves acting out more and in need of more mental health support. This resolution, in contrast, focuses on interventions that can help prevent student misbehavior and the prioritization of their behavioral and mental health outcomes.

As children begin to return to "normal" school settings in this ongoing pandemic, it is vital that we take proactive steps to help them be successful and to prevent them from experiencing further setbacks to their education and social and individual development.

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RELEVANT AMA POLICY

Juvenile Justice System Reform, H-60.919

Our AMA:
1. Supports school discipline policies that permit reasonable discretion and consideration of mitigating circumstances when determining punishments rather than "zero tolerance" policies that mandate out-of-school suspension, expulsion, or the referral of students to the juvenile or criminal justice system.
2. Encourages continued research to identify programs and policies that are effective in reducing disproportionate minority contact across all decision points within the juvenile justice system.
3. Encourages states to increase the upper age of original juvenile court jurisdiction to at least 17 years of age.
4. Supports reforming laws and policies to reduce the number of youth transferred to adult criminal court.
5. Supports the re-authorization of federal programs for juvenile justice and delinquency prevention, which should include incentives for: (a) community-based alternatives for youth who pose little risk to public safety, (b) reentry and aftercare services to prevent recidivism, (c) policies that promote fairness to reduce disparities, and (d) the development and implementation of gender-responsive, trauma-informed programs and policies across juvenile justice systems.
6. Encourages juvenile justice facilities to adopt and implement policies to prohibit discrimination against youth on the basis of their sexual orientation, gender identity, or gender expression in order to advance the safety and well-being of youth and ensure equal access to treatment and services.
7. Encourages states to suspend rather than terminate Medicaid coverage following arrest and detention in order to facilitate faster reactivation and ensure continuity of health care services upon their return to the community.
8. Encourages Congress to enact legislation prohibiting evictions from public housing based solely on an individual's relationship to a wrongdoer, and encourages the Department of Housing and Urban Development andlocal public housing agencies to implement policies that support the use of discretion in making housing decisions, including consideration of the juvenile's rehabilitation efforts.
CSAPH Rep. 08, A-16; Reaffirmed: Res. 917, I-16

School-Based and School-Linked Health Centers, H-60.921
Our AMA supports the concept of adequately equipped and staffed school-based or school-linked health centers (SBHCs) for the comprehensive management of conditions of childhood and adolescence.
CSAPH Rep. 1, A-15

Adolescent Health, H-60.981
It is the policy of the AMA to work with other concerned health, education, and community groups in the promotion of adolescent health to: (1) develop policies that would guarantee access to needed family support services, psychosocial services and medical services; (2) promote the creation of community-based adolescent health councils to coordinate local solutions to local problems; (3) promote the creation of health and social service infrastructures in financially disadvantaged communities, if comprehensive continuing health care providers are not available; and (4) encourage members and medical societies to work with school administrators to facilitate the transformation of schools into health enhancing institutions by implementing comprehensive health education, creating within all schools a designated health coordinator and ensuring that schools maintain a healthy and safe environment.
Res. 252, A-90; Reaffirmed by BOT Rep. 24, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed CSAPH Rep. 01, A-17

Providing Medical Services Through School-Based Health Programs, H-60.991
(1) The AMA supports further objective research into the potential benefits and problems associated with school-based health services by credible organizations in the public and private sectors. (2) Where school-based services exist, the AMA recommends that they meet the following minimum standards: (a) Health services in schools must be supervised by a physician, preferably one who is experienced in the care of children and adolescents. Additionally, a physician should be accessible to administer care on a regular basis. (b) On-site services should be provided by a professionally prepared school nurse or similarly qualified health professional. Expertise in child and adolescent development, psychosocial and behavioral problems, and emergency care is desirable. Responsibilities of this professional would include coordinating the health care of students with the student, the parents, the school and the student's personal physician and assisting with the development and presentation of health education programs in the classroom. (c) There should be a written policy to govern provision of health services in the school. Such a policy should be developed by a school health council consisting of school and community-based physicians, nurses, school faculty and administrators, parents, and (as appropriate) students, community leaders and others. Health services and curricula should be carefully designed to reflect community standards and values, while emphasizing positive health practices in the school environment. (d) Before patient services begin, policies on confidentiality should be established with the advice of expert legal advisors and the school health council. (e) Policies for ongoing monitoring, quality assurance and evaluation should be established with the advice of expert legal advisors and the school health council. (f) Health care services should be available during school hours. During other hours, an appropriate referral system should be instituted. (g) School-based health programs should draw on outside resources for care, such as private practitioners, public health and mental health clinics, and mental health and neighborhood health programs. (h) Services should be coordinated to ensure comprehensive care. Parents should be encouraged to be intimately involved in the health supervision and education of their children.
CSA Rep. D, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: Res. 412, A-05; Reaffirmed in lieu of Res. 908, I-12

Improving Pediatric Mental Health Screening, H-345.977
Our AMA: (1) recognizes the importance of, and supports the inclusion of, mental health (including substance use, abuse, and addiction) screening in routine pediatric physicals; (2) will work with mental health organizations and relevant primary care organizations to disseminate recommended and validated tools for eliciting and addressing mental health (including substance use, abuse, and addiction) concerns in primary care settings; and (3) recognizes the importance of developing and implementing school-based mental health programs that ensure at-risk children/adolescents access to appropriate mental health screening and treatment services and supports efforts to accomplish these objectives.
Res. 414, A-11; Appended: BOT Rep. 12, A-14; Reaffirmed: Res. 403, A-18

Access to Mental Health Services, H-345.981
Our AMA advocates the following steps to remove barriers that keep Americans from seeking and obtaining treatment for mental illness:
(1) reducing the stigma of mental illness by dispelling myths and providing accurate knowledge to ensure a more informed public;
(2) improving public awareness of effective treatment for mental illness;
(3) ensuring the supply of psychiatrists and other well trained mental health professionals, especially in rural areas and those serving children and adolescents;
(4) tailoring diagnosis and treatment of mental illness to age, gender, race, culture and other characteristics that shape a person's identity;
(5) facilitating entry into treatment by first-line contacts recognizing mental illness, and making

proper referrals and/or to addressing problems effectively themselves; and
(6) reducing financial barriers to treatment.
CMS Res. 9, A-01; Reaffirmation A-11; Reaffirmed: CMS Rep. 7, A-11, Reaffirmed: BOT action in response to referred for decision Res. 403, A-12; Reaffirmed in lieu of Res. 804, I-13; Reaffirmed in lieu of Res. 808, I-14; Reaffirmed: Res. 503, A-17; Reaffirmation: I-18

School Resource Officer Qualifications and Training, H-60.902
Our AMA encourages: (1) an evaluation of existing national standards (and legislation, if necessary) to have qualifications by virtue of training and certification that includes child psychology and development, restorative justice, conflict resolution, crime awareness, implicit/explicit biases, diversity inclusion, cultural humility, and individual and institutional safety and others deemed necessary for school resource officers; and (2) the development of policies that foster the best environment for learning through protecting the health and safety of those in school, including students, teachers, staff and visitors.
Res. 926, I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 017
(N-21)

Introduced by: Women Physicians Section

Subject: Gender Equity and Female Physician Work Patterns During the Pandemic

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, Studies show that women carry more responsibility than their male counterparts for personal and family life[1, 3]; and

Whereas, A study following a cohort of faculty from the 1995 National Faculty Survey through 17 years showed persistent gender disparities in rank, retention, and leadership positions;[2] and

Whereas, Prior to the pandemic, due to the culture of medicine, many female physicians made adjustments in their professional roles, including "part-time status, despite the known limitations on professional progression, career advancement, and economic potential. These adjustments further propagate gender inequities and the persistent compensation gap female physicians experience;"[3] and

Whereas, The COVID-19 pandemic is requiring additional adjustments to the professional lives of physicians and many of these adjustments will be made disproportionately by female physicians due to childcare and pregnancy;[4] and

Whereas, Since the pandemic, there has been a decrease in the percentage of physicians working full-time, a rise in the percentage who were laid off, and an increase in changes in physicians' usual activities. The decline in the percentage of parents with preschool-aged children among only female physicians may suggest a disproportionate uptake of childcare responsibilities among female physicians;[5] and

Whereas, In a recent survey, female scientists reported a decline in research time relative to male colleagues during the COVID-19 pandemic, but the most significant factor was having a young dependent less than 6 years of age;[6] and

Whereas, One in five physicians experienced a financial cut or furlough because of the pandemic, but there is limited data on how these cuts and furloughs have impacted female physicians specifically[7]; therefore be it

RESOLVED, That our American Medical Association advocate for research on physician-specific data analyzing changes in work patterns and employment outcomes among female physicians during the pandemic including, but not limited to, understanding potential gaps in equity, indications for terminations and/or furloughs, gender differences in those who had unpaid additional work hours, and issues related to intersectionality (Directive to Take Action); and be it further

RESOLVED, That our AMA collaborate with relevant organizations to evaluate obstacles affecting female physicians and medical students during the pandemic. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 10/07/21

AUTHORS STATEMENT OF PRIORITY

The pandemic has shed light on many inequities in our healthcare system. Some of these inequities deal with access to care and longstanding untreated health conditions in vulnerable and underrepresented populations. However, the pandemic has also highlighted the ways women are treated differently in our industry. Women physicians have had to juggle more responsibilities related to childcare and homeschooling as well as sometimes being the caregiver for aging parents. Due to these added barriers and inflexibility in workdays and environment, some women have been passed over for promotions, not allowed to work from home, or even fired. The pandemic is still underway, but even once it has passed, this time in history will have withstanding impacts on women physicians and their futures. Therefore, this resolution is timely and pertinent to support women physicians now to influence their professional and leadership trajectories.

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RELEVANT AMA POLICY

Principles for Advancing Gender Equity in Medicine H-65.961

Our AMA:

1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender);
2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;
3. endorses the principle of equal opportunity of employment and practice in the medical field;
4. affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;
5. acknowledges that mentorship and sponsorship are integral components of one's career advancement, and encourages physicians to engage in such activities;
6. declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;
7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;
8. affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion

rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and
9. affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas.
Our AMA encourages: (1) state and specialty societies, academic medical centers, medical schools, hospitals, group practices and other physician employers to adopt the AMA Principles for Advancing Gender Equity in Medicine; and (2) academic medical centers, medical schools, hospitals, group practices and other physician employers to: (a) adopt policies that prohibit harassment, discrimination and retaliation; (b) provide anti-harassment training; and (c) prescribe disciplinary and/or corrective action should violation of such policies occur.
Citation: BOT Rep. 27, A-19

AMA Principles for Physician Employment H-225.950
1. Addressing Conflicts of Interest
a) A physician's paramount responsibility is to his or her patients. Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address.
b) Employed physicians should be free to exercise their personal and professional judgement in voting, speaking and advocating on any manner regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests. Employed physicians also should enjoy academic freedom to pursue clinical research and other academic pursuits within the ethical principles of the medical profession and the guidelines of the organization.
c) In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.
d) Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients.
(i) No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to his/her religious beliefs or moral convictions; and
(ii) No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because he/she either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates his/her religious beliefs or moral convictions.
e) Assuming a title or position that may remove a physician from direct patient-physician relationships--such as medical director, vice president for medical affairs, etc.--does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.
Refer to the AMA Code of Medical Ethics for further guidance on conflicts of interest.
2. Advocacy for Patients and the Profession
a) Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated.

b) Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.

3. Contracting

a) Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession.

b) Physicians should never be coerced into employment with hospitals, health care systems, medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.

c) When a physician's compensation is related to the revenue he or she generates, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based.

d) Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under his/her care. When a physician's employment status is unilaterally terminated by an employer, the physician and his or her employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in his or her new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of his or her patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician.

(e) Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. When such cause relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff, the physician should be afforded full due process under the medical staff bylaws, and the agreement should not be terminated before the governing body has acted on the recommendation of the medical staff. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges. When such cause is non-clinical or not otherwise a concern of the medical staff, the physician should be afforded whatever due process is outlined in the employer's human resources policies and procedures.

(f) Physicians are encouraged to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions. Employers should never terminate agreements without cause when the underlying reason for the termination relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff.

(g) Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment.

(h) Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved.

Refer to the AMA Annotated Model Physician-Hospital Employment Agreement and the AMA Annotated Model Physician-Group Practice Employment Agreement for further guidance on physician employment contracts.

4. Hospital Medical Staff Relations

a) Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs.

b) Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes.

c) Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.

d) Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.

Refer to the AMA Conflict of Interest Guidelines for the Organized Medical Staff for further guidance on the relationship between employed physicians and the medical staff organization.

5. Peer Review and Performance Evaluations

a) All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings.

b) Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status.

c) Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians--not lay administrators--should be ultimately responsible for all peer review of medical services provided by employed physicians.

d) Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician's independent exercise of medical judgment.

e) Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc.

(f) Upon termination of employment with or without cause, an employed physician generally should not be required to resign his or her hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws. Automatic rescission of medical staff membership and/or clinical privileges following termination of an employment agreement is tolerable only if each of the following conditions is met:

i. The agreement is for the provision of services on an exclusive basis; and

ii. Prior to the termination of the exclusive contract, the medical staff holds a hearing, as defined by the medical staff and hospital, to permit interested parties to express their views on the matter, with the medical staff subsequently making a recommendation to the governing body as

to whether the contract should be terminated, as outlined in AMA Policy H-225.985; and
iii. The agreement explicitly states that medical staff membership and/or clinical privileges must be resigned upon termination of the agreement.
Refer to the AMA Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations (AMA Policy H-375.965) for further guidance on peer review.

6. Payment Agreements

a) Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.

b) Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.

Our AMA will disseminate the AMA Principles for Physician Employment to graduating residents and fellows and will advocate for adoption of these Principles by organizations of physician employers such as, but not limited to, the American Hospital Association and Medical Group Management Association.

Citation: BOT Rep. 6, I-12; Reaffirmed: CMS Rep. 6, I-13; Modified in lieu of Res. 2, I-13; Modified: Res. 737, A-14; Reaffirmed: BOT Rep. 21, A-16; Reaffirmed: CMS Rep. 05, A-17; Reaffirmed: CMS Rep. 07, A-19; Reaffirmed: CMS Rep. 11, A-19; Modified: BOT Rep. 13, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 018
(N-21)

Introduced by: Resident and Fellow Section, Medical Student Section

Subject: Support for Safe and Equitable Access to Voting

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, Universal vote-by-mail, also known as voting absentee, allows eligible citizens and
2 residents to vote by mail[1]; and
3
4 Whereas, Sixteen states require eligible voters to declare a reason in order to request a ballot
5 by mail, and at least five (Indiana, Louisiana, Mississippi, Tennessee, and Texas) do not accept
6 risk or fear of COVID-19 infection as a valid reason[2-4]; and
7
8 Whereas, COVID-19 is a novel, easily-transmissible viral respiratory disease that since January
9 2020 has been contracted by 6.7 million Americans and has been linked with the deaths of over
10 198,000[5-6]; and
11
12 Whereas, Risk factors for severe COVID-19 disease are common in the US, such as smoking,
13 with a prevalence of 14% of adults in 2018[7]; obesity, with a prevalence of 42% of adults in
14 2017-2018[8]; and diabetes with a prevalence of 10% of adults in 2018[9]; and
15
16 Whereas, Public health experts continue to warn governments and the public to prepare for
17 future pandemics which may arise similarly to the COVID-19 pandemic[10-12]; and
18
19 Whereas, A study of the 2020 Wisconsin primaries found "a statistically and economically
20 significant association between in-person voting and the spread of COVID-19 two to three
21 weeks after the election"[13]; and
22
23 Whereas, The COVID-19 pandemic is likely to be playing a role in voter suppression, with
24 reductions in new voter registrations by as much as 70% due to Department of Motor Vehicle
25 closures, limited in-person interactions, and the cancellation of many large public gatherings[14];
26 and
27
28 Whereas, Many previous poll workers declined to serve in the 2020 primary elections due to
29 fear of contracting severe COVID-19, and ultimately there were far fewer polling locations and
30 longer waiting times in the 2020 primaries[15-17]; and
31
32 Whereas, Following widespread adoption of community mitigation measures to target SARS-
33 CoV-2, influenza rates among sentinel countries in the southern hemisphere have been
34 dramatically lower than historical averages during their peak influenza season[18], suggesting the
35 continuance of such measures past the COVID-19 pandemic could contribute to a reduction in
36 the incidence of influenza; and
37
38 Whereas, 1 in 4 American adults, and 2 in 5 adults over the age of 65 live with a disability[19]; and

Whereas, In the 2016 general election, the US Government Accountability Office found that 60% of the polling places evaluated were inaccessible to voters with disabilities, resulting in unsafe or insecure conditions for these voters[20]; and

Whereas, Voters with disabilities are more likely to vote by mail, and implementing no-excuse absentee balloting and permanent absentee voting increases voter turnout among citizens with disabilities[21]; and

Whereas, A 2013 survey found 2.7% of Americans self-report as immunosuppressed, a figure that likely has increased in the years since given greater life expectancy among immunosuppressed adults due to advancements in medical management and new indications for immunosuppressive treatments[22]; and

Whereas, Universal vote-by-mail does not favor either major party's voter turnout or vote share[23]; and

Whereas, Vote-by-mail is already a commonly-used option amongst voters, with approximately 23.1% of all votes cast in the 2018 general election having been by mail[24]; and

Whereas, Members of the military have voted-by-mail in some form since the Civil War, and citizens living abroad also submit their ballots by mail[25-27]; and

Whereas, Universal vote-by-mail does not depress voter turnout, but rather moderately increases overall average turnout rates, in line with previous estimates[23]; and

Whereas, Numerous national and local government officials have expressed opposition to expanding eligibility to vote-by-mail despite the ongoing risk of COVID-19 infection[24,28-32]; and

Whereas, There is no demonstrated increased risk of election fraud via vote-by-mail, with one study finding only 0.0025% of votes being flagged as possible cases of election fraud in the 2016 and 2018 general elections[33]; and

Whereas, Our AMA recognized the severity of the COVID-19 pandemic, and chose to cancel the in-person proceedings of the 2020 Interim Meeting while preserving the voting process through transition to an innovative virtual format[34]; and

Whereas, While the 2020 General Election ends on November 03, COVID-19 exposure will continue to be an urgent risk for voters and poll workers in subsequent elections like federal runoff elections conducted in Georgia and Louisiana and local elections conducted in Spring 2021[35-38]; therefore be it

RESOLVED, That our AMA 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 (New HOD Policy);
and be it further

1 RESOLVED, That our AMA oppose requirements for voters to stipulate a reason in order
2 to receive a ballot by mail and other constraints for eligible voters to vote-by-mail. (New
3 HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 10/12/21

AUTHORS STATEMENT OF PRIORITY

The AMA missed an opportunity to have a more significant voice during the last special election and continues to be left out of the important discussion regarding voting as a right, the challenges associated with in-person voting, and its contribution to the social determinants of health. Discussion of this resolution is timely for state and local elections and, if we are to be prepared for 2022, we must pass this now to give our Board and staff time to strategize. The asks are appropriately narrow in scope, pertinent, and relevant to the large majority of our patients and colleagues.

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RELEVANT AMA POLICY

H-440.892 Bolstering Public Health Preparedness

Our AMA: (1) supports the concept that enhancement of surveillance, response, and leadership capabilities of state and local public health agencies be specifically targeted as among our nation's highest priorities; (2) supports, in principle, the funding of research into the determinants of quality performance by public health agencies, including but not limited to the roles of Boards of Health and how they can most effectively help meet community needs for public health leadership, public health programming, and response to public health emergencies; (3) encourages hospitals and other entities that collect patient encounter data to

report syndromic (i.e., symptoms that appear together and characterize a disease or medical condition) data to public health departments in order to facilitate syndromic surveillance, assess risks of local populations for disease, and develop comprehensive plans with stakeholders to enact actions for mitigation, preparedness, response, and recovery; (4) supports flexible funding in public health for unexpected infectious disease to improve timely response to emerging outbreaks and build public health infrastructure at the local level with attention to medically underserved areas; and (5) encourages health departments to develop public health messaging to provide education on unexpected infectious disease.
Sub. Res. 407, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Appended: Res. 912, I-19.

H-65.971 Mental Illness and the Right to Vote
Our AMA will advocate for the repeal of laws that deny persons with mental illness the right to vote based on membership in a class based on illness.
Res. 202, A-10; Reaffirmed: BOT Rep. 04, A-20.

H-295.953 Medical Student, Resident and Fellow Legislative Awareness
1. The AMA strongly encourages the state medical associations to work in conjunction with medical schools to implement programs to educate medical students concerning legislative issues facing physicians and medical students.
2. Our AMA will advocate that political science classes which facilitate understanding of the legislative process be offered as an elective option in the medical school curriculum.
3. Our AMA will establish health policy and advocacy elective rotations based in Washington, DC for medical students, residents, and fellows.
4. Our AMA will support and encourage institutional, state, and specialty organizations to offer health policy and advocacy opportunities for medical students, residents, and fellows.
Res. 14, A-91; Reaffirmed: Sunset Report, I-01; Appended: Res. 317, A-10; Appended: Res. 307, A-15

G-615.103 Improving Medical Student, Resident/Fellow and Academic Physician Engagement in Organized Medicine and Legislative Advocacy
Our AMA will: (1) study the participation of academic and teaching physicians, residents, fellows, and medical students in organized medicine and legislative advocacy; (2) study the participation of community-based faculty members of medical schools and graduate medical education programs in organized medicine and legislative advocacy; and (3) identify successful, innovative and best practices to engage academic physicians (including community-based physicians), residents/fellows, and medical students in organized medicine and legislative advocacy.
Res. 608, A-17

The Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession and the Community H-285.910
Our AMA endorses the following clause guaranteeing physician independence and recommends it for insertion into physician employment agreements and independent contractor agreements for physician services:
Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession, and the Community
In caring for patients and in all matters related to this Agreement, Physician shall have the unfettered right to exercise his/her independent professional judgment and be guided by his/her personal and professional beliefs as to what is in the best interests of patients, the profession, and the community. Nothing in this Agreement shall prevent or limit Physician's right or ability to advocate on behalf of patients' interests or on behalf of good patient care, or to exercise his/her own medical judgment. Physician shall not be deemed in breach of this Agreement, nor may

Employer retaliate in any way, including but not limited to termination of this Agreement, commencement of any disciplinary action, or any other adverse action against Physician directly or indirectly, based on Physician's exercise of his/her rights under this paragraph.
Citation: Res. 8, A-11; Reaffirmed: CEJA Rep. 1, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 019
(N-21)

Introduced by: Resident and Fellow Section

Subject: Disaggregation of Demographic Data for Individuals of Middle Eastern and North African (MENA) Descent

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, The American Association of Physical Anthropologists believes that "race does not
2 have its roots in biological reality, but…has become a social reality that structures societies and
3 how we experience the world. In this regard, race is real, as is racism, and both have real
4 biological consequences ";[1] and
5
6 Whereas, People of Middle Eastern and North African (MENA) descent are not recognized as
7 belonging to a unique, independent racial category in the U.S. Census data, and instead they
8 are aggregated under "White";[2] and
9
10 Whereas, MENA designation is not included in the National Institute of Health's racial and ethnic
11 categories, and thus is not required to be considered in any federally-funded research;[3] and
12
13 Whereas, MENA is not included as a race category nor an ethnicity category routinely collected
14 in survey and demographic data in the U.S.;[4,5] and
15
16 Whereas, There are discrepancies in the total population of MENA populations across the US
17 due to inaccurate identification and aggregation; [2,5] and
18
19 Whereas, There is limited research about the healthcare of populations from the MENA region
20 in U.S. epidemiological and public health literature and existing literature is focused on ethnic
21 enclaves which may not be reflective of the community as a whole;[4,6] and
22
23 Whereas, Americans of MENA descent disproportionately constitute immigrants from the past
24 two decades, share a set of cultural norms, and face recent marginalization and discrimination
25 towards this population;[4,5,7] and
26
27 Whereas, MENA populations have different risk factors and social determinants including high
28 rates of immigration and individuals seeking asylum;[6,8,9] and
29
30 Whereas, To the knowledge of the authors there has never been a prospective study examining
31 the health needs of MENA communities in the U.S.;[4] and
32
33 Whereas, Genetic disorders and familial inherited cancers occur at a higher frequency in some
34 MENA populations due to higher rates of consanguineous marriages, most commonly with first
35 cousins;[10] and
36
37 Whereas, Discrimination against MENA populations in the U.S. increased dramatically after
38 September 11th, 2001, including increased harassment, discrimination, violence, and targeted
39 hate crimes that have resulted in worsening health outcomes in this population;[6,11,12] and

Whereas, MENA populations in the US suffer from a high rate of serious psychosocial distress compared to the general population which may be in part due to their immigrant status;[13] and

Whereas, Classifying MENA populations as "White" has led to their "cultural invisibility" and perpetuates a cycle of undocumented health disparities[5] that greatly affects funding for health-related research, targeting of effective and personalized healthcare, and prevents patient-centered care and engagement;[4,5,6,10,14] and

Whereas, Including a race identifier for MENA populations on all medical records will increase the representation and visibility of the population, and increases the research and attention to the medical and public health needs of this community;[4,5,6,15] and

Whereas, Despite analysis issued by the U.S. Census Bureau in 2017 that "it is optimal to use a dedicated 'Middle Eastern or North African' response category," the Census Bureau declined to include a MENA identifier in the 2020 Census;[16] and

Whereas, The U.S. Census is used to direct federal resources, funding, and research, making it vitally important in the promotion of medicine and public health, and the Census has acknowledged that its inaccuracies in collection of race and ethnicity data act as a barrier to the Census' utility and accuracy;[17]and

Whereas, Separating the demographic identifier as MENA will allow for the disaggregation of data, in order to appropriately target research, preventive measures, and healthcare engagement; therefore be it

RESOLVED, That our American Medical Association add "Middle Eastern/North African (MENA)" as a separate racial category on all AMA demographics forms (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for the use of "Middle Eastern/North African (MENA)" as a separate race category in all uses of demographic data including but not limited to medical records, government data collection and research, and within medical education. (Directive to Take Action)

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

Received: 10/12/21

AUTHORS STATEMENT OF PRIORITY

In light of the increasing number of individuals coming to this country from the Middle East and North Africa, it is our professional responsibility to identify the specific medical concerns relevant to this disadvantaged group. The AMA has policy on disaggregation of data for other groups, including Asian-Americans and Pacific Islanders (AAPI), and this important policy would build on this foundation in order to help the AMA advocate for our patients, especially in addressing within-group health disparities.

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RELEVANT AMA POLICY

Disaggregation of Demographic Data Within Ethnic Groups H-350.954

1. Our AMA supports the disaggregation of demographic data regarding: (a) Asian-Americans and Pacific Islanders in order to reveal the within-group disparities that exist in health outcomes and representation in medicine; and (b) ethnic groups in order to reveal the within-group disparities that exist in health outcomes and representation in medicine. 2. Our AMA: (a) will advocate for restoration of webpages on the Asian American and Pacific Islander (AAPI) initiative (similar to those from prior administrations) that specifically address disaggregation of health outcomes related to AAPI data; (b) supports the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in health outcomes; (c) supports the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in representation in medicine, including but not limited to leadership positions in academic medicine; and (d) will report back at the 2020 Annual Meeting on the issue of disaggregation of data regarding AAPIs (and other ethnic subgroups) with regards to the ethnic subgroup disparities that exist in health outcomes and representation in medicine, including leadership positions in academic medicine.
Citation: Res. 001, I-17Appended: Res. 403, A-19

Accurate Collection of Preferred Language and Disaggregated Race and Ethnicity to Characterize Health Disparities H-315.963

Our AMA encourages the Office of the National Coordinator for Health Information Technology (ONC) to expand their data collection requirements, such that electronic health record (EHR) vendors include options for disaggregated coding of race, ethnicity and preferred language.
Citation: Res. 03, I-19

Accuracy in Racial, Ethnic, Lingual and Religious Designations in Medical Records H-315.996

Our AMA advocates precision without regulatory requirement or mandatory reporting of racial, ethnic, preferred language and religious designations in medical records, with information

obtained from the patient, always respecting the personal privacy and communication preferences of the patient.
Citation: Res. 4, I-83Reaffirmed: CLRPD Rep. 1, I-93Reaffirmed: CSA Rep. 8, A-05Modified: CSAPH Rep. 1, A-15Modified: Res. 03, I-19

Racism as a Public Health Threat H-65.952
1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA will identify a set of current, best practices for healthcare institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, providers, international medical graduates, and populations.
4. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
5. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
6. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.
Citation: Res. 5, I-20

Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice H-65.953
1. Our AMA recognizes that race is a social construct and is distinct from ethnicity, genetic ancestry, or biology.
2. Our AMA supports ending the practice of using race as a proxy for biology or genetics in medical education, research, and clinical practice.
3. Our AMA encourages undergraduate medical education, graduate medical education, and continuing medical education programs to recognize the harmful effects of presenting race as biology in medical education and that they work to mitigate these effects through curriculum change that: (a) demonstrates how the category “race” can influence health outcomes; (b) that supports race as a social construct and not a biological determinant and (c) presents race within a socio-ecological model of individual, community and society to explain how racism and systemic oppression result in racial health disparities.
4. Our AMA recommends that clinicians and researchers focus on genetics and biology, the experience of racism, and social determinants of health, and not race, when describing risk factors for disease.
Citation: Res. 11, I-20

Racial Essentialism in Medicine D-350.981
1. Our AMA recognizes that the false conflation of race with inherent biological or genetic traits leads to inadequate examination of true underlying disease risk factors, which exacerbates existing health inequities.

2. Our AMA encourages characterizing race as a social construct, rather than an inherent biological trait, and recognizes that when race is described as a risk factor, it is more likely to be a proxy for influences including structural racism than a proxy for genetics.
3. Our AMA will collaborate with the AAMC, AACOM, NBME, NBOME, ACGME and other appropriate stakeholders, including minority physician organizations and content experts, to identify and address aspects of medical education and board examinations which may perpetuate teachings, assessments, and practices that reinforce institutional and structural racism.
4. Our AMA will collaborate with appropriate stakeholders and content experts to develop recommendations on how to interpret or improve clinical algorithms that currently include race-based correction factors.
5. Our AMA will support research that promotes antiracist strategies to mitigate algorithmic bias in medicine.
Citation: Res. 10, I-20

Health Plan Initiatives Addressing Social Determinants of Health H-165.822
Our AMA:
1. recognizing that social determinants of health encompass more than health care, encourages new and continued partnerships among all levels of government, the private sector, philanthropic organizations, and community- and faith-based organizations to address non-medical, yet critical health needs and the underlying social determinants of health;
2. supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs;
3. encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health, including through such mechanisms as professional development and other training;
4. supports mechanisms, including the establishment of incentives, to improve the acquisition of data related to social determinants of health, while minimizing burdens on patients and physicians;
5. supports research to determine how best to integrate and finance non-medical services as part of health insurance benefit design, and the impact of covering non-medical benefits on health care and societal costs; and
6. encourages coverage pilots to test the impacts of addressing certain non-medical, yet critical health needs, for which sufficient data and evidence are not available, on health outcomes and health care costs.
Citation: CMS Rep. 7, I-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 020
(N-21)

Introduced by: Iowa

Subject: Recognizing and Remedying “Structural Urbanism” Bias as a Factor in Rural Health Disparities

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, Rural Americans’ health disparities are significant and unacceptable, with mortality
2 rates 23% higher, and preventable hospitalizations 40% higher-- across all racial and age
3 groups; and
4
5 Whereas, The differences in rural vs. urban health measures have been worsening over the last
6 30 years; and
7
8 Whereas, The percent of physicians who practice in rural areas is about 11%, despite 20% of
9 Americans living in rural America; and
10
11 Whereas, Health care research (Johnston, et al.[1]) has shown that the biggest reason for worse
12 rural mortality and preventable hospitalization rates is the shortage in “local-area supply of
13 specialists, which explained 55% of the differences in hospitalization rates and 40% of the
14 difference in mortality rates”; and
15
16 Whereas, Medicare’s physician geographic payment policy since 1992 (developed under the
17 direction of consultants from the Urban Institute) has chronically discriminated against rural
18 physicians, with the current policy adjusting rural physician E&M payments as much as 25-30%
19 lower than some urban areas, and adjusting rural diagnostic testing payments 50-60% lower
20 than some urban areas; and
21
22 Whereas, Another research group (Probst, et al.[2]) wrote that “rural health disparities are due in
23 part to declining healthcare provider availability and accessibility in rural communities” and
24 “these problems are exacerbated by structural urbanism” ... a bias which “systematically
25 shortchanges rural areas”. They also suggested that “current models of health care funding...
26 are innately biased in favor of large populations” and “until this bias is recognized, the
27 development of viable models of care across the rural-urban continuum cannot move forward”;
28 and
29
30 Whereas, In the CME report on Rural Health Physician Workforce Disparities, telehealth was
31 touted as one way to remedy rural health disparities, and the CME recognized some of the
32 telehealth barriers such as the current site of service Medicare payments. The problem is that
33 without geographic equity in telehealth payments there would be no financial incentive for urban
34 physicians to serve rural vs. urban patients, and keeping Medicare’s geographically adjusted
35 payments unchanged would give incentives for rural physicians to receive higher telehealth
36 payment for urban patients; and

Whereas, National telehealth services who serve rural and urban hospitals and physician groups do not give geographic discounts for their services, which means there is a national, not a local, “market price” for teleservices, unlike Medicare’s geographic payment policy which shortchanges rural physicians; therefore be it

RESOLVED, That our American Medical Association: (1) formally recognize that systemic bias in healthcare financing, called “Structural Urbanism,” has been a factor in leading to rural health disparities; (2) in future AMA strategic planning to reduce all of America’s health disparities, include plans to reduce/remedy the structural urbanism bias; and (3) point out, in advocating for health equity for all Americans, that Medicare payment policies have played a role in the shortage of rural physicians and the poorer health outcomes in rural America (Directive to Take Action); and be it further

RESOLVED, That our AMA, as part of our current advocacy for telehealth reform, specify that geographic payment equity be required in any telehealth legislation. (Directive to Take Action)

Fiscal note: Modest - between $1,000 - $5,000

Received: 10/11/21

AUTHORS STATEMENT OF PRIORITY

Our AMA has prioritized the identification and remediation of health disparities, and this resolution asks for action to help address a major, unacceptable disparity in health care access and outcomes, with identification of causes for the 23% higher mortality and 40% higher preventable hospitalizations that could impact 60 million rural Americans.
The resolution is also timely because the COVID-19 pandemic has highlighted the need for telehealth legislation to help improve access to care to all Americans, especially underserved rural residents. The telehealth resolution would ensure that increased access, which telehealth legislation would bring, is not a hollow promise.

References:
1. Johnston K, Wen H, Maddox KEJ. Lack of Access to Specialists Associated with Mortality and Preventable Hospitalizations of Rural Medicare Beneficiaries. Health Aff (Millwood) 2019; 38(12): 1993-2002
2. Probst J, Eberth JM, Crouch E. Structural Urbanism Contributes to Poorer Health Outcomes for Rural America. Health Aff (Millwood) 2019; 38(12): 1976-1984

RELEVANT AMA POLICY

Geographic Practice Cost Index D-400.985

Our AMA will: (1) use the AMA Physician Practice Information Survey to determine actual differences in rural vs. urban practice expenses; (2) seek Congressional authorization of a detailed study of the way rents are reflected in the Geographic Practice Cost Index (GPCI); (3) advocate that payments under physician quality improvement initiatives not be subject to existing geographic variation adjustments (i.e., GPCIs); and (4) provide annual updates on the Centers for Medicare and Medicaid Services efforts to improve the accuracy of Medicare Economic Index weights and geographic adjustments and their impact on the physician payment schedule, and AMA advocacy efforts on these issues.
Citation: (Sub. Res. 810, I-08; Reaffirmation A-09; Reaffirmed: BOT Action in response to referred for decision Res. 212, A-09; Appended: CMS Rep. 1, I-11; Reaffirmed in lieu of Res. 119, A-12 and Res. 122, A-12; Reaffirmation: I-12; Reaffirmation I-13)

Elimination of Payment Differentials Between Urban and Rural Medical Care H-240.971
Our AMA (1) supports elimination of Medicare reimbursement differentials between urban and rural medical care; and (2) supports efforts to inform the Congress of the impact of such programs on the rural population.
Citation: Res. 107, A-89; Reaffirmed: Sunset Report, A-00; Modified: CMS Rep. 6, A-10; Reaffirmed: CMS Rep. 01, A-20

Equal Pay for Equal Work D-400.989
Our AMA: (1) shall make its first legislative priority to fix the Medicare payment update problem because this is the most immediate means of increasing Medicare payments to physicians in rural states and will have the greatest impact; (2) shall seek enactment of legislation directing the General Accounting Office to develop and recommend to Congress policy options for reducing any unjustified geographic disparities in Medicare physician payment rates and improving physician recruitment and retention in underserved rural areas; and (3) shall advocate strongly to the current administration and Congress that additional funds must be put into the Medicare physician payment system and that continued budget neutrality is not an option.
Citation: BOT Rep. 14, A-02; Reaffirmation A-06; Reaffirmation I-07; Reaffirmation A-08; Reaffirmed: Sub. Res. 810, I-08; Reaffirmation A-09; Reaffirmed: BOT Action in response to referred for decision Res. 212, A-09; Reaffirmed: CMS Rep. 01, A-19

Improving Rural Health H-465.994
1. Our AMA (a) supports continued and intensified efforts to develop and implement proposals for improving rural health care, (b) urges physicians practicing in rural areas to be actively involved in these efforts, and (c) advocates widely publicizing AMA's policies and proposals for improving rural health care to the profession, other concerned groups, and the public.
2. Our AMA will work with other entities and organizations interested in public health to:
- Identify and disseminate concrete examples of administrative leadership and funding structures that support and optimize local, community-based rural public health.
- Develop an actionable advocacy plan to positively impact local, community-based rural public health including but not limited to the development of rural public health networks, training of current and future rural physicians in core public health techniques and novel funding mechanisms to support public health initiatives that are led and managed by local public health authorities.
- Study efforts to optimize rural public health.

Citation: Sub. Res. 72, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 06, A-18; Appended: Res. 433, A-19

Access to and Quality of Rural Health Care H-465.997
(1) Our AMA believes that solutions to access problems in rural areas should be developed through the efforts of voluntary local health planning groups, coordinated at the regional or state level by a similar voluntary health planning entity. Regional or statewide coordination of local efforts will not only help to remedy a particular community's problems, but will also help to avoid and, if necessary, resolve existing duplication of health care resources. (2) In addition to local solutions, our AMA believes that on a national level, the implementation of Association policy for providing the uninsured and underinsured with adequate protection against health care expense would be an effective way to help maintain and improve access to care for residents of economically depressed rural areas who lack adequate health insurance coverage. Efforts to place National Health Service Corps physicians in underserved areas of the country should also be continued.
Citation: CMS Rep. G, A-87; Modified: Sunset Report, I-97; Reaffirmation A-01; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed: CMS Rep. 1, A-21

Enhancing Rural Physician Practices H-465.981
The AMA: (1) supports legislation to extend the 10% Medicare payment bonus to physicians practicing in rural counties and other areas where the poverty rate exceeds a certain threshold, regardless of the areas's Health Professional Shortage Area (HPSA) status; (2) encourages federal and state governments to make available low interest loans and other financial assistance to assist physicians with shortage area practices in defraying their costs of compliance with requirements of the Occupational Safety and Health Administration, Americans with Disabilities Act and other national or state regulatory requirements; (3) will explore the feasibility of supporting the legislative and/or regulatory changes necessary to establish a waiver process through which shortage area practices can seek exemption from specific elements of regulatory requirements when improved access, without significant detriment to quality, will result; and (4) supports legislation that would allow shortage area physician practices to qualify as Rural Health Clinics without the need to employ one or more physician extenders.
Citation: CMS Rep. 9, A-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: CMS Rep. 01, A-16

Educational Strategies for Meeting Rural Health Physician Shortage H-465.988
1. In light of the data available from the current literature as well as ongoing studies being conducted by staff, the AMA recommends that:
A. Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents.
B. Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians.
C. Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians.
D. Our AMA encourage state and county medical societies and local medical schools to develop outreach and recruitment programs in rural counties to attract promising high school and college students to medicine and the other health professions.
E. Our AMA urge continued federal and state legislative support for funding of Area Health Education Centers (AHECs) for rural and other underserved areas.
F. Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships.
G. Our AMA support full funding of the new federal National Health Service Corps loan repayment program.
H. Our AMA encourage continued legislative support of the research studies being conducted by the Rural Health Research Centers funded by the National Office of Rural Health in the Department of Health and Human Services.
I. Our AMA continue its research investigation into the impact of educational programs on the supply of rural physicians.
J. Our AMA continue to conduct research and monitor other progress in development of educational strategies for alleviating rural physician shortages.
K. Our AMA reaffirm its support for legislation making interest payments on student debt tax deductible.
L. Our AMA encourage state and county medical societies to develop programs to enhance work opportunities and social support systems for spouses of rural practitioners.
2. Our AMA will work with state and specialty societies, medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education (ACGME), the Centers for Medicare and

Medicaid Services (CMS) and other interested stakeholders to identify, encourage and incentivize qualified rural physicians to serve as preceptors and volunteer faculty for rural rotations in residency.
3. Our AMA will: (a) work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates; and (b) work with interested stakeholders to formulate an actionable plan of advocacy with the goal of increasing residency training in rural areas.
4. Our AMA will undertake a study of issues regarding rural physician workforce shortages, including federal payment policy issues, and other causes and potential remedies (such as telehealth) to alleviate rural physician workforce shortages.
Citation: CME Rep. C, I-90; Reaffirmation A-00; Reaffirmation A-01; Reaffirmation I-01; Reaffirmed: CME Rep. 1, I-08; Reaffirmed: CEJA Rep. 06, A-18; Appended: Res. 956, I-18; Appended: Res. 318, A-19

Rural Health H-465.982
The AMA: (1) encourages state medical associations to study the relevance of managed competition proposals to meeting health care needs of their rural populations; (2) encourages state associations to work with their respective state governments to implement rural health demonstration projects; and (3) will provide all adequate resources to assist state associations in dealing with managed competition in rural areas.
Citation: (CMS Rep. H, A-93; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CMS Rep. 4, A-13)

Economic Viability of Rural Sole Community Hospitals H-465.979
Our AMA: (1) recognizes that economically viable small rural hospitals are critical to preserving patient access to high-quality care and provider sustainability in rural communities; and (2) supports the efforts of organizations advocating directly on behalf of small rural hospitals provided that the efforts are consistent with AMA policy.
Citation: (CMS Rep. 3, A-15)

Closing of Small Rural Hospitals H-465.990
Our AMA encourages legislation to reduce the financial constraints on small rural hospitals in order to improve access to health care.
Citation: (Res. 145, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10: Reaffirmed in lieu of Res. 807, I-13; Reaffirmed: CMS Rep. 3, A-15)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 021
(N-21)

Introduced by: Louisiana

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

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, On June 1, 2021, Dr. Russ Kridel, Chair, AMA Board of Trustees, issued a message to the members of the American Medical Association House of Delegates regarding certain recent events pertaining to discussion of the AMA's *Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity*; and

Whereas, As noted by Dr. Kridel, "Our House has always dealt with challenging topics with the same professionalism that we try to exhibit daily as practicing physicians". However, many at recent meetings of the AMA House, particularly those held virtually, we have witnessed some loss of professionalism in regard to comments regarding the strategic plan. Some members of our House are being personally attacked and threatened by others for their thoughts and ideas. Name calling, unsettling calls to family members, and other unprofessional communications have occurred;" and

Whereas, In light of recent deterioration in civility and professionalism in policy debate and discussion at the American Medical Association, the Louisiana Delegation to the AMA developed and submitted Late Resolution 1003 at the June meeting calling for enhanced standards of dignity, respect, tolerance and professionalism in AMA policy debate and discussions; and

Whereas, Louisiana-submitted Late Resolution 1003 was recommended for acceptance as business of the House of Delegates by the AMA HOD Committee on Rules and Credentials, and was recommended as meeting the priority threshold and recommended for acceptance as business by the AMA HOD Resolution Committee; and

Whereas, The AMA House of Delegates refused to consider Late Resolution 1003, thereby failing to address the recent deterioration in civility and professionalism characterizing AMA policy debate and discussion; therefore be it

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

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

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

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

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

Our American Medical Association unequivocally commits that the mere exposure to ideas that some may find offensive is not an act of violence or hatred;

Our American Medical Association unequivocally commits to a prohibition of the listing of people or organizations to be regarded as unacceptable, untrustworthy, excluded, or avoided based on ideological positions or differences;

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

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

Fiscal Note: Minimal - less than $1,000

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

On June 1, 2021, Russ Kridel, MD, Chair, AMA Board of Trustees, issued a message to the members of the American Medical Association House of Delegates regarding certain recent events pertaining to the *AMA's Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity, 2021–2023.* As noted by Dr. Kridel, "Our House has always dealt with challenging topics with the same professionalism that we try to exhibit daily as practicing physicians". However, many at recent meetings of the AMA House, particularly those held virtually, we have witnessed a loss of professionalism during comments regarding the Strategic Plan. Some members of our House are being personally attacked and threatened by others for their thoughts and ideas. Name calling, unsettling calls to family members, and other unprofessional communications have occurred. As the strategic plan will once again be discussed at the November 2021 meeting, the debate and hopefully the adoption of these policies and principles are paramount in order to have a professional and courteous conversation regarding the production and contents of the equity report. We believe the Speakers saw this firsthand during the June meeting.

[1] Russ Kridel, "A Communication from the Board Chair," email of June 1, 2021 (copy on file with author).

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 022
(N-21)

Introduced by: Louisiana

Subject: Prohibition of Racist Characterization Based on Personal Attributes

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, Recent events at the American Medical Association have resulted in that entity
2 publicly promulgating statements that are racially exclusive and racially characterizing, as
3 contained in the AMA *Organizational Strategic Plan to Embed Racial Justice and Advance*
4 *Health Equity*[i] (hereinafter *the Equity Strategic Plan*); and
5
6 Whereas, *The Equity Strategic Plan* endorses a racially exclusive definition of racism: Racism,
7 as defined by Camara Jones, MD, MPH, PhD, is a "system of structuring opportunity," which
8 assigns value based on race, disadvantaging people of color while offering advantage to
9 whites…. (P. 15); and
10
11 Whereas, *The Equity Strategic Plan* includes the following racially characterizing statements:
12 We must develop a critical consciousness that seeks truth and acknowledges the historical
13 realities that powerful organizations and structures, rooted in white patriarchy and affluent
14 supremacy such as the AMA, have both intentionally and unintentionally made invisible (p. 5).
15 White supremacy, constantly adapting to legal and cultural challenges, persists in part by the
16 way many whites ignore their whiteness to the point of invisibility, their role in a racial hierarchy,
17 and the privilege it gives them (p. 13). Locating white supremacy in individuals, rather than in
18 structures, is how the shared commitment to white ignorance preserves one's sense of self
19 while allowing oppressive structures to persist (p. 14); and
20
21 Whereas, Attempts by the Louisiana Delegation to the AMA to have the AMA House of
22 Delegates adopt policy, at its June 2021 Special Meeting, that prohibits racist characterization of
23 person or groups of persons based on personal attributes were unsuccessful; therefore be it
24
25 RESOLVED, That it be the policy of our American Medical Association that no person or group
26 of persons shall be considered or characterized as racist based on personal attributes of race,
27 color, religion, sex (including pregnancy, sexual orientation, or gender identity), national origin,
28 age, disability, or genetic information. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

On June 1, 2021, Russ Kridel, MD, Chair, AMA Board of Trustees, issued a message to the members of the American Medical Association House of Delegates regarding certain recent events pertaining to the *AMA's Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity, 2021–2023.* As noted by Dr. Kridel, "Our House has always dealt with challenging topics with the same professionalism that we try to exhibit daily as practicing physicians". However, many at recent meetings of the AMA House, particularly those held virtually, we have witnessed a loss of professionalism during comments regarding the Strategic Plan. Some members of our House are being personally attacked and threatened by others for their thoughts and ideas. Name calling, unsettling calls to family members, and other unprofessional communications have occurred. As the strategic plan will once again be discussed at the November 2021 meeting, the debate and hopefully the adoption of these policies and principles are paramount in order to have a professional and courteous conversation regarding the production and contents of the equity report. We believe the Speakers saw this firsthand during the June meeting.

[i] American Medical Association, *Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity,* (Chicago: American Medical Association, 2021), https://www.ama-assn.org/system/files/2021-05/ama-equity-strategic-plan.pdf.

RELEVANT AMA POLICY

Racism as a Public Health Threat H-65.952

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

Citation: Res. 5, I-20

Discrimination Against Patients by Medical Students H-295.865

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

Citation: (Res. 1, A-13)

Reference Committee A

CMS Report(s)

01 End-of-Life Care
03 Covering the Remaining Uninsured
05 Integrating Care for Individuals Dually Eligible for Medicare and Medicaid

Resolution(s)

101 Standardized Coding for Telehealth Services
102 Prevention of Hearing Loss-Associated-Cognitive-Impairment Through Earlier Recognition and Remediation
103 Oral Healthcare Is Healthcare
104 Improving Access to Vaccinations for Patients
105 Fertility Preservation Insurance Coverage for Women in Medicine
106 Reimbursement of School-Based Health Centers
107 Expanding Medicaid Transportation to Include Healthy Grocery Destinations
108 Medicaid and CHIP Coverage of Glucose Monitoring Devices for Patients with Diabetes
109 Amending D-440.985, Health Care Payment for Undocumented Persons, to Study Methods to Increase Health Care Access for Undocumented Immigrants
110 Caps on Insulin Co-Payments for Patients with Insurance
111 Addressing Healthcare Accessibility for Current and Aged-Out Youth in the Foster Care System
112 Expanding Coverage for and Access to Pulmonary Rehabilitation
113 Supporting Medicare Drug Price Negotiation
114 Medicare and Private Health Insurance for Hearing Aids
115 Bundled Payments and Medically Necessary Care
116 Recognizing the Need to Move Beyond Employer-Sponsored Health Insurance
117 Implant-Associated Anaplastic Large Cell Lymphoma
118 Expanding Site-of-Service Neutrality
119* Bundling Physician Fees with Hospital Fees
120* COBRA for College Students
121* Medicaid Tax Benefits
122* Increase Funding, Research and Education for Post-Intensive Care Syndrome

* Contained in the Handbook Addendum

REPORT 1 OF THE COUNCIL ON MEDICAL SERVICE (NOV-21)
End-of-Life Care
(Resolution 101-Nov-20)
(Reference Committee A)

EXECUTIVE SUMMARY

Referred Resolution 101-Nov-20, "End of Life Care Payment," raised concerns regarding patients who may benefit from custodial nursing care at the end of their lives but are prohibited under current Medicare rules from electing skilled nursing facility (SNF) and hospice benefits at the same time for the same condition. Except under very limited circumstances, Medicare's hospice benefit does not pay for room and board for its enrollees in nursing, skilled nursing, or assisted living facilities. People who pay out of pocket for stays at these facilities may elect hospice if qualified, and if there is an agreement between the facility and a hospice. However, patients using Medicare's SNF benefit post-hospitalization typically cannot elect hospice under current program rules. Research has suggested that of the large numbers of Medicare patients enrolled in the SNF benefit at the end of their lives, many would have elected hospice if they had not needed room and board coverage.

In line with polls showing that most people would prefer to die at home, most Medicare hospice services are provided at patients' residences. The Council recognizes that there is an ongoing need for supportive care and assistance with activities of daily living services among many end-of-life patients and the importance of discharging these patients to appropriate settings—preferably where the patient resides—with necessary, affordable supports. The Council believes that hospice is well-suited to provide supportive care services as part of routine home care, as needed (since it already does so), and that the provision of such services as determined by patient need may improve quality of life and prevent utilization of higher intensity care. Accordingly, the Council recommends supporting Medicare coverage of and payment for supportive care services, including assistance with activities of daily living, as needed, under the hospice benefit.

The Council believes the costs and benefits of care models incorporating elements of SNF and hospice are worthy of further study and recommends support for study and pilot testing by the Centers for Medicare & Medicaid Services of care models that allow concurrent use of Medicare's hospice and SNF benefits. Because the Council expects that many Medicare patients will continue to be discharged to SNFs in the last months of life, it also recommends supporting increased access to palliative care services in that setting.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-N-21

Subject: End-of-Life Care
(Resolution 101-Nov-20)

Presented by: Asa C. Lockhart, MD, MBA, Chair

Referred to: Reference Committee A

At the November 2020 Special Meeting, the House of Delegates referred Resolution 101, "End of Life Care Payment," which was sponsored by the New York Delegation. Resolution 101-Nov-20 directed the American Medical Association (AMA) to petition the Centers for Medicare & Medicaid Services (CMS) to allow hospice patients to cover the cost of housing (room and board) as a patient in a nursing home or assisted living facility, and to advocate that patients be allowed to use their skilled nursing home benefit while receiving hospice services. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates. This report provides overviews of Medicare's hospice and skilled nursing benefits, differentiates between hospice and palliative care, summarizes AMA policy and makes policy recommendations.

BACKGROUND

Except under very limited circumstances, Medicare's hospice benefit does not pay for room and board for its enrollees including those in nursing, skilled nursing, or assisted living facilities, where many Medicare enrollees spend the end of their lives. People who pay out of pocket for stays at these facilities may elect hospice if qualified, and if there is an agreement between the facility and a hospice.[1] Medicaid pays for room and board for its dually eligible enrollees who qualify for hospice if the facility has an agreement with a hospice. However, patients using Medicare's skilled nursing facility (SNF) benefit post-hospitalization typically cannot elect hospice under current program rules. An exception would be for patients enrolled in hospice who need skilled care for a condition unrelated to their terminal illness. For example, if a cancer patient in hospice falls and breaks a hip, Medicare may pay for care in a SNF that the patient needs to recover from the hip injury.[2]

Post-acute care services, including skilled nursing and rehabilitation, are commonly used by Medicare patients in the last months of life. Nearly one quarter of hospitalized Medicare patients are discharged from a hospital to a facility, usually a SNF, for post-acute care.[3] Because Medicare typically does not pay for concurrent coverage of hospice services and SNF care, some patients who could benefit from hospice instead elect Medicare's SNF benefit so that their room and board costs are paid for. It is a common challenge at hospital discharge to find post-acute placements for seriously ill patients who may have limited life expectancies, require more care and assistance than can be provided at home, and cannot afford the costs of nursing care or stays at a long-term care facility out of pocket. Because Medicare covers room and board under the SNF benefit, this can become the preferred option for patients deemed eligible for the benefit, even though SNFs are designed to provide rehabilitative, not palliative, care and some SNF services may not be consistent with appropriate end-of-life care.

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A frequently cited study from 2012 found that one-third of Medicare patients received SNF care during the last six months of life and nine percent died in a SNF, many within 30 days of admission.[4] More recent Centers for Disease Control and Prevention data reveal that, in 2016, nearly 30 percent of decedents 65 and over died at home, 28 percent died in the hospital, another 25 percent died in a facility that provides patient care (e.g., a nursing home, SNF, or long-term care facility), and 8.5 percent died in a hospice facility.[5] Research has suggested that of the large numbers of patients enrolled in the SNF benefit at the end of their lives, many would have elected hospice if they had not needed room and board coverage.[6] A 2018 *Health Affairs* blog describes this conundrum as follows:

> Either you get to receive restorative care in a nursing facility or end-of-life care at home. Unfortunately, this approach fails to meet the needs of real-world patients and families. If our current model persists, we will continue to cause patients and families to fall into a gap at some of the most tender moments in their family life cycle.[7]

Patients at the end of life who are too sick to benefit from skilled care, but are unable to return home, often remain hospitalized until death because there is no appropriate, affordable community placement available. Patients who need around-the-clock nursing care often end up in nursing facilities, including SNFs. Some Medicare enrollees cycle between hospital stays and nursing facilities in the last months of life, even when rehabilitation is unlikely to be successful. Many end-of-life patients remain at home with family members who become responsible for providing the care they need, including assistance with activities of daily living (ADL) services.

Medicare's Skilled Nursing Facility Benefit

Covered SNF services include post-hospital extended care services for which benefits are provided under Medicare Part A and include nursing care; bed and board in connection with furnishing of such nursing care; physical or occupational therapy and/or speech-language pathology services; medical social services; drugs, biologicals, supplies, appliances, and equipment; and other services necessary to the health of the patients.[8] Medicare does not cover SNF services for patients who only need custodial services (e.g., assistance with ADL such as bathing and dressing) but not skilled nursing benefits.

Medicare will cover skilled nursing under the SNF benefit if patients have a qualifying three-day hospital stay and documented daily skilled care needs, although CMS waived SNF three-day stay and discharge requirements during the public health emergency so that hospitals could focus on COVID-19 care. Care in a SNF is generally covered if it is documented that the patient requires daily skilled services that must be performed by or under the supervision of a professional and can only be provided to an inpatient at a SNF. Services must be reasonable and necessary for the treatment of a patient's illness or injury and consistent with the individual's medical needs and medical practice standards. According to the Medicare benefits manual, coverage does not depend on the patient's potential for improvement from the nursing care and/or therapy, but rather on the patient's need for skilled care.[9] Nonetheless, patients need to be able to participate in daily therapy services to be eligible for the SNF benefit and some seriously ill patients receiving hospice care cannot do so.

Medicare will cover up to 100 days of SNF care but only pays 100 percent of the costs for the first 20 days. At day 21, patients must begin paying a copay ($185.50 per day in 2021) through day 100 of a covered stay.[10] SNF services are costly; in 2019, Medicare's median payment per day was $498 and its median payment per stay was $18,559. Medicare spending on SNF services in 2019—when almost 1.5 million Medicare patients used the SNF benefit—was $27.8 billion.[11] In addition

to providing post-acute care, most SNFs are also certified to provide long-term care (nursing home care) that is not covered by Medicare.

Medicare's Hospice Benefit

More than 1.6 million Medicare patients received hospice services in 2019 at a total cost of $20.9 billion.[12] Medicare spending on hospice has increased substantially in recent years and was $15.1 billion in 2014, a figure cited by the Council in its most recent report on the program (Council on Medical Service Report 4-I-16, Concurrent Hospice and Curative Care). The literature on hospice costs to the Medicare program has been mixed, with some studies showing cost savings among hospice patients who are in the last one or two months of life. A MedPAC-commissioned analysis suggests that hospice produces savings for some patients, including cancer patients, but has not decreased net Medicare spending.[13]

The hospice benefit was introduced to the Medicare program in 1983 to provide a range of palliative and support services provided primarily in the home. To be eligible to elect hospice care under Medicare, patients must be certified as having a life expectancy of six months or less if the terminal illness runs its normal course; patients can be recertified for additional periods if they remain terminal.[14] Room and board costs in a nursing facility are not covered unless the patient qualifies for a short inpatient hospice or a respite stay. Covered hospice services include nursing care, medical social services, physician services, counseling and bereavement services, medical equipment and supplies (including prescription drugs), and other services included in a patient's individualized care plan. Skilled therapy services, such as physical, speech and occupational therapy are covered if they are deemed reasonable and necessary to manage symptoms or help maintain patient functioning. Under the supervision of a hospice nurse, hospice aides may provide personal care and some homemaker services that are deemed necessary to maintain a safe and sanitary environment in areas of the home used by the patient.[15]

Medicare pays for hospice care using per diem payment categories encompassing four levels of care: (1) routine home care, for which Medicare pays $199 per day for the first 60 days and $157 per day thereafter; (2) general inpatient care, paid $1,046 per day; (3) continuous home care, paid at a rate of $60 per hour; and (4) inpatient respite care, for which Medicare pays $461 per day (payment rates are for fiscal year 2021).[16] General inpatient care is provided around the clock in an inpatient facility (e.g., a hospice inpatient unit or SNF), usually for pain or symptom control which cannot be managed in other settings. It is intended to be short-term and, once symptoms stabilize, patients may be returned to their residences. Continuous home care consists mainly of nursing care provided on a continuous basis; this level of care is available only during brief periods of crisis and as needed to maintain the patient at home.[17] Inpatient respite care is provided in an approved facility on a short-term basis for respite. Service intensity add-on payments are made when hospice provides direct patient care by a registered nurse or social worker during patients' last seven days of life.

When Congress established Medicare's hospice benefit, it established two caps on payments to hospices—known as the inpatient cap and the aggregate cap—to ensure that hospice costs do not exceed the costs of conventional care. The inpatient cap limits the share of general and respite inpatient days that a hospice can provide to 20 percent of its total patient care days. Although this cap is rarely exceeded, the aggregate cap, which limits total aggregate payments any individual hospice can receive in a year ($30,684 in 2021), is exceeded by an estimated 16 percent of all hospices.[18]

Hospice use among Medicare enrollees has been incrementally increasing in recent years, such that 51.6 percent of enrollees who died in 2019 had used hospice services, up from 25 percent in 2000.[19] In 2018, a majority of hospice care days were provided at private residences, followed by assisted living facilities and nursing facilities, including SNFs.[20] Most care provided by hospice is routine home care, which accounted for 98 percent of Medicare-covered hospice days in 2019[21] and is in line with polls showing that seven in ten people would prefer to die at home.[22] Hospices vary and, even within the routine home level of care, the frequency and type of hospice visits and type and intensity of services may differ by patient and across hospices. While more people are turning to hospice at the end of life, families and the caregivers they hire provide much of the care and assistance with ADL services that home hospice patients often require.

Palliative Care

Palliative medicine focuses on reducing suffering, improving a patient's quality of life, and supporting patients with serious illness and their families. Palliative care can be provided alongside other medical treatments regardless of whether the patient can be cured and can be initiated early in one's disease course. Hospice is a type of palliative care for people who likely have six or fewer months to live and are willing to forego curative treatments for their terminal illness. Not all palliative care is hospice, although hospice care is always palliative.

The philosophies underlying hospice and palliative care are similar; however, care location, timing and eligibility often differ. At its core, palliative care is designed to assess, prevent and manage physical and psychological symptoms, address spiritual concerns, and focus on communications that establish patient goals of care and assist patients with medical decision-making about treatment options. Whereas hospice care is most commonly provided to patients in their homes, long-term care facilities, or wherever patients reside, non-hospice palliative care is frequently provided in hospitals or community settings such as cancer centers, clinics and nursing homes. Patients can receive palliative care while continuing curative treatment at any stage of their illnesses, and many studies have shown that early palliative care interventions improve quality of life and increase patient and family satisfaction. As suggested by Policy H-85.951, it is important for physicians to be familiar with hospice and palliative care resources and their benefit structures, as well as clinical practice guidelines developed by national medical specialty societies, and to refer seriously ill patients accordingly.

Medicare Advantage Plans and Hospice

Traditional Medicare has historically covered services related to a terminal illness under the hospice benefit even for patients enrolled in Medicare Advantage (MA) plans, meaning that fee-for-service Medicare has generally been responsible for coverage of most services while the MA plan is responsible for certain supplemental benefits. In 2021, CMS began testing the inclusion of hospice within the MA benefits package through the hospice component of the Value-Based Insurance Design (VBID) Model.[23] MA plans participating in the demonstration are permitted to offer palliative care as well as supplemental benefits such as meals, transportation, and in-home supports. The demonstration has started small; for example, Humana is offering the hospice benefit to enrollees in a handful of metropolitan areas. Humana's benefit allows transitional concurrent care and offers in-home respite care.[24]

Disparities in End-of-Life Care

Despite increases in the use of both hospice and palliative services in this country, racial disparities in end-of-life care persist, and communities of color remain underserved. Black and Latino people

are more likely to die in a hospital and be treated more intensively at the end of life than Whites.[25] Black Americans are less likely to utilize hospice than Whites and have more emergency department visits and hospitalizations in the last six months of life.[26] While some have posited that differences in trust of health systems and patient preferences contribute to existing disparities,[27] more research and efforts to understand and reduce these disparities, and address cultural competence in end-of-life care, are needed.

RELEVANT AMA POLICY

The AMA has long supported the goals of hospice and palliative care. Policy H-70.915 supports improved payments for health care practices caring for dying patients and encourages research into the needs of dying patients and how they could be better served by the health care system. Policy H-85.951, which was established through Council Report 4-I-16, (1) supports continued study and pilot testing by CMS of a variety of models for providing and paying for concurrent hospice, palliative and curative care; (2) encourages CMS to identify ways to optimize patient access to palliative care, and to provide appropriate coverage and payment for these services; and (3) encourages physicians to be familiar with local hospice and palliative care resources and their benefit structures and to refer seriously ill patients accordingly.

Policy H-85.966 maintains that the use of hospice should provide the patient and family with appropriate support, but not preclude or prevent the use of appropriate palliative therapies to continue to treat the underlying disease. Policy H-85.955 approves of the physician-directed hospice concept to enable the terminally ill to die in a more homelike environment; supports changes to the Medicaid program to allow provision of concurrent life-prolonging and palliative care; and supports broadening eligibility beyond six-month prognoses under Medicaid and Medicare hospice benefits. Policy D-155.995 supports greater evaluation of the use of disease management, case management, pay-for-performance, and end-of-life care programs for high-cost patients.

The AMA also has substantial policy on long-term care (LTC), including the financing of long-term services and supports (Policy H-280.945). Policy H-280.991 states that programs to finance LTC should cover needed services in a timely, coordinated manner in the least restrictive setting appropriate to the health care needs of the individual, and coordinate benefits across different LTC financing programs. Policy H-210.994 similarly supports the provision of LTC services in the least restrictive setting by affirming support of home health care as an alternative to nursing home or institutional care.

Policy H-290.982 supports: increasing public and private investments in home and community-based care, such as adult day care, assisted living facilities, congregate living facilities, and respite care; allowing states to use long-term care eligibility criteria that distinguish between persons who can be served in a home or community-based setting and those who can only be served safely and cost-effectively in a nursing facility; buy-ins for home and community-based care for persons with incomes and assets above Medicaid eligibility limits; and providing grants to states to develop new LTC infrastructures and to encourage expansion of LTC financing to middle-income families who need assistance.

Policy D-280.985 directs the AMA to work to identify additional mechanisms by which patients' out-of-pocket costs for SNF care can be fairly covered. Under Policy H-280.947, the AMA continues to advocate for elimination of the three-day stay rule and requirements related to inpatient hospitalization as a prerequisite before Medicare patients are eligible for SNF or LTC placement.

DISCUSSION

The 2015 Institute of Medicine (IOM) report, *Dying in America*, found that "significant problems remain in providing end-of-life care for Americans that is high quality and compassionate and preserves their choice while being affordable and sustainable."[28] The IOM report further highlighted the need for policy changes to support high-quality end-of-life care by stating:

> A major reorientation and restructuring of Medicare, Medicaid, and other health care delivery programs is needed to craft a system of care designed to ensure quality and address the central needs of all people nearing the end of life and their families. Current financial incentives and a lack of more appropriate alternatives drive a reliance on the riskiest and most costly care settings. These incentives should be changed, and positive alternatives should be further developed.
>
> In addition, many of the most urgent needs of these patients and their families are not medical per se and require the design and implementation of affordable support service programs that rigorously target the highest-risk patients and families, and tailor services to specific family needs as they evolve over time.[29]

The sentiment of the IOM report is relevant to the concerns raised by referred Resolution 101-Nov-20 regarding end-of-life care, for patients who may benefit from custodial nursing care but are prohibited under current rules from electing Medicare's SNF and hospice benefits at the same time for the same condition. The Council's work on long-term services and supports and home and community-based services has highlighted the challenges of caring for our aging population and identifying affordable and politically viable solutions that meet the care needs of many seniors. Council on Medical Service Report 4, which is also being considered at this meeting, recommends new AMA policy on the hospital at home model, which we believe could benefit some patients at the end of life.

Medicare's hospice benefit helps large numbers of patients and families, but it does not cover room and board for more than a small number of enrollees who qualify for short-term inpatient hospice, or a brief respite stay. Continuous home care that includes nursing and supportive care in one's residence is allowable under Medicare's hospice benefit but only during brief periods of crisis. Although routine home care makes up 98 percent of Medicare-covered hospice days, it is critical that general inpatient care, continuous home care, and respite inpatient care are available to hospice patients as their conditions change and their needs evolve.

The Council recognizes the ongoing need for custodial or continuous care, and ADL services, among many end-of-life patients and the importance of discharging these patients to appropriate settings—preferably where the patient resides—with necessary, affordable supports. The Council believes that hospice is well-suited to provide supportive care services as part of routine home care, as needed (since it already does so), and that the provision of such services as determined by patient need may improve quality of life and prevent utilization of higher intensity care. Accordingly, the Council recommends supporting Medicare coverage of and payment for supportive care services, including assistance with activities of daily living, as needed, under the hospice benefit.

The Council recognizes that a new room and board coverage benefit for hospice enrollees could significantly add to the costs of Medicare, a program already making headlines for its trust fund sustainability issues. The Council further recognizes that Medicare's SNF and hospice benefits were not designed to work in tandem and differ in many respects, including their mission and

goals, eligibility criteria, and duration of allowable services. SNFs are intended to provide rehabilitative—not palliative—services, some of which may not be needed at the end of life. Despite these differences, some similar services are provided by both SNFs and hospices, including skilled nursing, nursing aides, equipment, supplies and prescription drugs. A concurrent model would need to be carefully designed to prevent duplication of services, ensure administrative coordination and proper payment, and address site-neutral care. Although the Council does not recommend concurrent hospice and SNF care under the Medicare program, we believe the costs and benefits of care models incorporating elements of SNF and hospice are worthy of further study, especially given that COVID-19 may have impacted location preferences of hospice services. Accordingly, the Council recommends support for study and pilot testing by CMS of care models that allow concurrent use of Medicare's hospice and SNF benefits.

Because of financial incentives and coverage gaps within Medicare, the Council expects that many patients will continue to be discharged to SNFs in the last months of life, and some will die there, especially as the elderly population grows and the SNF benefit continues to be utilized for its room and board coverage. Consistent with AMA policy supportive of coverage and payment for palliative care, the Council recommends supporting increased access to palliative care services by Medicare patients in SNF. Finally, the Council acknowledges the breadth of existing AMA policy on hospice, palliative, and end-of-life care, and recommends reaffirmation of Policies H-85.966 and H-70.915.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 101-Nov-20, and that the remainder of the report be filed:

1. That our American Medical Association (AMA) support Medicare coverage of and appropriate payment for supportive care services, including assistance with activities of daily living, as needed, under Medicare's hospice benefit. (New HOD Policy)

2. That our AMA support study and pilot testing by the Centers for Medicare & Medicaid Services of care models that allow concurrent use of Medicare's hospice and skilled nursing facility (SNF) benefits for the same condition. (New HOD Policy)

3. That our AMA support increased access to palliative care services by Medicare patients in skilled nursing facilities. (New HOD Policy)

4. That our AMA reaffirm Policy H-85.966, which maintains that hospice care should provide the patient and family with appropriate physical and emotional support, but not preclude the use of appropriate palliative therapies to continue to treat underlying disease. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-70.915, which recognizes the importance of palliative care, encourages the education of health professionals and the public in caring for dying patients, and supports improved payment for health care practices that are important to good care of the dying patient. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

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REPORT 3 OF THE COUNCIL ON MEDICAL SERVICE (NOV-21)
Covering the Remaining Uninsured
(Resolution 123-J-21)
(Reference Committee A)

EXECUTIVE SUMMARY

With the enactment of the most recent COVID-19 relief bill, the American Rescue Plan Act of 2021 (ARPA), into law, the coverage dynamics in the US have shifted. The Council analyzed the remaining uninsured post-ARPA to assess whether new American Medical Association (AMA) policy is needed targeting select segments of the remaining uninsured. After reviewing AMA policy as well as health reform legislation and regulation at the state and federal levels, the Council sees an opportunity to further maximize coverage rates and improve affordability under the AMA proposal for reform by either amending existing policy, or establishing new policy, impacting the uninsured ineligible for Affordable Care Act (ACA) financial assistance due to falling into the coverage gap, immigration status, or having an "affordable" offer of employer coverage.

The Council is highly concerned about the more than two million uninsured who fall into ACA's coverage gap. With policy alternatives emerging to cover this segment of the uninsured, ranging from making them eligible for premium tax credits and cost-sharing reductions to purchase marketplace coverage, to establishing a standalone federal Medicaid-like program or other public option, the Council recommends new policy to advocate that any approach to cover the uninsured who fall into the coverage gap ensure this population has access to affordable, quality coverage, and protect against current expansion states from dropping their Medicaid expansions.

Addressing the uninsured ineligible for ACA financial assistance due to immigration status, Policy H-290.983 already enables the AMA to advocate in support of removing the five-year waiting period for lawfully present immigrants to enroll in Medicaid/Children's Health Insurance Program. However, additional policy is needed not only to provide a coverage option via unsubsidized ACA marketplace coverage for undocumented immigrants and Deferred Action for Childhood Arrivals recipients, but also recognize state and local efforts to provide coverage to immigrants regardless of immigration status.

The Council believes that additional policy options must be pursued to make coverage more affordable to individuals and families offered an "affordable" employer-sponsored plan which, in reality, is actually not affordable to them. To do so, the Council recommends the amendment of Policy H-165.828, to open the door to eligibility for premium tax credits and cost-sharing reductions to those facing an employer plan premium that is above the maximum affordability threshold applied to subsidized ACA marketplace plans. In addition, the Council recommends the amendment of the policy to enable the AMA to support additional solutions to fix ACA's "family glitch," to ensure that more families of workers are able to become eligible for subsidized ACA marketplace coverage.

The Council recognizes there is strong interest in the House of Delegates in how best to cover the population ages 60-64. In assessing the options available to cover the uninsured ages 60 to 64, the Council finds that the AMA proposal for reform, as well as the recommendations of this report, are preferable to other options, including lowering the Medicare eligibility age to 60. The AMA proposal for reform, as well as the recommendations of this report, strongly target each segment of the uninsured population ages 60 to 64, without causing health system disruptions.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-N-21

Subject: Covering the Remaining Uninsured (Resolution 123-J-21)

Presented by: Asa Lockhart, MD, MBA, Chair

Referred to: Reference Committee A

With the enactment of the most recent COVID-19 relief bill, the American Rescue Plan Act of 2021 (ARPA), into law, the coverage dynamics in the US have shifted. The nation has witnessed record enrollment in Affordable Care Act (ACA) coverage, via coverage offered on ACA marketplaces and under the Medicaid expansion, as well as through the Special Open Enrollment Period that recently ended. Resulting from the ARPA, a significant proportion of the uninsured is now eligible for ACA financial assistance, either in the form of premium tax credits to purchase marketplace coverage, or Medicaid. However, some segments of the uninsured population continue to be left behind, with potential negative effects on their health outcomes and financial security, as well as systemwide impacts resulting from how their care is provided and financed. After reviewing American Medical Association (AMA) policy as well as health reform legislation and regulation at the state and federal levels, the Council concluded that new and innovative AMA policy is needed targeting select segments of the uninsured population.

Subsequently, at the June 2021 Special Meeting of the House of Delegates, Resolution 123, Medicare Eligibility at Age 60, was referred. Introduced by the Medical Student Section, Resolution 123 asked that our AMA advocate that the eligibility threshold to receive Medicare as a federal entitlement be lowered from age 65 to age 60. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates.

This report provides background on the ACA improvements included in the ARPA; outlines the AMA proposal for reform; analyzes the need for new AMA policy to improve the coverage rates for each segment of the post-ARPA uninsured; examines the uninsured population ages 60 to 64 and evaluates potential pathways to increase coverage to this population, including lowering the Medicare eligibility age; and presents policy recommendations.

BUILDING UPON THE ACA: THE AMERICAN RESCUE PLAN ACT

The ARPA represents the largest coverage expansion since the ACA. Under the ACA, eligible individuals and families with incomes between 100 and 400 percent of the federal poverty level (FPL) (between 133 and 400 percent FPL in Medicaid expansion states) have been provided with refundable and advanceable premium credits that are inversely related to income to purchase coverage on health insurance exchanges. However, consistent with Policy H-165.824, the ARPA eliminated ACA's subsidy "cliff" for 2021 and 2022. As a result, individuals and families with incomes above 400 percent FPL ($51,040 for an individual and $104,800 for a family of four based on 2020 federal poverty guidelines) are eligible for premium tax credit assistance. Individuals eligible for premium tax credits include individuals who are offered an employer plan that does not

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have an actuarial value of at least 60 percent (i.e., 60 percent of benefit costs covered) or if the employee share of the premium exceeds 9.83 percent of income in 2021.

Also consistent with Policy H-165.824, ARPA increased the generosity of premium tax credits for two years, lowering the cap on the percentage of income individuals are required to pay for premiums of the benchmark (second-lowest-cost silver) plan. Premiums of the second-lowest-cost silver plan for individuals with incomes at and above 400 percent FPL are capped at 8.5 percent of their income. Notably, resulting from the changes, eligible individuals and families with incomes between 100 and 150 percent of the federal poverty level (133 percent and 150 percent FPL in Medicaid expansion states) now qualify for zero-premium silver plans, effective until the end of 2022. In addition, individuals receiving unemployment compensation who qualify for exchange coverage are eligible for a zero-premium silver plan in 2021.

Individuals and families with incomes between 100 and 250 percent FPL (between 133 and 250 percent FPL in Medicaid expansion states) also qualify for cost-sharing subsidies if they select a silver plan, which reduces their deductibles, out-of-pocket maximums, copayments and other cost-sharing amounts. The only change ARPA made to cost-sharing reduction eligibility and generosity was targeted to those receiving unemployment compensation. Individuals receiving unemployment compensation in 2021 who qualify for exchange coverage and enroll in a silver plan–regardless of income–are eligible for substantial cost-sharing reductions.

At the time that this report was written, 38 states and the District of Columbia had adopted the Medicaid expansion provided for in the ACA, which extended Medicaid eligibility to individuals with incomes up to 133 percent FPL.[1] ARPA included new incentives for states to implement Medicaid expansions. States that have not yet expanded Medicaid are now eligible for a five-percentage-point increase in their traditional Federal Medical Assistance Percentage Rate (FMAP) for two years if they newly implement the Medicaid expansion, applicable to a large share of their Medicaid population and spending. In the near term, the new five-percentage-point increase would be in addition to the current 6.2-percentage-point increase in the match rate provided under the Families First Coronavirus Response Act (FFCRA) pursuant to the COVID-19 public health emergency. Importantly, states that newly expand would also receive a 90 percent federal match for the expansion population.

THE AMA PROPOSAL FOR REFORM

Covering the uninsured and improving health insurance affordability have been long-standing goals of the AMA. Since the enactment of the ACA, the AMA proposal for reform has continued to evolve to ensure that AMA policy is able to address how to best cover the remaining uninsured in the current coverage environment. The AMA proposal for reform focuses on expanding health insurance coverage to four main population targets:

1. Individuals eligible for ACA's premium tax credits who remain uninsured (11 million);
2. Individuals eligible for Medicaid or the Children's Health Insurance Program (CHIP) who remain uninsured (7.3 million);
3. People who remain uninsured who are ineligible for ACA's premium tax credits due to an offer of "affordable" employer-sponsored coverage (3.5 million); and
4. People with low incomes who remain uninsured and are ineligible for Medicaid (2.2 million).[2]

By appropriately targeting the provision of coverage to the uninsured population, the AMA proposal for reform has aimed to make significant strides in covering the remaining uninsured and providing health insurance to millions more Americans:

- Premium tax credits would be available to individuals without an offer of "affordable" employer coverage, with no upper income limit (Policy H-165.824).
- Individuals currently caught in the "family glitch" and unable to afford coverage offered through their employers for their families would become eligible for ACA financial assistance based on the premium for family coverage of their employer plan (Policy H-165.828). Currently, in determining eligibility for premium tax credits, coverage for family members of an employee is considered to be affordable as long as employee-only coverage is affordable. The employee-only definition of affordable coverage pertaining to employer-sponsored coverage, commonly referred to as ACA's "family glitch," does not take into consideration the cost of family-based coverage, which commonly is much more expensive than employee-only coverage. As a result, the "family glitch" leaves many workers and their families ineligible to receive premium and cost-sharing subsidies to purchase coverage on health insurance exchanges, even though in reality they would likely have to pay well over 9.83 percent of their income for family coverage.
- To help employees currently having difficulties affording coverage, the threshold used to determine the affordability of employer coverage would be lowered, which would make more people eligible for ACA financial assistance based on income (Policy H-165.828).
- The generosity of premium tax credits would be increased to improve premium affordability, by tying premium tax credit size to gold-level instead of silver-level plan premiums, and/or lowering the cap on the percentage of income individuals are required to pay for premiums of the benchmark plan (Policy H-165.824).
- Young adults facing high premiums would be eligible for "enhanced" tax credits based on income (Policy H-165.824).
- Eligibility for cost-sharing reductions would be expanded to help more people with the cost-sharing obligations of the plan in which they enroll (Policy H-165.824).
- The size of cost-sharing reductions would be increased to lessen the cost-sharing burdens many individuals with low incomes face, which impact their ability to access and afford the care they need (Policy H-165.824).
- A permanent federal reinsurance program would be established, to address the impact of high-cost patients on premiums (Policy H-165.842).
- State initiatives to expand their Medicaid programs will continue to be supported. To incentivize expansion decisions, states that newly expand Medicaid would still be eligible for three years of full federal funding (Policies D-290.979 and H-290.965).
- Public options would be explored as potential pathways to provide health insurance coverage to uninsured individuals who fall into the "coverage gap" at no or nominal cost, provided that they meet the standards outlined in Policy H-165.823.
- To maximize coverage rates, the AMA would support the auto-enrollment of individuals who qualify for zero-premium marketplace coverage or Medicaid/CHIP in health insurance coverage, and continue to support the use of individual mandate penalties at the state and federal levels (Policies H-165.823, H-165.824 and H-165.848).
- To improve coverage rates of individuals eligible for either ACA financial assistance or Medicaid/CHIP but who remain uninsured, the AMA would support investments in outreach and enrollment assistance activities (Policies H-165.824, H-290.976, H-290.971, H-290.982 and D-290.982).
- States would continue to have the ability to test different innovations to cover the uninsured, provided such experimentations: a) meet or exceed the projected percentage of individuals covered under an individual responsibility requirement while maintaining or

improving upon established levels of quality of care; b) ensure and maximize patient choice of physician and private health plan; and c) include reforms that eliminate denials for pre-existing conditions (Policy D-165.942).

NEED FOR NEW AMA POLICY TO ADDRESS THE POST-ARPA UNINSURED: FILLING IN URGENT POLICY GAPS

While the exact number of the uninsured is in flux due to the COVID-19 pandemic and resulting changes in employment and eligibility for either ACA premium assistance or Medicaid, Kaiser Family Foundation (KFF) released estimates that offer a profile of the post-ARPA uninsured. Of note, these estimates are based on 2019 American Community Survey data; the time delay may affect overall numbers, but these estimates are still expected to provide a representative overview of the uninsured population. Overall, KFF estimates that 28.9 million nonelderly individuals are uninsured.[3] The Council has analyzed the remaining uninsured post-ARPA to assess whether new AMA policy is needed targeting select segments of the remaining uninsured. The Council's analysis concluded that how to best cover three segments of the uninsured population is currently not sufficiently addressed in AMA policy and AMA's plan to cover the uninsured: the uninsured who are ineligible for ACA financial assistance due to falling into ACA's coverage gap, the uninsured who are ineligible for ACA financial assistance due to immigration status, and the uninsured ineligible for ACA financial assistance due to having an offer of affordable employer coverage. Critically, without the implementation of policy solutions for these populations, many will be left without any affordable coverage options.

Uninsured Ineligible for ACA Financial Assistance Due to Falling into ACA's Coverage Gap

Resulting from states not implementing the Medicaid expansion provided for under the ACA, more than two million of the nonelderly uninsured find themselves in the coverage gap–not eligible for Medicaid, and not eligible for premium tax credits because they reside in states that did not expand Medicaid.[4] Approximately 60 percent of individuals who fall into the coverage gap are people of color. Three of four individuals who fall into the coverage gap reside in four states–Florida, Georgia, North Carolina and Texas.[5] Of note, an additional 1.8 million uninsured adults in non-expansion states with incomes between 100 and 133 percent FPL are currently eligible for premium tax credits and cost-sharing reductions to purchase ACA marketplace coverage but would become eligible for Medicaid if their state implemented the Medicaid expansion.[6]

Medicaid eligibility for adults in states that did not expand their Medicaid programs is quite limited. The median limit for parents in these states is 40 percent FPL. Childless adults–regardless of income–remain ineligible for Medicaid in nearly all states that did not expand their Medicaid programs. Significantly, childless adults make up more than three of four individuals who fall into the coverage gap. Overall, approximately half of individuals who fall into the coverage gap have incomes under 50 percent FPL, which amounts to $6,440 per year for an individual, or $537 per month.[7]

Approximately two-thirds of individuals in the coverage gap are in working families, with half working themselves.[8] Overall, individuals who fall in the coverage gap are in households in which workers earn low wages, work part-time, or are not consistently employed. Without access to Medicaid or heavily subsidized marketplace coverage, the uninsured in the coverage gap simply do not have access to affordable coverage options. For example, in 2021, the national average unsubsidized premium for a 40-year-old non-smoker seeking coverage on ACA marketplaces was $436 per month for the lowest-cost silver plan and $328 per month for a bronze plan. This is equivalent to roughly 80 percent of income for those at the lower income range of the coverage gap

(below 40 percent FPL), and nearly a third of income for those with incomes closer to the poverty line.[9]

Assessment of the Need for New AMA Policy

Policy D-290.979 states that our AMA will work with state and specialty medical societies in advocating at the state level in support of Medicaid expansion. Policy H-290.965 supports states that newly expand Medicaid being made eligible for three years of full federal funding. Policy H-290.966 encourages policymakers at all levels to focus their efforts on working together to identify realistic coverage options for adults currently in the coverage gap; encourages states that are not participating in the Medicaid expansion to develop waivers that support expansion plans that best meet the needs and priorities of their low income adult populations; and encourages the Centers for Medicare & Medicaid Services (CMS) to review Medicaid expansion waiver requests in a timely manner, and to exercise broad authority in approving such waivers, provided that the waivers are consistent with the goals and spirit of expanding health insurance coverage and eliminating the coverage gap for low-income adults. Policies H-165.920 and H-165.865 advocate for the promotion of individually selected and owned health insurance using refundable and advanceable tax credits that are inversely related to income so that patients with the lowest incomes will receive the largest credits. Policy H-165.855 encourages state demonstrations to provide coverage to their Medicaid beneficiaries using subsidies that enable acute care Medicaid beneficiaries to obtain private health insurance. Policy H-165.823 states that any public option shall be made available to uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid–having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credit eligibility–at no or nominal cost.

At the time that this report was written, there were three main pathways to provide coverage to the uninsured who fall into the coverage gap. One strategy, as past COVID-19 relief bill provisions aimed to do, would be to provide more incentives to states to adopt ACA's Medicaid expansion. The Council notes that, at this juncture, it is unclear whether additional financial incentives would cause any additional states to expand Medicaid. Another strategy would be to extend eligibility for premium tax credits and cost-sharing reductions to individuals with incomes below the poverty line, the current floor for eligibility. Lastly, the establishment of a federal Medicaid-like program or another type of public option has been discussed to cover those individuals who fall in the coverage gap in non-expansion states. While the AMA has policy relevant to each of the leading legislative approaches to provide individuals in the coverage gap with a source of health insurance coverage, the Council believes that new policy is needed to address the affordability of coverage offered under any federal approach to provide coverage to this population, as well as the impacts of any intervention on states that have already expanded Medicaid. The Council believes that there is a need for new policy to ensure that any federal approach targeted at the uninsured who fall in the coverage gap makes health insurance coverage available to this population at no or nominal cost, with significant cost-sharing protections. In addition, the Council believes that it is critical for any federal approach to address the coverage gap protect against current expansion states from dropping their Medicaid expansions.

Uninsured Ineligible for ACA Financial Assistance Due to Immigration Status

Almost four million of the nonelderly uninsured are ineligible for ACA financial assistance due to their immigration status.[10] Overall, lawfully present and undocumented immigrants were significantly more likely to be uninsured than citizens in 2019. Among the nonelderly population, 25 percent of lawfully present immigrants and 46 percent of undocumented immigrants were

uninsured, compared to nine percent of citizens. Critically, noncitizen children are more likely to be uninsured than citizen children.[11]

The higher uninsured rate among noncitizens is partially rooted in eligibility restrictions for Medicaid, CHIP and ACA marketplace coverage. Currently, many qualified non-citizens, including many lawfully permanent residents or green card holders, face a five-year waiting period after receiving qualified immigration status before becoming eligible for Medicaid and CHIP. Populations exempt from the five-year waiting period include refugees, asylees and lawfully permanent residents who used to be refugees or asylees. States currently have the option to eliminate the five-year waiting period for lawfully present children and pregnant women without a qualified immigration status. At the time this report was written, 35 states have extended coverage to affected children, with half of states having done so for impacted pregnant women.[12]

An alternative to coverage for lawfully present immigrants who are affected by the five-year waiting period or do not have a qualified immigration status is to seek coverage on ACA marketplaces and receive subsidies for coverage. These lawfully present immigrants with incomes below the poverty line are eligible to receive premium tax credits and cost-sharing reductions to purchase ACA marketplace coverage even if they are ineligible for Medicaid based on their immigration status. Lawfully present immigrants with incomes between 100 and 400 percent of FPL are eligible for premium tax credits and cost-sharing reductions to purchase coverage if they are not eligible for other coverage.

However, undocumented immigrants are not eligible to purchase coverage through the ACA marketplaces, even if they pay the full cost because they are not eligible for subsidies. In addition, they are not eligible to enroll in Medicaid or CHIP. These eligibility restrictions for Medicaid, CHIP and marketplace coverage also extend to individuals with Deferred Action for Childhood Arrivals (DACA) status, as they are not considered lawfully present and remain ineligible for coverage options, according to rules issued by CMS. With these restrictions in place, some states and localities have established programs to provide coverage to certain groups of immigrants regardless of immigration status, without the use of federal funds.

Assessment of the Need for New AMA Policy

Policy H-290.983 opposes federal and state legislation denying or restricting lawfully present immigrants Medicaid and immunizations. Policy H-440.903 directs the AMA to actively lobby federal and state governments to restore and maintain funding for public health care benefits for all lawfully present immigrants. Policy H-350.957 advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees. Policy H-440.876 opposes any policies, regulations or legislation that would criminalize or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants; opposes any policies, regulations, or legislation requiring physicians and other health care providers to collect and report data regarding an individual patient's legal resident status; and opposes proof of citizenship as a condition of providing health care. Policy D-440.985 states that our AMA shall assist states on the issue of the lack of reimbursement for care given to undocumented immigrants in an attempt to solve this problem on a national level.

The Council believes that existing policy sufficiently addresses the need to provide health insurance coverage to lawfully present immigrants and has enabled the AMA to advocate in support of removing the five-year waiting period for lawfully present immigrants to enroll in Medicaid/CHIP. The Council is cognizant that proper knowledge surrounding eligibility for

benefits is key to eligible immigrants enrolling in Medicaid, CHIP or marketplace coverage. The Council believes that existing policy addressing outreach and enrollment assistance for Medicaid/CHIP coverage, and financial assistance to purchase marketplace coverage, is sufficient to address this barrier to enrollment in coverage. However, there remains a gap in AMA policy that provides an avenue for undocumented immigrants and DACA recipients to access coverage options. There is a need for AMA policy in support of allowing undocumented immigrants and DACA recipients to purchase unsubsidized coverage on ACA marketplaces, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status. Without that guarantee in place, fear of immigration enforcement could preclude a segment of the immigrant population from enrolling in coverage. AMA policy also may be needed to address state and local initiatives to provide coverage to immigrants regardless of their immigration status; existing policy only addresses the reimbursement for the care provided to undocumented immigrants.

Uninsured Ineligible for ACA Financial Assistance Due to Having an Affordable Offer of Employer Coverage

Approximately 3.5 million of the nonelderly uninsured are ineligible for ACA's premium tax credits because they have an "affordable" offer of employer-sponsored insurance coverage.[13] To be considered "affordable," employer coverage must have an actuarial value of at least 60 percent and the employee share of the premium must be less than 9.83 percent of income in 2021. Notably, following the enactment of ARPA into law, inconsistencies now exist between the definition of affordable coverage pertaining to eligibility for premium and cost-sharing subsidies for those offered employer coverage, and the percentage of income at which premiums are capped for individuals with the highest incomes eligible for subsidized marketplace coverage. Premiums of the second-lowest-cost silver plan for individuals with incomes at and above 400 percent FPL are capped at 8.5 percent of their income. But employer coverage with an employee share of the premium less than 9.83 percent of income is considered to be "affordable."

In determining eligibility for premium tax credits, coverage for family members of an employee is considered to be affordable as long as employee-only coverage is affordable. Defining the affordability of employer coverage based on the premium contribution for employee-only coverage, and not family-based coverage, is rooted in ambiguity within the ACA as to how affordability is defined for family members of employees offered employer-sponsored coverage. As a result, the Joint Committee on Taxation interpreted the law to base the definition of employer-sponsored coverage solely on the cost of employee-only coverage; this interpretation was ultimately adopted in regulations issued by the Internal Revenue Service. The employee-only definition of affordable coverage pertaining to employer-sponsored coverage, commonly referred to as ACA's "family glitch," does not take into consideration the cost of family-based coverage, which commonly is much more expensive than employee-only coverage. The average employee contribution for self-only coverage was estimated to be $1,243 in 2020, while the average contribution for family coverage was estimated to be $5,588.[14]

The "family glitch" leaves many families of workers ineligible to receive premium and cost-sharing subsidies to purchase coverage on health insurance exchanges, even though in reality they would likely have to pay well over 9.83 percent of their income for family coverage. Overall, 5.1 million individuals fall into ACA's family glitch, more than half of whom are children. Of this number, 4.4 million are currently covered by an employer plan, 315,000 are enrolled in unsubsidized individual market coverage, and 451,000 are uninsured.[15] A study from 2016 estimated that, on average, families who fall into the family glitch spent 15.8 percent of their incomes on employer-sponsored coverage.[16]

Assessment of the Need for New AMA Policy

Policy H-165.828 supports modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered employer-sponsored coverage by lowering the threshold that determines whether an employee's premium contribution is affordable to that which applies to the exemption from the individual mandate of the ACA. Existing AMA policy, therefore, does not take into consideration the inconsistency between the definition of affordable coverage pertaining to eligibility for premium and cost-sharing subsidies for those offered employer coverage, and the percentage of income at which premiums are capped for individuals with the highest incomes eligible for subsidized marketplace coverage. The Council believes that this inconsistency should be rectified.

Policy H-165.828 also supports legislation or regulation, whichever is relevant, to fix the ACA's "family glitch," thus determining the affordability of employer-sponsored coverage with respect to the cost of family-based or employee-only coverage. However, current discussions surrounding fixing ACA's family glitch are exploring a different solution to fixing the glitch, which would in effect decouple the worker from their family in determining eligibility for premium tax credits to purchase coverage. As such, a spouse and/or child in a family offered "affordable" employee-only coverage but unaffordable family coverage would become eligible for premium subsidies to purchase marketplace coverage. The worker, meanwhile, would remain only eligible for the employee-only employer-sponsored coverage, not premium subsidies to purchase coverage on the ACA marketplaces. Because employees would not be newly eligible for premium tax credits, there would be no impact on liability for employers under the employer mandate, as the mandate is only applicable if an employee receives subsidies, not their family members.

Under this option, the family would be covered by at least two different health plans and would be responsible for the premiums associated with each plan, including that associated with the employee-only employer-sponsored coverage as well as that associated with the marketplace plan. Accordingly, not all families would necessarily be better off switching from their employer-sponsored family plan. However, many families would be better off, even those that may still need to pay more than 9.83 percent of their income for coverage of their entire family between employer-sponsored and marketplace plan premiums. It has been estimated that families switching from their employer plans would save approximately $400 per person in premiums on average, with families with incomes below 200 percent FPL saving $580 per person. Overall, while some currently covered by employer-sponsored coverage would transition to marketplace or Medicaid/CHIP coverage under this approach to fixing the family glitch, it also has been projected to cover nearly 200,000 uninsured individuals impacted by ACA's family glitch.[17]

POST-ARPA UNINSURED POPULATIONS FOR WHOM AMA POLICY IS SUFFICIENT: LOOKING AHEAD

The Council's analysis concluded that AMA policy sufficiently addresses how best to cover three segments of the post-ARPA uninsured population: the uninsured eligible for ACA premium tax credits, the uninsured eligible for Medicaid, and the uninsured who have an affordable ACA marketplace plan available to them without the need for any subsidy. That being said, the Council underscores the need for AMA policy to be implemented to cover these populations, ranging from ramping up outreach and enrollment assistance, to making additional improvements to ACA's premium tax credits and cost-sharing subsidies, to implementing auto-enrollment for those eligible for zero-premium marketplace plans or Medicaid.

Uninsured Eligible for ACA Premium Tax Credits

Eleven million of the nonelderly uninsured are eligible for premium tax credits, at least six million of whom are eligible for zero-premium marketplace plans.[18] Of those individuals eligible for zero-premium marketplace plans, approximately 1.3 million have incomes below 150 percent FPL ($19,140 for an individual and $39,300 for a family of four based on 2020 federal poverty guidelines) and are eligible for zero-premium silver plans with cost-sharing reductions that result in their deductibles being reduced to an average of $177 and thus resembling platinum-level coverage[19] (90 percent of benefit costs covered). Individuals receiving unemployment compensation in 2021 who qualify for exchange coverage and enroll in a silver plan–regardless of income–are also eligible for substantial cost-sharing reductions that also cause their coverage to resemble that of a platinum plan. Even with the additional premium assistance provided for in the ARPA, a segment of the uninsured eligible for premium tax credits may not see the benefit in getting covered if they cannot afford their deductibles, copayments, and other cost-sharing responsibilities.

<u>Assessment of the Need for New AMA Policy</u>

Under Policy H-165.824, (1) there would be adequate funding for and expansion of outreach efforts to increase public awareness of advance premium tax credits; (2) the generosity of premium tax credits would be increased to improve premium affordability, by tying premium tax credit size to gold-level instead of silver-level plan premiums, and/or lowering the cap on the percentage of income individuals are required to pay for premiums of the benchmark plan; (3) young adults facing high premiums would be eligible for "enhanced" tax credits based on income; (4) eligibility for cost-sharing reductions would be expanded to help more people with the cost-sharing obligations of the plan in which they enroll; (5) the size of cost-sharing reductions would be increased to lessen the cost-sharing burdens many individuals with low incomes face, which impact their ability to access and afford the care they need; and (6) the subsidy "cliff" would be eliminated. Policy H-165.823 highlights the potential for auto-enrollment as a strategy to cover the more than six million individuals eligible for zero-premium marketplace plans who remain uninsured.

As such, the Council believes that existing AMA policy is sufficient to address how best to cover uninsured individuals eligible for premium tax credits. Policy H-165.823 would provide a pathway for the six million uninsured individuals eligible for zero-premium coverage to become insured. Policy H-165.824 would enable the AMA to not only advocate to make the ARPA enhancements–improved premium tax credit generosity and ACA subsidy cliff elimination–permanent, but would support advocacy efforts to take additional steps to make premiums more affordable for the uninsured who are subsidy-eligible, as well as tackle barriers posed by deductibles and cost-sharing requirements. The policy also recognizes that uninsured individuals eligible for premium tax credits can only enroll in subsidized coverage if they are aware that they are eligible, which is why outreach efforts are so critical.

Uninsured Eligible for Medicaid

More than seven million of the nonelderly uninsured are eligible for Medicaid/CHIP, which includes adults in the Medicaid expansion population and populations eligible for Medicaid/CHIP under pre-ACA rules but who have not enrolled.[20] The reasons for this group remaining uninsured remain multifaceted, ranging from not being aware of their eligibility for coverage, to perceived stigma associated with public coverage, to facing barriers to enrollment, including those which are administrative or technical in nature.

Assessment of the Need for New AMA Policy

To improve coverage rates of individuals eligible for Medicaid/CHIP but who remain uninsured, AMA policy supports investments in outreach and enrollment assistance activities (Policies H-290.976, H-290.971, H-290.982 and D-290.982). Policy H-165.823 states that individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would, therefore, include individuals eligible for Medicaid/CHIP.

As such, the Council believes that existing AMA policy is sufficient to address how best to cover uninsured individuals eligible for Medicaid. Policy H-165.823 would provide a mechanism through which the uninsured who are Medicaid-eligible would be able to gain coverage via auto-enrollment. Until auto-enrollment for Medicaid-eligible individuals is able to be implemented, investments in outreach and enrollment assistance activities will be essential to get this segment of the uninsured covered.

Uninsured Who Have an Affordable Marketplace Plan Available to Them

More than one million of the nonelderly uninsured have an affordable ACA marketplace plan available to them with an unsubsidized benchmark premium that is less than 8.5 percent of their household income without a premium tax credit, making them ineligible for ACA financial assistance.[21] Of note, this segment of the uninsured has higher incomes, but removing ACA's subsidy cliff still does not make them eligible for premium assistance.

Assessment of the Need for New AMA Policy

Policy H-165.824 supports lowering the cap on the percentage of income individuals are required to pay for premiums of the benchmark plan. Policy H-165.848 supports a requirement that individuals and families earning greater than 500 percent FPL obtain, at a minimum, coverage for catastrophic health care and evidence-based preventive health care, using the tax structure to achieve compliance.

The Council notes that a segment of this population could potentially become eligible for premium tax credits if the cap on premiums as a percentage of income were lowered even further than what the ARPA accomplished. That being said, using a policy "stick" to get this population covered may be necessary, including a state and/or federal individual mandate penalty. Accordingly, the Council believes that existing AMA policy is sufficient to address how best to cover this segment of the uninsured population.

COVERING THE UNINSURED AGES 60 TO 64

Following the referral of Resolution 123 at the June 2021 Special Meeting of the House of Delegates, the Council examined the segment of the uninsured ages 60 to 64 to ascertain what improvements, if any, need to be made to AMA's proposal for reform to ensure that this population has a pathway to coverage, and to assess the merits of lowering the Medicare eligibility age to age 60. Of the 20.8 million individuals ages 60 to 64 in the US, 56.3 percent are enrolled in employer-sponsored coverage, 14.5 percent are enrolled in Medicaid, 11.3 percent are enrolled in non-group coverage, 10.1 percent are enrolled in other public coverage (e.g., Medicare and military coverage), and 7.8 percent are uninsured.[22]

Of the uninsured ages 60 to 64, nearly half are eligible for premium tax credits. Further, nearly 20 percent are eligible for Medicaid, 15 percent are ineligible for ACA financial assistance due to having an affordable offer of employer coverage, 10 percent fall in the coverage gap and seven percent are ineligible for ACA financial assistance due to immigration status.[23]

Assessment of the Need for New AMA Policy

The Council notes that the earlier sections of this report address how existing AMA policy pertains to each segment of the uninsured population ages 60 to 64. For the uninsured eligible for premium tax credits, making premium tax credit assistance more generous, and expanding eligibility for and improving the generosity of cost-sharing subsidies, will be highly beneficial. The Council understands that when this population is able to enroll in ACA marketplace coverage, affordable cost-sharing levels will be critical so they will be able to access the care they need. The Council believes that subsidized ACA marketplace coverage with improved cost-sharing assistance is the preferable option to cover this segment of the uninsured population ages 60 to 64, especially considering that most current traditional Medicare beneficiaries are enrolled in supplemental insurance through either a Medicare supplemental plan, Medicaid, or an employer to provide more comprehensive cost-sharing protections than what is offered in the traditional Medicare program. Subsidized ACA marketplace assistance would also become available to some of the uninsured ages 60-64 currently ineligible due to having an affordable offer of employer coverage under current AMA policy, as well as recommendations for new policy proposed in this report.

For uninsured individuals ages 60 to 64 who are eligible for zero-premium marketplace coverage, as well as the 20 percent of the uninsured eligible for Medicaid, the Council believes that auto-enrollment again can be used as a mechanism to provide health insurance to these individuals at no cost to them. Existing AMA policy, and recommendations for new policy in this report, applicable to the uninsured who fall in the coverage gap, and ineligible for ACA financial assistance due to immigration status, would also pertain to those ages 60 to 64.

The Council also recognizes the role Policy H-330.896 plays in improving the consistency between Medicare and Social Security eligibility. The policy supports restructuring Medicare's age-eligibility requirements and incentives to match the Social Security schedule of benefits. However, lowering the age to become eligible for Medicare from 65 to 60 is not consistent with the intent of Policy H-330.896, and is projected to have unintended consequences.

While lowering the age of Medicare eligibility to 60 could cover many of the uninsured in the 60-64 age bracket, the Council believes that the AMA proposal for reform, as well as the recommendations of this report, provide a better pathway to get this age cohort of the uninsured covered without causing significant health system changes and potential negative impacts to physicians, hospitals, and other entities. For example, lowering the age of Medicare eligibility to 60 has been projected by KFF to also have the potential to shift nearly 12 million individuals with employer coverage and 2.4 million with non-group coverage into Medicare.[24] Such a shift would notably impact the payer mix of physician practices. At the same time, only one-third of the approximately 1.6 million uninsured in this age cohort remains ineligible for premium tax credits to purchase marketplace coverage, or Medicaid, because they do not qualify for ACA financial assistance due to an affordable offer of employer coverage, falling into the coverage gap, or due to immigration status. Accordingly, the Council believes that the AMA proposal for reform can cover this population without the unwanted policy tradeoffs that lowering the Medicare eligibility age would present.

The Council recognizes that there are equity considerations associated with each alternative to cover the uninsured ages 60 to 64, and those associated with lowering the Medicare eligibility age must be examined. While lowering the Medicare eligibility age to 60 would open the door to Medicare to individuals aged 60-64, doing so would notably eliminate subsidized marketplace coverage eligibility for these individuals, potentially increasing their cost of coverage. They still would, however, be able to choose to remain on their employer-sponsored coverage. In light of the premium tax credit enhancements included in the ARPA, lower-income individuals currently enrolled in a marketplace plan may have the potential to face higher premiums in traditional Medicare. In addition, considering that half of the uninsured ages 60 to 64 are eligible for premium tax credits, the Council believes that they should not lose access to the most affordable coverage pathway available to them–critical for those with the lowest incomes. Avalere found that current marketplace subsidies are consistently more generous for lower-income individuals than the subsidies available to Medicare beneficiaries.[25] Accordingly, the Council believes that improving the generosity of premium tax credits and cost-sharing reductions, and making cost-sharing reductions available to more people, as outlined in AMA policy, provides low-income uninsured ages 60 to 64 with a more preferable choice of coverage option than lowering the Medicare eligibility age to 60.

Overall, lowering the Medicare eligibility age to 60 has been projected to cost $200 billion over ten years.[26] The aforementioned shift in coverage from employer coverage to Medicare shifts a large share in health spending to the federal budget. While certain proposals to date reiterate that lowering the Medicare eligibility age to 60 would be funded by general revenues, they would still need a pay-for. Proposals to lower the Medicare eligibility age to 60 could also threaten the fiscal stability of the Medicare Trust Fund. Notably, the Council emphasizes that the AMA proposal for reform would not only have a smaller fiscal footprint over a ten-year period, but also would not negatively impact the Medicare Trust Fund. The potential for other unintended consequences of lowering the Medicare eligibility age must be assessed, including on graduate medical education (GME).

Finally, the Council is highly concerned that lowering the Medicare eligibility age to 60 would negatively impact the payer mix of physician practices. It is expected that lowering the Medicare eligibility age to 60 would lower the revenues for physicians, hospitals, and other providers delivering care to the 60-64 age cohort. Physician and hospital payment rates from private plans tend to be higher than those paid by Medicare, with the difference between the two increasing over time.[27]

DISCUSSION

The AMA proposal for reform, based on AMA policy, is still the right direction to pursue in order to cover the remaining uninsured. The enactment of the ARPA into law has provided a preview as to what ACA improvements, many of which reflect the AMA proposal for reform, can accomplish. The Council underscores that Policy H-165.824 supports making the ARPA changes to the ACA permanent–increasing the generosity of premium tax credits as well as eliminating ACA's subsidy "cliff." However, the Council is cognizant that more needs to be done to cover the uninsured eligible for premium tax credits and Medicaid, as well as the uninsured already eligible for an affordable ACA marketplace plan without any subsidy. Policy H-165.823, by outlining the potential for auto-enrollment for the segment of the uninsured eligible for coverage options that would be of no cost to them after the application of any subsidies, provides a coverage pathway for the 7.3 million uninsured individuals eligible for Medicaid/CHIP and the six million eligible for zero-premium marketplace coverage. Until auto-enrollment is enacted for these populations, the Council believes that outreach and enrollment assistance efforts will be absolutely critical, so

individuals are aware that they are eligible for premium tax credits or Medicaid/CHIP and receive any necessary assistance to enroll in coverage. Outreach and enrollment assistance efforts are also vital to facilitate the enrollment of immigrants eligible for ACA financial assistance in health insurance coverage.

Policy H-165.824 also contains highly important provisions to improve the affordability of not only the premiums for individuals who remain uninsured despite being eligible for premium tax credits as well as those who already have access to an affordable marketplace plan, but also deductibles and other cost-sharing obligations. A component of the uninsured may not see the benefit to enrolling in coverage if they know they will not be able to afford the cost-sharing responsibilities of the plan in which they can enroll. In addition, uninsured individuals already eligible for affordable ACA marketplace coverage without any subsidy may need the "stick" of an individual mandate penalty to get coverage, advocated for in Policies H-165.848 and Policy H-165.824.

However, the Council sees an opportunity to further maximize coverage rates and improve coverage affordability under the AMA proposal for reform by either amending existing policy, or establishing new policy, impacting the uninsured ineligible for ACA financial assistance due to falling into the coverage gap, immigration status, or having an affordable offer of employer coverage. The Council is highly concerned about the more than two million uninsured who fall into ACA's coverage gap. It has been the hope of the Council that, following existing AMA policy, the states that have not yet expanded their Medicaid programs would do so, and enjoy the associated significant, positive financial incentives. With policy alternatives emerging to cover this segment of the uninsured, ranging from making them eligible for premium tax credits and cost-sharing reductions to purchase marketplace coverage, to establishing a standalone federal Medicaid-like program or other public option, the Council underscores that Policies H-165.838 and H-165.823 recommended for reaffirmation collectively constitute a critical baseline for any federal approach to cover the uninsured who fall in the coverage gap to meet. In addition, the Council recommends new policy to advocate that any approach to cover the uninsured who fall into the coverage gap ensure this population has access to affordable, quality coverage, and protect against current expansion states from dropping their Medicaid expansions. These new policies, as well as existing policy outlining standards that any public option to expand health insurance coverage must meet, supersede Policy H-290.966, which is recommended to be rescinded.

Addressing the uninsured ineligible for ACA financial assistance due to immigration status, Policy H-290.983 already enables the AMA to advocate in support of removing the five-year waiting period for lawfully present immigrants to enroll in Medicaid/CHIP. However, additional policy is needed not only to provide a coverage option via unsubsidized ACA marketplace coverage for undocumented immigrants and DACA recipients, but to recognize state and local efforts to provide coverage to immigrants regardless of immigration status. In implementing initiatives to improve the coverage rates of immigrants, the Council believes it is critical that entities overseeing these programs do not collect and/or report data regarding enrollee immigration status.

The Council believes that additional policy options must be pursued to make coverage more affordable to individuals and families offered an "affordable" employer-sponsored plan which, in reality, is actually not affordable to them. To do so, the Council recommends the amendment of Policy H-165.828, to open the door to eligibility for premium tax credits and cost-sharing reductions to those facing an employer plan premium that is above the maximum affordability threshold applied to subsidized ACA marketplace plans. In addition, the Council recommends the amendment of the policy to enable the AMA to support additional solutions to fix ACA's "family glitch," to ensure that more families of workers are able to become eligible for subsidized ACA marketplace coverage.

In assessing the options available to cover the uninsured ages 60 to 64, the Council finds that the AMA proposal for reform, as well as the recommendations of this report, are preferable to other options, including lowering the Medicare eligibility age to 60. Current AMA policy and these recommendations strongly target each segment of the uninsured population ages 60 to 64, without causing health system disruptions. The Council still believes there is a role for Policy H-330.896, which supports restructuring age-eligibility requirements and incentives of Medicare to match the Social Security schedule of benefits. The Council finds lowering the Medicare eligibility age to 60 has multiple downsides:

- Individuals ages 60 to 64 would lose access to health plan choices, including subsidized ACA marketplace coverage.
- As current ACA marketplace subsidies are consistently more generous for lower-income individuals than the subsidies available to Medicare beneficiaries, lower-income individuals currently enrolled in a marketplace plan may have the potential to face higher premiums in traditional Medicare.
- The level of benefits under Medicare differs from options currently available to individuals ages 60 to 64, underscoring why most current, traditional Medicare beneficiaries are also enrolled in supplemental insurance.
- The projected crowd-out of millions of individuals from employer-sponsored and other private coverage to Medicare has the potential to negatively impact the payer mix of physician practices and hospitals.
- Physician and hospital payment rates from private plans tend to be higher than those paid by Medicare, with the difference between the two increasing over time.

The Council believes its recommendations address gaps in AMA policy with respect to covering the uninsured–including those ages 60 to 64–necessary to ensure that our patients are able to secure affordable and meaningful coverage and access the care that they need. There is now an opportunity to build upon the ACA and ARPA to cover more of the uninsured. The Council affirms that our AMA is well-positioned to move forward in its advocacy efforts in support of coverage of the uninsured, guided by policy and its resulting plan to cover the uninsured, which will include the recommendations of this report.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 123-J-21, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) advocate that any federal approach to cover uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid–having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credit eligibility–make health insurance coverage available to uninsured individuals who fall into the coverage gap at no or nominal cost, with significant cost-sharing protections. (New HOD Policy)

2. That our AMA advocate that any federal approach to cover uninsured individuals who fall into the coverage gap provide states that have already implemented Medicaid expansions with additional incentives to maintain their expansions. (New HOD Policy)

3. That our AMA support extending eligibility to purchase unsubsidized Affordable Care Act (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood

Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status. (New HOD Policy)

4. That our AMA recognize the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status. (New HOD Policy)

5. That our AMA reaffirm Policy H-290.983, which opposes federal and state legislation denying or restricting lawfully present immigrants Medicaid and immunizations. (Reaffirm HOD Policy)

6. That our AMA amend Policy H-165.828 by addition and deletion to read as follows:

   a. Our AMA supports modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered employer-sponsored coverage by lowering the threshold that determines whether an employee's premium contribution is affordable to ~~that which applies to the exemption from the individual mandate of~~ the level at which premiums are capped for individuals with the highest incomes eligible for subsidized coverage in Affordable Care Act (ACA) marketplaces.
   b. Our AMA supports legislation or regulation, whichever is relevant, to fix the ACA's "family glitch," thus determining the eligibility of family members of workers for premium tax credits and cost-sharing reductions based on the affordability of family employer-sponsored coverage ~~with respect to the cost of family-based or employee-only coverage~~ and household income. … (Modify Current HOD Policy)

7. That our AMA reaffirm Policy D-290.979, which states that our AMA will work with state and specialty medical societies in advocating at the state level in support of Medicaid expansion. (Reaffirm HOD Policy)

8. That our AMA reaffirm Policy H-290.965, which supports states that newly expand Medicaid being made eligible for three years of full federal funding. (Reaffirm HOD Policy)

9. That our AMA reaffirm Policy H-165.823, which supports auto-enrolling individuals in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies, including zero-premium marketplace coverage and Medicaid/Children's Health Insurance Program (CHIP); and outlines standards that any public option to expand health insurance coverage must meet. (Reaffirm HOD Policy)

10. That our AMA reaffirm Policy H-165.838, which states that insurance coverage options offered in a health insurance exchange should be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians. (Reaffirm HOD Policy)

11. That our AMA reaffirm Policy H-165.824, which supports: (1) adequate funding for and expansion of outreach efforts to increase public awareness of advance premium tax credits; (2) providing young adults with enhanced premium tax credits while maintaining the current premium tax credit structure which is inversely related to income; (3) state innovation, including considering state-level individual mandates, auto-enrollment and/or reinsurance, to maximize the number of individuals covered and stabilize health insurance premiums without undercutting any existing patient protections; (4) eliminating the subsidy "cliff," thereby

expanding eligibility for premium tax credits beyond 400 percent of the federal poverty level (FPL); (5) increasing the generosity of premium tax credits; (6) expanding eligibility for cost-sharing reductions; and (7) increasing the size of cost-sharing reductions. (Reaffirm HOD Policy)

12. That our AMA reaffirm Policies H-290.976, H-290.971, H-290.982 and D-290.982, which support investments in Medicaid/CHIP outreach and enrollment assistance activities. (Reaffirm HOD Policy)

13. That our AMA reaffirm Policy H-165.848, which supports a requirement that individuals and families earning greater than 500 percent FPL obtain, at a minimum, coverage for catastrophic health care and evidence-based preventive health care, using the tax structure to achieve compliance. (Reaffirm HOD Policy)

14. That our AMA rescind Policy H-290.966, as it is superseded by Policy H-165.823 as well as the recommendations of this report. (Rescind HOD Policy)

15. That our AMA reaffirm Policy H-330.896, which supports restructuring Medicare age-eligibility requirements and incentives to match the Social Security schedule of benefits. (Reaffirm HOD Policy)

Fiscal note: Less than $500.

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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5-N-21

Subject: Integrating Care for Individuals Dually Eligible for Medicare and Medicaid

Presented by: Asa C. Lockhart, MD, Chair

Referred to: Reference Committee A

Council on Medical Service Report 5-Nov-20, Medicaid Reform, addressed the Medicaid program generally without specifically addressing coverage and payment for care of individuals dually eligible for Medicare and Medicaid. Delivery of care and financing reform for the dual eligible population was the topic of Council on Medical Service Report 5-A-13, when several state demonstrations designed to better integrate care were just getting started. Evidence from a variety of integrated models tested over the intervening years is now available to inform new American Medical Association (AMA) policy on integrated benefits for this predominantly low-income, medically complex population. Although many dually eligible individuals live with some combination of chronic conditions, mental illness, substance use disorder, and cognitive and/or physical disabilities, this is an extremely heterogeneous group. Because they tend to be high-need, high-cost enrollees, state and federal policymakers continuously search for ways to increase care quality while saving Medicare and Medicaid dollars. For example, recent policy discussions have focused on how to enroll more dually eligible individuals into integrated plans, especially Medicare Advantage Dual-Eligible Special Needs Plans (D-SNPs).

The incidence of long COVID-19, considered a disabling condition under the Americans with Disabilities Act when it substantially limits major life activities, may increase the number of dually eligible enrollees—a group already disproportionately impacted by the pandemic—and highlight the need for improved health outcomes. Integrated care refers to delivery system and financing approaches that coordinate and integrate covered services and supports for dually eligible individuals. In theory, integrated plans should have a high potential for reducing costs and improving care; in reality, achieving integration has been difficult due in part to the complex and diverse needs among dually eligible people and the involvement of siloed government health programs that were not designed to work together. This report, initiated by the Council, provides an overview of existing integrated models, summarizes relevant AMA policy, and recommends new AMA policy outlining criteria essential to successful integrated care.

BACKGROUND

The number of individuals dually eligible for Medicare and Medicaid has risen steadily in recent years to almost 12.3 million people.[1] In comparison to Medicare-only enrollees, dually eligible patients have more complex and chronic health needs and are more likely to experience inequities in social determinants of health that contribute to chronic disease.[2] Nearly half of dually eligible enrollees are people of color; dually eligible individuals are also more likely to be female, have functional and activities of daily living limitations, and report being in poorer health.[3]

According to preliminary Medicare COVID-19 data from the Centers for Medicare & Medicaid Services (CMS), dually eligible individuals were more than twice as likely to be infected with

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COVID-19, and more than three times as likely to be hospitalized by the virus, than Medicare-only patients.[4] Sixty-one percent of dually eligible individuals are age 65 and over, and 40 percent utilize Medicaid long-term services and supports (LTSS) ranging from nursing home care to home and community-based supports.[5] Over 40 percent have at least one mental health diagnosis, and just over half become dually eligible for Medicare-Medicaid because of disability.[6]

Although dually eligible individuals often face barriers to accessing primary and preventive care, this population utilizes more covered services,[7] including services in emergency departments.[8] Accordingly, dually eligible patients are disproportionately more costly to Medicare and Medicaid than traditional enrollees.[9] Although dually eligible individuals make up 20 percent of Medicare enrollees and 15 percent of Medicaid enrollees, they account for 34 percent of Medicare spending and 32 percent of Medicaid spending.[10]

Because Medicare and Medicaid are complex programs, each with distinct goals and coverage and payment rules, care for dually eligible individuals can be fragmented, poorly coordinated and difficult for patients to navigate. Cost-shifting persists across Medicare and Medicaid, and one program may be less likely to implement policy or program changes that result in savings to the other. Many stakeholders have noted that the disconnect between Medicare and Medicaid complicates care coordination and increases inefficiencies as well as administrative burdens among patients, physicians, and other providers.[11] Suboptimal care coordination may in turn compromise patient care and increase program spending.

Medicare benefits for this population include primary care, preventive care, inpatient and outpatient acute care, post-acute skilled nursing (SNF) care, and prescription drug coverage. Medicare is the primary payer while Medicaid may cover a range of services not covered by Medicare, including—depending on the state—LTSS, some behavioral health benefits, and transportation. Medicaid coverage varies by state and between partial-benefit and full-benefit dually eligible enrollees, with full-benefit enrollees—who make up over 70 percent of the dual eligible population—eligible for all services that are covered by Medicaid in their state. Partial-benefit enrollees receive Medicaid assistance with Medicare premiums and, in some cases, Medicare cost-sharing, but are not eligible for other Medicaid benefits. State and federal efforts to integrate benefits focus predominantly on full-benefit dual eligible enrollees.

INTEGRATED CARE MODELS

Many stakeholders have maintained that managed care plans offering both Medicare and Medicaid services would improve quality and reduce spending for dually eligible individuals, and several integrated models were developed over the last decade. Early integrated care plans in Massachusetts, Minnesota, and Wisconsin were identified as promising in that they reduced enrollee use of hospital services and, importantly, redirected some LTSS use from nursing facilities to home and community-based care.[12] The most prominent integrated care plans include models tested through CMS demonstrations, D-SNPs, and the Program of All-Inclusive Care for the Elderly (PACE).

Financial Alignment Initiative: CMS has long cited financial misalignment between Medicare and Medicaid as a barrier to coordinating care for dually eligible enrollees, and it tests models with states using waivers. Financial Alignment Initiative (FAI) demonstrations are designed to better align financing and integrate primary, acute, behavioral health and LTSS for Medicare-Medicaid enrollees. FAI, which began in 2013, offers options to states for integrating care, including a capitated model that establishes Medicare-Medicaid Plans (MMP), a managed fee-for-service model, and a state option to create an alternative model. Nine of the 11 states that currently

participate have chosen the capitated MMP model, in which CMS, a state, and a health plan enter a contract under which CMS and the state pay each health plan a prospective capitated monthly payment. States are permitted under the FAI to increase participation in MMPs using passive enrollment, which automatically enrolls dually eligible individuals in an MMP with the ability to opt out. Enrollment in MMPs has been lower than expected, although participation rates vary across participating states. Notably, a significant number of dually eligible people who have been passively enrolled in an MMP have subsequently opted out. Although evaluations have shown this model to be associated with decreased emergency department use and hospitalizations, other impacts—for example, on Medicare spending and savings—have been mixed and varied across participating states.[13]

Under FAI's managed fee-for-service (FFS) model, care is provided through FFS with assigned care coordinators to help enrollees obtain needed care. The state of Washington is implementing the FFS model and has experienced good enrollment numbers. Washington uses Medicaid health homes with a care coordinator and multidisciplinary team serving dually eligible enrollees. Evaluations of this model have shown decreased inpatient and SNF admissions and long-stay nursing facility use as well as major reductions in Medicare spending (which the state was able to share).

Dual-Eligible Special Needs Plans: D-SNPs were introduced in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and made permanent under the Bipartisan Budget Act of 2018. D-SNPs are available in 44 states and are required to contract with the Medicaid agency in each state in which they operate. "MIPPA" contracts, named for the Medicare Improvements for Patients and Providers Act under which they are authorized, are used by states to increase the level of integration. For example, states can use MIPPA contracts to require D-SNPs to align with managed LTSS (where such managed programs are available) so that dually eligible individuals are able to access Medicare and Medicaid services (including LTSS) through the same entity. States can similarly require D-SNP contractors to ensure coordination of behavioral health and/or other Medicaid services, and to share Medicare data with the state.

Predominant D-SNP integrated models fall into two categories: those that require aligned Medicaid managed LTSS; and fully integrated D-SNPs, which provide Medicare and Medicaid benefits, consistent with state policy. Research has found D-SNPs to be associated with reduced hospitalizations and readmissions; however, results have been mixed with regard to emergency department use and LTSS services.[14] There has been some evidence of decreased Medicare spending among D-SNPs, and many stakeholders find D-SNPs promising because they are widely available and have enrolled over three million dually eligible people.[15]

PACE: PACE provides comprehensive, interdisciplinary medical and social services to certain frail people over age 55, enabling them to remain at home instead of in a nursing home. PACE is the most integrated model but only serves about one percent of dually eligible individuals across 31 states. The program has been associated with reduced inpatient hospital use but the impact on nursing facility use and Medicaid spending has been mixed.

Only about one in ten dually eligible individuals is enrolled in integrated care models despite considerable work over the years. Although D-SNPs have enrolled over three million people, PACE and FAI—both highly integrated—have enrolled 55,000 and 395,000 enrollees, respectively.[16] Most dually eligible enrollees (more than 70 percent) are in fee-for-service plans and, among those with Medicare Advantage plans, one quarter are in non-integrated plans.[17] Low enrollment numbers have been attributed to the lack of program availability in some areas and high

rates of disenrollment from certain programs.[18] Resource constraints and competing priorities in states may also limit the availability of integrated programs.

ELEMENTS OF SUCCESSFUL INTEGRATED CARE MODELS

At least 43 combinations of Medicare and Medicaid coverage are available nationwide, giving many dually eligible enrollees several plan options from which to choose.[19] D-SNP, MMP and PACE are targeted towards dually eligible individuals; additionally, some qualify for institutional special needs (I-SNP) plans, which are MA plans limited to patients with institutional-level care needs. While the literature has highlighted data challenges, including the lack of available Medicaid data, individuals enrolled in integrated programs have reported satisfaction with reduced cost-sharing and improved access to medical, behavioral health and other services.[20]

Each of the integrated models has different strengths and limitations in terms of level of integration, availability across states, enrollee experience, capacity to scale, and cost savings. A literature review of integrated models by Health Management Associates highlighted the following factors that contribute to improved programming for dually eligible individuals:

- Individual consumer engagement in program design, communications, implementation and ongoing program oversight;
- Provider engagement and robust networks;
- Care coordination and risk stratification;
- Strong state and federal government collaboration;
- Adequate state capacity; and
- Performance and outcome measures tailored to the population.[21]

Stakeholder interviews with patients, physicians, advocates, health plans, and state officials informed a second Health Management Associates brief that identified essential program elements needed for plans to successfully support dually eligible individuals. As stated in the report, the ten essential elements are:

1. Simplified Medicare and Medicaid eligibility processes and paperwork;
2. Comprehensive and expert consumer choice counseling and/or enrollment assistance;
3. Diverse consumer engagement to inform tailored delivery systems and integrated programs;
4. Robust data infrastructure to tailor and adapt program approaches and drive health equity;
5. Coordinated efforts to maximize capabilities to address unmet social needs;
6. Single process for assessments and plans of care, and one care team for each consumer;
7. Meaningful and transparent quality measurement to empower consumers and stakeholders;
8. Payment models to incentivize consumer quality of life improvements;
9. Adequate, engaged, and diverse workforce to support consumer needs; and
10. Access to needed services in rural areas.[22]

Of note, states are at various junctures of integrating care for dually eligible individuals. Some states, including Arizona, Idaho, and Tennessee, have made greater use of MIPPA authority and are providing fully integrated care. On the other hand, no integrated care options are available in North Dakota and Wyoming.[23] States may also employ multiple strategies to integrate care, as Ohio does by implementing both PACE and FAI.

Viable enhancements to integrated care plans are regularly discussed by the Medicaid and CHIP Payment and Access Commission and the Medicare Payment Advisory Commission. At least one

proposal, from the Dual Eligible Coalition and Leavitt Partners, envisions consolidation of care under a new program—Title 22—that combines Medicare, Medicaid, and state funding into a fully integrated program specifically for dually eligible individuals.[24]

RELEVANT AMA POLICY

Policy H-290.967, established by Council Report 5-A-13, includes the following principles on the delivery of care and financing reform for Medicare and Medicaid dually eligible patients: (1) various approaches to integrated delivery of care should be promoted under demonstrations; (2) customized benefits and services from health plans are necessary according to each beneficiary's specific medical needs; (3) care coordination demonstrations should not interfere with established patient-physician relationships; delivery and payment reform for dually eligible beneficiaries should involve practicing physicians and take into consideration the diverse patient population and local area resources; (4) states with approved financial alignment demonstration models should provide education and counseling to beneficiaries on options for receiving Medicare and Medicaid benefits; (5) conflicting payment rules between the Medicare and Medicaid programs should be eliminated; (6) Medicare and Medicaid benefit plans and the delivery of benefits should be coordinated; and (7) care plans for beneficiaries should be streamlined among all clinicians and social service agencies.

Addressing Medicare-Medicaid dual eligible demonstration programs, Policy D-290.980 advocates that established patient-provider relationships and current treatment plans will not be disrupted; dually eligible individuals should not be automatically enrolled without their approval or consent; any savings from coordination of care to dually eligible individuals should arise from better health outcomes and efficiencies gained; and demonstrations should not be employed as a policy lever to reduce provider payment rates. Policy H-290.984 strongly opposes mandatory enrollment of Medicare and/or Medicaid patients in managed care plans. Similarly, Policy D-290.978 calls on CMS to require states to develop processes to facilitate opting out of managed care programs by dual-eligible individuals. Policies D-290.998 and H-290.978 advocate that states pay Medicare deductibles and cost-sharing for dual-eligible patients.

The AMA advocates for the same policies for Medicaid managed care that are advocated for private managed care plans, as well as criteria for federal and state oversight of Medicaid managed care plans that are delineated in Policy H-290.985. Network adequacy elements for public and private health plans are outlined in Policy H-285.908. Policy H-285.973 (1) advocates that all managed care plans be required to provide appropriate access, when geographically available, to representatives of all medical and surgical specialties and subspecialties; and (2) advocates that health plans not restrict appropriate referrals to medical and surgical subspecialists, including those specialties that are age group specific.

Policy H-280.945 supports (1) incentivizing states to expand the availability of and access to home and community-based services; and (2) better integration of health and social services and supports, including the PACE program. Policy H-165.822 (1) encourages new and continued partnerships to address non-medical, yet critical health needs and the underlying social determinants of health; (2) supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs; and (3) encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health. Policy H-180.944 states that "health equity," defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.

DISCUSSION

Because dually eligible individuals are typically medically complex and in need of a wide range of services and supports, they are among the highest need and highest cost enrollees within Medicare and Medicaid.[25] Integrated care plans are promising models for providing care that addresses the medical, behavioral, long-term care and social needs of this diverse patient population. In its review of the literature, the Council found that new models as well as enhancements to existing models have the potential to improve care quality and life quality for dually eligible people, but that success often depends on state capacity and resources available to implement integrated care. Managing the costs of care for dually eligible people is particularly challenging because nearly half of enrollees require LTSS, including those who receive institutional-level care. The Council highlights its recent work on LTSS, including Council on Medical Service Report 5-A-18, Financing LTSS, which established AMA policy (Policy H-280.945) supportive of incentivizing states to expand the availability of and access to home and community-based services. Council on Medical Service Report 4, presented at this meeting, recommends new AMA supporting streamlined funding for home and community-based services.

The Council supports ongoing study and refinement by CMS and states and hopes that increased collaboration and learning will help expand best practices. Accordingly, in lieu of supporting any specific model, the Council recommends support for integrated care that aligns with AMA policy and meets additional criteria that are critical to ensuring an integrated model's success.

The Council further recommends reaffirmation of Policy H-290.967, which establishes principles on care delivery and financing reform for dually eligible patients; Policy D-290.978, which calls on CMS to require all states to develop processes to facilitate opting out of managed care programs by dual eligible individuals; and Policy H-165.822 on health plan initiatives addressing social determinants of health. Finally, the Council recommends reaffirmation of Policy H-180.944, which defines health equity as optimal health for all and promotes equity in care. In comparison to Medicare enrollees, a greater share of dual eligible individuals are people of color, women, and people with disabilities. Advances in health equity and reducing disparities in health and health access must be considered by integrated care models if they are to improve care quality, life quality, and health outcomes over the long term.

RECOMMENDATIONS

The Council on Medical Service recommends that the following recommendations be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) support integrated care for individuals dually eligible for Medicare and Medicaid that aligns with AMA policy and meets the following criteria:

    a. Care is grounded in the diversity of dually eligible enrollees and services are tailored to individuals' needs and preferences.
    b. Coverage of medical, behavioral health, and long-term services and supports is aligned.
    c. Medicare and Medicaid eligibility and enrollment processes are simplified, with enrollment assistance made available as needed.
    d. Enrollee choice of plan and physician is honored, allowing existing patient-physician relationships to be maintained.
    e. Services are easy to navigate and access, including in rural areas.

f. Care coordination is prioritized, with quality case management available as appropriate.
g. Barriers to access, including inadequate networks of physicians and other providers and prior authorizations, are minimized.
h. Administrative burdens on patients, physicians and other providers are minimized.
i. Educational materials are easy to read and emphasize that the ability and power to opt in or out of integrated care resides solely with the patient.
j. Physician participation in Medicare or Medicaid is not mandated nor are eligible physicians denied participation. (New HOD Policy)

2. That our AMA reaffirm Policy H-290.967, which establishes principles on the delivery of care and financing reform for Medicare and Medicaid dually eligible patients. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy D-290.978, which calls on the Centers for Medicare & Medicaid Services to require all states to develop processes to facilitate opting out of managed care programs by dual eligible individuals. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-165.822, which encourages new and continued partnerships to address non-medical health needs and the underlying social determinants of health; supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs; and encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-180.944, which states that health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health services, research and data collection; promoting equity in care; increasing health workforce diversity; influencing social determinants of health; and voicing and modeling commitment to health equity. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 101
(N-21)

Introduced by: Virginia, American Association of Clinical Urologists, District of Columbia, Oklahoma, Tennessee, Alabama, New Jersey, North Carolina, Mississippi, Georgia, Kentucky

Subject: Standardized Coding for Telehealth Services

Referred to: Reference Committee A

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1 Whereas, Telehealth services have expanded rapidly during the SARS-CoV-2 pandemic and
2 these services are anticipated to continue to be highly utilized moving forward; and
3
4 Whereas, Physicians and other health care providers face complex rules for coding and
5 reimbursement which hinder the efficient utilization of telehealth for the benefit of our patients;
6 and
7
8 Whereas, Telehealth services are easily identified by using place of service (02) on claims
9 submitted for reimbursement. However, many private payors additionally require a modifier
10 (GT or 95) to indicate the service was performed using telemedicine. Other payors require
11 additional billing requirements making claim submission even more complex and prone to
12 errors leading to rejected claims and delayed or absent reimbursement for these services;
13 therefore be it
14
15 RESOLVED, That our American Medical Association advocate by regulation and/or legislation
16 that telehealth services are uniformly identified by using place of service (02) without any
17 additional requirements, such as modifiers imposed by third party payors, for claim submission
18 and reimbursement. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 09/07/21

AUTHOR'S STATEMENT OF PRIORITY

As the United States enters the 4th wave of the SARS-Cov-2 pandemic, telehealth will continue to be an important vehicle for physicians to provide care for their patients. Also, during the pandemic overall reimbursement for medical services has declined for many practices while costs, such as PPE's, have significantly increased. The varied and complex rules for coding telehealth by the various payors cause unnecessary confusion for physician practices and invariably leads to rejected claims and delayed or absent reimbursement. Our AMA should immediately advocate for standardized and simplified telehealth coding in order to help sustain physician practices and allow them to continue to provide telehealth and other essential services during this pandemic and afterwards.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 102
(N-21)

Introduced by: Senior Physicians Section

Subject: Prevention of Hearing Loss-Associated-Cognitive-Impairment through Earlier Recognition and Remediation

Referred to: Reference Committee A

Whereas, Our AMA holds out as a primary objective "to promote the art and science of medicine and the betterment of public health;" and

Whereas, Our AMA has adopted policy in support of health promotion and preventive care, community preventive services, healthy lifestyles, coverage for preventive care and immunizations, health information and education, training in the principles of population-based medicine, values-based decision-making in the healthcare system, and encouragement of new advances in science and medicine via strong financial and policy support for all aspects of biomedical science and research;[1-8] and

Whereas, Our AMA has prior policy supporting insurance coverage for hearing remediation[9] as well as for dementia treatment;[10] and

Whereas, There is mounting evidence that there is a strong link between hearing impairment in middle and later life and the development of cognitive, as well as social impairments and falls, although its specific causality in relation to later cognitive loss has not yet conclusively been established;[11-31] and

Whereas, The landmark Lancet Commission on Dementia Prevention, Intervention and Care of 2017, amplified by the 2020 follow-up report[13-15] concluded that age-related hearing loss (ARHL) may account for nine percent of all cases of dementia, making this the single largest potentially modifiable risk factor for that condition, beginning in mid-life; and

Whereas, Compared to individuals with normal hearing, those individuals with a mild, moderate, and severe hearing impairment, respectively, have been shown to have a 2-, 3-, and 5-fold increased risk of incident all-cause dementia over 10 years of follow-up in one study;[29] and

Whereas, Based on prior and pilot studies,[30-31] the causative link between hearing impairment in middle age and later life to cognitive impairment is likely to be confirmed by ongoing ACHIEVE[32] and other clinical trials now in progress; and

Whereas, The return on investment for hearing remediation, especially but not exclusively in mid-life, will be substantial and time-sensitive insofar as it may ameliorate (by delay in onset or even prevention of cognitive decline) far more costly care for those with cognitive decline (direct and indirect costs). Delaying the onset of Alzheimer's Disease by even one year has significant fiscal benefits. A 2014 study estimated a one-year delay in the onset of Alzheimer's disease would save $113 Billion by 2030. This underscores the urgency of current action to reduce the cost of healthcare (including, and perhaps especially, to Medicare) while improving other measures influencing the quality of life;[33-40] and

Whereas, A generally held calculation for the yearly cost of caring for those with dementia exceeds $307 billion as of 2010, and is expected to rise to $624 billion in 2030 and $1.5 trillion by 2050. The current yearly market cost of hearing aids in the US is estimated at $9 billion. This suggests that, with a 9% increase in risk of development of cognitive loss later in life due to unaddressed hearing loss,[13,15] remediating even this single important element linked to cognitive decline would be cost-effective immediately, and will be increasingly so in the future;[39,40] and

Whereas, The issue of hearing impairment is also a matter of health and social equity, with serious immediate and long-term consequences resulting from neglect of remediation. Unaddressed hearing loss reduces earnings potential and increases disability during gainful years, even before factoring in the likelihood of developing cognitive loss later. Sadly, the cost of hearing amplification and other forms of remediation is significant enough (even with over-the-counter products, which while possibly helpful do not come with professional guidance) to defer purchase and implementation by an indigent population;[46] and

Whereas, It is indisputable that promotion of any possibly effective means of delay, prevention, as well as timely treatment of cognitive impairment and dementia is highly desirable for public health, for humane as well as financial reasons; and

Whereas, Congress has shown interest in expanding coverage for hearing remediation in the most recent bill, HR 1118, 'Medicare Hearing Act of 2021,' filed in the current Congressional Session, affording a strategic opportunity for our AMA to more effectively advocate now for expanding coverage to include coverage of preventive strategies in middle age, promoting that as a way to mitigate future Medicare costs;[41-43] and

Whereas, Some developed countries such as Brazil have launched national efforts to bring hearing remediation to the masses[45] as a means of reducing later cognitive decline, suggesting that early remediating of hearing is felt by other nations to be a cost-effective pursuit; and

Whereas, The issues involved in analyzing all factors impeding adequate distribution of hearing remediation are complex, and require physicians to be current, informed, and involved in the discussion with patients;[44,47-48] and

Whereas, A number of groups have a stake in promoting hearing remediation, including professional and citizen and Federal Agencies, such as the Agency for Health Research and Quality and the National Institute on Deafness and Other Communication Disorders (NIDCD); therefore be it

RESOLVED, That our American Medical Association promote awareness of hearing impairment as a potential contributor to the development of cognitive impairment in later life, to physicians as well as to the public (Directive to Take Action); and be it further

RESOLVED, That our AMA promote, and encourage other stakeholders, including public, private, and professional organizations and relevant governmental agencies, to promote, the conduct and acceleration of research into specific patterns and degrees of hearing loss to determine those most linked to cognitive impairment and amenable to correction (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for increased hearing screening, and expanding all avenues for third party coverage for effective hearing loss remediation beginning in mid-life or whenever detected, especially when such loss is shown conclusively to contribute significantly to the development of, or to magnify the functional deficits of cognitive impairment, and/or to limit the capacity of individuals for independent living. (Directive to Take Action)

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

Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Unaddressed hearing loss has a major effect on many physicians and patients, especially seniors. Additionally, unaddressed hearing loss has been shown to have a disproportionate impact on underrepresented or disadvantaged populations, an important health care disparity issue for our AMA. Increased hearing screening and remediation is a public health issue that is very consistent with our mission and strategic plan. It is reliably estimated that at 9%, unaddressed age-related hearing loss is the single most remediable cause of cognitive decline. Delaying the onset of cognitive decline by even one year has predictably VERY significant societal and fiscal benefits, and accordingly, there is a remarkably negative societal impact for every year that this issue is not effectively addressed.

AMA has significant related policy, but important gaps exist, including education about the connection between hearing loss and cognitive decline, emphasizing the importance of hearing screening at MIDlife, in order to promote remediation, and thereby help to prevent cognitive decline. A few commercial insurers have begun to acknowledge the need. Our AMA must update policy and promote this trend. The proposed action is likely to have meaningful impact but requires new policy or modification of existing policy to implement. There is pending Congressional action that makes this a timely political issue. An AMA resolution is one of the most appropriate avenues to address the issue.

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5. H-425.972 Healthy Lifestyles
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8. H-450.938 Value-Based Decision-Making in the Health Care System
9. H-185.929 Hearing Aid Coverage
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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 103
(N-21)

Introduced by: Senior Physicians Section

Subject: Oral Healthcare IS Healthcare

Referred to: Reference Committee A

Whereas, Nationwide, around 50% of Americans 65 and older lack any source of dental insurance, and since its inception in 1965, Medicare has only covered dental care under narrowly prescribed circumstances[1]; and

Whereas, Nearly half of Americans 65 and over didn't visit a dentist in the last year, citing expense, (and 12% have not received dental care in five or more years). Nearly one in five have lost all their natural teeth (even higher in black and non-Hispanic populations)[2]; and

Whereas, Unaddressed tooth and gum disease dramatically increases the risks of cardiovascular events such as heart attacks and stroke, and such events are leading causes of death and disability in Medicare recipients, and there is a correlation between poor oral health and chronic diseases more common in the elderly, such as diabetes and Alzheimer's, as well as head and neck cancers[3]; and

Whereas, Prevention and treatment of dental diseases is effective in reducing many of these adverse health consequences; and

Whereas, Dental issues are a major source of pain, interfering directly with nutrition and hydration, and painful dental infections are a common cause of emergency department visits, some life threatening, requiring hospitalization and major expense; and

Whereas, In a 2019 AARP poll, 84 percent of Americans supported adding dental, vision and hearing coverage to Medicare, even if their costs would increase[4], and

Whereas, In all populations, including seniors, dental issues are a major source of both economic as well as healthcare disparity, and

Whereas, Congress is poised to consider Medicare expansion under various current and pending proposals; therefore be it

RESOLVED, That our American Medical Association reaffirm that dental and oral health are integral components of basic health care and maintenance regardless of age (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA, through the Center for Healthcare Equity, highlight the substantial contribution of dental and oral healthcare disparities to health inequity as well as to social and economic disparities (Directive to Take Action); and be it further

1 RESOLVED, That our AMA support ongoing research, legislative actions and administrative
2 efforts to promote access to and adequate coverage in the public and private payers by
3 preventative and therapeutic dental services as integral parts of overall health maintenance to
4 all populations (New HOD Policy); and be it further
5
6 RESOLVED, That our AMA work with other organizations to explore avenues to promote efforts
7 to expand Medicare benefits to include preventative and therapeutic dental services without
8 increasing the already proposed decrease in Medicare Part B Reimbursements. (Directive to
9 Take Action)

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

Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Poor dental and oral health have proven, and sometimes disastrous deleterious effects on many physicians and patients, especially seniors. Additionally, poor oral health has been shown to have a disproportionate impact on underrepresented or disadvantaged populations, which is an important health care disparity issue for our AMA. Limited access to preventative and therapeutic dental care is a public health issue, addressing which is very consistent with our mission and strategic plan. Lack of access to dental healthcare has very well documented deleterious effects on physical health, and the seriousness and costs of delayed or denied dental care especially in older populations with their vulnerability to cardiovascular and neoplastic conditions expand dramatically with every year of delay. Poor oral health is a well-documented economic and social disparity issue as well.

AMA has related policy, but has not lobbied effectively for Medicare dental coverage, seemingly for non-health related reasons. The proposed action is likely to have meaningful impact, but requires new policy or modification of existing policy to implement. There is pending Congressional action in the 117th Session (the Medicare Dental Coverage Act of 2021) that makes this a very timely political issue, especially at our Advocacy meeting. An AMA resolution promoting legislative action is one of the most appropriate avenues to address the issue.

RELEVANT AMA POLICY

Medicare Coverage for Dental Services H-330.872
Our AMA supports: (1) continued opportunities to work with the American Dental Association and other interested national organizations to improve access to dental care for Medicare beneficiaries; and (2) initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease in the Medicare population, the optimal dental benefit plan designs to cost-effectively improve health and prevent disease in the Medicare population, and the impact of expanded dental coverage on health care costs and utilization.
Citation: CMS Rep. 03, A-19;

Importance of Oral Health in Patient Care D-160.925
Our AMA: (1) recognizes the importance of (a) managing oral health and (b) access to dental care as a part of optimal patient care; and (2) will explore opportunities for collaboration with the American Dental Association on a comprehensive strategy for improving oral health care and education for clinicians.
Citation: Res. 911, I-16; Reaffirmed: CMS Rep. 03, A-19;

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 104
(N-21)

Introduced by: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Subject: Improving Access to Vaccinations for Patients

Referred to: Reference Committee A

Whereas, Over the past two years a new shingles vaccine, Shingrix, has become available. However, that vaccine is only reimbursed under Medicare Part D, which does not pay for office-based treatment. It remains unclear why that decision was made as the previous shingles vaccine, Zostavax, was covered in an office-based practice (Medicare Part B); and

Whereas, Medicare does cover other vaccines (influenza, both pneumococcal vaccines and Td) in the office; and

Whereas, Commercial insurers in Massachusetts, unlike Medicare, cover this vaccine in an office-based practice as they do with other vaccines; and

Whereas, This policy of the Centers for Medicaid and Medicare Services (not to cover in-office administration of the Shingrix vaccine) encourages our patients to forego the convenience of having their vaccine while being present for an office visit. They must travel to the pharmacy to obtain the vaccine; and

Whereas, It is generally acknowledged that patients are much more likely to accept a treatment as part of a meeting with their health care provider than if they have to make a separate trip to access the treatment, such that deferring the vaccination lessens the likelihood that the patient will receive it; and

Whereas, It is important to improve our patients access to this vaccine; therefore be it

RESOLVED That our American Medical Association encourage all payors, including the Centers for Medicare and Medicaid Services, to cover, without cost sharing, all vaccines recommended by the Centers for Disease Control and Prevention, when administered in the physician office. (Directive to Take Action)

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

Received: 10/06/21

AUTHORS STATEMENT OF PRIORITY

This is urgent because current Medicare policy forces patients to seek alternative sites for having their vaccine thus delaying vaccination. Shingles itself is a very common healthcare condition estimated to effect up to 50% of individuals over their lifetime. Making access to this vaccination more difficult is not in our patients' best interest. It often takes a few years of encouragement before people finally get their vaccinations done whereas it would have been done at the time of their initial visit. This delay in care is inappropriate, never mind absorbing a healthcare providers time to readdress the same issue repeatedly when our time could be put to better use.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 105
(N-21)

Introduced by: Women Physicians Section

Subject: Fertility Preservation Insurance Coverage for Women in Medicine

Referred to: Reference Committee A

Whereas, Many women in medicine feel pressure to defer pregnancy during their training, which often coincides with peak fertility years;[1] and

Whereas, Many Fortune 100 Companies offer an employee benefit of egg freezing, allowing women to have the option of having children while managing their careers;[2] and

Whereas, As a medical industry that performs egg freezing procedures, employers should offer this as a covered benefit through employer paid insurance plans or cash reimbursement for their own physician employees, including the medical student level; and

Whereas, By doing so, women physicians gain reproductive autonomy, reducing the pressure to sacrifice their careers in order to start their families, thereby reducing the gender gap in leadership roles;[2] and

Whereas, It may increase women physician retention in an organization, as employees who obtain social egg freezing benefits are more loyal to their employers;[2,3] and

Whereas, Fertility preservation benefits for active duty military personnel is being explored as a covered benefit with Tricare (AMA Policy H-510.984); and

Whereas, Data from one study of U.S. female physicians indicate that medical professionals have substantially higher infertility rates than the general population, with one in four respondents reporting a diagnosis of infertility;[4] and

Whereas, Our AMA has policy that encourages infertility and fertility preservation insurance coverage (AMA Policy H-185.990); and

Whereas, Our AMA has policy which encourages insurance coverage for medical students (AMA Policy H-295.942); therefore be it

RESOLVED, That our American Medical Association advocate for fertility preservation as a covered employee benefit through employer paid insurance plans or cash reimbursement for women in medicine. (Directive to Take Action)

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

Received: 10/07/21

AUTHORS STATEMENT OF PRIORITY

Women physicians have made conscious decisions to become physicians in various fields of medicine. After completing medical school, residency, and fellowship before embarking on our careers, some of us are faced with the reality that our fertility (or the ability to naturally conceive a child) has decreased for various reasons. As women age and face decreasing fertility, there may be a conflict between choosing their careers and being mothers. Data from one study of women physicians indicate that medical professionals have substantially higher infertility rates than the general population, with one in four respondents reporting a diagnosis of infertility. While many businesses offer egg freezing as an employee benefit, thus allowing women the option of having children while managing their careers, this option is often not afforded to women in medicine as a whole. This resolution is a way to support women physicians' choices in preserving their fertility while accomplishing their professional goals.

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RELEVANT AMA POLICY

Infertility Benefits for Veterans H-510.984

1. Our AMA supports lifting the congressional ban on the Department of Veterans Affairs (VA) from covering in vitro fertilization (IVF) costs for veterans who have become infertile due to service-related injuries.
2. Our AMA encourages interested stakeholders to collaborate in lifting the congressional ban on the VA from covering IVF costs for veterans who have become infertile due to service-related injuries.
3. Our AMA encourages the Department of Defense (DOD) to offer service members fertility counseling and information on relevant health care benefits provided through TRICARE and the VA at pre-deployment and during the medical discharge process.
4. Our AMA supports efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address infertility due to service-related injuries.
5. Our AMA supports additional research to better understand whether higher rates of infertility in servicewomen may be linked to military service, and which approaches might reduce the burden of infertility among service women.

Citation: CMS Rep. 01, I-16; Appended: Res. 513, A-19

Infertility and Fertility Preservation Insurance Coverage H-185.990

1. Our AMA encourages third party payer health insurance carriers to make available insurance benefits 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.

Citation: (Res. 150, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Appended: Res. 114, A-13; Modified: Res. 809, I-14)

Insurance Coverage for Medical Students and Resident Physicians H-295.942
The AMA urges (1) all medical schools to pay for or offer affordable policy options and, assuming the rates are appropriate, require enrollment in disability insurance plans by all medical students; (2) all residency programs to pay for or offer affordable policy options for disability insurance, and strongly encourage the enrollment of all residents in such plans; (3) medical schools and residency training programs to pay for or offer comprehensive and affordable health insurance coverage, including but not limited to medical, dental, and vision care, to medical students and residents which provides no less than the minimum benefits currently recommended by the AMA for employer-provided health insurance and to require enrollment in such insurance; (4) carriers offering disability insurance to: (a) offer a range of disability policies for medical students and residents that provide sufficient monthly disability benefits to defray any educational loan repayments, other living expenses, and an amount sufficient to continue payment for health insurance providing the minimum benefits recommended by the AMA for employer-provided health insurance; and (b) include in all such policies a rollover provision allowing continuation of student disability coverage into the residency period without medical underwriting. (5) Our AMA: (a) actively encourages medical schools, residency programs, and fellowship programs to provide access to portable group health and disability insurance, including human immunodeficiency virus positive indemnity insurance, for all medical students and resident and fellow physicians; (b) will work with the ACGME and the LCME, and other interested state medical societies or specialty organizations, to develop strategies and policies to ensure access to the provision of portable health and disability insurance coverage, including human immunodeficiency virus positive indemnity insurance, for all medical students, resident and fellow physicians; and (c) will prepare informational material designed to inform medical students and residents concerning the need for both disability and health insurance and describing the available coverage and characteristics of such insurance.
Citation: (BOT Rep. W, I-91; Reaffirmed: BOT Rep. 14, I-93; Appended: Res. 311, I-98; Modified: Res. 306, A-04; Modified: CME Rep. 2, A-14)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 106
(N-21)

Introduced by: Medical Student Section

Subject: Reimbursement of School-Based Health Centers

Referred to: Reference Committee A

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1 Whereas, School Based Health Centers (SBHCs) are facilities located within the kindergarten
2 through twelfth grade school setting that provide an array of high-quality health care services to
3 students [1,2]; and
4
5 Whereas, SBHCs were first established in the 1960's by the American Academy of Pediatrics to
6 increase access to primary health care and preventative health services, especially for the most
7 vulnerable underserved population of children[3]; and
8
9 Whereas, Services available are driven by community need, ranging from primary medical care
10 to dental, vision, and behavioral health services, alongside wraparound programming such as
11 substance abuse counseling and social case management, and about 40% of SBHCs employ
12 physicians[1,2,4]; and
13
14 Whereas, The benefits of routine preventive care are well-established and are incredibly
15 important for children from infancy to adolescence, providing 1) prevention of serious medical
16 illnesses through vaccination and screening, 2) tracking growth and development, 3) raising
17 medical-related concerns, and 4) creating a strong patient-centered medical home[5]; and
18
19 Whereas, The SBHC model provides students with increased access to health care resources
20 and improved long- and short-term health care outcomes, including decreased emergency
21 department visits and hospital utilizations [3,6,7]; and
22
23 Whereas, SBHCs act as a "safety net health care delivery model" for uninsured, underinsured
24 children or those who lack accessible healthcare[8] ; and
25
26 Whereas, SBHCs can receive both grant funding by private organizations and the government,
27 and reimbursement for services rendered by a third-payer payer, most commonly Medicaid and
28 the Children's Health Insurance Program (CHIP); through private organizations;[9] or through
29 direct funding programs established by federal, state and local governments[10]; and
30
31 Whereas, The federally qualified health center (FQHC) program funds community health
32 centers that serve medically underserved populations, such as SBHCs, by providing cash
33 grants, drug discounts, legal protections, medical staff and, most uniquely, per-visit
34 reimbursement by Medicaid[11] ; and
35
36 Whereas, Funding SBHCs has been shown to be cost-effective by increasing access to
37 preventive care and reducing utilization of expensive acute care services, leading to a net
38 savings for Medicaid of $30 to $969 per visit[12]; and

Whereas, School-based health centers have grown substantially over the past two decades, primarily due to an increase in federally qualified health center (FQHC) sponsorship, with 2,584 SBHCs in the United States in 2017, more than double in number present in 1998, and since 2008, SBHC growth in urban areas has been greatly outpaced by growth in rural and suburban settings[13] ; and

Whereas, The majority of students without access to SBHCs attend schools in low-income communities eligible for Title I funding, and while increased FQHC sponsorship has greatly contributed to recent growth, 80% of FQHCs are not currently partnered with SBHCs[4]; and

Whereas, Many SBHCs rely on public funding,[9] although in 2014 only 89% of SBHCs billed Medicaid and 71% billed CHIP in 2014[4]; and

Whereas, Not all services rendered can be reimbursed under Medicaid at SBHCs, since among many requirements: 1) the child must be Medicaid-eligible, 2) the service must be among those covered by Medicaid and 3) the service must be provided by a Medicaid-participating provider - further, until 2014, reimbursement was not allowed for services given without charge to the beneficiary, except under rare exceptions[4,14,15] ; and

Whereas, Apart from seven state Medicaid agencies, SBHCs are not considered a provider type[16] making the reimbursement of services more difficult for SBHCs;

Whereas, The lack of differentiation on claims data means that Medicaid is unable to identify what services were rendered by an SBHC versus a different type of provider, making it difficult to track and attribute improvements in quality of care or outcomes to SBHCs, making it difficult for SBHCs to meet quality standards expected by the state[16]; and

Whereas, Multiple states have recently enacted policies that have facilitated or increased Medicaid reimbursement to SBHCs, with seven states (Delaware, Illinois, Louisiana, Maine, New Mexico, North Carolina, and West Virginia) naming SBHCs as a provider under Medicaid, four states (Louisiana, Maryland, Michigan, and New Mexico) mandating Medicaid reimbursement through a managed care organization, and eight states (Connecticut, Delaware, Illinois, Louisiana, Maine, Maryland, North Carolina, and West Virginia) waiving prior authorization[16]; and

Whereas, The AMA supports the study of SBHCs and recommends SBHC standards (H-60.991), supports adequately resourced SBHCs for healthcare delivery to children and adolescents (H-60.921), and supports physician service reimbursement and reimbursement for physician practices (H-240.966; H-385.990; H-385.942; 385.952); therefore be it

RESOLVED, That our American Medical Association amend Policy H-60.921, "School-Based and School-Linked Health Centers," by addition and deletion to read as follows:

School-Based and School-Linked Health Centers, H-60.921

1. Our AMA supports ~~the concept of adequately equipped and staffed~~ the implementation, maintenance, and equitable expansion of school-based or school-linked health centers (SBHCs) for the comprehensive management of conditions of childhood and adolescence.

2. Our AMA recognizes that school-based health centers increase access to care in underserved child and adolescent populations.

3. Our AMA supports identifying school-based health centers in claims data from Medicaid and other payers for research and quality improvement purposes.

4. Our AMA supports efforts to extend Medicaid reimbursement to school-based health centers at the state and federal level, including, but not limited to the recognition of school-based health centers as a provider under Medicaid. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

The pandemic has had particularly profound impacts upon the health of pediatric populations. Children are facing pandemic-induced setbacks to their development and their physical, mental, and emotional health, and it is urgent that our healthcare system be ready to better support them. Our AMA recognizes health care as a human right and strives to increase access through various methods. School-Based Health Centers (SBHCs) are an important tool for providing healthcare for kids in kindergarten through 12th grade, especially for underserved populations. However, it is difficult for SBHCs to bill Medicaid, leading to financial problems for these critical safety nets. Our AMA has previously supported the concept of SBHCs but not addressed their difficulty in obtaining funding. This resolution will amend current policy to support the expansion of these centers, enable future research on quality improvement methods, and enable SBHCs to receive reimbursement from Medicaid. These asks align with the AMA's increasing focus on equity in healthcare and we believe should be considered a priority for the House of Delegates.

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RELEVANT AMA POLICY

Providing Medical Services through School-Based Health Programs H-60.991

(1) The AMA supports further objective research into the potential benefits and problems associated with school-based health services by credible organizations in the public and private sectors. (2) Where school-based services exist, the AMA recommends that they meet the following minimum standards: (a) Health services in schools must be supervised by a physician, preferably one who is experienced in the care of children and adolescents. Additionally, a physician should be accessible to administer care on a regular basis. (b) On-site services should be provided by a professionally prepared school nurse or similarly qualified health professional. Expertise in child and adolescent development, psychosocial and behavioral problems, and emergency care is desirable. Responsibilities of this professional would include coordinating the health care of students with the student, the parents, the school and the student's personal physician and assisting with the development and presentation of health education programs in the classroom. (c) There should be a written policy to govern provision of health services in the school. Such a policy should be developed by a school health council consisting of school and community-based physicians, nurses, school faculty and administrators, parents, and (as appropriate) students, community leaders and others. Health services and curricula should be carefully designed to reflect community standards and values, while emphasizing positive health practices in the school environment. (d) Before patient services begin, policies on confidentiality should be established with the advice of expert legal advisors and the school health council. (e) Policies for ongoing monitoring, quality assurance and evaluation should be established with the advice of expert legal advisors and the school health council. (f) Health care services should be available during school hours. During other hours, an appropriate referral system should be instituted. (g) School-based health programs should draw on outside resources for care, such as private practitioners, public health and mental health clinics, and mental health and neighborhood health programs. (h) Services should be coordinated to ensure comprehensive care. Parents should be encouraged to be intimately involved in the health supervision and education of their children.
CSA Rep. D, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: Res. 412, A-05; Reaffirmed in lieu of Res. 908, I-12

School-Based and School-Linked Health Centers H-60.921

Our AMA supports the concept of adequately equipped and staffed school-based or school-linked health centers (SBHCs) for the comprehensive management of conditions of childhood and adolescence.
CSAPH Rep. 1, A-15

Reimbursement to Physicians and Hospitals for Government Mandated Services H-240.966

(1) It is the policy of the AMA that government mandated services imposed on physicians and hospitals that are peripheral to the direct medical care of patients be recognized as additional practice cost expense.
(2) Our AMA will accelerate its plans to develop quantitative information on the actual costs of

regulations.
(3) Our AMA strongly urges Congress that the RBRVS and DRG formulas take into account these additional expenses incurred by physicians and hospitals when complying with governmentally mandated regulations and ensure that reimbursement increases are adequate to cover the costs of providing these services.
(4) Our AMA will advocate to the CMS and Congress that an equitable adjustment to the Medicare physician fee schedule (or another appropriate mechanism deemed appropriate by CMS or Congress) be developed to provide fair compensation to offset the additional professional and practice expenses required to comply with the Emergency Medical Treatment and Labor Act.
Sub Res. 810, I-92; Appended by CMS 10, A-98; Reaffirmation: I-98; Reaffirmation: A-02; Reaffirmation: I-07; Reaffirmed in lieu of Res. 126, A-09; Reaffirmed: CMS Rep. 01, A-19

Payment for Physicians' Services H-385.990
Our AMA:
(1) Recognizes the validity of a pluralistic approach to third party reimbursement methodology and recognizes that indemnity reimbursement, as a schedule of benefits, as well as "usual and customary or reasonable" (UCR), have positive aspects which merit further study.
(2) Reaffirms its support for: (a) freedom for physicians to choose the method of payment for their services and to establish fair and equitable fees; (b) freedom of patients to select their course of care; and (c) neutral public policy and fair market competition among alternative health care delivery and financing systems.
(3) Reaffirms its policy encouraging physicians to volunteer fee information to patients and to discuss fees in advance of services, where feasible.
(4) Urges physicians to continue and to expand the practice of accepting third party reimbursement as payment in full in cases of financial hardship, and to voluntarily communicate to their patients through appropriate means their willingness to consider such arrangements in cases of financial need or other circumstances.
CMS Rep. B, I-83; Reaffirmed: BOT Rep. TT, I-92; Reaffirmed: CMS Rep. E, A-93; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: Sub. Res. 137, A-94; Reaffirmed: CMS Rep. 5, A-04; Reaffirmed: BOT Rep. 10, I-05; Reaffirmed in lieu of Res. 127, A-10; Reaffirmed: CMS Rep. 01, A-20

CMS Use of Regulatory Authority to Implement Reimbursement Policy H-385.942
The AMA urge (1) CMS in the strongest terms possible to solicit the participation and counsel of relevant professional societies before implementing reimbursement policies that will affect the practice of medicine; (2) CMS to make every effort to determine the clinical consequences of such reimbursement policy changes before the revised policies are put in place; and (3) CMS in the strongest terms possible not to misapply either quality measurement data or clinical practice guidelines developed in good faith by the professional medical community as either standards or the basis for changes in reimbursement policies.
Res. 124, A-98; Modified and Reaffirmed: CMS Rep. 4, A-08; Reaffirmed: CMS Rep. 01, A-18; Reaffirmed: Res. 105, A-18

Appropriate Physician Reimbursement by Centers for Medicare & Medicaid Services H-385.952
Our AMA: (1) opposes both CMS's and local carriers' efforts to reduce or deny physician payments for appropriate services; and (2) will work to assure that all evaluation and management services are appropriately reimbursed.
Res. 118, I-95; Reaffirmation: A-00; Reaffirmation: A-02; Reaffirmation: A-06; Reaffirmation: A-09; Reaffirmed: CMS Rep. 01, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 107
(N-21)

Introduced by: Medical Student Section

Subject: Expanding Medicaid Transportation to Include Healthy Grocery Destinations

Referred to: Reference Committee A

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1 Whereas, Food insecurity is defined as the disruption of food intake or eating patterns due to
2 lack of money and other resources[1–5]; and
3
4 Whereas, Food insecurity increases the risk of developing chronic diseases such as obesity,
5 type II diabetes, and cardiovascular disease[1–7]; and
6
7 Whereas, Health care expenditures from 2011-2013 of food-insecure individuals were $1,863
8 higher per person compared to food-secure individuals, resulting in $77.5 billion of additional
9 health care spending[8]; and
10
11 Whereas, Medicaid eligibility is correlated with food insecurity and lack of access to grocery
12 stores[9]; and
13
14 Whereas, In 2015, 12.7% of the United States census tracts were categorized as low income
15 and were concurrently categorized as areas with limited access to a food store (supermarket,
16 grocery store)[10]; and
17
18 Whereas, In 2015, 18.2 million housing units were estimated to be in low-income census tracts
19 where at least 100 households without a vehicle lived more than half a mile from the nearest
20 supermarket or large grocery store, or where at least a third of the tract was more than 20 miles
21 from the nearest store[10]; and
22
23 Whereas, Over 9.5 million parents, 15.6 million nonparents, and 25.8 million children were
24 eligible for Supplemental Nutrition Assistance Program (SNAP) and Medicaid benefits in 2015[11];
25 and
26
27 Whereas, Individuals of lower socioeconomic status report inadequate geographical location of
28 food stores as a major barrier to proper nutrition, including inadequate transportation[12–15]; and
29
30 Whereas, Lack of access to supermarkets, as compared to relatively ready access to
31 convenience stores, can limit the availability of healthy foods, resulting in poorer health
32 outcomes, such as obesity or diabetes[16–20]; and
33
34 Whereas, There is extensive research to support that initiatives improving food access in low
35 income populations results in improved health outcomes[21–23]; and

Whereas, Non-emergency medical transportation services (NEMT) covered by State Medicaid includes transportation for prescriptions and medical supplies but not grocery stores, farmers markets, food banks or pantries[24,25]; and

Whereas, In the past 2 decades, various pilot programs in areas such as Los Angeles, California, north Nampa, Idaho and Flint, Michigan were initiated to provide transportation to and from specific grocery stores for residents in food deserts[23,26–29]; and

Whereas, A 10-week pilot program in Michigan's Upper Peninsula to improve food access, involving a local farmer's market and 32 patients with at least one chronic disease, motivation to begin a healthy lifestyle, and demonstrated difficulty in accessing fruits and vegetables, resulted in an increase of 1.2 cups of fruits and vegetables consumed per day and a significant increase in reported quality of life[22]; and

Whereas, Participants in an East Texas transportation voucher program that included grocery store access reported improved health and well-being, and were more likely to be aware of and utilize SNAP benefits[30]; and

Whereas, Pilot test healthy food access programs found that when barriers such as cost and access were removed, individuals from lower SES communities increased their purchase and consumption of fruits and vegetables[31,32]; and

Whereas, One study found that after a full-service supermarket was opened in a low-SES neighborhood, the rate of increase of diagnosed high cholesterol and arthritis incidence was reduced[33]; and

Whereas, Many pilot programs, such as LyftUp Grocery Access Program, run for a limited period of time, with ambiguity of future continuity, therefore offering only temporary aid[34,35]; and

Whereas, Medicaid has offered NEMT services since 1966 under the Code of Federal Regulations and authorized under the Social Security Act, providing 104 million healthcare-related trips at no cost to eligible individuals in 2013[24,36]; and

Whereas, NEMT costs Medicaid less than one percent of its total expenditures annually[37,38]; and

Whereas, Current AMA policy (D-150.978) encourages the "development of a healthier food system through tax incentive programs, community-level initiatives and federal legislation"; and

Whereas, Current AMA policy (H-130.954) only encourages the "development of non-emergency patient transportation systems… [for the accessibility] of health care", there is no policy that addresses the lack of transportation support to and from healthy grocery destinations; therefore be it

RESOLVED, That our American Medical Association: (1) support the implementation and expansion of transportation services for accessing healthy grocery options; and (2) advocate for inclusion of supermarkets, food banks and pantries, and local farmers markets as destinations offered by Medicaid transportation at the federal level; and (3) support efforts to extend Medicaid reimbursement to non-emergent medical transportation for healthy grocery destinations. (Directive to Take Action)

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

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Although there are various existing AMA policies that address food deserts, the ongoing pandemic has highlighted their inadequacy to address issues of food insecurity and nutrition, particularly for older adults and other high-risk populations. The majority of those who live in food deserts also rely on Medicaid. Access to healthy foods is essential to maintaining good health, much like access to healthcare.

Our resolution adds to policy by asking our AMA to advocate for increasing access to healthy food options, utilizing the already existing non-emergent medical transportation service of Medicaid to connect Medicaid participants with healthy groceries. Healthcare only comprises 10-15% of one's health outcomes, and the rest - genetics, individual behavior, social/environmental factors - all have a play in the food one has access to.

There have been various pilot programs offering transportation services to and from grocery destinations. Many of these pilot programs run for a couple months and then dispel with wide uncertainty of whether or not they return to stay. Medicaid would provide a stable baseline service to its participants and its inclusion is integral for the longevity of such services. Once this baseline is established, then other companies/options can be utilized as supplementation.

This resolution addresses a critical gap for marginalized populations, suggesting innovative ways to focus on prevention and better daily living. Our AMA has recently been a leader in addressing discrimination, and as the issue of achieving appropriate nutrition becomes exacerbated by the difficulties of the ongoing pandemic, this issue is an urgent, timely, and priority resolution for American physicians.

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RELEVANT AMA POLICY

Non-Emergency Patient Transportation Systems H-130.954

The AMA: (1) supports the education of physicians and the public about the costs associated with inappropriate use of emergency patient transportation systems; and (2) encourages the development of non-emergency patient transportation systems that are affordable to the patient, thereby ensuring cost effective and accessible health care for all patients.
Res 812, I-93; Reaffirmed: CMS Rep 10, A-03; Reaffirmed in lieu of Res 101, A-12; Modified: CMS Rep 02, I-18

Food Environments and Challenges Accessing Healthy Food H-150.925
Our AMA (1) encourages the U.S. Department of Agriculture and appropriate stakeholders to study the national prevalence, impact, and solutions to challenges accessing healthy affordable food, including, but not limited to, food environments like food mirages, food swamps, and food deserts; (2) recognizes that food access inequalities are a major contributor to health inequities, disproportionately affecting marginalized communities and people of color; and (3) supports policy promoting community-based initiatives that empower resident businesses, create economic opportunities, and support sustainable local food supply chains to increase access to affordable healthy food.
Res 921, I-18; Modified: Res. 417, A-21

Improvements to Supplemental Nutrition Programs H-150.937
1. Our AMA supports: (a) improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity; (b) efforts to decrease the price gap between calorie-dense, nutrition-poor foods and naturally nutrition-dense foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrollment, of existing programs that seek to improve nutrition and reduce obesity, such as the Farmer's Market Nutrition Program as a part of the Women, Infants, and Children program; and (c) the novel application of the Farmer's Market Nutrition Program to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize the consumption of naturally nutrition-dense foods in wider food distribution venues than solely farmer's markets as part of the Women, Infants, and Children program.
2. Our AMA will request that the federal government support SNAP initiatives to (a) incentivize healthful foods and disincentivize or eliminate unhealthful foods and (b) harmonize SNAP food offerings with those of WIC.
3. Our AMA will actively lobby Congress to preserve and protect the Supplemental Nutrition Assistance Program through the reauthorization of the 2018 Farm Bill in order for Americans to live healthy and productive lives.
Res 414, A-10; Reaffirmed A-12; Reaffirmation A-13; Appended: CSAPH Rep 1, I-13; Reaffirmation A-14; Reaffirmation I-14; Reaffirmation A-15; Appended: Res 407, A-17; Appended: Res 233, A-18

Sustainable Food D-150.978
Our AMA: (1) supports practices and policies in medical schools, hospitals, and other health care facilities that support and model a healthy and ecologically sustainable food system, which provides food and beverages of naturally high nutritional quality; (2) encourages the development of a healthier food system through tax incentive programs, community-level initiatives and federal legislation; and (3) will consider working with other health care and public health organizations to educate the health care community and the public about the importance of healthy and ecologically sustainable food systems.
CSAPH Rep. 8, A-09; Reaffirmed in lieu of Res. 411, A-11; Reaffirmation: A-12; Reaffirmed in lieu of Res. 205, A-12; Modified: Res. 204, A-13; Reaffirmation: A-15

Medicare’s Ambulance Service Regulations H-240.978
1. Our AMA supports changes in Medicare regulations governing ambulance service coverage guidelines that would expand the term "appropriate facility" to allow full payment for transport to the most appropriate facility based on the patient’s needs and the determination made by

physician medical direction; and expand the list of eligible transport locations from the current three sites of care (nearest hospital, critical access hospital, or skilled nursing facility) based upon the onsite evaluation and physician medical direction.
2. Our AMA will work with the Centers for Medicare & Medicaid Services (CMS) to pay emergency medical services providers for the evaluation and transport of patients to the most appropriate site of care not limited to the current CMS defined transport locations.
Res 37, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep 3, A-08; Modified: Res 124, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 108
(N-21)

Introduced by: Medical Student Section

Subject: Medicaid and CHIP Coverage for Glucose Monitoring Devices for Patients with Diabetes

Referred to: Reference Committee A

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1 Whereas, Type 1 diabetes mellitus (T1DM) and type 2 diabetes mellitus (T2DM) pose large and
2 steadily increasing health threats for both adults and youth in the United States, with
3 approximately 26.8 million adults and 210,000 youth under the age of 20 currently diagnosed
4 with either disease[1–6]; and
5
6 Whereas, There is increasing evidence for the role of glycemic variability in the development of
7 diabetic complications and mortality, particularly cardiovascular disease, stroke, and kidney
8 disease, which alongside diabetes are four of the top 10 leading causes of death in the U.S.[7-12];
9 and
10
11 Whereas, Glycemic variability for both T1DM and T2DM patients overall has been shown to
12 reduce quality of life and increase the burden of diabetes to healthcare systems, which currently
13 stands at over $1 billion annually[12-15]; and
14
15 Whereas, National trends in U.S. hospitalizations show an increasing number of admissions for
16 hypoglycemia among those with T2DM in recent years, with highest rates among Black
17 Medicare beneficiaries and those older than 75 years old[16]; and
18
19 Whereas, Investigators found that frequency of hypoglycemic events can be markedly reduced
20 in individuals with impaired hypoglycemia awareness through use of continuous glucose
21 monitors (CGM) for patients with T1DM, T2DM and gestational diabetes mellitis[17,18]; and
22
23 Whereas, CGM use has been demonstrated to improve patients' quality of life, reduce fear of
24 hypoglycemia, and provide a sense of empowerment to patients and their caregivers[19–27]; and
25
26 Whereas, Data show that restrictive access to CGMs in the Medicare and Medicaid populations
27 may have deleterious health, economic, and quality of life consequences[17,26]; and
28
29 Whereas, Many Medicare beneficiaries are subject to restrictive criteria for eligibility of CGMs,
30 such as documenting four fingerstick glucose tests per day for coverage of CGMs, despite only
31 100 test strips per 3 months being covered for non-insulin dependent diabetics[17,28,29]; and
32
33 Whereas, As of February 2020, 11 of 36 state Medicaid programs have required similar
34 stringent criteria of individuals needing to document four fingerstick glucose tests per day for
35 coverage of CGMs, and only four states have openly committed to Medicaid covering CGMs in
36 patients with T2DM regardless of durable medical equipment (DME) classification[17]; and

Whereas, CGMs offer a cost-effective alternative to traditional self-monitoring via fingerprick at an additional $653 over a patient's lifetime, translating to $8898 per QALY (quality-adjusted life year) gained that is well below the $100,000 per QALY cost-effectiveness threshold often cited in healthcare economics studies[30,31]; and

Whereas, Approximately 14% of adults under 65 covered by Medicaid have a form of diabetes[32]; and

Whereas, Retrospective analysis of patients prescribed to a professional CGM for T2DM showed no statistically significant increase in total annual costs compared to those who were not prescribed a professional CGM, but did see an improvement in hemoglobin A1c (HbA1c) without intensification of the current treatment regimen[19,33]; and

Whereas, While long-term cost effectiveness studies have demonstrated CGMs' potential to decrease overall costs for patients with T2DM through elimination of test strips and lancets, a majority of financial benefit is due to lower HbA1c readings and mitigation of direct diabetes related complications such as hospitalizations, emergency room visits, non-diabetes prescription medications, and indirect costs such as hampered productivity, which collectively account for 73.1% of total diabetes care cost[17,33]; and

Whereas, The lowest-cost option among CGMs, with an out-of-pocket price of less than $100 for uninsured individuals, are an alternative non-invasive glucose monitor called flash glucose monitoring which provides glucose readings on demand and allows for downloadable glucose data, and use has been found to decrease acute diabetes-related events and all-cause inpatient hospitalizations in patients with T2DM treated with short or rapid acting insulin[34-36]; and

Whereas, Patients with T2DM treated with oral agents are often placed on a basal-bolus regimen of insulin while admitted to the hospital for glucose control, and use of flash glucose monitoring in these patients during admission demonstrated lower average daily glucose and increased detection of hypoglycemia[37,38]; and

Whereas, CGMs have been able to provide increased insight into nocturnal glucose levels, glucose metabolism during exercise and feeding, and relative impact of medications on ambient glucose than any form of episodic elf-monitoring of blood glucose for all patients with diabetes, and CGM users spent significantly less time in hypoglycemic ranges compared to their self-monitoring of blood glucose counterparts[17,39]; and

Whereas, AMA Directive D-185.983 asks our AMA Board of Trustees to consider a legal challenge, if appropriate, to the authority of the Centers for Medicare & Medicaid Services (CMS) and other health care insurers placing onerous barriers on diabetic patients to procure medically necessary "durable medical equipment and supplies"; and

Whereas, Certain CGMs which require adjunctive therapy are deemed "non-therapeutic" and thus are ineligible to be classified as durable medical equipment (DME) and supplies, despite their ability to influence medical decision making[40]; and

Whereas, CMS Proposal CMS-1739-P includes a section on reclassifying "therapeutic" and "non-therapeutic" CGMs as DME, as access to DME has been associated with better outcomes and significantly lower healthcare spending due to patients' ability to receive care at home, and variations in Medicaid definitions of DME have been linked to variations in geographic healthcare expenditure[40,41]; and

Whereas, Increased eligibility and access to all glucose monitors, including CGM and flash glucose monitoring, would provide improved, cost-effective health care outcomes for low-income patients with diabetes on Medicaid and Medicare[19,33-35,37,38]; and

Whereas, Medicaid and public state medical insurance expansions that include CGM devices have been demonstrated to improve glycemic control and reduce disparities in pediatric patients with type 1 diabetes[42,43]; and

Whereas, Current AMA policy H330.885 supports coverage of CGM for Medicare patients with insulin-dependent diabetes but does not address Medicaid or CHIP; therefore be it

RESOLVED, That our American Medical Association advocate for broadening the classification criteria of Durable Medical Equipment to include all clinically effective and cost-saving diabetic glucose monitors (Directive to Take Action); and be it further

RESOLVED, That our AMA amend AMA Policy H-330.885 by addition and deletion to read as follows:

> ~~Medicare~~ Public Insurance Coverage of Continuous Glucose Monitoring Devices for Patients with Insulin-Dependent Diabetes H-330.885
>
> Our AMA supports efforts to achieve ~~Medicare~~ coverage of continuous and flash glucose monitoring systems for all patients with ~~insulin-dependent~~ diabetes by all public insurance programs. (Modify Current HOD Policy)

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

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Diabetes is a slow, silent, but remarkably effective killer. In the current pandemic, diabetes has been an impactful comorbid condition greatly increasing morbidity and mortality with COVID-19. Glucose monitoring is a tool that is effective at improving glucose control and preventing complications. Although our AMA currently supports glucose monitoring, it does not support equal access to glucose monitoring for all patients, thereby leaving a gap that results in tens of thousands of patients without this tool. This resolution supports patient access to tools that can help protect them from this current epidemic as well as other complications from varying glucose levels. Barriers to coverage right now include discrepancies in classification of certain monitors as Durable Medical Equipment and differences in coverage between various public insurance programs. This resolution aims to bridge those gaps and allow for a low-cost, high-quality intervention for our patients. It is vital for our AMA to continue to be on the forefront of protecting this vulnerable patient population's access to tools that make a literal life-and-death difference for them every day.

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RELEVANT AMA POLICY

Diabetic Documentation Requirements D-185.983

1. Our AMA Board of Trustees will consider a legal challenge, if appropriate, to the authority of the Centers for Medicare & Medicaid Services (CMS) and other health care insurers placing onerous barriers on diabetic patients to procure medically necessary durable medical equipment and supplies.
2. Our AMA Board of Trustees will consider a legal challenge, if appropriate, to the authority and policy of CMS and other insurers to practice medicine through their diabetes guidelines, and place excessive time and financial burdens without reimbursement on a physician assisting patients seeking reimbursement for supplies needed to treat their diabetes.

Res. 730, A-13

Medicare Coverage of Continuous Glucose Monitoring Devices for Patients with Insulin-Dependent Diabetes H-330.885

Our AMA supports efforts to achieve Medicare coverage of continuous glucose monitoring systems for patients with insulin-dependent diabetes.

Res. 126, A-14

CMS Required Diabetic Supply Forms H-330.908

Our AMA requests that CMS change its requirement so that physicians need only re-write prescriptions for glucose monitors every twelve months, instead of a six month requirement, for Medicare covered diabetic patients and make the appropriate diagnosis code sufficient for the determination of medical necessity.

Sub Res. 102, A-00; Reaffirmation and Amended: Res. 520, A-02; Modified: CMS Rep. 4, A-12

Physician Ordering of Durable Medical Equipment and Home Health Services H-330.936

The AMA urges CMS and other payers to require that durable medical equipment and home health and other outpatient medical services be ordered by the physician responsible for the patient's care, with appropriate documentation of medical necessity, before such services are offered to the patient or family; and that suppliers provide to the physician the charge for all durable medical equipment and home health and other outpatient services prior to the time the physician signs the order.

Res. 112, I-96; Reaffirmed by Res. 122, A-97; Amended: CMS Rep. 4, I-97; Reaffirmation: A-99; Reaffirmation: A-04; Reaffirmation: A-08; Reaffirmed: CMS Rep. 01, A-18

Access to Medical Care D-480.991

Our AMA shall work with the Centers for Medicare and Medicaid Services to maximize access to the devices and procedures available to Medicare patients by ensuring reimbursement at least covers the cost of said device or procedure.
Res. 130, A-02; Reaffirmation: A-04; Reaffirmed: CMS Rep. 1, A-14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 109
(N-21)

Introduced by: Medical Student Section

Subject: Amending D-440.985, "Health Care Payment for Undocumented Persons," to Study Methods to Increase Health Care Access for Undocumented Immigrants

Referred to: Reference Committee A

Whereas, Based on results from the 2018 American Community Survey (ACS), the current undocumented immigrant population within the United States is around 10.6 million[1]; and

Whereas, The Personal Responsibility and Work Opportunity Act of 1996 bars the majority of both authorized and unauthorized immigrants who have not resided in the United States for 5 years from qualifying for federally funded benefits[2]; and

Whereas, Around two thirds of undocumented immigrants who would qualify for Medicaid live below the federal poverty line and around half are uninsured[2,3]; and

Whereas, Thirty-three percent of undocumented immigrant children are uninsured[4]; and

Whereas, Undocumented immigrants are not eligible for any type of coverage offered under the Affordable Care Act, including participation in the insurance marketplaces[4]; and

Whereas, Most undocumented immigrants receive health care through Federally Qualified Health Centers (FQHCs) or free medical clinics[5]; and

Whereas, FQHCs are funded by federal grants, non-profits, or private donations, which allow them to provide care regardless of immigration status[5]; and

Whereas, Emergency Medicaid is often utilized by undocumented immigrants and authorized immigrants who have been lawfully present for less than 5 years in order to obtain medical care in both urgent and chronic medical condition[6]; and

Whereas, Emergency Medicaid costs around $2 billion per year to provide health care to approximately 100,000 individuals who would qualify for Medicaid if not for their immigration status[6]; and

Whereas, Allowing immigrants increased access to health care could reduce the burden of chronic diseases through preventative care, alleviate public health concerns such as tuberculosis, and reduce the utilization of emergency health services[5]; and

Whereas, Immigrants often have lower rates of health care utilization and expenditures as compared to natural born citizens[2,3,7]; and

Whereas, As of January 2020, only 6 states provided Medicaid or Children's Health Insurance Program (CHIP) to children regardless of immigration status, while 26 other states provide coverage to lawfully residing children[8]; and

Whereas, California and Massachusetts have expanded health insurance access to undocumented immigrants who are not lawfully residing through mechanisms that are state funded[2]; and

Whereas, Through a program known as MediCal, California has expanded health insurance access to children and young adults up to the age of 25, with the goal of providing care to undocumented seniors in the near future[9,10]; and

Whereas, The COVID-19 pandemic has highlighted the need for appropriate health care coverage at both the state and federal level for undocumented immigrants, especially given the fact that undocumented immigrants had difficulty accessing testing and treatment throughout the pandemic[9,10]; and

Whereas, Current AMA policies establish precedent for increasing health care and providing equitable care to immigrants, refugees, and migrant farm workers regardless of immigration status, especially covering care for children of undocumented immigrants (D-65.992-Medical Needs of Unaccompanied, Undocumented Immigrant Children); and

Whereas, The AMA has made a commitment to assisting states with the issue of uncompensated care to undocumented immigrants by solving the problem on a national level (D-440.985, "Health Care Payment for Undocumented Persons"); therefore be it

RESOLVED, That our American Medical Association amend Policy D-440.985, "Health Care Payment for Undocumented Persons," by addition to read as follows:

Health Care Payment for Undocumented Persons D-440.985

Our American Medical Association: (1) shall assist states on the issue of the lack of reimbursement for care given to undocumented immigrants in an attempt to solve this problem on a national level~~.~~; and (2) support methods to increase health insurance access for undocumented immigrants, such as allowing them to purchase health insurance on the Affordable Care Act marketplaces. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

The combination of the COVID-19 pandemic and multiple high-publicity episodes of mistreatment of refugees and immigrants have made it clear that these vulnerable populations urgently need better protection. Undocumented immigrants in particular have faced worse health outcomes in the pandemic, in part due to their lack of access to regular care. This lack of regular care leads to eventual worse outcomes, making it more expensive to have had undocumented immigrants lacking health insurance, besides leading to preventable and tragic losses of human life and ability. This resolution addresses the urgent inequity of lacking care by supporting methods to increase health insurance access for undocumented immigrants, such as allowing them to purchase health insurance on the Affordable Care Act marketplaces. Our AMA's increasing recognition of the importance of health equity, and the increasing awareness in the ongoing pandemic that the health of the whole community is interwoven, makes this issue a high priority meriting consideration at this meeting.

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RELEVANT AMA POLICY

Impact of Immigration Barriers on the Nation's Health D-255.980

1. Our AMA recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.

Alt. Res. 308, A-17; Modified: CME Rep. 01, A-18; Reaffirmation: A-19; Reaffirmed: CME Rep. 4, A-21

Patient and Physician Rights Regarding Immigration Status H-315.966
Our AMA supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented.
Res. 018, A-17

Opposing the Detention of Migrant Children H-60.906
Our AMA: (1) opposes the separation of migrant children from their families and any effort to end or weaken the Flores Settlement that requires the United States Government to release undocumented children “without unnecessary delay” when detention is not required for the protection or safety of that child and that those children that remain in custody must be placed in the “least restrictive setting” possible, such as emergency foster care; (2) supports the humane treatment of all undocumented children, whether with families or not, by advocating for regular, unannounced, auditing of the medical conditions and services provided at all detention facilities by a non-governmental, third party with medical expertise in the care of vulnerable children; and (3) urges continuity of care for migrant children released from detention facilities.
Res. 004, I-18

Addressing Immigrant Health Disparities H-350.957
1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.
2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.
3. Our AMA will call for asylum seekers to receive all medically-appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.
Res. 804, I-09 Appended: Res. 409, A-15; Reaffirmation: A-19; Appended: Res. 423, A-19; Reaffirmation: I-19

HIV, Immigration, and Travel Restrictions H-20.901
Our AMA recommends that: (1) decisions on testing and exclusion of immigrants to the United States be made only by the U.S. Public Health Service, based on the best available medical, scientific, and public health information; (2) non- immigrant travel into the United States not be restricted because of HIV status; and (3) confidential medical information, such as HIV status, not be indicated on a passport or visa document without a valid medical purpose.
CSA Rep. 4, A-03; Modified: Res. 2, I-10; Modified: Res. 254, A-18

Redefining AMA's Position on ACA and Healthcare Reform D-165.938
1. Our AMA will develop a policy statement clearly stating this organization's policies on the following aspects of the Affordable Care Act (ACA) and healthcare reform:
A. Opposition to all P4P or VBP that fail to comply with the AMA's Principles and Guidelines;
B. Repeal and appropriate replacement of the SGR;

C. Repeal and replace the Independent Payment Advisory Board (IPAB) with a payment mechanism that complies with AMA principles and guidelines;
D. Support for Medical Savings Accounts, Flexible Spending Accounts, and the Medicare Patient Empowerment Act ("private contracting");
E. Support steps that will likely produce reduced health care costs, lower health insurance premiums, provide for a sustainable expansion of healthcare coverage, and protect Medicare for future generations;
F. Repeal the non-physician provider non-discrimination provisions of the ACA.
2. Our AMA will immediately direct sufficient funds toward a multi-pronged campaign to accomplish these goals.
3. There will be a report back at each meeting of the AMA HOD.
Res. 231, A-13; Reaffirmed in lieu of Res. 215, A-15; Reaffirmation: A-17

Presence and Enforcement Actions of Immigration and Customs Enforcement (ICE) in Healthcare D-160.921
Our AMA: (1) advocates for and supports legislative efforts to designate healthcare facilities as sensitive locations by law; (2) will work with appropriate stakeholders to educate medical providers on the rights of undocumented patients while receiving medical care, and the designation of healthcare facilities as sensitive locations where U.S. Immigration and Customs Enforcement (ICE) enforcement actions should not occur; (3) encourages healthcare facilities to clearly demonstrate and promote their status as sensitive locations; and (4) opposes the presence of ICE enforcement at healthcare facilities.
Res. 232, I-17

Increasing Access to Healthcare Insurance for Refugee Populations H-350.956
Our AMA supports state, local, and community programs that remove language barriers and promote education about low-cost health-care plans, to minimize gaps in health-care for refugees.
Res. 006, A-17

Improving Medical Care in Immigrant Detention Centers D-350.983
Our AMA will: (1) issue a public statement urging U.S. Immigrations and Customs Enforcement Office of Detention Oversight to (a) revise its medical standards governing the conditions of confinement at detention facilities to meet those set by the National Commission on Correctional Health Care, (b) take necessary steps to achieve full compliance with these standards, and (c) track complaints related to substandard healthcare quality; (2) recommend the U.S. Immigrations and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the National Commission on Correctional Health Care; and (3) advocate for access to health care for individuals in immigration detention.
Res. 017, A-17

Opposition to Regulations That Penalize Immigrants for Accessing Health Care Services D-440.927
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.
Res. 254, A-18

Medical Needs of Unaccompanied, Undocumented Immigrant Children D-65.992
1. Our AMA will take immediate action by releasing an official statement that acknowledges that

the health of unaccompanied immigrant children without proper documentation is a humanitarian issue.
2. Our AMA urges special consideration of the physical, mental, and psychological health in determination of the legal status of unaccompanied minor children without proper documentation.
3. Our AMA will immediately meet and work with other physician specialty societies to identify the main obstacles to the physical health, mental health, and psychological well-being of unaccompanied children without proper documentation.
4. Our AMA will participate in activities and consider legislation and regulations to address the unmet medical needs of unaccompanied minor children without proper documentation status, with issues to be discussed to include the identification of: (A) the health needs of this unique population, including standard pediatric care as well as mental health needs; (B) health care professionals to address these needs, to potentially include but not be limited to non-governmental organizations, federal, state, and local governments, the US military and National Guard, and local and community health professionals; (C) the resources required to address these needs, including but not limited to monetary resources, medical care facilities and equipment, and pharmaceuticals; and (D) avenues for continuity of care for these children during the potentially extended multi-year legal process to determine their final disposition.
Res. 5, I-15; Reaffirmed: BOT Action in response to referred for decision: Res. 003, I-18

Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients H-440.876
1. Our AMA: (a) opposes any policies, regulations or legislation that would criminalize or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants; (b) opposes any policies, regulations, or legislation requiring physicians and other health care providers to collect and report data regarding an individual patient's legal resident status; and (c) opposes proof of citizenship as a condition of providing health care. 2. Our AMA will work with local and state medical societies to immediately, actively and publicly oppose any legislative proposals that would criminalize the provision of health care to undocumented residents.
Res. 920, I-06; Reaffirmed and Appended: Res. 140, A-07; Modified: CCB/CLRPD Rep. 2, A-14

Health Care Payment for Undocumented Persons D-440.985
Our AMA shall assist states on the issue of the lack of reimbursement for care given to undocumented immigrants in an attempt to solve this problem on a national level.
Res. 148, A-02; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17; Reaffirmation: A-19; Reaffirmation: I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 110
(N-21)

Introduced by: Medical Student Section

Subject: Caps on Insulin Co-Payments for Patients with Insurance

Referred to: Reference Committee A

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1 Whereas, Diabetes affects approximately 9.4% of the U.S. population and is the seventh
2 leading cause of death nationally[1,2]; and
3
4 Whereas, Direct medical costs for diagnosed diabetes were estimated at $327.2 billion in 2017,
5 with nearly $102 billion lost due to lower productivity resulting from diabetes[3]; and
6
7 Whereas, The annual average medical cost per person with diabetes is $13,240 with
8 approximately 44% of expenditures stemming from prescription medications, including insulin[4];
9 and
10
11 Whereas, From 2012 to 2016, the average point-of-sale price of insulin nearly doubled from 13
12 cents per unit to 25 cents per unit, translating to a daily cost increase from $7.80 to $15 for a
13 patient with Type 1 diabetes using an average amount of insulin (60 units per day)[5]; and
14
15 Whereas, One in four patients reported cost-related insulin underuse, including taking smaller
16 doses and skipping doses, which was independent of the patient's prescription drug coverage
17 plan[6]; and
18
19 Whereas, Patients who report cost-related underuse were more likely to have poor glycemic
20 control, which is associated with an increased risk for complications such as hypertension,
21 chronic kidney disease, neuropathy, lower limb amputations, retinopathy, stroke, coronary heart
22 disease, depression, and cancer[6,7]; and
23
24 Whereas, Seven states have approved legislation on insulin copayment caps since April 2020,
25 instituting a $35-$100 maximum copayment for a 30-day insulin supply[8]; and
26
27 Whereas, The Centers for Medicare & Medicaid Services (CMS) plans to limit insulin
28 prescription costs through Medicaid Part D for the 2021 plan year to a maximum $35 copay for
29 a 30-day supply, and estimate annual out-of-pocket savings per patient to be reduced by 66%[9];
30 and
31
32 Whereas, Individual and family savings resulting from caps on insulin copayments have the
33 potential to alleviate financial burden[10]; and
34
35 Whereas, The AMA has policy consistent with the principle of increasing access to prescription
36 medications including insulin for patients[11-16]; and

Whereas, Some private insurance programs have shown the capability to offer a capped copayment on insulin for their customers, without any increased cost to their insurance premium or plan[17]; therefore be it

RESOLVED, That our American Medical Association amend Policy H-110.984, "Insulin Affordability," by addition to read as follows:

Insulin Affordability H-110.984
Our AMA will: (1) encourage the Federal Trade Commission (FTC) and the Department of Justice to monitor insulin pricing and market competition and take enforcement actions as appropriate; ~~and~~ (2) support initiatives, including those by national medical specialty societies, that provide physician education regarding the cost-effectiveness of insulin therapies~~.~~; and (3) support state and national efforts to limit the copayments insured patients pay per month for prescribed insulin. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Insulin prices tripled since 2005 because of predatory PBMs. Millions of patients now ration insulin due to cost. Copay caps would save patients hundreds of dollars a year, prevent the harmful, potentially lethal effects of DKA, and avoid millions in hospitalization expenses. Twelve states have passed caps, and another 30 states across the political spectrum debated legislation this year. However, these laws only impact state-regulated plans. CMS instated $35 monthly caps for Medicare Part D this year, but Congressional legislation on caps in federally regulated ERISA and ACA plans is still pending. Existing AMA policy on tying cost-sharing in general to patient income and clinical value is laudable, but those broader systemic changes to our insurance market require years to decades of incremental advocacy, addressing hundreds of services and medications, in dozens of policies, in 50 states and Congress, facing formidable resistance from insurers and PhRMA. While we continue long-term efforts to build a better system, the political dominoes on insulin affordability are aligned, thanks to invested policymakers and vocal patient advocates. Our AMA cannot give up this historic chance to directly address an urgent and legislatively timely issue--a tangible win is within reach. We must join diabetes advocates now to improve insulin affordability for all patients. Given ongoing bipartisan momentum on this issue, our AMA should explicitly support federal and state policies to ensure consistent insulin affordability in all plans nationwide. No patient should be forced to ration insulin and risk DKA.

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RELEVANT AMA POLICY

Additional Mechanisms to Address High and Escalating Pharmaceutical Prices H-110.980

1. Our AMA will advocate that the use of arbitration in determining the price of prescription drugs meet the following standards to lower the cost of prescription drugs without stifling innovation:
a. The arbitration process should be overseen by objective, independent entities;
b. The objective, independent entity overseeing arbitration should have the authority to select neutral arbitrators or an arbitration panel;
c. All conflicts of interest of arbitrators must be disclosed and safeguards developed to minimize actual and potential conflicts of interest to ensure that they do not undermine the integrity and legitimacy of the arbitration process;
d. The arbitration process should be informed by comparative effectiveness research and cost-effectiveness analysis addressing the drug in question;
e. The arbitration process should include the submission of a value-based price for the drug in question to inform the arbitrator's decision;
f. The arbitrator should be required to choose either the bid of the pharmaceutical manufacturer or the bid of the payer;
g. The arbitration process should be used for pharmaceuticals that have insufficient competition; have high list prices; or have experienced unjustifiable price increases;
h. The arbitration process should include a mechanism for either party to appeal the arbitrator's decision; and
i. The arbitration process should include a mechanism to revisit the arbitrator's decision due to new evidence or data.
2. Our AMA will advocate that any use of international price indices and averages in determining the price of and payment for drugs should abide by the following principles:

a. Any international drug price index or average should exclude countries that have single-payer health systems and use price controls;
b. Any international drug price index or average should not be used to determine or set a drug's price, or determine whether a drug's price is excessive, in isolation;
c. The use of any international drug price index or average should preserve patient access to necessary medications;
d. The use of any international drug price index or average should limit burdens on physician practices; and
e. Any data used to determine an international price index or average to guide prescription drug pricing should be updated regularly.
3. Our AMA supports the use of contingent exclusivity periods for pharmaceuticals, which would tie the length of the exclusivity period of the drug product to its cost-effectiveness at its list price at the time of market introduction.
CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 3, I-20

Insulin Affordability H-110.984
Our AMA will: (1) encourage the Federal Trade Commission (FTC) and the Department of Justice to monitor insulin pricing and market competition and take enforcement actions as appropriate; and (2) support initiatives, including those by national medical specialty societies, that provide physician education regarding the cost-effectiveness of insulin therapies.
CMS Rep. 07, A-18

Pharmaceutical Costs H-110.987
1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
7. Our AMA supports legislation to shorten the exclusivity period for biologics.
8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and

increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.
11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.
12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.
13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.
CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Appended: BOT Rep. 14, A-19; Reaffirmed: Res. 105, A-19

Controlling the Skyrocketing Costs of Generic Prescription Drugs H-110.988
1. Our American Medical Association will work collaboratively with relevant federal and state agencies, policymakers and key stakeholders (e.g., the U.S. Food and Drug Administration, the U.S. Federal Trade Commission, and the Generic Pharmaceutical Association) to identify and promote adoption of policies to address the already high and escalating costs of generic prescription drugs.
2. Our AMA will advocate with interested parties to support legislation to ensure fair and appropriate pricing of generic medications, and educate Congress about the adverse impact of generic prescription drug price increases on the health of our patients.
3. Our AMA encourages the development of methods that increase choice and competition in the development and pricing of generic prescription drugs.
4. Our AMA supports measures that increase price transparency for generic prescription drugs.
Sub. Res. 106, A-15: Reaffirmed: CMS 2, I-15; Reaffirmed in lieu of: Res. 2017, A-17; Reaffirmed: BOT Rep. 14, A-18

Cost of Prescription Drugs H-110.997
Our AMA:
(1) Consistent with AMA Policy H-165.925, supports coverage of prescription drugs, including insulin, in the AMA standard benefits package.
(2) Supports consumer choice of at least two options for their pharmaceutical benefits program. This must include a fee-for-service option where restrictions on patient access and physician autonomy to prescribe any FDA-approved medication are prohibited.
(3) Reaffirms AMA Policy H-110.997, supporting the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourage physicians to supplement medical judgments with cost considerations in making these choices.
(4) Supports a managed pharmaceutical benefits option with market-driven mechanisms to control costs, provided cost control strategies satisfy AMA criteria defined in AMA Policy H-110.997 and that drug formulary systems employed are consistent with standards defined in AMA Policy H-125.991.
(5) Supports prospective and retrospective drug utilization review (DUR) as a quality assurance component of pharmaceutical benefits programs, provided the DUR program is consistent with Principles of Drug Use Review defined in AMA Policy H-120.978.
(6a) Encourages physicians to counsel their patients about their prescription medicines and when appropriate, to supplement with written information; and supports the physician's role as the "learned intermediary" about prescription drugs.

(6b) Encourages physicians to incorporate medication reviews, including discussions about drug interactions and side effects, as part of routine office-based practice, which may include the use of medication cards to facilitate this process. Medication cards should be regarded as a supplement, and not a replacement, for other information provided by the physician to the patient via oral counseling and, as appropriate, other written information.
(7) Reaffirms AMA Policy H-120.991, supporting the voluntary time-honored practice of physicians providing drug samples to selected patients at no charge, and to oppose legislation or regulation whose intent is to ban drug sampling.
(8) Supports CEJA's opinion that physicians have an ethical obligation to report adverse drug or device events; supports the FDA's MedWatch voluntary adverse event reporting program; and supports FDA efforts to prevent public disclosure of patient and reporter identities.
(9) Opposes legislation that would mandate reporting of adverse drug and device events by physicians that would result in public disclosure of patient or reporter identities.
(10) Reaffirms AMA Policy H-120.988, supporting physician prescribing of FDA-approved drugs for unlabeled indications when such use is based upon sound scientific evidence and sound medical opinion, and supporting third party payer reimbursement for drugs prescribed for medically accepted unlabeled uses.
(11) Reaffirms AMA Policy H-100.989, supporting the present classification of drugs as either prescription or over-the-counter items and opposing the establishment of a pharmacist-only third (transitional) class of drugs..
BOT Rep. O, A-90; Sub. Res. 126 and Sub. Res. 503, A-95; Reaffirmed: Res. 502, A-98; Reaffirmed: Res. 520, A-99; Reaffirmed: CMS Rep. 9, I-99; Reaffirmed: CMS Rep. 3, I-00; Reaffirmed: Res. 707, I-02; Reaffirmation: A-04; Reaffirmed: CMS Rep. 3, I-04; Reaffirmation: A-06; Reaffirmed in lieu of Res. 814, I-09; Reaffirmed in lieu of Res. 201, I-11; Reaffirmed in lieu of Res. 207, A-17; Reaffirmed: BOT Rep. 14, A-18; Modfied: CMS Rep. 1, A-21

Reducing Prescription Drug Prices D-110.993
Our AMA will (1) continue to meet with the Pharmaceutical Research and Manufacturers of America to engage in effective dialogue that urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs; and (2) encourage state medical associations and others that are interested in pharmaceutical bulk purchasing alliances, pharmaceutical assistance and drug discount programs, and other related pharmaceutical pricing legislation, to contact the National Conference of State Legislatures, which maintains a comprehensive database on all such programs and legislation.
CMS Rep. 3, I-04; Modified: CMS Rep. 1, A-14; Reaffirmation: A-14; Reaffirmed in lieu of Res. 229, I-14

Prescription Drug Prices and Medicare D-330.954
1. Our AMA will support federal legislation which gives the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs.
2. Our AMA will work toward eliminating Medicare prohibition on drug price negotiation.
3. Our AMA will prioritize its support for the Centers for Medicare & Medicaid Services to negotiate pharmaceutical pricing for all applicable medications covered by CMS.
Res. 211, A-04; Reaffirmation: I-04; Reaffirmed in lieu of Res. 201, I-11; Appended: Res. 206, I-14; Reaffirmed: CMS Rep. 2, I-15; Appended: Res. 203, A-17; Reaffirmed: CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 3, I-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 111
(N-21)

Introduced by: Medical Student Section

Subject: Addressing Healthcare Accessibility for Current and Aged-Out Youth in the Foster Care System

Referred to: Reference Committee A

Whereas, More than 33% of youth entering foster care have a chronic medical condition and up to 80% struggle with significant mental health conditions, requiring sophisticated long-term medical attention well past the age of 18 [1,2]; and

Whereas, Many youths in the foster care system struggle to receive regular health care as they frequently change caregivers and locations, often leading to gaps in their medical and immunization records and poor long term treatment follow through [1]; and

Whereas, Nearly 20,000 children age out of the foster system each year, with the majority leaving with inadequate educational, social and financial support amongst other necessities [3, 4]; and

Whereas, Around 26,000 former foster youth face significant challenges in receiving health care each year [5, 6]; and

Whereas, People who have aged out of the foster system are at increased risk for a lifetime of health problems including severe obesity, diabetes, and stroke amongst others due to adverse childhood experiences[7]; and

Whereas, The Affordable Care Act requires states to provide Medicare coverage for youth who have aged out of the foster care system in their state until their 26th birthday [8]; and

Whereas, Currently, 37 states interpret the law to require Medicaid coverage for 18 to 26-year-old youths who aged out of the foster care system in their own state, not any other state [8 9]; and

Whereas, AMA policy supports comprehensive, evidence-based care only for children currently in foster care (H-60.910); therefore be it

RESOLVED, That our American Medical Association amend Policy H-60.910 by addition and deletion to read as follows:

Addressing Healthcare Needs of ~~Children~~ Youth in Foster Care

1. Our AMA advocates for comprehensive and evidence-based care that addresses the specific health care needs of youth ~~children~~ in foster care.
2. Our AMA advocates that all youth currently in foster care remain eligible for Medicaid or other publicly funded health coverage in their state until at least 26 years of age. (Modify Current Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Our AMA has made great strides toward prioritizing health protections and access for vulnerable populations. Youth in or aging out of the foster care system are a particularly vulnerable population and represent a large, at-risk population needing more consistent access to care. Current AMA policy on the subject of transitions of care and foster youth is lacking, making it important to expand the reach of our AMA's advocacy efforts in this area. The vast majority of U.S. states limit coverage for those who have aged-out from the foster care system. Aged-out individuals across the nation can receive timely detection and treatment for chronic health illness and mental health problems, both of which occur at higher rates in this population.

The new language will help ensure that all aged-out foster care individuals are supported until the age of 26, regardless of residence. We urge our AMA to consider this resolution and the health of this marginalized population a priority.

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RELEVANT AMA POLICY

Addressing Healthcare Needs of Children in Foster Care H-60.910

Our AMA advocates for comprehensive and evidence-based care that addresses the specific health care needs of children in foster care.
Res. 907, I-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 112
(N-21)

Introduced by: American Thoracic Society

Subject: Expanding Coverage for and Access to Pulmonary Rehabilitation

Referred to: Reference Committee A

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1 Whereas, Pulmonary Rehabilitation is defined as: “a comprehensive intervention based on a
2 thorough patient assessment followed by patient-tailored therapies that include, but are not
3 limited to, exercise training, education, and behavior change, designed to improve the physical
4 and psychological condition of people with chronic respiratory disease and to promote the long-
5 term adherence to health-enhancing behaviors (1);” and
6
7 Whereas, Pulmonary Rehabilitation has been shown to have numerous benefits for patients
8 with chronic respiratory disease, including measurable physiologic benefits, reduction in
9 symptoms of shortness of breath, psychosocial benefits, and economic benefits (2); and
10
11 Whereas, Pulmonary Rehabilitation has been shown to be effective for numerous conditions,
12 including COPD and sequelae of acute COVID-19 infection (3,4); and
13
14 Whereas, Pulmonary Rehabilitation is a cost-effective intervention with benefits to the health
15 care system in addition to individual patients (5); and
16
17 Whereas, While many physicians prescribe pulmonary rehabilitation programs for their patients
18 with a wide variety of respiratory diseases and symptoms, patients often struggle to obtain
19 insurance coverage for these services; and
20
21 Whereas, Improved insurance coverage of Pulmonary Rehabilitation programs would lead to
22 proliferation of such programs, which is difficult for many patients to find; therefore be it
23
24 RESOLVED, That our American Medical Association advocate for insurance coverage for and
25 access to pulmonary rehabilitation for any patient with chronic lung disease or chronic
26 shortness of breath. (Directive to Take Action)

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

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

Pulmonary Rehabilitation is a critical therapeutic option for patients with chronic lung disease or chronic shortness of breath, including symptoms related to sequelae of COVID-19. Even prior to the pandemic, obtaining access and/or insurance coverage to pulmonary rehabilitation programs was difficult. However, with millions of Americans infected with COVID-19 and significant fractions of them suffering prolonged respiratory symptoms, increasing coverage and access to pulmonary rehabilitation programs has become urgent that our AMA advocate for patients struggling to breathe.

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 113
(N-21)

Introduced by: California

Subject: Supporting Medicare Drug Price Negotiation

Referred to: Reference Committee A

Whereas, State Legislatures, Congress, and the Centers for Medicare and Medicaid Services (CMS) continue to propose and implement health care cost containment measures aimed at physicians - even though physician spending is growing at a slower rate than other sectors - partly because it is politically difficult to impose those reforms on the powerful pharmaceutical industry; and

Whereas, Patient spending on prescription drugs has nearly doubled since the 1990s (GAO 2017) and physicians are concerned that patients cannot afford necessary medications that will improve their health; and

Whereas, One in four patients report that they or another family member did not fill a prescription in the last year because of cost. One in four patients with cancer are choosing not to fill a prescription or are taking less due to cost (KFF 2018); and

Whereas, Pharmaceutical and biotechnology sales revenue increased from $534 billion to $775 billion between 2006 and 2015; 67% of drug companies increased their annual profit margins during the same period—with margins up to 20 percent for some companies - while drug industry spending for research and development only increased from $82 billion in 2008 to $89 billion in 2014. (GAO 2017); and

Whereas, From 2016-2020, 14 leading drug companies spent $577 billion on stock buybacks and dividends - $56 billion more than they spent on R&D over the same period and top executive compensation totaled $3.2 billion, a 14% increase over 5 years. (US House of Representatives Committee on Oversight July 2021); and

Whereas, Multiple studies, including a 2021 nonpartisan Congressional Budget Office report, found that pharmaceutical company drug price hikes have little to no connection to the cost of drug development or improvements in drug efficacy; and

Whereas, 80% of Americans believe prescription drugs are too expensive and 90% support allowing the government to negotiate drug prices. This is because half of all adults do not fill their prescriptions reliably due to the cost (June 2021 Kaiser Family Foundation poll); and

Whereas, Congress is currently debating one of the most meaningful drug bills in decades that would authorize Medicare to negotiate drug prices with pharmaceutical companies to reduce drug costs. The bill is limited to the most expensive drugs and it sets a price ceiling at not more than 120% of the drug's volume-weighted net average price in six large western industrialized nations; and

Whereas, The nonpartisan Congressional Budget Office (CBO) estimates that Medicare drug price negotiation bill would reduce net drug prices by an average 55% for Medicare and privately insured patients if it is tied to an international drug price index; and

Whereas, There are other Congressional proposals that would limit annual drug price increases to the rate of inflation similar to the way other providers are paid under Medicare; and

Whereas, According to a September 2021 Harvard University-POLITICO Poll, drug price negotiation is the single most important issue to American voters. "Americans support letting government negotiate drug prices above all other major priorities in the infrastructure and social spending packages now before Congress"; and

Whereas, Medicaid and the Veterans Administration are authorized to directly negotiate best prices for drugs and according to a recent *JAMA Internal Medicine* study, the VA pays 38-50% less than Medicare Part D; and

Whereas, While current AMA policy supports Medicare drug price negotiation, the policy does not support basing the prices on the average international market price if single-payer countries are included, and therefore, AMA has not been able to support the legislation moving through Congress; and

Whereas, Physicians, hospitals, nursing homes, home health and all other providers participating in the Medicare program are subject to a fee schedule but Pharma is allowed to set its own prices which places more Medicare cost containment pressure on physicians; and

Whereas, U.S. physicians and patients are subject to much higher drug prices than prices paid in other industrialized nations and the Medicare program, which is essentially a single-payer program for seniors ages 65+, should be allowed to negotiate prices based on reasonable rates paid in these other countries. Otherwise, US taxpayers are subsidizing drug costs in these other countries; and

Whereas, AMA's strong engagement and advocacy for Medicare drug price negotiation could tip the scales in Congress in favor of passing meaningful drug price reforms for our patients; and

Whereas, The nonpartisan Congressional Budget Office has estimated the cost savings to the Medicare program from the Medicare drug price negotiation bill to be at least $500 billion over ten years; and

Whereas, Physicians are facing nearly 10% Medicare payment cuts on January 1, 2022, the MACRA program no longer provides annual payment updates, and few physicians reporting on quality measures have benefitted from meaningful MACRA bonus payments while other Medicare providers enjoy annual inflation updates and Pharma continues to impose high costs on the Medicare program and our patients; and

Whereas, Some of the savings from enacting Medicare drug price negotiation legislation could be reinvested in Medicare physician payment which currently lags at least 20% behind the costs to operate a practice; therefore be it

RESOLVED, That our American Medical Association aggressively advocate for passage of legislation that authorizes Medicare to negotiate drug prices with pharmaceutical companies to bring down the cost of prescription drugs for our patients (Directive to Take Action); and be it further

RESOLVED, That our AMA amend Policy H-110.980, “Additional Mechanisms to Address High and Escalating Pharmaceutical Prices” to support indexing Medicare Part D drug prices to a reasonable percentage of the prices paid in other large western industrialized nations by addition and deletion to read as follows:

H-110.980 - Additional Mechanisms to Address High and Escalating Pharmaceutical Prices

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

a. ~~Any international drug price index or average should exclude countries that have single-payer health systems and use price controls;~~

~~b. Any international drug price index or average should not be used to determine or set a drug’s price, or determine whether a drug’s price is excessive, in isolation;~~

a. Any international drug price index used to determine Medicare Part D drug prices should be based on a reasonable percentage of the drug’s volume-weighted net average price in at least six large western industrialized nations;

~~c.~~b. The use of any international drug price index or average should preserve patient access to necessary medications;

~~d.~~c. The use of any international drug price index or average should limit burdens on physician practices; and

~~e.~~d. Any data used to determine an international price index or average to guide prescription drug pricing should be transparent and updated regularly~~.~~; and

e. Any international drug price index used to determine Medicare Part D drug prices should ensure that American taxpayers are not unnecessarily subsidizing drug costs in other large western industrialized nations. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA support legislation that limits Medicare annual drug price increases to the rate of inflation (New HOD Policy); and be it further

RESOLVED, That our AMA support legislation that reinvests a portion of any savings from Medicare drug price negotiation into the Medicare physician fee schedule and other Medicare physician value-based payments. (New HOD Policy)

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

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

Congress is working to pass legislation before December that would allow Medicare to negotiate drug prices with pharmaceutical companies. Therefore, immediate AMA policy and action is needed. This bill would reduce the cost of the 25 most expensive drugs by 55% for our Medicare patients. Half of adults report they do not fill their prescriptions reliably because of the cost. This legislation impacts all physicians and patient health. While AMA has policy supporting Medicare drug price negotiation, the policy does not support basing prices on the average international market price (for large western industrialized countries) if single-payer countries are included, and therefore, AMA has not been able to support the legislation moving through Congress. If AMA policy is amended, AMA's strong engagement could help tip the scales in Congress to pass this bill over the powerful pharmaceutical industry's objections. If physicians don't act, the bill may not pass. It is important that the AMA act now to help bring down drug costs and improve access to affordable medications to improve our patients' health. The savings from the legislation could also be applied to stop some of the Medicare payment cuts slated for January 1, 2022.

RELEVANT AMA POLICY

Additional Mechanisms to Address High and Escalating Pharmaceutical Prices H-110.980
1. Our AMA will advocate that the use of arbitration in determining the price of prescription drugs meet the following standards to lower the cost of prescription drugs without stifling innovation:
a. The arbitration process should be overseen by objective, independent entities;
b. The objective, independent entity overseeing arbitration should have the authority to select neutral arbitrators or an arbitration panel;
c. All conflicts of interest of arbitrators must be disclosed and safeguards developed to minimize actual and potential conflicts of interest to ensure that they do not undermine the integrity and legitimacy of the arbitration process;
d. The arbitration process should be informed by comparative effectiveness research and cost-effectiveness analysis addressing the drug in question;
e. The arbitration process should include the submission of a value-based price for the drug in question to inform the arbitrator's decision;
f. The arbitrator should be required to choose either the bid of the pharmaceutical manufacturer or the bid of the payer;
g. The arbitration process should be used for pharmaceuticals that have insufficient competition; have high list prices; or have experienced unjustifiable price increases;
h. The arbitration process should include a mechanism for either party to appeal the arbitrator's decision; and
i. The arbitration process should include a mechanism to revisit the arbitrator's decision due to new evidence or data.
2. Our AMA will advocate that any use of international price indices and averages in determining the price of and payment for drugs should abide by the following principles:
a. Any international drug price index or average should exclude countries that have single-payer health systems and use price controls;
b. Any international drug price index or average should not be used to determine or set a drug's price, or determine whether a drug's price is excessive, in isolation;
c. The use of any international drug price index or average should preserve patient access to necessary medications;
d. The use of any international drug price index or average should limit burdens on physician practices; and
e. Any data used to determine an international price index or average to guide prescription drug

pricing should be updated regularly.
3. Our AMA supports the use of contingent exclusivity periods for pharmaceuticals, which would tie the length of the exclusivity period of the drug product to its cost-effectiveness at its list price at the time of market introduction.
Citation: CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 3, I-20

Prescription Drug Prices and Medicare D-330.954
1. Our AMA will support federal legislation which gives the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs.
2. Our AMA will work toward eliminating Medicare prohibition on drug price negotiation.
3. Our AMA will prioritize its support for the Centers for Medicare & Medicaid Services to negotiate pharmaceutical pricing for all applicable medications covered by CMS.
Citation: Res. 211, A-04; Reaffirmation I-04; Reaffirmed in lieu of Res. 201, I-11; Appended: Res. 206, I-14; Reaffirmed: CMS Rep. 2, I-15; Appended: Res. 203, A-17; Reaffirmed: CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 3, I-20

Pharmaceutical Costs H-110.987
1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
7. Our AMA supports legislation to shorten the exclusivity period for biologics.
8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.
11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.

12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.
13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.
Citation: CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Appended: BOT Rep. 14, A-19; Reaffirmed: Res. 105, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 114
(N-21)

Introduced by: New Mexico

Subject: Medicare and Private Health Insurance for Hearing Aids

Referred to: Reference Committee A

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1 Whereas, Hearing loss affects one in eight people in the United States (13 percent, or 30
2 million) aged 12 years or older with hearing loss in both ears, based on standard hearing
3 examinations. About 2 percent of adults aged 45 to 54 have disabling hearing loss. The rate
4 increases to 8.5 percent for adults aged 55 to 64; and
5
6 Whereas, Hearing aids are considered not a covered benefit by Medicare, Medicaid, and most
7 other payers, resulting in depriving nearly two thirds of patients who would benefit from having
8 hearing aids; and
9
10 Whereas, Hearing loss contributes to the isolation, depression, memory loss and dementia of
11 patients, all of which are major health problems; and
12
13 Whereas, Impoverished patients with hearing loss suffer from worse health disparities, because
14 of the inability to access health care by telemedicine or telephone; and
15
16 Whereas, The isolation is made worse by the COVID Pandemic; therefore be it
17
18 RESOLVED, That our American Medical Association support Congress expanding Medicare
19 Coverage for medical grade hearing aids (New HOD Policy); and be it further
20
21 RESOLVED, That our AMA advocate for coverage with minimal copays or coinsurance for
22 medical-grade hearing aids as medically necessary for all health insurance, including Medicaid.
23 (Directive to Take Action)

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

Received: 10/12/21

AUTHORS STATEMENT OF PRIORITY

The NMMS submits a single resolution for the 2021 AMA Interim Meeting.

1. Hearing loss affects one in eight people in the United States (13% or 30 million).
2. Hearing loss contributes to the isolation, depression, memory loss and dementia of patients.
3. Medical grade hearing aids are expensive at $3000+ each.
4. HR 1118, “Medicare Hearing Aid Coverage Act of 2021” was introduced on 2/18/2021. The bill would allow Medicare coverage of hearing aids and related examinations by amending title XVIII of the Social Security Act to remove the exclusion of Medicare coverage.
5. Excerpts from the Lancet (www.thelancet.com, Vol 396, August 8, 2020) summarize the concern precisely, “increased risk of dementia per 10 dB or worsening of hearing loss… midlife hearing impairment measured by audiometry, is associated with steeper temporal lobe volume loss, including in the hippocampus and entorhinal cortex… hearing loss was only associated with worse cognition in those not using hearing aids… immediate and delayed recall deteriorated less after initiation of hearing aid use… Hearing aid use was the largest factor protecting from decline… prospective studies suggest hearing aid use is protective.”

The goal of the NMMS resolution is to require Medicare, private insurance, and Medicaid to purchase for prescription, medical-grade hearing aids for patients to prevent decline in cognition, and progression into dementia, in those with hearing loss.

RELEVANT AMA POLICY

Hearing Aid Coverage H-185.929

1. Our AMA supports public and private health insurance coverage that provides all hearing-impaired infants and children access to appropriate physician-led teams and hearing services and devices, including digital hearing aids.
2. Our AMA supports hearing aid coverage for children that, at minimum, recognizes the need for replacement of hearing aids due to maturation, change in hearing ability and normal wear and tear.
3. Our AMA encourages private health plans to offer optional riders that allow their members to add hearing benefits to existing policies to offset the costs of hearing aid purchases, hearing-related exams and related services.
4. Our AMA supports coverage of hearing tests administered by a physician or physician-led team as part of Medicare's Benefit.
5. Our AMA supports policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly.
6. Our AMA encourages increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids.
7. Our AMA supports the availability of over-the-counter hearing aids for the treatment of mild-to-moderate hearing loss.

Citation: CMS Rep. 6, I-15; Appended: Res. 124, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 115
(N-21)

Introduced by: Ohio

Subject: Bundled Payments and Medically Necessary Care

Referred to: Reference Committee A

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1 Whereas, Medicare has bundled payments for several diagnoses including total knee
2 replacements, total hip replacement, myocardial infarction, and others where the payment
3 needs to cover all medical care for 90 days after the initial hospital stay; and
4
5 Whereas, Medicaid is starting similar programs called Episodes of Care; and
6
7 Whereas, Even unrelated events (like cataract surgery or fractured hip from a fall) that occur
8 within 90 days after the initial hospital stay must be covered by the bundled payment, and
9
10 Whereas, Some unrelated events can be very costly and cause significant spending beyond the
11 limits of the bundle which cannot be controlled by the initial physician; and
12
13 Whereas, The incentive for the physicians who are caring for the patient is to save money by
14 limiting the services the patient receives regardless of the medical needs of the patient, because
15 the money saved is returned to the physician; and
16
17 Whereas, Every patient is an individual with different responses to treatment and different
18 co-morbidities; and
19
20 Whereas, Some patients need further therapy in an Inpatient Rehabilitation Unit or Skilled
21 Nursing Facility, but are not offered those options due to cost containment; therefore be it
22
23 RESOLVED, That our American Medical Association study the issue of “Bundled Payments and
24 Medically Necessary Care” and report back to the AMA House of Delegates at 2022 Annual
25 Meeting, to make sure that our health care system is reasonable and fair to all, allows medically
26 appropriate and necessary care for our patients, and allows for fair reimbursement for
27 physicians. (Directive to Take Action)

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

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

Medicare has bundled payments for several diagnoses including total knee replacements, total hip replacement, myocardial infarction, and others where the payment needs to cover all medical care for 90 days after the initial hospital and Medicaid is starting similar programs called Episodes of Care.

Such unrelated events can be very costly and cause significant spending beyond the limits of the bundle which cannot be controlled by the initial physician. Physicians are then encouraged to save money by limiting the services the patient receives regardless of the medical needs of the patient.

Patient impact is broad as every patient is an individual with different responses to treatment and different co-morbidities. Some patients need further therapy in an Inpatient Rehabilitation Unit or Skilled Nursing Facility, but are not offered those options due to cost containment.

We would categorize this a medium to low priority resolution based on timelines in that it is asking for a study and report back.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 116
(N-21)

Introduced by: Resident and Fellow Section

Subject: Recognizing the Need to Move Beyond Employer-Sponsored Health Insurance

Referred to: Reference Committee A

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1 Whereas, Americans entering the workforce currently have from one quarter to one eighth of the
2 average job tenure as workers now aging into retirement[1]; and
3
4 Whereas, Trends such as a higher average worker education level and an increasing share of
5 available jobs in industries with shorter-tenured careers are also contributing to increasing
6 worker mobility, likely more so than any generational differences[1]; and
7
8 Whereas, Union membership has been in a prolonged decline, decreasing by 50% in the last 40
9 years, decreasing the collective bargaining power of today's workers to attain benefits such as
10 quality health insurance[2]; and
11
12 Whereas, The number of Americans that have employer-sponsored health insurance has
13 declined steadily over the past 20 years to 66% in 2014, with the greatest decline seen among
14 low- and middle-income families[3]; and
15
16 Whereas, Even among those workers with employer-sponsored health insurance, as many as
17 25% have out-of-pocket costs so high as to be effectively uninsured[4]; and
18
19 Whereas, In addition to being increasingly inaccessible and insufficient for workers, reliance on
20 employer-sponsored health insurance results in undesirable effects on the American worker
21 such as "job-lock" (being unable to leave a job because of reliance on its health benefits),
22 medical bankruptcy when a patient changes or loses their job while they or a family member
23 requires ongoing medical treatment, and downward pressure on wages[5]; and
24
25 Whereas, The predominance of employer-sponsored insurance arose by accident out of an
26 attempt to reduce inflation during WWII by capping wage growth with the Stabilization Act of
27 1942, and was never intended to become the principal form of health insurance in the United
28 States[6]; and
29
30 Whereas, As a result of these and other trends, reliance upon a health insurance system tied to
31 employment is becoming increasingly untenable for large portions of the United States
32 population; therefore be it
33
34 RESOLVED, That our American Medical Association recognize the importance of providing
35 avenues for affordable health insurance coverage and health care access to patients who do
36 not have employer-sponsored health insurance, or for whom employer-sponsored health
37 insurance does not meet their needs (New HOD Policy); and be it further

1 RESOLVED, That our AMA recognize that a significant and increasing proportion of patients are
2 unable to meet their health insurance or health care access needs through employer-sponsored
3 health insurance, and that these patients must be considered in the course of ongoing efforts to
4 reform the healthcare system in pursuit of universal health insurance coverage and health care
5 access. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 10/12/21

AUTHORS STATEMENT OF PRIORITY

This policy position would create discussion around an important weakness in our country that all patients with employer-sponsored healthcare encounter. As we face discussions with the new administration around the future of healthcare, the AMA needs to have a clear answer to whether tying insurance to employment is a requirement for our support as an organization. There is no better way for the AMA to know how to move forward in this advocacy space than to know what our members think by bringing this to the floor of the HOD before a national political fight around healthcare which many members of the Biden administration and congress incorporated into their platforms.

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4. Collins, Sara; Gunja, Munira; Doty, Michelle. How Well Does Insurance Coverage Protect Consumers from Health Care Costs?: Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2016. The Commonwealth Fund. Oct 18 2017. https://www.commonwealthfund.org/publications/issue-briefs/2017/oct/how-well-does-insurance-coverage-protect-consumers-health-care
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RELEVANT AMA POLICY

The Future of Employer-Sponsored Insurance H-165.829
Our AMA: (1) supports requiring state and federally facilitated Small Business Health Options Program (SHOP) exchanges to maximize employee choice of health plan and allow employees to enroll in any plan offered through the SHOP; and (2) encourages the development of state waivers to develop and test different models for transforming employer-provided health insurance coverage, including giving employees a choice between employer-sponsored coverage and individual coverage offered through health insurance exchanges, and allowing employers to purchase or subsidize coverage for their employees on the individual exchanges
Citation: CMS Rep. 6, I-14

Trends in Employer-Sponsored Health Insurance H-165.843
Our AMA encourages employers to:
a) promote greater individual choice and ownership of plans;
b) enhance employee education regarding how to choose health plans that meet their needs;
c) offer information and decision-making tools to assist employees in developing and managing their individual health care choices;
d) support increased fairness and uniformity in the health insurance market; and
e) promote mechanisms that encourage their employees to pre-fund future costs related to retiree health care and long-term care.
Citation: CMS Rep. 4, I-07; Reaffirmed CMS Rep. 1, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 117
(N-21)

Introduced by: Resident and Fellow Section

Subject: Implant-Associated Anaplastic Large Cell Lymphoma

Referred to: Reference Committee A

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1 Whereas, In 2016, the World Health Organization provisionally classified breast implant-
2 associated anaplastic large cell lymphoma (BIA-ALCL) as a T-cell lymphoma[1]; and
3
4 Whereas, Policies concerning breast cancer treatment do not encompass BIA-ALCL given that
5 this cancer is a lymphoma; and
6
7 Whereas, The 2019 National Comprehensive Cancer Care Network consensus guidelines state
8 clearly that, "Essential to the treatment of BIA-ALCL is timely diagnosis and complete surgical
9 excision."[2]; and
10
11 Whereas, Patients with BIA-ALCL suffer delays in care as they fight with their insurance
12 companies to cover surgery to remove the cancer and their breast implants, as the insurance
13 company may initially classify the surgery as cosmetic and not cover it,[3] therefore be it
14
15 RESOLVED, That our American Medical Association support appropriate coverage of cancer
16 diagnosis, treating surgery and other systemic treatment options for implant-associated
17 anaplastic large cell lymphoma. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 10/12/21

AUTHORS STATEMENT OF PRIORITY

This policy is lower priority. It will help bring the spotlight on a disease often overlooked by insurance companies making it harder for this population of patients to cover the costs of their care.

References:

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3. Denise Grady. A shocking diagnosis: breast implants 'gave me cancer.' *The New York Times*. 2017 May 14. Available at: https://www.nytimes.com/2017/05/14/health/breast-implants-cancer.html

RELEVANT AMA POLICY
Breast Implants H-525.984
Our AMA: (1) supports that women be fully informed about the risks and benefits associated with breast implants and that once fully informed the patient should have the right to choose; and (2) based on current scientific knowledge, supports the continued practice of breast augmentation or reconstruction with implants when indicated.
Citation: CSA Rep. M, I-91Modified: Sunset Report, I-01Reaffirmed: Res. 727, I-02Modified: CSAPH Rep. 1, A-12

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 118
(N-21)

Introduced by: Texas

Subject: Expanding Site-of-Service Neutrality

Referred to: Reference Committee A

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1 Whereas, Site-of-service differential (also known as site-of-service neutrality) is a payment
2 policy issue stemming from the Medicare program's use of separate payment systems in its
3 rate-setting calculations; and
4
5 Whereas, Site-of-service differential policies support higher payment in the hospital outpatient
6 department (HOPD) setting, which results in a shift in the delivery of certain services from
7 community-based physician practices to the HOPD, resulting in increased costs to patients,
8 employers, and taxpayers; and
9
10 Whereas, Over a three-year period, Medicare paid an additional $2.7 billion on services, and
11 patients spent $411 million more out of pocket when certain services were delivered in a
12 hospital-owned setting; and
13
14 Whereas, A 2021 study found that employers and workers would collectively save $14.1 billion
15 annually if price differentials between HOPDs and physician offices were eliminated for all
16 physician-administered outpatient drugs; and
17
18 Whereas, Site-of-service differential policies that support higher payment in the HOPD setting
19 also encourage the acquisition of office-based physician practices, further restricting patient
20 access to care in the lower-cost community setting; and
21
22 Whereas, Studies show that when care is initiated in the typically higher-paying HOPD setting,
23 the services that follow also result in higher spending relative to when care is initiated in the
24 office setting; and
25
26 Whereas, By passage of site-neutral payment provisions in the Bipartisan Budget Act of 2015,
27 Congress recognized the negative consequences this policy has on patients, employers, and
28 taxpayers; and
29
30 Whereas, Medicare should pay the same fee, adjusted for geographic differences in market
31 conditions and business costs, for the same service regardless of the setting where it is
32 performed; therefore be it
33
34 RESOLVED, That our American Medical Association continue to support Medicare payment
35 policies for outpatient services that are site-neutral without lowering total Medicare payments
36 (Directive to Take Action); and be it further
37
38 RESOLVED, That our AMA pursue and support passage of legislation and agency policies that
39 expand site-neutral payment to equalize payments across sites of service for all outpatient
40 services (Directive to Take Action); and be it further

1 RESOLVED, That our AMA pursue policy that creates patient incentives for services to be
2 performed in the most cost-effective location, such as a physician's office.(Directive to Take
3 Action)

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

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

Fortifying AMA policy to call for the expansion of site-of-service neutrality payment policies affects all physician specialties, their patients, as well as taxpayers.

Since facilities are acquiring independent practices at alarming rates, it is important for the AMA to act upon this policy at this meeting.

Preservation of independent physician practices fits squarely within the AMA mission and strategic plan.

Immediate action on this resolution should be pursued to help address unnecessarily high patient copays for services received in higher cost settings.

Though AMA has some policy in this area, the expansion of site neutral payment policies should be pursued to equalize payments across sites of service for all outpatient services. The adoption of policy that creates patient incentives for services to be performed in the most cost-effective location, such as a physician's office, would help support the independent practice of medicine.

AMA action on this policy will be positive for physicians, their patients, and taxpayers, and the AMA is most appropriate organization to tackle this issue.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 119
(N-21)

Introduced by: New York

Subject: Bundling Physician Fees with Hospital Fees

Referred to: Reference Committee A

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1 Whereas, There is some thought about bundling the fees of physicians with those of the hospital
2 in which the services are provided; and
3
4 Whereas, Such “bundled” payments will go to the hospital which will then control the
5 payments; and
6
7 Whereas, Such a policy will likely make it not only harder for the physician to get paid, but also
8 much more dependent on the hospitals; and
9
10 Whereas, Hospitals would similarly never agree to bundled payments that went directly to
11 physicians; therefore be it
12
13 RESOLVED, That our American Medical Association oppose bundling of physician payments
14 with hospital payments, unless the physician has agreed to such an arrangement in advance.
15 (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 10/13/21

AUTHOR’S STATEMENT OF PRIORITY

New York rates this resolution as a number one priority requiring action to ensure that physicians are compensated fairly and accurately. This issue is vital and affects all physicians who have a relationship of any type with a hospital or hospital system. Physicians have no visibility to bundled payments and cannot therefore verify that their share of a payment is paid properly. Only the hospital would have information about what share of a bundled payment belonged to the appropriate physician or the hospital. The proposed 17% share of the hospital payment is inadequate in terms of payment and does not specify how the bundled payment would be disbursed. Bundled payments to hospitals do not account for how many physicians were involved in the care of a hospitalized patient and would make it very difficult for practices to claim secondary or supplemental benefits under any coordinated benefits the patient might have. This would increase physician stress since income would be affected and increased time would be required on the part of physicians to verify that they are paid fairly. Data used for the purposes of Fairhealth cost estimates could be affected by bundling of payments to hospitals. This issue would have far-reaching consequences if implemented.

RELEVANT AMA POLICY

Health Care Reform Physician Payment Models D-385.963
1. Our AMA will: (a) work with the Centers for Medicare and Medicaid Services and other payers to participate in discussions and identify viable options for bundled payment plans, gain-sharing plans, accountable care organizations, and any other evolving health care delivery programs; (b) develop guidelines for health care delivery payment systems that protect the patient-physician relationship; (c) make available to members access to legal, financial, and ethical information, tools and other resources to enable physicians to play a meaningful role in the governance and clinical decision-making of evolving health care delivery systems; and (d) work with Congress and the appropriate governmental agencies to change existing laws and regulations (eg, antitrust and anti-kickback) to facilitate the participation of physicians in new delivery models via a range of affiliations with other physicians and health care providers (not limited to employment) without penalty or hardship to those physicians.
2. Our AMA will: (a) work with third party payers to assure that payment of physicians/healthcare systems includes enough money to assure that patients and their families have access to the care coordination support that they need to assure optimal outcomes; and (b) will work with federal authorities to assure that funding is available to allow the CMMI grant-funded projects that have proven successful in meeting the Triple Aim to continue to provide the information we need to guide decisions that third party payers make in their funding of care coordination services.
3. Our AMA advises physicians to make informed decisions before starting, joining, or affiliating with an ACO. Our AMA will provide information to members regarding AMA vetted legal and financial advisors and will seek discount fees for such services.
4. Our AMA will develop a toolkit that provides physicians best practices for starting and operating an ACO, such as governance structures, organizational relationships, and quality reporting and payment distribution mechanisms. The toolkit will include legal governance models and financial business models to assist physicians in making decisions about potential physician-hospital alignment strategies. The toolkit will also include model contract language for indemnifying physicians from legal and financial liabilities.
5. Our AMA will continue to work with the Federation to identify, publicize and promote physician-led payment and delivery reform programs that can serve as models for others working to improve patient care and lower costs.
6. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.
7. Our AMA will work with states to: (a) ensure that current state medical liability reform laws apply to ACOs and physicians participating in ACOs; and (b) address any new liability exposure for physicians participating in ACOs or other delivery reform models.
8. Our AMA recommends that state and local medical societies encourage the new Accountable Care Organizations (ACOs) to work with the state health officer and local health officials as they develop the electronic medical records and medical data reporting systems to assure that data needed by Public Health to protect the community against disease are available.
9. Our AMA recommends that ACO leadership, in concert with the state and local directors of public health, work to assure that health risk reduction remains a primary goal of both clinical practice and the efforts of public health.
10. Our AMA encourages state and local medical societies to invite ACO and health department leadership to report annually on the population health status improvement, community health problems, recent successes and continuing problems relating to health risk reduction, and measures of health care quality in the state.
Citation: Sub. Res. 128, A-10; Appended: Res. 819, I-10; Appended: CMS Rep. 8, A-11; Appended: CMS Rep. 1, A-11; Reaffirmation A-11; Modified: BOT Rep. 18, A-12; Reaffirmation: I-12; Appended: Res. 702, A-13; Appended: Res. 827, I-14; Modified: Speakers Rep., I-15; Reaffirmed: CMS Rep. 09, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 120
(N-21)

Introduced by: New York

Subject: COBRA for College Students

Referred to: Reference Committee A

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1 Whereas, The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a health insurance
2 program that allows an eligible employee and his or her dependents the continued benefits of
3 health insurance coverage in the case that an employee loses his or her job or experiences a
4 reduction of work hours; and
5
6 Whereas, COBRA allows former employees to obtain continued health insurance coverage at
7 group rates that otherwise might be terminated and which are typically less expensive than
8 those associated with individual health insurance plans; and
9
10 Whereas, Such COBRA coverage reduces the disruption, financial and otherwise, that could
11 occur when a person's employment is terminated; and
12
13 Whereas, College students enjoy similar group rate discounts with student health
14 insurance; and
15
16 Whereas, These students, upon graduation or other termination of an enrollment, potentially
17 face similar disruption in their healthcare coverage; therefore be it
18
19 RESOLVED, That our American Medical Association call for legislation similar to COBRA to
20 allow college students to continue their healthcare coverage, at their own expense, for up to
21 18 months after graduation or other termination of enrollment. (Directive to Take Action)

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

Received: 10/13/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution calls for an important option for recent college graduates who need to retain/obtain health insurance. Most, if not all, once graduated do not have the option of continued coverage under their parent's health insurance due to loss of student status and/or their age. EVERYONE needs to have health insurance and this has been a critically important issue as the COVID pandemic has progressed. While they are seeking employment, it would be beneficial to all if a COBRA-type program existed which would cover these new graduates/ job seekers until they are hired and covered by employer health insurance.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 121
(N-21)

Introduced by: New York

Subject: Medicaid Tax Benefits

Referred to: Reference Committee A

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1 Whereas, There are many patients with Medicaid or no health insurance that physicians care for
2 routinely for little or no payment; and
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4 Whereas, It may be politically complicated to rectify this fact directly with improved payments to
5 physicians; and
6
7 Whereas, One way to offset the problem would be to use tax deduction techniques; and
8
9 Whereas, The AMA currently has contrary policy, H-180.965, "Income Tax Credits or
10 Deductions as Compensation for Treating Medically Uninsured or Underinsured," that opposes
11 providing tax deductions or credits for the provision of care to the medically uninsured and
12 underinsured; therefore be it
13
14 RESOLVED, That our American Medical Association advocate for legislation that would allow
15 physicians who take care of Medicaid or uninsured patients to receive some financial benefit
16 through a tax deduction such as (a) a reduced rate of overall taxation or (b) the ability to use
17 the unpaid charges for such patients as a tax deduction. (Directive to Take Action)

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

Received: 10/13/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution and its goals had strong support in the MSSNY House of Delegates. This resolution is particularly important because AMA currently has contrary policy 180.965 that indicates that "the AMA will not pursue efforts to have federal laws changed to provide tax deductions or credits for the provision of care to the medically uninsured and underinsured." If AMA is to support physicians, this policy must change.

Physicians are often faced with treatment for patients having no insurance, but physicians can no longer afford to provide care as a charitable act. Payments from Medicaid do not adequately compensate physicians for patient care. Tax credits would provide incentive to continue treating uninsured patients and help to counteract patient care without payment.

RELEVANT AMA POLICY

Income Tax Credits or Deductions as Compensation for Treating Medically Uninsured or Underinsured H-180.965
The AMA will not pursue efforts to have federal laws changed to provide tax deductions or credits for the provision of care to the medically uninsured and underinsured.
Citation: BOT Rep. 49, I-93; Reaffirmed: CMS Rep. 7, A-05; Reaffirmed in lieu of Res. 141, A-07; Reaffirmed: CMS Rep. 01, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 122
(N-21)

Introduced by: Society of Critical Care Medicine

Subject: Increase Funding, Research and Education for Post-Intensive Care Syndrome

Referred to: Reference Committee A

Whereas, AMA Policy D-460.965, “Call for Increased Funding, Research and Education for Post Viral Syndromes,” asks for coding and funding for the post-acute sequelae of COVID-19; and

Whereas, The COVID-19 pandemic has substantially increased the number of patients requiring critical care; and

Whereas, After critical illness, new or worsening impairments in physical, cognitive, and/or mental health function are common among patients who survive, independent of virally driven mechanisms; and

Whereas, There is attention and heightened interest by both the public and medical communities to understand post-COVID effects, with new terminologies being used such as “long-COVID,” “long-haul COVID” and “Chronic COVID” which includes patients with COVID discharged from the ICU; and

Whereas, Post-intensive care syndrome (PICS) is a defined term which the critical care community is using in research, diagnosis and treatment and thus already captures an important population of post-COVID patients making it topical to more formally define via ICD-10 codes and work efforts; and

Whereas, One-quarter to one-half or more of critical illness survivors will suffer from some component of PICS, including muscle weakness, poor mobility, poor concentration, poor memory, fatigue, anxiety, and depressed mood, which are typically corroborated by examination and formal testing; and

Whereas, Although recovery is possible, many of the signs and symptoms of PICS last for months to years, increasing health care utilization, particularly within the first 90 days of discharge (1); and

Whereas, Current relevant ICD-10 codes are limited to G72.81, Critical illness myopathy, and F43.1, Post-traumatic stress disorder, which do not encompass the breadth or specificity of symptoms experienced by patients with PICS; therefore be it

RESOLVED, That our American Medical Association support the development of an ICD-10 code or family of codes to recognize Post-Intensive Care Syndrome (PICS) (New HOD Policy); and be it further

1 RESOLVED, That our AMA advocate for legislation to provide funding for research and
2 treatment of Post-Intensive Care Syndrome, including for those cases related to COVID-19.
3 (Directive to Take Action)

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

Received: 10/14/21

AUTHORS STATEMENT OF PRIORITY

The Society of Critical Care Medicine seeks to include “Increase Funding, Research and Education for Post-Intensive Care Syndrome” for consideration as an urgent resolution in our special meeting in November. This resolution asks the AMA to support the development of an ICD-10 code for post-intensive care syndrome (PICS) and that the AMA advocate for funding research and treatment of PICS. There has been much interest in understanding post-COVID effects (ie long covid or chronic covid) and many of these patients have been sick enough to receive care in the ICU. Prior to the pandemic, the critical care community was focused around PICS - a syndrome comprised of physical and cognitive symptoms which occur after ICU stay and critical illness. Many of these patients with PICS are the very same COVID patients that researchers, physicians and the lay public seek to understand. We believe this resolution is timely to help us avoid re-inventing the wheel when it comes to data collection and research, and to help us accelerate understanding of how to treat post-COVID illness and other post-ICU related illnesses. If this resolution is not considered, there is a risk of advancing a uncoordinated research and treatment agenda during the pandemic for both COVID and general ICU patients.

(1) Mikkelsen ME, Still M, Anderson BJ, et al. Society of Critical Care Medicine's International Consensus Conference on Prediction and Identification of Long-Term Impairments After Critical Illness. Crit Care Med. 2020;48(11):1670-1679. doi:10.1097/CCM.0000000000004586

RELEVANT AMA POLICY

Call for Increased Funding, Research and Education for Post Viral Syndromes D-460.965
Our AMA: (1) supports the development of an ICD-10 code or family of codes to recognize Post-Acute Sequelae of SARS-CoV-2 infection (“PASC” or “Long COVID”) and other novel post-viral syndromes as distinct diagnoses; (2) will advocate for legislation to provide funding for research, prevention, control, and treatment of post viral syndromes and long-term sequelae associated with viral infections, such as COVID-19; (3) will provide physicians and medical students with accurate and current information on post-viral syndromes and long-term sequalae associated with viral infections, such as COVID-19; and (4) will collaborate with other medical and educational entities to promote education among patients about post viral syndromes and long-term sequalae associated with viral infections, such as COVID-19, to minimize the harm and disability current and future patients face.
Citation: Alt. Res. 410, A-21

Reference Committee B

BOT Report(s)

02 Policing Reform
08 Improved Access and Coverage to Non-opioid Modalities to Address Pain
09 Medical Marijuana License Safety
10 Physician Access to Their Medical and Billing Records
12 Direct-to-Consumer Genetic Tests
14 Net Neutrality and Public Health

Resolution(s)

201 Protection of Peer-Review Process
202 RESOLUTION WITHDRAWN
203 Poverty-Level Wages and Health
204 Supporting Collection of Data on Medical Repatriation
205 Reducing the Prevalence of Sexual Assault by Testing Sexual Assault Evidence Kits
206 Updating Policy on Immigration Laws, Rules, Legislation, and Health Disparities to Better Address National Crises
207 Authority to Grant Vaccine Exemptions
208 Protections for Incarcerated Mothers in the Perinatal Period
209 Increasing Access to Hygiene and Menstrual Products
210 Advocating for the Amendment of Chronic Nuisance Ordinances
211 Support for Mental Health Courts
212 Sequestration
213 Eliminating Unfunded or Unproven Mandates and Regulations
214 Stakeholder Engagement in Medicare Administrative Contractor Policy
215 Pharmacy Benefit Manager Reform as a State Legislative Priority
216 Preserving Appropriate Physician Supervision of Midlevel Providers and Ensuring Patient Awareness of the Qualifications of Physicians vs. Midlevel Providers
217 Studying Physician Supervision of Allied Health Professionals Outside of their Fields of Graduate Medical Education
218 Physician Opposition to the Coordinated Effort by Corporations and Midlevel Providers to Undermine the Physician-Patient Relationship and Safe Quality Care
219 The Impact of Midlevel Providers on Medical Education
220 Gonad Shields: Regulatory and Legislation Advocacy to Oppose Routine Use
221 Promoting Sustainability in Medicare Physician Payments
222 Opposing Federal Preemption of State Licensing Laws and Scope-of-Practice Expansion Under the Ninth Amendment to Declaration Under the PREP Act
223 Paying Physicians for Services According to the Physician Fee Schedule
224 Improve Physician Payments
225 End Budget Neutrality
226 Addressing Adolescent Telehealth Confidentiality Concerns
227 Medication for Opioid Use Disorder in Physician Health Programs
228 Resentencing for Individuals Convicted of Marijuana-Based Offenses
229* CMS Administrative Requirements
230* Medicare Advantage Plan Mandates
231* Prohibit Ghost Guns
232* Ban the Gay/Trans (LGBTQ+) Panic Defense

* Contained in the Handbook Addendum

Reference Committee B

Resolution(s)

233* Insurers and Vertical Integration

234* Permitting the Dispensing of Stock Medications for Post Discharge Patient Use and the Safe Use of Multi-dose Medications for Multiple Patients

* Contained in the Handbook Addendum

REPORT 02 OF THE BOARD OF TRUSTEES (N-21) Policing Reform
(Resolution 410-NOV-20)
(Reference Committee B)

EXECUTIVE SUMMARY

Because of structural racism, historically marginalized and minoritized communities in the United States, particularly Black and Native American populations, shoulder the unfair, unjust, and disproportionate burden of police violence, experiencing higher levels of mortality, morbidity, inequity, and intergenerational trauma. At the 2020 November Meeting, the House of Delegates referred the Third, Fourth, and Eighth Resolve Clauses of Resolution 410-NOV-20, "Policing Reform," for a report back to the House of Delegates. These clauses recommend that the AMA support repeal of qualified immunity for law enforcement officers, termination of federal programs that provide military equipment to local law enforcement agencies, and the establishment of community-based oversight boards with disciplinary authority over law enforcement officers. This report provides background, discussion, and recommendations on each of these issues.

First, the qualified immunity doctrine grants civil immunity to individual government officials performing discretionary duties within the scope of their employment. Repeal of the doctrine has been advanced as a way of preventing excessive use-of-force by law enforcement officers. As it applies to law enforcement officers, supporters of qualified immunity believe it is necessary to give some deference to officers making "split-second judgments" about the amount of force that is necessary in a particular situation. The rationale for abolishing qualified immunity posits that the threat of personal liability will be so great that officers will curb their behavior. Second, the U.S. Department of Defense (DOD) 1033 Program (1033 Program) permits eligible federal, state, and local agencies, under certain circumstances, to obtain certain DOD personal property, including equipment, clothing, vehicles, aircraft, weapons, and ammunition. The 1033 Program is often charged with over militarizing local law enforcement agencies, particularly in communities of color. Supporters of sending excess military equipment argue that it helps to increase safety and is an efficient and wise use of tax dollars. Critics argue that such programs have led to a culture that leads to excess lethal force on suspects. Third, community oversight boards (COBs) empower members of the public to review, investigate, or discipline law enforcement officer wrongdoings. Proponents say that such boards improve public trust, ensure accessible complaint processes, ensure thorough investigations, increase transparency, and deter police misconduct. However, COBs have been found to be largely ineffective.

There is a lack of evidence that abolishing qualified immunity, terminating the 1033 Program, and/or establishing COBs would reduce police violence. Therefore, the AMA's contribution to the national conversation about policing would be better focused on a holistic approach to policing. In particular, procedurally just policing models and greater community involvement in policing policies and practices are promising, evidence-based means of decreasing use-of-force. In addition, because of the similarities between medicine and law enforcement—professionals in both fields are frequently placed in high-pressure situations in which they must make split second, life-or-death decisions—it may benefit law enforcement to borrow some of the strategies and practices that the medical profession uses to ensure that its members provide safe and effective care, such as establishing evidence-based standards and practices, implementing sentinel event reviews following an adverse event, and encouraging further research into the impact of law enforcement practices and programs.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 2-N-21

Subject: Policing Reform
(Resolution 410-NOV-20)

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee B

INTRODUCTION

At the 2020 November Meeting, the House of Delegates referred the Third, Fourth, and Eighth Resolve Clauses of Resolution 410-NOV-20, "Policing Reform," introduced by the Medical Student Section, which asked:

> That our AMA advocate for the elimination or reform of qualified immunity, barriers to civilian oversight, and other measures that shield law enforcement officers from consequences for misconduct.
>
> That our AMA support efforts to demilitarize law enforcement agencies, including elimination of the controlled category of the United States Department of Defense 1033 Program and cessation of federal and state funding for civil law enforcement acquisition of military-grade weapons.
>
> That our AMA support the creation of independent, third-party community-based oversight committees with disciplinary power whose mission will be to oversee and decrease police-on-public violence.

The reference committee heard mixed testimony on these resolves, including significant support for referral to allow for a more thorough analysis. This Board report, therefore, addresses the Third, Fourth, and Eighth Resolve Clauses of Resolution 410-NOV-20, specifically, and provides background, discussion, and recommendations.

BACKGROUND

Following the well-publicized deaths of Black Americans during police encounters—including George Floyd, Breonna Taylor, and too many others—as well as the widespread protests in their aftermath, our nation is engaging in a long-overdue conversation about police violence and excess force, and how racism and systemic and structural racial injustice manifest in over-policing of Brown and Black communities. While the AMA recognizes that many who serve in law enforcement are committed to social justice in their holistic view of justice, AMA policy acknowledges the need for changes at the federal, state, and local levels to end discriminatory practices and unnecessary or excessive use of police force. The AMA has been and continues to be engaged in advocating for such changes. As noted in an AMA Viewpoint by then-Immediate Past AMA Board Chair Jesse M. Ehrenfeld, MD, MPH, and then-Immediate Past President Patrice Harris, MD, MA:

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> …the violence inflicted by police in the news headlines today must be understood in relation to the larger social and economic arrangements that put individuals and populations in harm's way, leading to both premature illness and death. Police violence is a striking reflection of our American legacy of racism—a system that assigns value and structures opportunity while unfairly advantaging some and disadvantaging others based on their skin color… Importantly, racism is detrimental to health in all its forms.[1]

Because of structural racism, historically marginalized and minoritized communities in the United States shoulder the unfair, unjust, and disproportionate burden of police violence, experiencing higher levels of mortality, morbidity, inequity, and intergenerational trauma. Police violence is a leading cause of death for young men in the United States.[2] Over their life course, about one in every 1,000 Black men can expect to be killed by police. The risk of being killed by police peaks between the ages of 20 years and 35 years for men and women and for all racial and ethnic groups. Black women and men and American Indian and Alaska Native women and men, however, are significantly more likely than white women and men to be killed by police. Latino men are also more likely to be killed by police than are white men.[3] According to the Mapping Police Violence database, Black people comprise 28 percent of those killed by police in 2020—despite being only 13 percent of the population.[4] It is important to note that the disproportionate exposure of communities of color to fatal police violence does not correlate to crime rates.[5] Police-related deaths have distinct causes, distributions, and consequences for population health from other forms of violence and currently number in the thousands every year.[6]

Beyond the increased rate of fatalities, research also shows that racially marginalized communities are disproportionally subject to police force, and there is a correlation between policing and adverse health outcomes. Studies have shown that, "Men, racial/ethnic minorities, young people, and those living in economically disadvantaged areas are particularly at risk, especially those at the intersection of these social stratifications."[7] Standardized policies, such as stop and frisk, normalize racial profiling and structural racism.[8] An increased prevalence of police encounters is linked to elevated stress and anxiety levels, along with increased rates of high blood pressure, diabetes, and asthma—and fatal complications of those comorbid conditions—for both the victim and the community, including children.[9,10] Racism as a driver of health inequity is also particularly evident in findings from a 2018 *Lancet* study showing that law enforcement-involved deaths of unarmed Black individuals were associated with adverse mental health consequences among Black American adults—regardless of whether the individual affected had a personal relationship with the victim or the incident was experienced vicariously. The trauma of violence in a person's life course is associated with chronic stress, higher rates of comorbidities, and lower life expectancy.[11]

QUALIFIED IMMUNITY

Qualified immunity is a judicially created legal principle that grants civil immunity to individual government officials performing discretionary duties within the scope of their employment. Only if a plaintiff demonstrates that the government official violated, "clearly established statutory or constitutional rights of which a reasonable person would have known" may a civil suit proceed.[12] It operates as an affirmative defense for individual government officials, barring damages even if an unlawful, unconstitutional act was committed. Though qualified immunity is often discussed as it applies to law enforcement officers, it also applies to most other executive branch officers. Importantly, qualified immunity is only applied in civil claims and only in suits against government officials individually. Criminal proceedings and suits against the government itself for damages caused by officials' actions do not trigger the qualified immunity doctrine.

The doctrine of qualified immunity was established in 1982 by the U.S. Supreme Court and was intended to, "protect officials who are required to exercise discretion and the related public interest in encouraging the vigorous exercise of official authority."[13] As it applies to law enforcement officers, supporters of qualified immunity believe it is necessary to give some deference to officers making "split-second judgments—in circumstances that are tense, uncertain, and rapidly evolving—about the amount of force that is necessary in a particular situation."[14]

The doctrine is often implicated in civil rights lawsuits against state and local police under 42 U.S.C. § 1983 (Section 1983), which creates an avenue to seek damages for civil rights violations in state or federal court. Over time, the Supreme Court has broadened qualified immunity and narrowed the path to proceed in a case against a government official, diminishing the protections of Section 1983. A *Reuters* analysis of appellate court records showed that lower courts have increasingly granted immunity in cases alleging excessive use of force by law enforcement officers.[15]

Qualified immunity is a federal doctrine, and, for that reason, it can only fully be abolished or amended by the Supreme Court or Congress. Nevertheless, some states have acted to limit the application of qualified immunity in state courts. In June 2020, for example, Colorado became the first state to explicitly limit qualified immunity for local law enforcement officers, sheriff's deputies, and Colorado State Patrol officers. The Enhance Law Enforcement Integrity Act (the Act) creates a new "civil action for deprivations of rights" which enables state residents to sue law enforcement officers in state court for alleged violations of the Colorado Constitution. The Act also requires law enforcement agencies to indemnify their officers.

In April 2021, New Mexico enacted the New Mexico Civil Rights Act which bars the defense of qualified immunity for any state or local public official who has caused "the deprivation of any rights, privileges or immunities secured by the Constitution of New Mexico." The New Mexico law also creates a new cause of action under which a plaintiff may sue the government employer for damages for violations of rights under the state Constitution. Whereas Colorado's law applies only to law enforcement officers, New Mexico's applies to all state officials. Neither state law affects federal civil rights claims filed in federal court.

Recent high-profile deaths at the hands of law enforcement have put repeal of the qualified immunity doctrine into the spotlight as a means of preventing excessive use-of-force by law enforcement officers. Many understand qualified immunity to grant too much deference and insulate law enforcement officers from the consequences of misconduct, particularly that aimed at members of minoritized and marginalized communities. In a 2018 dissent, U.S. Supreme Court Justice Sonia Sotomayor wrote that qualified immunity gives license to police to, "shoot first and think later, and it tells the public that palpably unreasonable conduct will go unpunished."[16]

The rationale for abolishing qualified immunity posits that the threat of personal liability will be so great that officers will "think twice" before engaging in misconduct. Indeed, the International Association of Chiefs of Police warns that the "loss of this protection would have a profoundly chilling effect on police officers and limit their ability and willingness to respond to critical incidents without hesitation."[17] There is reason to doubt, however, that repeal of the qualified immunity doctrine would create the intended effect. Research shows that law enforcement officers are almost always indemnified by their employer and governments pay of 99.98 percent of damages recovered for violations of civil rights.[18] Indemnification creates a moral hazard wherein an individual officer does not bear the full costs of his or her behavior, reducing or eliminating the incentive for individual change in behavior. If law enforcement agencies are responsible for their employee's individual actions, however, this may compel departments to implement better policies

to curb officer misconduct to avoid financial repercussions. These hypotheses are unproven, though the recently enacted laws in Colorado and New Mexico may provide the evidence needed in the future to evaluate the effectiveness of repealing qualified immunity, as a means, to curb excessive use-of-force.

In addition, incentivizing behavior change via personal liability assumes that civil rights violations are committed intentionally and that, with the right incentives or disincentives in place, an officer would choose a different course of action. While bad actors exist and intentional brutality does tragically occur, many cases result from officers, in their minds, making the best decision they could at the time. In this way, reforming the principle of qualified immunity does not address systemic failure in policing practices.

Discussion

As a physician organization, the AMA is invested in the betterment of the public health. AMA policy recognizes that policing is a social determinant of health and that inequitable law enforcement practices are a result of structural racism and have a direct, negative impact on health, particularly among historically marginalized and minoritized communities that shoulder the disproportionate burden of police violence. If the inability to hold law enforcement officers individually liable in civil court has a measurable impact on the health of our patients, then police accountability may be ripe for AMA involvement. Literature linking the application of qualified immunity for law enforcement officers to health outcomes, however, is not available and, as noted above, claims that abolishing qualified immunity would result in better policing outcomes are untested. Given that constitutional law doctrines are generally outside the scope of the AMA's work and the lack of evidence that abolishing qualified immunity would indeed reduce police violence, the AMA's contribution to the national conversation about policing might better be focused on a holistic approach to policing. In particular, because of the similarities between medicine and law enforcement—professionals in both fields are frequently placed in high-pressure situations in which they must make split second, life-or-death decisions—it may benefit law enforcement to borrow some of the strategies and practices that the medical profession uses to ensure that its members provide safe and effective care.

First, in medicine, reliance on evidence is a bedrock of clinical decision-making, but the same is not true in policing. The approximately 18,000 law enforcement jurisdictions set policies and procedures independently and generally without the benefit of research to inform those policies. Though efforts are underway to expand evidence-based policing through organizations like the American Society of Evidence-Based Policing, those efforts are nascent. More research is needed to understand and implement those practices and strategies that effectively control crime while maintaining the trust and confidence of the public and ending those that are harmful and result in inequitable, discriminatory treatment of marginalized and minoritized communities.

In addition, law enforcement lacks standardization. Unlike in medicine, where multiple governmental and nongovernmental entities set standards and guidelines for training and clinical practice, law enforcement entities are not required to adhere to external standards, often resulting in fragmented and inconsistent policies.[19] Although accreditation alone will not prevent all negative events, it may be one tool for review and ongoing measurement. Entities like the Commission on Accreditation for Law Enforcement Agencies, Inc. (CALEA) set professional standards for law enforcement through an accreditation program, though accreditation is voluntary, and fewer than 1,000 of the 18,000 law enforcement jurisdictions are currently accredited by CALEA.[20]

Furthermore, application of sentinel event reviews, like those conducted in health care and aviation settings, following a negative event, such as a police shooting, provide a promising upstream approach to reform. A sentinel event review focuses not on assigning blame but bringing together key community stakeholders to conduct a root cause analysis of all factors that led to a negative outcome and reforms that can strengthen the system to prevent recurrence. Like sentinel event reviews in health care, the approach recognizes that failures are often system-wide and not the result of a single individual's actions. The goal, therefore, is to enable systems changes in practice and culture. Sentinel event reviews are an emerging effort, though the U.S. Department of Justice Sentinel Events Initiative has been encouraging and evaluating their adoption since 2014. One of the first jurisdictions to adopt a sentinel event review board (Review Board) was the Tucson Police Department, which convened in summer 2020 following two in-custody deaths of Latino men.[21] The 15 members of the Review Board identified 32 contributing factors and agreed unanimously on 53 recommendations for the Tucson Police Department, the Tucson Fire Department, and the Tucson Public Safety Communications Department to prevent future in-custody deaths. An implementation report produced six months later found that, as a result, of the review, agencies had adopted new policies, procedures, and training to address prior failings.[22]

MILITARIZED EQUIPMENT

The recent controversy over policing methods and excessive or unreasonable force has refocused attention on programs that transfer military equipment to law enforcement agencies across the country. Images during the summer protests of 2020 following the death of George Floyd in police custody that were widely broadcast by news shows and online repeatedly showed police outfitted with tactical gear, including full-body armor and in militarized vehicles, facing off with protestors. Concerns have been raised over whether law enforcement agencies have become too militarized, the use of such equipment, and the impact of the use of such equipment, particularly on communities of color.

Eligible federal, state, and local agencies, under certain circumstances, may obtain certain U.S. Department of Defense (DOD) personal property, including equipment, clothing, vehicles, aircraft, weapons, and ammunition for use in law enforcement, counterdrug, counterterrorism, border security, and/or humanitarian activities.[23] DOD's disposal of excess or surplus military equipment, through sale, transfer, donation, or reutilization, originally dates to the end of World War II. What is now known as the 1033 Program, however, was temporarily authorized by Congress through the National Defense Authorization Act (NDAA) in 1990.[24] It allowed law enforcement agencies to acquire excess military property for a bona fide law enforcement purpose. The original intent was to transfer military equipment in the "War on Drugs" to federal and state agencies to help assist in the fight against drug production and trafficking.[25] Congress officially created the 1033 Program through the Fiscal Year 1997 NDAA.[26] The 1033 Program allowed the transfer or donation of excess DOD property to state, local, and Tribal law enforcement agencies. Agencies that used the property for counterdrug or counterterrorism activities received preference.[27]

The Law Enforcement Support Office (LESO) of the DOD's Defense Logistics Agency (DLA) is responsible for facilitating and managing the 1033 Program and, according to information on LESO's website, more than 8,000 law enforcement agencies to date have enrolled in the 1033 Program.[28] Once accepted into the 1033 Program, a law enforcement agency can review online the available excess DOD inventory that is suitable for law enforcement and make requests for property through the state coordinator. Every request for property must have a justification outlining how the property will be used, and requests must be for bona fide law enforcement purposes. Agencies do not pay for the property but must pay for shipping the items as well as potential storage costs.[29] A caveat of the 1033 Program included a requirement to deploy the

equipment within one year of receipt which may incentivize police to use the equipment for other purposes. Agencies that do not use the equipment within the one-year timeframe are required to return the unused items.[30]

There are two types of property that can be transferred to law enforcement under the program: controlled and uncontrolled. Controlled property consists of military items that are provided via a conditional transfer or "loan" basis; title for the property remains with DLA. Controlled property includes items such as small arms/personal weapons, demilitarized vehicles and aircraft, and night vision equipment. When a law enforcement agency no longer wants the controlled property, it must be returned to LESO. Non-controlled property, on the other hand, consists of common items DLA would sell to the general public, such as office equipment, first aid kits/supplies, hand tools, sleeping bags, computers, and digital cameras. After one-year, general property becomes the property of the law enforcement agency. Most of the equipment transferred is non-controlled property.[31] According to *Politifact.com*, small arms weapons such as rifles and side-arms normally make up about five percent of the total, while less than one percent of property issued is tactical vehicles.[32] In order to request and receive controlled property, participating law enforcement agencies must receive the local governing authority's approval and must certify that, in addition to receiving such approval, they have adopted publicly available protocols for the appropriate use of controlled property, the supervision of such use, and the evaluation of the effectiveness of such use, including auditing and accountability policies.[33] Since the 1033 Program's beginning, more than $7.5 billion worth of property (based on initial acquisition value) has been transferred to law enforcement agencies.[34]

There are certain military items that are not available for transfer to law enforcement agencies through the 1033 Program. This prohibited equipment includes: any aircraft, vessels or vehicles that inherently contain weaponry, (e.g., tanks, Bradley fighting vehicles, armed drones); crew served/large caliber (.50 caliber or greater) weapons and ammunition; military uniforms; body armor; Kevlar helmets; and explosives or pyrotechnics of any kind. Also, aircraft and vehicles available in the program are "demilitarized," meaning that any specific military technology (e.g., communication equipment) are removed prior to transfer to law enforcement agencies.[35]

There are several oversight tools that DLA uses for the program to maintain and ensure compliance with all program requirements and property accountability, including an annual certified inventory by each participating state, biennial federal level program compliance reviews, and annual state coordinator reviews of at least five percent of the law enforcement agencies that have acquired property. In addition, state coordinators and law enforcement agencies may be suspended or terminated from the 1033 Program for non-compliance.[36] In addition, the law was amended by Congress in 2015 to make it clear that each individual agency acquiring controlled equipment has responsibility for training its personnel in the proper use, maintenance, and repair. The law requires each law enforcement agency to certify on an annual basis that it provides annual training to relevant personnel on the maintenance, sustainment, and appropriate use of controlled property.[37] Additional oversight is provided through coordination between LESO and the DOJ to identify law enforcement agencies that are under DOJ investigation or under a consent decree and thus ineligible for the program.

After calls for transparency about the 1033 Program following the Black Lives Matter protests in 2014 in Ferguson, Missouri, in the aftermath of the police shooting of Michael Brown, the DOD released data about the tactical equipment it tracks through the program, and for the first time identified the agencies that received items.[38] Since 2016, there has been more transparency than there was during the first 20 years of the 1033 Program, when record keeping was very spotty.

LESO has a public website page that links to a detailed spreadsheet, that lists all equipment issued to agencies, by state.[39]

While the 1033 Program is perhaps the most publicly well-known program, there are additional DOD programs that allow law enforcement to purchase military-grade equipment. For example, under the 1122 Program, originally authorized in the NDAA for FY1994 (P.L. 103-160, codified at 10 U.S.C §281), the Secretary of Defense is allowed to establish procedures for state and local governments to purchase law enforcement equipment for counterdrug, homeland security, and emergency response activities. Section 885 of the FY2009 NDAA (P.L. 110-417) expanded the program to include homeland security and emergency response operations. The U.S. Army, notably, manages the 1122 Program. Moreover, another program authorizes the Secretary of Defense to sell surplus military equipment to state and local law enforcement, firefighting, homeland security, and emergency management agencies at fair market value. Authorized equipment includes pistols, revolvers, shotguns, rifles of a caliber not exceeding .30, ammunition for such firearms, gas masks, personal protective equipment, and other appropriate equipment. The equipment cannot be transferred or resold by the acquiring agency.[40]

Similar to the 1122 Program, the Department of Homeland Security's (DHS) Urban Areas Strategy Initiative provides grant funds to allow police and sheriffs' departments to purchase crowd-control items such as cuffs, batons, helmets, gas masks, and other such equipment or allow them to use their own money to buy it at discounted federal prices.[41] DHS also has another grant program, the State Homeland Security Program, that provides funding to state, local, and Tribal governments, for terrorism preparedness. Notably, there is less transparency about these other programs, and they do not have the same restrictions as the 1033 Program.

Following the Ferguson protests, numerous concerns were raised about the 1033 Program by members of Congress, the media, and research groups. Congressional hearings were held and in May 2015, following the recommendations of a working group he appointed, then President Barack Obama signed an executive order that prohibited state and local law enforcement from receiving certain types of property, such as grenade launchers and weaponized aircraft, under the 1033 Program.[42] Subsequently, former President Donald Trump rescinded the Obama-era restrictions.

More recently, in the wake of the police killing of George Floyd and the subsequent protests, a provision to place restrictions on the 1033 Program was included in the FY21 NDAA, which was passed over then President Trump's veto. Specifically, Section 1053 bars the transfer to law enforcement agencies of bayonets, lethal grenades, weaponized tracked combat vehicles, and aerial drones equipped with weapons. The provision also requires that personnel in law enforcement agencies that receive DOD equipment under the program undergo training in respect for citizens' constitutional rights and in conflict de-escalation. Finally, legislation was introduced in Congress in 2020 and again this year that includes provisions to demilitarize police departments, i.e., the "George Floyd Justice in Policing Act" (H.R. 1280, 117th Congress), which passed the House of Representatives on March 3, 2021. Section 365 of the bill would place limitations on the 1033 Program, including banning the transfer of controlled equipment (e.g., firearms, ammunition, bayonets, grenade launchers, grenades, explosives, most vehicles, drones, certain aircraft) and require more accountability and reporting from agencies receiving equipment and from DOD to Congress. This provision remains one of the stumbling blocks in negotiations on the bill in the Senate.

Discussion

Supporters of the 1033 Program, including many members of Congress and law enforcement agencies, argue that it provides an efficient way for local police agencies to obtain recycled equipment they otherwise could not afford, and was a good use of tax dollars. Law enforcement notes that there are high risk situations when use of such equipment is necessary and appropriate, such as during mass shooting events. They also point to the numbers, arguing that the 1033 Program does not contribute to militarization given that most of the transferred equipment is of general use, such as first aid kits, blankets, gym equipment, cold weather clothing, and large storage bins, while less than one percent of the equipment are tactical vehicles and only five percent are small arms.[43] Proponents also argue that the 1033 Program helps to increase safety in cities, particularly for law enforcement officers and the public.[44] In an evaluation of the 1033 Program published in 2018 that was conducted by the RAND Corporation and was required by the 2017 NDAA, the authors concluded that the DOD's LESO manages an efficient program that effectively reuses excess property, benefits the law enforcement community, responds diligently to oversight, and is faithful to congressional intent. The study authors acknowledged, however, that, "these efforts are unlikely to resolve perceptions that the program contributes to the militarization of police."[45]

Opponents and critics, however, argue that the 1033 Program has led to an excessive militarization of local police agencies, adversely impacts police culture, erects barriers between police and local communities, and has led to an association with the use of lethal force on suspects.[46] For example, recent research has analyzed factors that increase an agency's likelihood of acquiring specific categories of equipment through the 1033 Program. One study found that agencies with "warrior" tendencies (measured through agencies' body armor policies and special units) and that use asset forfeiture were significantly more likely to acquire a mine-resistant ambush-protected (MRAP) vehicle.[47] Another study assessing the influence of violent crime rates, drug arrest rates, and proportion of minority population on agencies' participation in the 1033 Program, found that high violent crime rates and high proportion of Black population increased an agency's likelihood to obtain any equipment from the 1033 Program.[48] In a 2014 report by the American Civil Liberties Union that examined the use of SWAT teams, the authors stated that, "the use of hyperaggressive tools and tactics results in tragedy for civilians and police officers, escalates the risk of needless violence, destroys property, and undermines individual liberties."[49]

In light of the different ways agencies acquire military equipment, it is difficult to assess the extent to which and whether local police agencies are militarized and how such equipment is actually used. As discussed above, there is no consensus in research studies on the actual impact of the 1033 Program on communities or on police. There is also no clear evidence that regulating or limiting the 1033 Program alone would resolve these issues given the other programs through which law enforcement agencies acquire military equipment, especially since there is less publicly available information on them. Without such evidence, it is difficult to reach conclusions on whether the AMA should support limiting or eliminating the 1033 Program or funding for additional DOD or DHS military equipment programs. And, without such evidence, it would be difficult for the AMA to impactfully advocate on such a position. Therefore, while acknowledging the concerns expressed by Resolution 410, and its sponsors and supporters, the Board determined that the AMA should defer to outside organizations that have the appropriate expertise and resources to fully examine and study these issues and encourage such endeavors.

COMMUNITY-BASED OVERSIGHT BOARDS

Community or civilian oversight boards (COBs) are entities comprised of members of the public who may review, investigate, or discipline law enforcement officer wrongdoings. They vary tremendously in terms of composition, scope, and authority, but generally follow three main models: investigation-focused models that operate separately from law enforcement; review-focused models that review the quality of completed internal affairs investigations; and auditor/monitor models that focus on large-scale systemic reform and, at times, participate in or monitor internal investigations. Currently, there are approximately 200 COBs among the 18,000 law enforcement jurisdictions in the United States, including in 24 of the 50 largest cities.[50,51] Most COBs are created locally by cities, towns, and counties.[52]

The movement toward modern civilian oversight, dates back, to the civil rights era when Black and Latino communities successfully advocated for civilian oversight in their communities. Since that time, many COBs have been created in direct response to high profile events and racially disparate policing. For example, the City of Chicago created its Police Accountability Task Force in response to the 2014 shooting of Laquan McDonald.[53] The findings from the Chicago task force investigation led to the creation of a civilian oversight body.[54] Often, COBs are created in a consent decree between the DOJ and a municipality. For instance, Albuquerque's COB was established via settlement agreement with the DOJ in 2014 following findings of patterns of excessive force by the DOJ.[55]

Proponents of community oversight say that such boards improve public trust, ensure accessible complaint processes, ensure thorough investigations, increase transparency, and deter police misconduct. The push for community oversight also stems from skepticism of self-regulation by police. Proponents argue that internal investigations and disciplinary processes conducted by fellow law enforcement officers are inherently conflicted and biased, and lead to overly permissive supervision that fails to hold officers accountable for wrongdoing. Citizen-led investigatory and disciplinary processes, it is argued, are a necessary external check on police power.

However, despite their growing popularity, evidence of COBs promoting accountability, improving police-community relations, and curbing police misconduct is limited. There is some evidence that external civilian review of internal investigations is associated with a greater likelihood that misconduct complaints will be found to have merit, but, to date, COBs have been found to be largely ineffective due to political opposition, lack of authority to investigate, and lack of power to discipline.[56,57]

Many COBs have limited authority by design. A survey conducted by the National Association for Civilian Oversight of Law Enforcement found that 63 percent of oversight boards have authority to conduct investigations that are independent of the police, but others are limited to audits or reviews of prior internal investigations. Only 40 percent had subpoena power, without which COBs cannot compel witnesses to testify or produce documents.[58] In some instances, because they are staffed by civilians, COBs are not granted access to confidential personnel records or internal investigations documents that might be relevant.[59] Further, COB findings are often advisory and non-binding. For those that can recommend disciplinary action, police chiefs or others may reject their recommendations. Only six percent have authority to discipline officers.[60] One study estimated that when COBs handle civilian misconduct complaints, only seven to nine percent of the complaints result in officer discipline.[61] COBs are sometime limited in scope as well. Some can only investigate serious police violence, which puts systemic failings out of the COBs' reach. Some COBs can only investigate incidents rather than general policing policies, reinforcing the reactive, rather than proactive, approach to police misconduct.[62]

Police unions can sometimes impede COBs. Some object to civilians, who they consider to be unknowledgeable in policing, having the power to judge police actions and argue there are other systems in place to investigate police misconduct, like internal affairs units.[63] Consequently, police or their unions sometimes place restrictions on what information can be released to the COBs or otherwise restrict COBs via collective bargaining agreements.

Discussion

Because of the limitations of existing COBs and limited research demonstrating their effectiveness, it is unclear if expanding civilian authority of police oversight would improve police-community relations and decrease officer misconduct. It may be that authorizing COBs to conduct independent investigations and issue binding disciplinary orders would deter police violence. The necessary attributes of an effective COB, however, remain unclear. Questions about what form COBs ought to take, what powers it ought to be granted, and how to untangle agreements made between police unions and local governments extend beyond the scope of the AMA's expertise.

We also note that medicine has a long tradition of self-regulation that is supported by AMA policy. When a state medical board conducts an investigation or inquiry of a physician's quality of care, we believe that the standard of care must be determined, not only by a physician, but by a physician from the same specialty. Similarly, AMA policy supports peer review processes that are conducted by physicians within the same specialty. We also advocate for strict confidentiality of the proceedings of peer review processes and information reported to licensing boards. If COBs were proposed to oversee physicians' actions, physicians would undoubtedly object.

Again, policy supporting a more holistic approach to policing may be more impactful way for the AMA to advocate. Specifically, there is a movement underway towards more police coordination and engagement with communities on the front-end, which allows communities visibility and input into policing strategies, and elevates them to a meaningful partner in the production of public safety. Community policing has four important features: community-based crime prevention; reorientation of patrol activities to emphasize non-emergency servicing; accountability to the public; and decentralization of command.[64] A community-focused approach has been found to reduce citizen fear and increase citizen satisfaction, which are often linked to a citizen's perception of legitimacy of the police.[65] In a short-term study, brief interactions with the police were shown to improve attitudes towards the police and increase trust of the police.[66]

"Community-oriented" policing is on the rise and quickly becoming the dominant philosophy for policing in America, with over 81 percent of agencies using some community policing approaches.[67] A 2018 report from the Policing Project at NYU School of Law, Police Foundation, and National Urban League, however, found that while most law enforcement agencies are taking steps to build community relations, more can be done. According to this 2018 report, community members desire more input into department policies and practices.[68] More community involvement on the front-end could address some of the upstream, systemic issues that lead to racially disparate policing.

In addition to community-oriented policing, improving, and expanding training on procedurally just policing has been lauded as a strategy for decreasing use-of-force and increasing citizen satisfaction with police. The "procedural justice" model of policing prioritizes transparency, explaining policing actions, and responding to community concerns.[69] In Seattle, for example, a procedural justice training program designed to "slow down" police officers' interaction with community members reduced use-of-force between 15 and 40 percent.[70] Similarly the National Academy of Sciences found that large-scale implementation of procedural justice training in

Chicago led to both reduced complaints against the police by 10 percent and reduced the use of force against civilians by 6.4 percent over two years.[71] Another study found that officers who attended training on procedural justice were more likely to endorse the importance of giving members of the public a voice, granting them dignity and respect, demonstrating neutrality, and trusting them to do the right thing.[72]

We recognize, however, that procedurally just policing and community policing must be accompanied by greater police accountability. Accountability for individual police actions is essential if police are to effectively and equitably protect all citizens, and if police are to have legitimacy in the eyes of community members. As discussed above, there is currently insufficient evidence to support the widescale adoption of police accountability reform proposals that seek to decentralize disciplinary processes away from internal police mechanisms and instead empower independent actors (e.g. community boards and courts) with disciplinary authority. Research does, however, suggest that certain internal accountability mechanisms, such as written policies on use of force, greater supervision of officers by their supervisors, early intervention systems that identify officers with patterns of misconduct, and hiring practices that prevent officers who have been dismissed for misconduct from being unknowingly rehired by other departments, may be effective at changing individual police conduct.[73] While the AMA is not in a position to determine which reforms are preferable over others, we do recognize that greater accountability is necessary to end discriminatory practices and unnecessary or excessive use of police force.

AMA POLICY

AMA policy affirms that physical and verbal violence between law enforcement officers and public citizens, particularly within racial and ethnic minority populations, is a social determinant of health. Policy further encourages data collections and the study of public health effects of violence between law enforcement officers and public citizens, particularly within ethnic and racial minority communities and mandatory reporting of legal intervention deaths and law enforcement officer homicides to public health agencies (Policy H-515-955, “Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes”).

In November 2020, the AMA adopted new policy recognizing police brutality as a manifestation of structural racism which disproportionately impacts Black, Indigenous, and other people of color and pledging to work with interested medical societies in a public health effort to support the elimination of excessive use of force by law enforcement officers. AMA policy also advocates against the utilization of racial and discriminatory profiling by law enforcement, for appropriate anti-bias training and individual monitoring, and for trauma-informed, community-based safety practices (Policy H-65.954, “Policing Reform”).

AMA policy supports implementation of law enforcement-based crisis intervention training programs for assisting those individuals with a mental illness, such as the Crisis Intervention Team model programs, and federal funding to encourage increased community and law enforcement participation in crisis intervention training programs. AMA policy also supports evidence-based training programs for corrections officers on effectively interacting with people with mental health and other behavioral issues in all detention and correction facilities (Policy H-345.972, “Mental Health Crisis Interventions”). AMA policy also encourages national standards for school resource officers to include training and certification in child psychology and development, restorative justice, conflict resolution, crime awareness, implicit/explicit biases, diversity inclusion, cultural humility, and individual and institutional safety and the development of policies that foster the best environment for learning through protecting the health and safety of those in school, including

students, teachers, staff and visitors (Policy H-60.902, "School Resource Officer Qualifications and Training").

Several AMA policies directly address law enforcement processes and procedures. AMA policy does not regard the choke and sleeper holds as casually applied and easily reversible tranquilizers, but as the use of deadly force with the potential to kill and advocates that with all incidents involving the application of choke and sleeper holds there should be timely medical surveillance of the inmate (Policy H-430.998, "Use of the Choke and Sleeper Hold in Prisons"). AMA policy recommends that law enforcement departments and agencies should have in place specific guidelines, rigorous training, and an accountability system for the use of conducted electrical devices (CEDs) and encourages evaluation, management, and post-exposure monitoring and independent research of field deployment of CEDs to better understand the risks and benefits under conditions of actual use (Policy H-145.977, "Use of Conducted Electrical Devices by Law Enforcement Agencies"). AMA policy supports expanded use of body-worn cameras for law enforcement (Policy D-160.919, "Increased Use of Body-Worn Cameras by Law Enforcement Officers D-160.919). AMA policy advocates for guidelines governing police pursuits and use of advanced technologies to reduce high-speed chases (Policy H-15.964, "Police Chases and Chase-Related Injuries H-15.964"). New AMA policy adopted in 2021 supports prohibiting the use of rubber bullets, chemical irritants, and kinetic impact projectiles to control protests and crowds that do not pose an immediate threat (Policy H-145.969, "Less-Lethal Weapons and Crowd Control "). AMA policy also recommends that law enforcement agencies have in place specific guidelines, rigorous training, and an accountability system for the use of kinetic impact projectiles and chemical irritants, as well as greater use of de-escalation techniques and the development of crowd-control techniques which pose a more limited risk of physical harm (Policy H-145.969, "Less-Lethal Weapons and Crowd Control").

AMA policy opposes the use of the terms "excited delirium," expresses concern about law enforcement officer use of force accompanying "excited delirium" that leads to disproportionately high mortality among communities of color, particularly among Black men, and denounces "excited delirium" solely as a justification for the use of force by law enforcement officers (Policy H-130.932, "Pharmacological Intervention for Agitated Individuals in the Out-of-Hospital Setting"). AMA policy opposes the use of sedative/hypnotic and dissociative agents as a pharmacological intervention for agitated individuals in the out-of-hospital setting, when done solely for a law enforcement purpose and recognizes that sedative/hypnotic and dissociative pharmacological interventions for agitated individuals have significant risks (Policy H-130.932, "Pharmacological Intervention for Agitated Individuals in the Out-of-Hospital Setting"). AMA policy also urges training for law enforcement and frontline emergency medical service personnel on de-escalation techniques and the appropriate use of pharmacological intervention for agitated individuals (Policy H-130.932, "Pharmacological Intervention for Agitated Individuals in the Out-of-Hospital Setting"). Finally, AMA policy urges medical and behavioral health specialists, not law enforcement, to serve as first responders and decision makers in medical and mental health emergencies in local communities and that administration of any pharmacological treatments in the out-of-hospital setting be done equitably, in an evidence-based, anti-racist, and stigma-free way (Policy H-130.932, Pharmacological Intervention for Agitated Individuals in the Out-of-Hospital Setting").

RECOMMENDATIONS

The Board recommends that the following be adopted in lieu of the Third, Fourth, and Eighth Resolve Clauses of Resolution 410-NOV-20, and that the remainder of the report be filed.

1. That our AMA advocate for efforts to implement evidence-based policing and the creation of evidence-based standards for law enforcement. (New HOD Policy)

2. That our AMA advocate for sentinel event reviews in the criminal justice system following an adverse event, such as an in-custody death. (New HOD Policy)

3. That our AMA encourage further research by subject matter experts on the issues related to the transfer of military equipment to law enforcement agencies, including the impact on communities, particularly those in minoritized and marginalized communities. (New HOD Policy)

4. That our AMA support greater police accountability, procedurally just policing models, and greater community involvement in policing policies and practices. (New HOD Policy)

5. That Policy H-65.954, "Policing Reform," be reaffirmed. (Reaffirm HOD Policy)

6. That Policy H-515.955, "Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes," be reaffirmed. (Reaffirm HOD Policy)

7. That Policy H-345.972, "Mental Health Crisis Interventions," be reaffirmed. (Reaffirm HOD Policy)

8. That Policy H-145.969, "Less-Lethal Weapons and Crowd Control," be reaffirmed. (Reaffirm HOD Policy).

Fiscal Note: Less than $5,000.

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Appendix A: AMA Policies Recommended for Reaffirmation

H-65.954 Policing Reform
Our AMA: (1) recognizes police brutality as a manifestation of structural racism which disproportionately impacts Black, Indigenous, and other people of color; (2) will work with interested national, state, and local medical societies in a public health effort to support the elimination of excessive use of force by law enforcement officers; (3) will advocate against the utilization of racial and discriminatory profiling by law enforcement through appropriate anti-bias training, individual monitoring, and other measures; and (4) will advocate for legislation and regulations which promote trauma-informed, community-based safety practices. (Res. 410, I-20; Reaffirmed: CSAPH Rep. 2, A-21)

H-515.955 Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes
Our AMA:
1. Encourages the National Academies of Sciences, Engineering, and Medicine and other interested parties to study the public health effects of physical or verbal violence between law enforcement officers and public citizens, particularly within ethnic and racial minority communities.
2. Affirms that physical and verbal violence between law enforcement officers and public citizens, particularly within racial and ethnic minority populations, is a social determinant of health.
3. Encourages the Centers for Disease Control and Prevention as well as state and local public health agencies to research the nature and public health implications of violence involving law enforcement.
4. Encourages states to require the reporting of legal intervention deaths and law enforcement officer homicides to public health agencies.
5. Encourages appropriate stakeholders, including, but not limited to the law enforcement and public health communities, to define “serious injuries” for the purpose of systematically collecting data on law enforcement-related non-fatal injuries among civilians and officers. (Res. 406, A-16; Modified: BOT Rep. 28, A-18)

H-345.972 Mental Health Crisis Interventions
Our AMA: (1) continues to support jail diversion and community based treatment options for mental illness; (2) supports implementation of law enforcement-based crisis intervention training programs for assisting those individuals with a mental illness, such as the Crisis Intervention Team model programs; (3) supports federal funding to encourage increased community and law enforcement participation in crisis intervention training programs; and (4) supports legislation and federal funding for evidence-based training programs by qualified mental health professionals aimed at educating corrections officers in effectively interacting with people with mental health and other behavioral issues in all detention and correction facilities. (Res. 923, I-15; Appended: Res. 220, I-18; Reaffirmed: CSAPH Rep. 2, A-21)

H-145.969 Less-Lethal Weapons and Crowd Control
Our American Medical Association (1) supports prohibiting the use of rubber bullets, including rubber or plastic-coated metal bullets and those with composites of metal and plastic, by law enforcement for the purposes of crowd control and management in the United States; (2) supports prohibiting the use of chemical irritants and kinetic impact projectiles to control crowds that do not pose an immediate threat; (3) recommends that law enforcement agencies have in place specific guidelines, rigorous training, and an accountability system, including the collection and reporting of data on injuries, for the use of kinetic impact projectiles and chemical irritants; (4) encourages guidelines on the use of kinetic impact projectiles and chemical irritants to include considerations such as the proximity of non-violent individuals and bystanders; for kinetic impact projectiles, a

safe shooting distance and avoidance of vital organs (head, neck, chest, and abdomen), and for all less-lethal weapons, the issuance of a warning followed by sufficient time for compliance with the order prior to discharge; (5) recommends that law enforcement personnel use appropriate de-escalation techniques to minimize the risk of violence in crowd control and provide transparency about less-lethal weapons in use and the criteria for their use; and (6) encourages relevant stakeholders including, but not limited to manufacturers and government agencies to develop and test crowd-control techniques which pose a more limited risk of physical harm. (BOT Rep. 10, A-21)

REPORT OF THE BOARD OF TRUSTEES

B of T Report 8-N-21

Subject: Improved Access and Coverage to Non-opioid Modalities to Address Pain (Alternate Resolution 218-A-19)

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee B

INTRODUCTION

At the 2019 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted an alternate resolution to Resolutions 218, which is now AMA Policy H-120.922, "Improved Access and Coverage to Non-Opioid Modalities to Address Pain."

The following resolves were referred:

> That although our AMA supports all interventional pain interventions and therapies in general, due to current issues with limitations in coverage and noncoverage, in particular, spine and large joint radiofrequency ablation and other arbitrarily limited non-covered interventional pain management procedures, by private insurance carriers, third party reviewing agencies, Medicare and Medicaid contractors, and Medicare Advantage Plans, the AMA supports coverage of these medically necessary procedures in particular, at this time; and
>
> That our AMA supports coverage of evidence-based spinal cord stimulation trials and implantation, and peripheral nerve stimulation trials and implantation (as both CPT code sets are linked to their respective ICD10 codes as outlined in the AMA CPT Manual) by private insurance carriers, third party reviewing agencies, Medicare and Medicaid contractors, and Medicare Advantage Plans.

Original Resolutions 218 and 235 from the 2019 AMA HOD Annual Meeting contained highly specific information relating to specific medications and medical conditions. Resolution 218 asked that the AMA, "petition the Centers for Medicare and Medicaid Services (CMS) to allow reimbursement for off label use of medications like gabapentin or lidocaine patches at the lowest copayment tier for the indication of pain so that patients can be effectively treated for pain and decrease the number of opioid prescriptions written." Resolution 235 asked that the AMA, "encourage the U.S. Food and Drug Administration (FDA) to consider approving other indications in addition to post-herpetic neuralgia for transdermal lidocaine patches."

During HOD testimony, it became clear that physician delegates had many concerns about a wide range of non-opioid pain care treatment options in addition to the ones listed in the original resolutions. There also was concern raised about ensuring that AMA advocacy to CMS and FDA was focused on actions that CMS and FDA could reasonably be expected to take rather than asking them to take actions beyond their regulatory scope.

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As a result of the detailed testimony, the reference committee suggested an alternate "omnibus" resolution to provide for AMA support for a broad range of non-opioid pain care treatment options for coverage and access, as well as placement on a payer's lowest cost-sharing tier. The alternate resolution received support from the Board of Trustees primarily due to the fact that the comprehensive nature of support for patients with pain would augment ongoing AMA advocacy in support of patients with pain and the physicians who provide pain care. After a robust discussion, the HOD adopted the reference committee's "omnibus" recommendation, which is now AMA Policy H-120.922, "Improved Access and Coverage to Non-Opioid Modalities to Address Pain," which states:

> Our AMA will: (1) advocate for increased access and coverage of non-opioid treatment modalities including pharmaceutical pain care options, interventional pain management procedures, restorative therapies, behavioral therapies, physical and occupational therapy, and other evidence-based therapies recommended by the patient's physician; (2) advocate for non-opioid treatment modalities being placed on the lowest cost-sharing tier for the indication of pain so that patients have increased access to evidence-based pain care as recommended by the HHS Interagency Pain Care Task Force; and (3) encourage the manufacturers of pharmaceutical pain care options to seek DEA approval for additional indications related to non-opioid pain management therapy.

On their face, the referred resolves involve the same type of highly specific medical procedures and payer responsibilities for those procedures that were at issue in original Resolutions 218 and 235. This report will provide background on the issues presented, discuss relevant AMA policy and provide recommendations.

DISCUSSION

One of the most common elements of the nation's opioid epidemic has been for policymakers and public health officials to largely bypass the fact that improving pain care for America's patients is integral to ending the nation's opioid epidemic. The AMA has long called for the balance needed between policymaking intended to address the opioid epidemic with medical evidence, policy and patient compassion—alongside the reality that there are millions of patients in pain, and that the opioid epidemic has fully shifted to one driven by illicitly manufactured fentanyl, fentanyl analogs, heroin, cocaine and methamphetamine. While policymakers have almost entirely focused on opioid prescribing, physicians and other health care professionals on a national level began to make more judicious opioid prescribing decisions in 2012-13. Part of that decision-making process, however, must not discount the clinical experience that opioid therapy works for many patients. It also must not discount the practical reality faced by physicians and patients daily that if opioid therapy is not the preferred course of treatment, patients must have access to affordable, available non-opioid treatment options supported by medical evidence.

These overarching principles and concerns have guided the AMA in calling for pain-related policies and practices that do more than simply promote, prioritize or pay for minimizing prescription opioid prescribing. Such restrictive policies not only run the risk of undertreating pain, but they may lead to sub-optimal outcomes, increased stigma and ongoing barriers to care.[1] AMA advocacy, therefore, strongly supports efforts focused on health insurance plans, PBMs and other payer policies to be changed and aligned to support comprehensive multimodal, multidisciplinary and restorative pain care. This includes removing administrative and financial barriers (e.g., prior authorization, inappropriate specialty tiering in formularies, prohibitive cost-sharing), as well as supporting payment policies that will promote optimal pain care. Despite recognition among the medical and patient community, these barriers remain pervasive and harm patients.

The U.S. Department of Health and Human Services (HHS) Interagency Pain Care Task Force reported in 2019 that, "multidisciplinary, multimodal approaches to acute and chronic pain are often not supported in time and resources, leaving clinicians with few options to treat often challenging and complex underlying conditions."[2] The report also found that:

> The recent advent of retail pharmacies limiting the duration of prescriptions, making changes to dosage, amounts, or placing restrictive barriers to obtaining properly prescribed pain medications has had the unintended consequence of limiting access to pain care. Without access to sufficient pain care, many patients face unnecessary medical complications, prolonged suffering, and increased risk for psychiatric conditions.

The AMA is deeply concerned that corporate and retail pharmacy and PBM practices are having the unintended consequence of limiting access to pain care—leading to medical complications, heightened stigma and increased pain. These combined payer, pharmacy chain and PBM policies need further investigation and rescission to help ensure patients with pain can receive the type of comprehensive, multidisciplinary, multimodal care that pain experts support, and patients deserve. This applies to a broad range of evidence-based restorative therapies, interventional procedures, behavioral health approaches and complementary and integrative health strategies. More than 90 percent of pain medicine specialists said that they have been required to submit a prior authorization for non-opioid pain care—with them and their staff spending hours per day on these requests.[3]

The AMA Opioid Task Force (Task Force) broadly supports access to the treatments prescribed and recommended by a patient's physician for pain-related care. The Task Force included, among its first recommendations, support for physicians who treat patients with pain. The Task Force recommended support for patients' and physicians' access to comprehensive, affordable, compassionate treatment, including a comprehensive, multidisciplinary, multimodal approach to pain management. The Task Force emphasized that, "[t]his means that payers and employers need to improve access to non-opioid and non-pharmacologic treatment for pain."[4]

The Task Force furthered its 2015 recommendation on comprehensive pain care in 2019, urging additional action by policymakers. The recommendation emphasized the need to, "[r]emove administrative and other barriers to comprehensive, multimodal, multidisciplinary pain care and rehabilitation programs."[5] In part, the 2019 recommendation responded to the fact that physicians had reduced opioid prescribing by 33 percent between 2013-18, but many patients receiving opioid therapy—and part of stable, ongoing care—found themselves subject to payer, chain pharmacy, PBM and state legislative policies that either strongly encouraged or required quantity and/or dosage restrictions on opioid analgesics.

The AMA Pain Care Task Force (PCTF) was formed in 2018 with a goal of identifying a set of priorities for improving pain care that are actionable and that will potentially provide opportunities for collaborative action. The PCTF has prepared a manuscript for publication later this year that describes many of the barriers to effective, high quality and evidence-informed care for patients with pain. Policy and payer issues, workforce and training challenges, legal issues, research challenges, stigma and patient beliefs and expectations all contribute to the barriers physicians and patients experience and are explored in the document. The PCTF also has documented principles for evidence-informed pain management. Additionally, the PCTF continues to be engaged in conversations related to education of physicians along their continuum on issues relevant to the intersection of pain care, opioids, and addiction.

There is no question that the nation's physicians have reduced opioid analgesic supply—both in volume and dose strength—but there has not been a concomitant increase in access to or affordability of evidence-based non-opioid alternatives. This includes medication, including non-opioid pain relievers, anticonvulsants, antidepressants, musculoskeletal agents, anxiolytics, as well as opioid analgesics when appropriate. It includes restorative therapies such as physical therapy, occupational therapy, physiotherapy, therapeutic exercise, osteopathic manipulative therapy (OMT) and other modalities such as massage and therapeutic ultrasound. It also includes interventional procedures, such as neuromodulation, radio frequency ablation, peripheral nerve stimulation, central and peripheral nerve ablation, spine surgery and steroid injections and other emerging interventional therapies as part of the multimodal pain care plan.

The Board notes that these are among the therapies pain specialists use but are routinely subject to prior authorization and other utilization management protocols imposed by payers.[6] In urging the U.S. Centers for Disease Control and Prevention to help reduce payer-imposed barriers to comprehensive pain care, AMA Executive Vice President and CEO, James L. Madara, MD, explained that, "[i]t is challenging for physicians to be directed by the federal government to increase access to nonopioid pain care options when payers and PBMs make that difficult, to impossible, to achieve."[7]

As the above discussion makes clear, the AMA already strongly supports broad access to the types of therapies called for under both the original resolutions and the referred resolves. The Board notes that the policy approved by the HOD at A-19 were a direct response to avoiding having AMA policy focus too narrowly on one type of therapy. The Board is concerned that in focusing too intently on one type of therapy, it potentially raises the risk of excluding other types of non-opioid pain care as part of AMA advocacy. For example, if a payer decided to remove prior authorization and other barriers to the therapies in the referred resolves, they could argue that they have satisfied AMA policy without enhancing access to the much more robust areas of non-opioid pain care used by physicians.

In addition to the overly narrow focus on specific therapies in the referred resolves, the Board also is concerned by the overly vague nature of "coverage," as it is presented in the referred resolves. It is not clear from the testimony or the language of the resolves referred precisely what is meant by "coverage" as that is a term of art used by CMS. Specifically, CMS has processes for the development of National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), both of which require extensive levels of evidence and consideration by CMS.[8] There also is separate CMS policy and processes for trials of a particular service. It is far beyond the scope of this report to delve into whether the procedures named in the referred resolves have the requisite levels of outcomes data, evidence and other criteria needed by CMS as part of the NCD, LCD or other coverage determination. Thus, while the Board supports the underlying intent of the original resolutions and the referred resolves to help ensure patients have access to the therapies recommended by their physician, and the Board would almost certainly support actions by CMS to remove barriers to those therapies, the Board is not aware that CMS has been presented with applications or other information as part of an NCD or LCD. It is challenging, to say the least, to suggest that the AMA should support an NCD or LCD without having access to the data and other information required by CMS. This is not to suggest that the AMA does not support patients receiving those therapies, but it is premature to suggest AMA support for a specific NCD or LCD for a specific therapy at this time.

The Board's recommendation to not adopt the referred resolves does not limit AMA advocacy for increasing access to non-opioid pain care. This is due to the fact that the policies adopted by the HOD in lieu of original resolutions 218 and 235 encompass the underlying intent of the referred

resolves. This is also due to the fact that additional AMA policies outlined below, as well as ongoing AMA advocacy, demonstrate AMA already advocates for a broad range of non-opioid pain care access for patients. The AMA does not and should not favor one evidence-based option over another, which is what the referred resolves are asking the AMA to do. Accordingly, to help ensure AMA advocacy and programmatic efforts continue to support all physicians who treat patients with pain, it is recommended that the resolves referred be not adopted.

AMA POLICY

As discussed thoroughly above, AMA has comprehensive policy in support of ensuring patients have access to the pain care therapies and modalities recommended by their physician. This includes advocating for, "increased access and coverage of non-opioid treatment modalities including pharmaceutical pain care options, interventional pain management procedures, restorative therapies, behavioral therapies, physical and occupational therapy, and other evidence-based therapies recommended by the patient's physician," as well as, "non-opioid treatment modalities being placed on the lowest cost-sharing tier for the indication of pain so that patients have increased access to evidence-based pain care as recommended by the HHS Interagency Pain Care Task Force. (Policy H-120.922, "Improved Access and Coverage to Non-Opioid Modalities to Address Pain")

Similar AMA policy stresses, "ensuring access to multiple analgesic strategies, including non-opioid options and interventional approaches when appropriate, with a focus on achieving improvement in function and activities of daily living." (Policy H-185.931, "Workforce and Coverage for Pain Management") Notably, AMA policy supports, "health insurance coverage that gives patients access to the full range of evidence-based chronic pain management modalities, and that coverage for these services be equivalent to coverage provided for medical or surgical benefits." (Policy H-185.931, "Workforce and Coverage for Pain Management")

Interventional chronic pain management means the diagnosis and treatment of pain-related disorders with the application of interventional techniques in managing sub-acute, chronic, persistent and intractable pain. The practice of pain management includes comprehensive assessment of the patient, diagnosis of the cause of the patient's pain, evaluation of alternative treatment options, selection of appropriate treatment options, termination of prescribed treatment options when appropriate, follow-up care, the diagnosis and management of complications and collaboration with other health care providers.

When AMA policy does discuss invasive pain management procedures or techniques—unlike the referred resolves—AMA policy appropriately provides for a wide range, including but not limited to "ablation of targeted nerves; procedures involving any portion of the spine, spinal cord, sympathetic nerves or block of major peripheral nerves, including percutaneous precision needle placement within the spinal column with placement of drugs such as local anesthetics, steroids, and analgesics, in the spinal column under fluoroscopic guidance or any other radiographic or imaging modality; and surgical techniques, such as laser or endoscopic discectomy, or placement of intrathecal infusion pumps, and/or spinal cord stimulators." (Policy H-410.950, "Pain Management")

RECOMMENDATION

The Board recommends that the referred resolves in Alternate Resolution 218-A-19 not be adopted and the remainder of the report be filed.

Fiscal Note: None

REFERENCES

1. The Board notes that the AMA Opioid Task Force has received hundreds of emails and other communication from patients who have been nonconsensually tapered from their current opioid analgesic regimen. The communications also include patients who have not been able to find a physician willing to prescribe opioid analgesics due to fear from investigation or prosecution. In all cases, it is clear to the Board that patients across the country face increased pain and suffering due to misapplication of opioid sparing policies, stigmatization of chronic pain and fear of providing opioid-based pain therapy.
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6. See ABPM survey, note 3.
7. AMA letter to Deborah Dowell, MD, MPH, Senior Medical Advisor/Chief Medical Officer, Division of Unintentional Injury Prevention, U.S. Centers for Disease Control and Prevention. James L. Madara, MD. October 29, 2019. Available at https://searchlf.ama-assn.org/undefined/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2019-10-29-Letter-to-Dowell-Compton-Giroir.pdf
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REPORT OF THE BOARD OF TRUSTEES

B of T Report 9-N-21

Subject: Medical Marijuana License Safety (Resolution 219-A-19)

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee B

INTRODUCTION

At the 2019 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) referred Resolution 219-A-19, "Medical Marijuana License Safety," introduced by the Oklahoma delegation, which asked:

> That our American Medical Association draft model state legislation to amend states' prescription drug monitoring programs to include a medical marijuana license registry.

Testimony on Resolution 219 raised numerous issues, including increasing legalization of medical and recreational cannabis; concerns about cannabis use by patients with—or without—a physician's knowledge; how medical marijuana license registries function in select states; and the potential intersection with and appropriate role(s) of a state prescription drug monitoring program (PDMP). This report provides relevant background and discussion, a review of relevant AMA policy and makes policy recommendations.

BACKGROUND

It is likely that any patient who sees a physician will be asked for a current list of any medications, supplements, herbal remedies or other substances being taken. This information is essential to ensure the physician has complete and accurate information that may be relevant to a patient's diagnosis and treatment options for any given ailment or disease.

The U.S. Food and Drug Administration (FDA) is charged with, among other things, reviewing new drug applications, including making recommendations about a drug's scheduling. The U.S. Drug Enforcement Administration (DEA) receives that recommendation and is charged with determining the drug's schedule or changing an existing drug's schedule. Cannabis (also referred to as marijuana or marihuana by DEA), contains the active ingredient delta-9-tetrahydrocannabinol (THC) and is a Schedule I controlled substance.[1] This means that under federal law, there is "no currently accepted medical use in the United States, a lack of accepted safety for use under medical supervision, and a high potential for abuse." Other Schedule I substances include heroin, LSD, peyote, methamphetamine and Ecstasy.[2]

In testimony to Congress earlier this year, Douglas Throckmorton, MD, Deputy Director, Center for Drug Evaluation and Research, FDA, explained that the FDA has approved four products containing cannabinoids: Epidiolex (standardized, plant derived cannabidiol (CBD)), Marinol (dronabinol, synthetic THC), Syndros (dronabinol), and Cesamet (nabilone, a synthetic THC

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derivative). These approved drug products are only available with a prescription from a licensed health care provider. Importantly, FDA has not approved any other cannabis, cannabis-derived or CBD products.

According to the National Conference of State Legislatures, more than 30 states allow for marijuana use by persons with certain medical conditions and an additional 14 states allow for recreational use of marijuana by adults.[3] In the "medical marijuana"[4] states, 29 states provide for the establishment of a patient registry and/or identification card, three states' provisions are pending and Washington does not have such a provision.[5] With respect to patient registries in "medical marijuana" states, it is common for states to require a considerable amount of personally identifiable information and other information, which may be made available to law enforcement and others. For example:

- California established a voluntary, web-based registry to allow law enforcement and the general public to verify the validity of a medical marijuana identification card for a patient. The registry is maintained by the California Department of Public Health.[6]
- Colorado's web-based registry allows patients to apply for an identification card as well as allows so-called "medical marijuana centers" to check whether a card has been revoked. It also has functionality to allow law enforcement to verify a card's validity among other features.[7]
- Ohio patients seeking medical marijuana must first have a certified physician submit information to the registry—after which the patient will receive an email prompting the patient to complete their application and pay a $50 fee.[8]
- North Dakota's patient registry requires patients to apply online, including uploading a photo, in which the state requires eyes to be open and indicates further that applicants should, "[a]void wearing dark, tinted glasses, hats or head coverings when taking the photo."[9]

These examples are not meant to be representative of all patient registries. Most patient registries also include information about whether the patient has a qualifying medical condition, which might include AIDS, amyotrophic lateral sclerosis, Alzheimer's disease, cancer, chronic traumatic encephalopathy, Crohn's disease, epilepsy or another seizure disorder, fibromyalgia, glaucoma, hepatitis C, inflammatory bowel disease, multiple sclerosis, pain that is either chronic and severe or intractable, Parkinson's disease, positive HIV status, post-traumatic stress disorder, sickle cell anemia, spinal cord disease or injury, Tourette's syndrome, traumatic brain injury and/or ulcerative colitis.

Nearly every state has a PDMP[10] that includes information about controlled substances dispensed to patients, as well physicians' and other health care professionals' controlled substances prescribing history. The pharmacist (or other dispenser) is typically required to submit certain information to the PDMP, as well. This typically includes a patient's name, date of birth, address, contact information, physician's DEA registration or National Provider Identifier, dose and quantity of the prescription and potentially a wide variety of information ranging from the site from which the prescription was issued, type of identification and whether the prescription was for a human or animal subject.[11]

Nearly every state has the ability to share PDMP data across state lines.[12] Nearly all PDMPs are administered by the state board of pharmacy. While there is some variation in state law and policy, most state PDMPs contain Schedule II-V information. This information is generally viewed as helpful clinical information for health care professionals. Encouraging physicians to register for

and use state PDMPs when clinically indicated was one of the first recommendations of the AMA Opioid Task Force (the Task Force) in 2015.[13]

DISCUSSION

Most physicians agree that PDMPs have the capability to provide relevant clinical information for physicians and other health care professionals as part of the clinical decision-making process. The Task Force identified many of the useful features of a state-based PDMP in its first recommendations in 2015.[14] The Task Force emphasized the need for PDMPs to be integrated into clinical workflow, including having the PDMP data easily accessible in the electronic health record (EHR) without having to perform multiple clicks, enter multiple passwords, close and open multiple screens and other time-consuming barriers to PDMP use. While this has occurred in some settings, and is improving in others, it is not the norm.

Despite the barriers to PDMP use, registration and use of state-based PDMPs has significantly increased. Registration increased to nearly 2 million physicians and other health care professionals in 2019—almost a 300 percent increase from 2014; and PDMP queries have increased more than 1,100 percent during the same time period to more than 739 million.[15] It is worth noting that while most states now have a legislative mandate to use a PDMP in certain circumstances, voluntary PDMP registration and use began to increase prior to those mandates taking effect.

What is less clear, however, is whether the increased registration and use has led to improved patient outcomes, reduced opioid- and drug-related mortality, an increase in referrals for treatment of a substance use disorder or any other potential benefits of a PDMP.[16] It is also not clear whether any state PDMP already includes information regarding cannabis use. As noted above, with only four exceptions, cannabis, cannabis-derived and cannabinoid products remain Schedule I controlled substances and are not included in any state PDMP law. Resolution 219-A-19 is accurate in the assumption that state laws would need to be changed to allow for a Schedule I controlled substance to be part of the information captured into a state PDMP.

Another possibility is to somehow merge the information that is contained in a medical marijuana patient registry with a state PDMP. The technical aspects of such an endeavor are beyond the scope of the report, but even a cursory review of state PDMPs and medical marijuana patient registries reveals that the underlying software development and database management appear to be different in most states, including the fact that the state pharmacy board is typically not the state agency that administers the medical marijuana patient registry.

In addition, it is not clear if merging PDMPs and medical marijuana patient registries would further allow law enforcement to make inquiries into a state PDMP. Not only does this raise potential conflicts with AMA policy as detailed below, but it is unclear what precisely would be entered into the PDMP. Proponents of including medical marijuana registry information suggest that physicians should have information that a patient has registered for and received authorization to possess, obtain or purchase medical marijuana. On the surface, this sounds like a reasonable position.

Data does not exist, however, on how law enforcement currently uses medical marijuana patient registry information. Data also does not exist on what physicians might do with this information. The AMA Board of Trustees (the Board) is concerned that adding more information to a state PDMP without appropriate safeguards to ensure patient privacy could expose patients' personal health information to law enforcement in ways that could be detrimental. The mere existence of a patient's registration for medical marijuana should not be used as pretext for law enforcement to conduct unfettered searches in a patient's or physician's PDMP record.[17]

In addition to the concerns around increased law enforcement access to a PDMP, the Board notes that the existence of opioid prescriptions in a patient's PDMP report has resulted in myriad complications for patients, including non-consensual tapering, reports of physicians no longer prescribing opioids to such patients and patients subsequently not being able to find a physician willing to provide opioid therapy. Given that use of a legitimate medical prescription has become subject to intense scrutiny, stigma and negative consequences, the Board is concerned that adding information about a patient's authorization to use a Schedule I controlled substance could lead to similar negative consequences.

The other side to this argument is that medical diagnosis, treatment and management of disease are improved when the physician has access to all relevant information about his or her patient. This certainly includes whether a patient is using cannabis for medicinal or recreational use, as well as whether a physician has certified that a patient has one or more of the medical conditions that a state has determined qualify the patient to use cannabis for medicinal purposes. Data is not clear as to whether a patient's primary care physician is the one who is typically certifying the patient. If not, what happens when the primary physician—if reviewing new medical marijuana patient registry data—newly discovers that the patient has been certified for a serious medical condition? What effect(s) would this have on the patient-physician relationship? In addition to the above concerns, the Board notes that there is nothing currently preventing a physician from asking about these issues and that a fully functioning EHR could help resolve incomplete information about the patient's medical history.

While EHRs continue to improve, full integration with PDMPs remains a work-in-progress. In addition, the challenges with data integration would likely be increased significantly given that medical marijuana patient registry data are housed in agencies separate from those administering state PDMPs. It also is not clear what data would be integrated into a state PDMP from the registry. What would law enforcement's access be? Do the potential unintended consequences of listing patient's certification for medicinal cannabis outweigh the potential benefits for the physician and other health care professionals knowing that a patient has been certified? These are among the many questions for which clinical experience, medical evidence and objective data do not exist. Therefore, while the Board supports efforts to ensure physicians have all relevant information about their patients' potential use of cannabis for medicinal use, based on the above discussion and potential unintended consequences, it is premature to recommend developing model legislation.

AMA POLICY

AMA policy on the use of cannabis for medicinal use provides well-established balance for patient safety, autonomy and assurances for free and unfettered communication between the patient and his or her physician (Policy D-95.969, "Cannabis Legalization for Medicinal Use").

With appropriate patient privacy safeguards, the AMA also has strongly advocated in support of PDMPs sharing information on prescriptions for controlled substances among states (Policy H-95.947, "Prescription Drug Monitoring to Prevent Abuse of Controlled Substances"). This includes strong support for having PDMPs administered by, "a state agency whose primary purpose and mission is health care quality and safety rather than a state agency whose primary purpose is law enforcement or prosecutorial," to help ensure the information "is protected from release outside of the health care system" (Policy H-95.946, "Prescription Drug Monitoring Program Confidentiality").

The AMA has advocated for the benefits of PDMPs and "supports the voluntary use of state-based prescription drug monitoring programs (PDMP) when clinically appropriate." Recognizing the

workflow challenges, however, AMA policy simultaneously, "encourages states to implement modernized PDMPs that are seamlessly integrated into the physician's normal workflow, and provide clinically relevant, reliable information at the point of care" (Policy H-95.939, "Development and Promotion of Single National Prescription Drug Monitoring Program").

RECOMMENDATIONS

The Board recommends that the following be adopted in lieu of Resolution 219-A-19 and the remainder of the report be filed.

1. That our American Medical Association (AMA) support efforts to limit information about medical cannabis in states' prescription drug monitoring programs to only whether a patient has been certified to receive medicinal cannabis consistent with AMA principles safeguarding patient privacy and confidentiality; (New HOD Policy)

2. That our AMA continue its monitoring of state legislation relating to the inclusion of cannabis and related information in state PDMPs. (Directive to Take Action)

Fiscal Note: Less than $500.

REFERENCES

1. U.S. Drug Enforcement Administration. Controlled Substances by CSA Schedule. Available at https://www.deadiversion.usdoj.gov/schedules/orangebook/e_cs_sched.pdf
2. U.S. Drug Enforcement Administration. Schedule I Controlled Substances. Available at https://www.deadiversion.usdoj.gov/schedules/
3. State Medical Marijuana Laws. National Conference of State Legislatures. Last updated Oct. 16, 2019. Available at https://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx
4. Disclaimer: While AMA policy makes a clear distinction between cannabis for medicinal use and the recreational use of marijuana, for the purposes of this report, "medical marijuana" will be used throughout as it is how state policy commonly uses the term to refer to cannabis for medicinal use.
5. Id.
6. California Department of Public Health Medical Marijuana Identification Card Program. Available at https://www.cdph.ca.gov/Programs/CHSI/Pages/MMICP.aspx
7. Colorado Department of Health & Environment. Medical Marijuana Registry. Available at https://www.colorado.gov/pacific/cdphe/medicalmarijuana
8. Ohio Medical Marijuana Control Program "How to obtain medical marijuana." https://www.medicalmarijuana.ohio.gov/
9. North Dakota Medical Marijuana Program. Patient Application Instructions. Available at https://mmregistration.health.nd.gov/static/web/InstructionsPatients.pdf
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12. National Association of Boards of Pharmacy PMP Interconnect®. https://nabp.pharmacy/initiatives/pmp-interconnect/
13. *See* AMA Opioid Task Force fact sheet. "Thinking of prescribing an opioid? Did you check your state prescription drug monitoring program? 2015. Available at https://www.end-opioid-epidemic.org/wp-content/uploads/2017/05/15-0398-opioid-one-physician.pdf
14. AMA Opioid Task Force. "Thinking of prescribing an opioid? Did you check your state prescription drug monitoring program?" 2015. Available at https://www.end-opioid-epidemic.org/wp-content/uploads/2017/05/15-0398-opioid-one-physician.pdf
15. Fact sheet: Physicians' and health care professionals' use of state prescription drug monitoring programs surpass 739 million queries—more than 10 times the queries in 2014. AMA Opioid Task Force. https://end-overdose-epidemic.org/wp-content/uploads/2020/07/AMA-Fact-Sheet-PDMP-use-and-registration-increase-2014-2019-FINAL.pdf
16. It is beyond the scope of this report to detail the research, data and other information concerning effects of PDMPs, but this is an area well-discussed in previous BOT reports, including BoT Report 30-A-19; BoT Report 7-I-18; BoT Report 12-A-18; BoT Report 13-A-17; and BoT Report 3-I-16
17. *See,* for example. CMA tells California Supreme Court it must protect patient data in CURES. November 2, 2015. November 02, 2015. https://www.cmadocs.org/newsroom/news/view/ArticleId/27453/CMA-tells-California-Supreme-Court-it-must-protect-patient-data-in-CURES. The AMA joined CMA in filing an amicus brief emphasizing that patients have a basic right to privacy of their medical information and records. The AMA and CMA argued that access to PDMPs by non-health care individuals should be limited to those instances in which there is probable cause that an unlawful act or a breach of the standard of care may have occurred.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 10-N-21

Subject: Physician Access to their Medical and Billing Records (Resolution 226-A-19)

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee B

INTRODUCTION

At the 2019 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) considered Resolution 226, "Physician Access to their Medical and Billing Records," introduced by the New York Delegation, which asked:

1. The American Medical Association (AMA) advocate that licensed physicians must always have access to all medical and billing records for their patients from and after date of service including after physician termination.

2. The AMA press for legislation or regulation to eliminate contractual language that bars or limits the treating physician's access to the medical and billing records such as treating these records as trade secrets or proprietary.

The HOD heard positive testimony that the AMA has strong policy regarding physician access and management of medical records. Also, testimony was given that the AMA has model state legislation regarding physician employment including a provision that a "physician is entitled to copies of patient charts and any other records relating to the physician's provision of physician services." The Council on Legislation (COL) testified, however, that the COL is currently examining issues surrounding data ownership and stewardship. AMA policy is limited in scope to the physician-patient relationship and a paradigm shift is occurring where patient information is being viewed as a patient-centered concept and information from outside of the physician-patient relationship is growing. Additionally, the COL testified that the first resolve is too broad because a patient may not want a physician to have access to or share all of the patient's medical and billing information for unrelated care that occurs outside of a specific physician-patient relationship. As a result, Resolution 226 was referred.

DISCUSSION

Resolution 226 raises very significant concerns regarding potential physician liability for non-compliance with federal and state laws regarding claims for payment submitted on behalf of the physician. For example, as the Office of the Inspector General of the U.S. Department of Health and Human Services stated, "Physicians should remember that they remain responsible to the Medicare program for bills sent in the physician's name or containing the physician's signature, even if the physician had no actual knowledge of a billing impropriety."[1] Accordingly, AMA policy states that: "Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as

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may be necessary to verify that such bills are correct."[2] A physician's inability to access billing records and associated medical records sufficient to monitor compliance with legal and other requirements can potentially expose the physician to severe penalties.

Resolution 226 First Resolve

Given the importance of the issues that Resolution 226 raises, the Board of Trustees (Board) believes that the AMA should engage in advocacy that addresses these issues, with a few qualifications. One qualification concerns the breadth of the advocacy to which the first resolve would commit the AMA. As reference committee testimony noted, the first resolve would require the AMA to advocate that physicians have access to all of a patient's medical and billing records. A patient may not want a physician to have access to or share all of their medical and billing information for unrelated care that occurs outside of a specific physician-patient relationship. The Board agrees with this testimony. Accordingly, the Board recommends that the AMA advocate that physicians have access to their billing records and associated patients' medical records, but not that physicians have access to *all* of those records. The records should also include any billing records submitted under the physician's name, regardless of whether the physician directly provided the item or service.

Although the Board obviously believes that physicians must always have immediate access to the medical records of patients under their care, the Board does not recommend that the AMA advocate that physicians must always have access to their billing records and associated medical records. Instead, the Board recommends that, following Medicare reassignment regulations, the AMA should advocate that physicians have "unrestricted access" to their billing records and related medical records. Medicare reassignment regulations require an entity, e.g., physician practice or hospital, that submits claims on a physician's behalf give the physician unrestricted access to those claims.[3] The Board recommends this approach for two reasons.

First, while the Centers for Medicare and Medicaid Services (CMS) has provided at least some informal guidance concerning what "unrestricted access" means, the first resolve does not define "always." Taken literally, if the HOD adopted the first resolve as written, "always" could be read to require the AMA to advocate that entities, e.g., physician practices, must give employed and contracted physicians immediate access to their billing records and associated medical records at all times. Such an access requirement would likely impose a significant and unnecessary administrative burden on at least some physician practices or other physician-led entities. In contrast, CMS informally interprets "unrestricted access" to mean that an entity may not reasonably refuse or delay access to billing records. CMS has declined to define how quickly an entity must give the physician access to his or her billing records after receiving a request, or when an entity may reasonably refuse to provide access, e.g., when a physician already has the records.[4] Instead, CMS suggests that entities use "common sense."[5] Although CMS' interpretation of "unrestricted access" may not be highly specific, it does appear to provide more direction for AMA advocacy than "always," allows for flexibility and is thus not as likely to impose as great an administrative burden on physician practices or other physician organizations as the undefined term "always" might have.

Second, requiring the AMA to advocate for an access standard other than "unrestricted access" could subject physician practices to an additional administrative burden. Medicare's "unrestricted access" requirement has been in place for independent physician contractors since 2004 and physician employees since 2006.[6] Physician practices and other physician-led organizations may have long-standing policies and procedures in place delineating how their organizations comply with the unrestrictive access requirement. Asking the AMA to advocate for an access different

from the Medicare's regulation could require some practices and physician-led organizations to rewrite long-standing policies and procedures that have worked well for many years.

Finally, the first resolve asks the AMA to advocate that licensed physicians always have access to all medical and billing records for their patients…including after termination. The Board does not believe that the AMA should advocate that entities like physician practices and physician-led organizations incur the administrative burden of an unlimited obligation to provide billing records to physicians after employment or an independent contract has ended, e.g., merely upon request of the physician. Instead, the Board recommends that the AMA adopt policy stating that, after termination of employment or other contractual arrangement, physicians should be given access to their billing records and associated medical records analogous to AMA policy with regard to post-termination access to patient medical records. Policy H-225.950 "AMA Principles for Physician Employment," states in part:

> Where physician possession of all medical records of his or her patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician.[7]

Absent state law or a patient request, Policy H-225.950 does not state that after termination, the physician should be given access to all of his or her patients' medical records. Instead, the physician should be given patient medical records when necessary for the physician's defense in malpractice actions, administrative investigations or other proceedings against the physician. The Board recommends adopting new policy taking a similar approach, namely, that a physician employer or other entity that bills on behalf of an employed or contracted physician should, post-employment or contract, be obligated to provide the physician with his or her billing records when necessary to defend malpractice actions, administrative investigations or other proceedings against the physician. Taking this approach would reduce the burden that an open-ended obligation might create for physician-owned or led entities and be consistent with existing AMA policy.

Resolution 226 Second Resolve

With regard to the second resolve, the Board agrees that the AMA should advocate that medical records and billing records should not be kept from a physician on the grounds that those records are proprietary or constitute trade secrets. This is particularly true given the physician's need to ensure compliance with fraud and abuse laws, which outweigh any countervailing concerns regarding privilege or secrecy.

Model State Legislation

The Board has adopted state model legislation entitled the "Physician Access to Medical and Billing Records Act" to advocate as outlined in this board report. Any AMA member can access this model bill by e-mailing arc@ama-assn.org.

AMA POLICY

The AMA has several policies addressing issues that Resolution 226 raises. Policy H-190.971, "Physicians' Right to Receive Billing and Remittance Information," states that all physicians are entitled to receive detailed itemized billing and remittance information for medical services they provide, and that the AMA develop strategies to assist physicians who are denied such information.

Policy H-225.950, "AMA Principles for Physician Employment," advises that employers should indemnify, defend and save harmless, employed physicians with respect to any violation of law or regulation, or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee. Policy H-385.939, "Hospital Billing on Behalf of Physicians," requires that our AMA: (1) advocate that personnel performing diagnostic and procedural coding of physicians' services provide that information, including itemized billing information, collection rates, procedures, and remittance information, to those physicians providing the coded services; (2) urge physicians to participate in the processes used by entities submitting claims for and receiving payment on behalf of physicians; (3) urge that any entity billing for physicians' services ensure that, when a physician's choice of CPT code has been changed, the physician be so notified and the recoder identified before submission of a bill; (4) encourage physicians to carefully evaluate their billing procedures upon selling their practice or contracting for billing services; (5) encourage physicians to establish billing practice policies and billing compliance programs that include monitoring and reviewing billing accuracy; and (6) encourage physicians who sell their practice or contract out billing services to establish a mechanism for continually reviewing the collection methods and procedures of the billing entity.

RECOMMENDATIONS

In light of these considerations, the Board recommends that the following be adopted in lieu of Resolution 226-A-19 and the remainder of this report be filed:

1. That our AMA advocate that licensed physicians have unrestricted access to all their patients' billing records and associated medical records during employment or while under contract to provide medical or health care items or services. The records should also include any billing records submitted under the physician's name, regardless of whether the physician directly provided the item or service. (Directive to Take Action)

2. That our AMA advocate that, where physician possession of all his or her billing records is not already required by state law, the employment or other contractual arrangement between a physician and entity submitting claims on behalf of the physician should specify that the physician is entitled to copies of his or her billing records subsequent to the termination of employment or contractual arrangement, when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician. (Directive to Take Action)

3. That our AMA advocate for legislation or regulation to eliminate contractual language that bars or limits the treating physician's access to his or her billing records and associated medical records, such as treating these records as trade secrets or proprietary. (Directive to Take Action)

Fiscal Note: Less than $500

REFERENCES

[1]. Federal Register 65:194 (October 5, 2000) pages 59447- 59452
[2]. AMA Principles for Physician Employment H-225.950
[3]. 2 CFR § 424.80(d)(2)
[4]. Federal Register 71:231 (December 1, 2006) page 69689
[5]. Id.
[6]. Federal Register 69:219 (November 15, 2004) pages 66314-66318; Federal Register 71:231 (December 1, 2006) pages 69688-69689
[7]. AMA Policy H-225.950 AMA Principles for Physician Employment (3)(d)

RELEVANT AMA POLICY

Policy H-190.971, “Physicians' Right to Receive Billing and Remittance Information”
AMA policy is that all physicians are entitled to receive detailed itemized billing and remittance information for medical services they provide, and that the AMA develop strategies to assist physicians who are denied such information.

Policy H-225.950, “AMA Principles for Physician Employment”
1. Addressing Conflicts of Interest
a) A physician's paramount responsibility is to his or her patients. Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address.
b) Employed physicians should be free to exercise their personal and professional judgement in voting, speaking and advocating on any manner regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests. Employed physicians also should enjoy academic freedom to pursue clinical research and other academic pursuits within the ethical principles of the medical profession and the guidelines of the organization.
c) In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.
d) Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients.
(i) No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to his/her religious beliefs or moral convictions; and
(ii) No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because he/she either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates his/her religious beliefs or moral convictions.
e) Assuming a title or position that may remove a physician from direct patient-physician relationships--such as medical director, vice president for medical affairs, etc.--does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.

Refer to the AMA Code of Medical Ethics for further guidance on conflicts of interest.

2. Advocacy for Patients and the Profession
a) Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated.
b) Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.

3. Contracting
a) Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession.
b) Physicians should never be coerced into employment with hospitals, health care systems, medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.

c) When a physician's compensation is related to the revenue he or she generates, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based.
d) Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under his/her care. When a physician's employment status is unilaterally terminated by an employer, the physician and his or her employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in his or her new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of his or her patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician.
(e) Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. When such cause relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff, the physician should be afforded full due process under the medical staff bylaws, and the agreement should not be terminated before the governing body has acted on the recommendation of the medical staff. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges. When such cause is non-clinical or not otherwise a concern of the medical staff, the physician should be afforded whatever due process is outlined in the employer's human resources policies and procedures.
(f) Physicians are encouraged to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions. Employers should never terminate agreements without cause when the underlying reason for the termination relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff.
(g) Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment.
(h) Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolve.

Refer to the AMA Annotated Model Physician-Hospital Employment Agreement and the AMA Annotated Model Physician-Group Practice Employment Agreement for further guidance on physician employment contracts.

4. Hospital Medical Staff Relations
a) Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs.
b) Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes.
c) Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.
d) Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.

Refer to the AMA Conflict of Interest Guidelines for the Organized Medical Staff for further guidance on the relationship between employed physicians and the medical staff organization.

5. Peer Review and Performance Evaluations
a) All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings.
b) Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status.
c) Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians--not lay administrators--should be ultimately responsible for all peer review of medical services provided by employed physicians.
d) Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician's independent exercise of medical judgment.
e) Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc.
(f) Upon termination of employment with or without cause, an employed physician generally should not be required to resign his or her hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws. Automatic rescission of medical staff membership and/or clinical privileges following termination of an employment agreement is tolerable only if each of the following conditions is met:
i. The agreement is for the provision of services on an exclusive basis; and
ii. Prior to the termination of the exclusive contract, the medical staff holds a hearing, as defined by the medical staff and hospital, to permit interested parties to express their views on the matter, with the medical staff subsequently making a recommendation to the governing body as to whether the contract should be terminated, as outlined in AMA Policy H-225.985; and
iii. The agreement explicitly states that medical staff membership and/or clinical privileges must be resigned upon termination of the agreement.

Refer to the AMA Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations (AMA Policy H-375.965) for further guidance on peer review.

6. Payment Agreements
a) Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.
b) Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.
The AMA will disseminate the AMA Principles for Physician Employment to graduating residents and fellows and will advocate for adoption of these Principles by organizations of physician employers such as, but not limited to, the American Hospital Association and Medical Group Management Association.

Policy H-385.939 “Hospital Billing on Behalf of Physicians”
The AMA:
(1) advocates that personnel performing diagnostic and procedural coding of physicians' services provide that information, including itemized billing information, collection rates, procedures, and remittance information, to those physicians providing the coded services;
(2) urges physicians to participate in the processes used by entities submitting claims for and receiving payment on behalf of physicians;
(3) urges that any entity billing for physicians' services ensure that, when a physician's choice of CPT code has been changed, the physician be so notified and the recoder identified before submission of a bill;
(4) encourages physicians to carefully evaluate their billing procedures upon selling their practice or contracting for billing services;
(5) encourages physicians to establish billing practice policies and billing compliance programs that include monitoring and reviewing billing accuracy; and
(6) encourages physicians who sell their practice or contract out billing services to establish a mechanism for continually reviewing the collection methods and procedures of the billing entity.

REPORT 12 OF THE BOARD OF TRUSTEES (N-21)
Direct-to-Consumer Genetic Tests
(Resolution 207-A-19)
(Reference Committee B)

EXECUTIVE SUMMARY

Background: This report is in response to Resolution 207-A-19, "Direct-to-Consumer Genetic Tests," which was introduced by the Illinois Delegation. Resolution 207, referred by the House of Delegates, asked the AMA to: 1) regard research using consumer genome data as research on human subjects requiring both informed consent and consumer "opt in"; 2) advocate to prevent genetic testing entities from transferring identifying information to third-parties without consent; 3) support standards that disclose any privacy breaches and prohibit those with ties to testing companies from sharing identifying information without user consent; 4) advocate to extend federal genetic discrimination protections to long-term care, disability, and life insurance.

This report examines: (1) American Medical Association (AMA) policy on direct-to-consumer (DTC) genetic testing and privacy; (2) the DTC genetic testing landscape; (3) genetic databases for clinical research; (4) research using consumer genomic data; (5) third-party and forensic applications; (6) legislation on genetic nondiscrimination, privacy, and human subjects research; and (7) physician guidance and related AMA efforts.

Discussion: The AMA has extensive policy that covers the related topics of human subject research, privacy and consent, genetic discrimination, and genomic testing. Consumer genomic testing has seen explosive growth in participant numbers as well as new use cases. Integration of clinical-grade genetic information into patient care has also been expanding, including via genomic testing partnership models. Research efforts require increasingly large and diverse genetic databases and, in some cases, returning results to participants that may impact clinical care. The use of consumer genetic databases for third party applications and forensics has raised privacy concerns.

Conclusion: Current genetic nondiscrimination protections are limited to the areas of health insurance and employment at the federal level, meaning that consumers in most states today are without protections for additional areas such as life, disability, or long-term care insurance. Users of consumer genetic testing should be advised of the potential risks of their participation including through appropriate informed consent. Notice should be given, and consent provided by users whenever their genetic information is used or shared.

The Board of Trustees recommends that language be adopted to more accurately reflect the intent of the resolution, and that these statements be adopted in lieu of Resolution 207-A-19.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 12-N-21

Subject: Direct-to-Consumer Genetic Tests (Resolution 207-A-19)

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee B

INTRODUCTION

Resolution 207-A-19, "Direct-to-Consumer Genetic Tests," which was introduced by the Illinois Delegation and referred by the House of Delegates, asked that:

> Our American Medical Association regard research using consumer genome data derived from saliva or cheek swab samples as research on human subjects requiring consents in compliance with the Health and Human Services (HHS) Office for Human Research Protection (OHRP), and recommend an "opt in" option to allow more consumer choice in the consent process;
>
> Our AMA amend Policy H-315.983, "Patient Privacy and Confidentiality," by addition to align with current research and privacy infringement findings, 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, <u>while working with the Department of Health and Human Services (HHS) to stop the transfer of birthdates and state of residence by genetic testing companies and their affiliates, unless there is explicit user approval, to prevent re-identification of the test user by way of surname inference methods.</u>
> 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

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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 deidentified 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. <u>Our AMA regards studies using consumer genome data derived from saliva, cheek swab, or other human tissue samples as research on human subjects requiring consents in compliance with the HHS Office for Human Research Protections (OHRP). An “opt in” option is recommended to allow more consumer choice in the consent process.</u>

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 43 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. <u>The AMA will work with Congress and HHS to modify the Genetic Information Nondiscrimination Act of 2008 (GINA), which bans genome-based policy and hiring decisions by health insurance companies and employers, by adding Long-Term Care, Life Insurance, and Disability Insurance to the Act to prevent applicant rejection based on their genetic make up.</u>

18. Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes. <u>a. Our AMA supports privacy standards that would prohibit pharmaceutical companies, biotechnology companies, universities, and all other entities with financial ties to the genetic testing company from sharing identified information with other parties without the consent of the user. An exception would be made when requested by law enforcement authorities or when</u>

keeping the information would seriously threaten their health or that of others. If a data security breach occurs with the Direct-To-Consumer genetic company or its collaborators, then the company has the responsibility to inform all users of the breach and the impact of the unprotected private data on those individuals;

19. Our AMA supports privacy standards that require pharmacies and drug store chains to 50 disclose the source of financial support for drug mailings or phone calls.

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

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

Our AMA work with the Department of Health and Human Services or other relevant parties to modify the rules to prevent genetic testing entities from transferring information about the user's date of birth and state of residence to third parties which may result in the re-identification of the user based on surname inference;

Our AMA work with Congress and the Department of Health and Human Services to extend the consumer protections of the Genetic Information Non-Discrimination Act (GINA) of 2008 by adding long-term care, disability insurance, and life insurance to the Act, modeled after the laws of other states, such as California.

CURRENT AMA POLICY

Existing AMA policy addresses direct-to-consumer (DTC) genetic testing and privacy (see Appendix for full text). AMA Policy D-480.987, "Direct-to-Consumer Marketing and Availability of Genetic Testing," recommends that genetic testing be carried out under the personal supervision of a qualified health professional and that advertisements disclose test limitations. AMA Policy H-480.941, "Direct-to-Consumer Laboratory Testing," advocates for vigilant oversight of DTC laboratory testing and encourages physicians to educate their patients about the risks of DTC tests. AMA Policy H-65.969, "Genetic Discrimination and the Genetic Information Nondiscrimination Act," supports education as well as legislation intended to provide more comprehensive protections. AMA Policies H-460.916, "Protection of Human Subjects in Research," and H-460.980, "Ethical and Societal Considerations in Research," encourage additional education on ethical principles for investigators in human subject research. AMA Policy H-315.983, "Patient Privacy and Confidentiality," affirms that genetic information should be kept confidential and should not be disclosed to third parties without explicit informed consent.

BACKGROUND

DTC genetic testing landscape

Genetic tests have traditionally been ordered by a physician for specific conditions with clear diagnostic and other medical purposes. This report focuses on DTC genetic testing which may not require a physician order. Beginning with saliva or a cheek swab, DTC genetic tests can reveal DNA segments shared with other individuals, offering insights into familial relationships and ancestry. DTC genetic tests can also report specific variants associated with diverse traits and health conditions.

DTC genetic testing has grown exponentially over the past decade. About 30 million consumers, largely from the United States, have already participated in DTC genetic testing. At this rate, an estimated 100 million individuals will undergo DTC genetic testing by 2021.[1]

While the FDA currently does not review all DTC genetic tests before they are offered to the public, those that disclose moderate to high risk health information, such as cancer screening results, are reviewed for evidence that the tests work as advertised.[2] In 2013, 23andMe stopped providing consumers with genetic health risk information after the FDA sent the company a letter. This action led other DTC companies to stop disclosing genetic health risks to consumers. In 2015, 23andMe was cleared by the FDA to market tests that release results for health conditions including increased risk of cancer, and in 2018 was cleared for pharmacogenomic reports.[3,4] To date, 23andMe remains the only company that has received FDA clearance for a DTC genetic test.[2]

Another approach has emerged called a "hybrid" or "DTC 2.0" model of consumer genetic testing that begins with a physician order for screening of healthy individuals.[5–7] Different models include those of AncestryDNA, Color Genomics, and Invitae, which may not be required to seek regulatory clearance from the FDA to return genetic health information, based on the inclusion of a physician order. These tests may also be offered through partnerships with employers and health systems, and include cancer risk and pharmacogenomic results.[8,9] In some cases, College of American Pathologists (CAP) accredited and Clinical Laboratory Improvement Amendments (CLIA) certified laboratories may provide what is considered clinical grade data that may be included in health records and used to support medical decisions.

Genetic databases for clinical research

Genetic databases and biobanks have been designed to support biomedical research by offering various forms of access to participant data. This research has contributed to uncovering the molecular basis for thousands of human diseases and has helped to advance drug discovery.[10] Database sizes are growing which may be necessary to power polygenic risk scores and other findings beyond single gene associations. Such database sizes may be not be feasible to build for a single study, so groups instead may work with common datasets.

Shortcomings of the traditional biobank approach have included a lack of participant diversity, and a need to more frequently return results back to participants.[11,12] When biobanks seek to form external partnerships, particularly with industry, there may be public concern about data security and privacy.[13] Initiatives such as the 100,000 Genomes Project in the United Kingdom have begun leveraging their participant results to help advance clinical care.[14] However, a distinction between research and clinical grade genetic results may mean that some research findings should be considered only initial screening information that should undergo clinical confirmation prior to any changes in patient care.[15]

The All of Us Research Program

The National Institutes of Health (NIH)'s *All of Us* Research Program was launched in 2018 as part of President Obama's Precision Medicine Initiative, as "an ambitious effort to gather data over time from 1 million or more people living in the United States." The program does not focus on any subset of diseases or conditions. Instead, a key focus is recruiting participation from populations traditionally underrepresented in biomedical research, which has long been a challenge for the genetics field. By late-2019, more than 230,000 total participants were enrolled in *All of Us*, with most participants from underrepresented populations.[16]

Genetic data has been highlighted as a key component of the program and in 2018, *All of Us* announced the first awards to three genome centers.[17] In 2019, the program announced a five-year award to Color Genomics to offer genetic counselling services and assist with participant education.[18] Genomic results may be returned to some *All of Us* participants by 2020.[19]

Participant data for the *All of Us* program are stored in a cloud environment where identifying information is removed. This platform will allow computation and interactive testing of hypotheses without access to any individual participant data, thus safeguarding against some potential forms of security breaches. Researchers apply for data access and make their names and descriptions of their projects publicly available. Participants will also have access to their own data including their physical measurements, survey data, and genomic results, and they can choose whether to share results with their physician.[16]

Research using consumer genomic data

Genetic testing companies such as 23andMe also can engage in peer-reviewed genetic research, leveraging their own genetic databases including in many cases partnerships with academics.[20] In addition, genetic testing companies have engaged in their own drug discovery and have partnered with industry via data sharing agreements. In 2018, 23andMe announced a $300 million drug development partnership with GlaxoSmithKline.[21] In 2020, 23andMe sold the rights to license the first drug that the company had internally developed as a potential treatment for inflammation.[22] While users have been informed that they can opt out of having their data used for research at any time, around 80 percent of users have elected to participate.[23] Currently, users are assigned no rights or compensation for the company's research or commercial products.[24]

Other models are being explored to directly compensate participants for their research contributions. A recently launched platform named LunaDNA provides users the capability to sell their genomic and other health data for medical research, where data is exchanged for shares of stock. In 2019, LunaDNA merged with the Genetic Alliance's Platform for Engaging Everyone Responsibly (PEER).[25] One stated aim is to help individuals become partners and active participants in research, in addition to the possibility of receiving a small share of royalties resulting from future drug discoveries.

Third-party and forensic applications

DTC companies such as 23andMe and AncestryDNA allow users to download their own raw genomic data. These raw data files can then be uploaded to various third-party interpretation platforms which provide services such as mining the biomedical literature or genealogy tools. Use of third-party interpretation platforms has been identified as having the potential to increase a user's risks including validity of results and privacy.[26–28]

In terms of privacy, increasingly it has been recognized that genetic data cannot be deidentified. A DNA profile alone may now be adequate to identify most individuals even in the absence of other identifying information, including individuals that have not previously participated in genetic testing.[29] This may increasingly be the case as DNA databases continue to grow with participation from biological relatives that may help uncover identities through DNA matches. It may also be difficult to place safeguards against additional potential uses of genetic data other than those originally intended. For example, an individual's DNA profile designed for a specific purpose such as forensics may be linked to additional genetic data that could reveal health and other sensitive information.[30]

Awareness around forensic applications of DTC genetic data increased in 2018, when a suspect for the Golden State Killer was identified after the upload of crime scene DNA to GEDmatch.[31] This platform offered genealogical services by aggregating user data from other services into a large genetic database. Investigators were able to track down a single individual that fit their profile based on a DNA match to distant family members. Many users left the database when its use by law enforcement in criminal investigations became apparent, and GEDmatch changed its terms of service to require "opt-in" for matching to police-uploaded DNA.[32] In 2019, GEDmatch was acquired by the forensic genomics firm Verogen.

Terms of service from DTC companies have been shown to have tremendous variability around the use and sharing of genetic data.[33] Such terms may also be subject to change with little notice. In 2019, Family Tree DNA surprised many users by announcing that it had been collaborating with the FBI and supporting queries via access to user genetic information, allegedly without informed consent from their users.[34] These revelations led to the Future of Privacy forum, which had released best practices in 2018 that prohibited the sharing of genetic data without consent or as required by law, to remove Family Tree DNA as a supporter.[35]

The U.S. Department of Defense warned in 2019 that use of DTC genetic testing could place military service members at risk, allowing the enemy to target them via "mass surveillance and the ability to track individuals without their authorization or awareness," with unintended security consequences.[36] Accordingly, service members have been advised to refrain from using DTC genetic tests. Information about some genetic variants can also affect a service member's career, which may be particularly problematic when the validity of some DTC genetic tests has been questioned.

DTC genetic testing demand appears to have experienced a decline in 2019.[37] It is unclear whether this may due to privacy or other consumer concerns. This development may signal saturation or a shift to more comprehensive models of genetic testing such as those offered by health systems.

Genetic Nondiscrimination and Privacy Legislation

Federal legislation that covers genetic privacy in the U.S. includes the Health Insurance Portability and Accountability Act (HIPAA) and the Genetic Information Nondiscrimination Act (GINA). The HIPAA Privacy Rule applies to health plans, health care providers, and health information clearinghouses but not to third parties outside of health care.[38] GINA applies to health insurers and employers but not to other contexts such as life, disability, or long-term care insurance.[39]

Various states including California also have additional laws enacted that extend genetic discrimination protections to other areas such as life insurance and educational settings.[39] The California Consumer Privacy Act (CCPA) may also offer additional privacy protections for some consumers. However, extending GINA's protections to other contexts in all states would require an act of Congress.

Human Subjects Research Legislation

Unlike earlier genetic research studies using a traditional model, researchers using DTC genetic data from 23andMe have argued that their work is not human subjects research as defined under the U.S. Department of Health and Human Services, which would require fully informed consent and institutional review board (IRB) approval of the research protocols.[40] Journal editors who published the study agreed that the researchers did not violate the Common Rule because they only

used deidentified data. Extending additional protections, as implemented through IRBs, to data used for research by consumer genetics companies will likely require new legislation.

Physician guidance and related AMA efforts

The American College of Medical Genetics and Genomics has released a position statement on DTC genetic testing.[41] Additional guidance on this topic is available from the Association for Molecular Pathology[42] and the American Society of Human Genetics.[43,44] The *AMA Journal of Ethics* has published an issue on precision health including DTC genetic testing.[45] *JAMA* has also published a number of articles covering topics related to consumer genetic testing.[46]

The AMA has several initiatives to help physicians navigate precision medicine including education, research, and advocacy.[47] The AMA has collaborated with The Jackson Laboratories and Scripps Research Translational Institute on a continuing medical education series called "Precision Medicine For Your Practice," which includes a module called "Genomic Testing for the Healthy Individual."[48] The AMA hosted a "Driving the Future of Precision Medicine Roundtable" in 2019 that examined the current landscape and innovative practices for precision medicine implementation. The AMA is also represented on the National Academies of Sciences, Engineering, and Medicine (NASEM) Roundtable on Genomics and Precision Health and participated in a 2019 workshop on consumer genomics.[49]

Previous Council on Science and Public Health reports have addressed DTC genetic tests and related issues including genetic discrimination, the Precision Medicine Initiative, and payment and coverage for precision medicine.[50–52] In 2019, the AMA sent a letter to the Department of Justice to oppose a proposal for the use of DNA testing for detained immigrants.[53] The AMA has also worked with states, including Delaware, to extend GINA protections.[54]

CONCLUSION

The AMA has extensive policy on human subject research, consent, and genetic discrimination. The current federal GINA protections are limited to health insurance and employment, leaving consumers in most states without protections for areas such as life, disability, or long-term care insurance. It is important that users of consumer genetic testing are aware of the potential risks of their participation, particularly as the numbers of participants and the various use cases continue to grow. Participants in consumer genetic testing should receive notice and provide consent whenever their genetic information is used or shared.

RECOMMENDATIONS

For purposes of clarity, the Board of Trustees recommends that the following statements be adopted in lieu of Resolution 207-A-19, and that the remainder of this report be filed.

1. That our AMA adopt the following new policy:

   "Consumer Genetic Testing and Privacy"
   Our AMA:

   (1) will work with relevant stakeholders to advance laws and regulations that prevent genetic testing entities without explicit, informed, and non-coerced user consent from transferring information about a user such as birthdates and state of residence to third parties which

may result in the re-identification of the user based on surname inference (New HOD Policy).

(2) supports privacy standards that would prohibit pharmaceutical companies, biotechnology companies, universities, and all other entities with financial ties to the genetic testing company from sharing identifiable information, including DNA, with other parties without informed consent of the user. An exception would be made when requested for a duly executed court order or when compelled for public health or safety reasons as outlined in existing AMA policy including H-315.983, "Privacy and Confidentiality," and Medical Code of Ethics 4.1.4, "Forensic Genetics." If a data security or privacy breach occurs with a direct-to-consumer (DTC) genetic company or its collaborators, then the company has the responsibility to inform all users and relevant regulatory bodies of the breach and the impact of the unprotected private data on those individuals (New HOD Policy).

(3) will advocate that research using consumer genomic data derived from saliva or cheek swabs or other human samples should be treated as research on human subjects requiring informed consent consistent with or similar to those required by the Health and Human Services (HHS) Office for Human Research Protection (OHRP), and recommend an "opt in" option to allow more consumer choice in the consent process (New HOD Policy).

(4) will advocate for extending the consumer protections of the Genetic Information Non-Discrimination Act (GINA) of 2008 by adding long-term care, disability insurance, and life insurance to the Act, modeled after the laws of other states, such as California (New HOD Policy).

2. That the following policies be reaffirmed: H-65.969, "Genetic Discrimination and the Genetic Information Nondiscrimination Act," H-185.972, "Genetic Information and Insurance Coverage," D-480.987, "Direct-to-Consumer Marketing and Availability of Genetic Testing," H-480.941, "Direct-to-Consumer Laboratory Testing," H-460.916, "Protection of Human Subjects in Research," H-460.980, "Ethical and Societal Considerations in Research," and H-315.983, "Patient Privacy and Confidentiality" (Reaffirm HOD Policy).

Fiscal Note: Less than $500.

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APPENDIX – Current AMA Policy

D-480.987, "Direct-to-Consumer Marketing and Availability of Genetic Testing"
Our AMA: (1) recommends that genetic testing be carried out under the personal supervision of a qualified health care professional; (2) encourages individuals interested in obtaining genetic testing to contact a qualified healthcare professional for further information; (3) will work with relevant organizations to develop criteria on what constitutes an acceptable advertisement for a direct-to-consumer genetic test; (4) encourages the U.S. Federal Trade Commission, with input from the U.S. Food and Drug Administration and the Centers for Medicare and Medicaid Services, to require that direct-to-consumer advertisements for genetic testing are truthful and not misleading; such advertisements should include all relevant information regarding capabilities and limitations of the tests, and contain a statement referring patients to physicians to obtain further information; (5) will work to educate and inform physicians regarding the types of genetic tests that are available directly to consumers, including information about the lack of scientific validity associated with some direct-to-consumer genetic tests, so that patients can be appropriately counseled on the potential harms.

H-480.916, "Direct-to-Consumer Laboratory Testing,"
Our AMA will: (1) advocate for vigilant oversight of direct-to-consumer (DTC) laboratory testing by relevant state and federal agencies; and (2) encourage physicians to educate their patients about the risks and benefits of DTC laboratory tests, as well as the risks associated with interpreting DTC test results without input from a physician or other qualified health care professional.

H-65.969, "Genetic Discrimination and the Genetic Information Nondiscrimination Act"
Our AMA: (1) strongly opposes discrimination based on an individual's genetic information; (2) will pursue and support legislation intended to provide robust and comprehensive protections against genetic discrimination and misuse of genetic information; and (3) supports education for health care providers and patients on the protections against genetic discrimination currently afforded by federal and state laws.

H-185.972, "Genetic Information and Insurance Coverage"
AMA believes: (1) Health insurance providers should be prohibited from using genetic information, or an individual's request for genetic services, to deny or limit any health benefit coverage or establish eligibility, continuation, enrollment or contribution requirements. (2) Health insurance providers should be prohibited from establishing differential rates or premium payments based on genetic information or an individual's request for genetic services. (3) Health insurance providers should be prohibited from requesting or requiring collection or disclosure of genetic information. (4) Health insurance providers and other holders of genetic information should be prohibited from releasing genetic information without express prior written authorization of the individual. Written authorization should be required for each disclosure and include to whom the disclosure would be made.

H-460.916, "Protection of Human Subjects in Research"
Our AMA encourages institutions conducting research with human subjects to implement an ongoing credentialing process to assure that all investigators and relevant staff have been appropriately educated in the ethical principles and relevant government regulations related to human subjects research.

H-460.980, "Ethical and Societal Considerations in Research"
(1) Private organizations and academic institutions should jointly develop a means to continue and enhance broadly based study and discussion of ethical and societal issues in biomedical research. (2) The federal government should provide the resources to support new initiatives within the National Institutes of Health for the funding of research studies in bioethics. Existing federal programs that fund bioethical research studies should be preserved. Private foundations should be encouraged to provide resources to support research studies in bioethics. (3) A uniform set of federal regulations governing research with human subjects, based on the core regulations of the Department of Health and Human Services should be adopted by all federal agencies. Uniformity should not preclude additions to Department regulations that do not conflict with the core regulations or that enhance the protection of research subjects. (4) Associations of regional institutional review boards (IRBs) should be formed to enhance IRB performance through the development of educational site visits and local workshops. (5) Each institution should have a system both for monitoring the conduct of biomedical research and for investigating and reporting allegations of research

misconduct. (6) All investigators involved in research projects should be responsible for the clear articulation and enforcement of standards that ensure the integrity of scientific data and conclusions. Regardless of whether the research project is a result of individual or collaborative efforts, investigators should thoroughly understand the data and conclusions in research publications and studies. (7) As part of their formal training in research investigation, graduate, medical and postdoctoral students should be instructed on the importance of adhering to the ethical and scientific requirements in research conduct and in the reporting of research results. (8) Our AMA encourages study of the inclusion of Socioeconomic Status (SES) data in clinical and public health research identify appropriate minimum standards for the inclusion of such data in research studies.

H-315.983, "Patient Privacy and Confidentiality"
1. Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information: (a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure; and (e) That the Health Insurance Portability and Accountability Act of 1996 (HIPAA) be the minimal standard for protecting clinician-patient privilege, regardless of where care is received. 2. Our AMA affirms: (a) that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment, and (c) that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law. 3. Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible. (b) Patients, physicians, and medical students should be educated about the consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information. (d) A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure. 4. Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review.
5. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use. 6. Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained. 7. Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual. 8. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end. 9. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures. 10. Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or

prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB. 11. Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures 12. Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights. 13. Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned. 14. Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance. 15. In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands. 16. The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine. 17. Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing. 18. Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes. 19. Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls. 20. Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes. 21. Our AMA will draft model state legislation requiring consent of all parties to the recording of a physician-patient conversation.

Code of Medical Ethics 4.1.4, “Forensic Genetics”
With the exception of genetic information (or material) collected under the jurisdiction of a coroner, medical examiner, or other medical legal officer, the release of genetic information from a physician’s records without the patient’s informed consent constitutes a breach of confidentiality. However, under limited circumstances with overriding legal and social considerations, all physicians may disclose such information to the criminal justice system.
Physicians from whom genetic information is sought for purposes of criminal justice: (a) May ethically carry out DNA analysis on stored tissue samples or release genetic information without the consent of a living or deceased patient (or the patient’s authorized surrogate) in response to a warrant or court order. (b) Should release only the minimum information necessary for the specific purpose. (c) Should not be required to provide genetic information when: (i) a suspect whose location is known refuses to provide a tissue sample for genetic analysis; or (ii) a tissue sample for the suspect can be obtained from other sources (such as the body of a deceased suspect). (d) Should decline to participate in the use of information from a genetic database created exclusively for criminal justice for any purpose other than identification.
Issued: 2016

REPORT OF THE BOARD OF TRUSTEES

B of T Report 14-N-21

Subject: Net Neutrality and Public Health
(Resolutions 208-I-19 and 211-I-19)

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee B

INTRODUCTION

At the 2019 Interim Meeting, the House of Delegates (HOD) heard mixed testimony regarding Resolution 208, "Net Neutrality and Public Health," which was introduced by the Medical Student Section and Resolution 211, "Effects of Net Neutrality on Public Health," introduced by the Michigan Delegation.

Resolution 208, "Net Neutrality and Public Health" reads as follows:

> RESOLVED, That our American Medical Association advocate for policies that ensure internet service providers transmit essential healthcare data no slower than any other data on that network; and be it further
>
> RESOLVED, That our AMA collaborate with the appropriate governing bodies to develop guidelines for the classification of essential healthcare data requiring preserved transmission speeds; and be it further
>
> RESOLVED, That our AMA oppose internet data transmission practices that reduce market competition in the health ecosystem.

Resolution 211, "Effects of Net Neutrality on Public Health" reads as follows:

> RESOLVED, That our American Medical Association amend current policy H-478.980, "Increasing Access to Broadband Internet to Reduce Health Disparities," by addition and deletion as follows:
>
> Increasing ~~Access to Broadband~~ Internet Access to Reduce Health Disparities
>
> Our AMA: (1) will advocate for net neutrality; and (2) will advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas of the U.S. while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services.

During the House of Delegates Interim Meeting the reference committee heard testimony on both Resolution 208 and 211, which were heard together. Testimony was heard that favored maintaining the rules of net neutrality, as repeal could lead companies to place limits on how, where, and when patients and providers are able to access health care data. Other concerns regarding repeal of net

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neutrality focused on the potential for companies to pursue policies that could lessen both innovation and competition in health care technology, or increase the cost of health care delivery, thus negatively impacting both physicians and patients. Testimony concerning the use of the term "net neutrality" and its impact on potential AMA advocacy activities was provided as well. Additionally, testimony was given regarding existing AMA policy which already supports the expansion of broadband and wireless connectivity to all rural and underserved areas of the U.S. Finally, testimony was provided that defining essential health data needs to be further evaluated because the transmission of certain health data may need to take precedence over other data. The resolutions were heard during the House of Delegates 2019 Interim Meeting prior to the start of the coronavirus (COVID-19) pandemic.

BACKGROUND

Net neutrality is the principle guiding the strict regulations placed on internet service providers (ISPs) that prohibit or limit content-controlling behavior in order to ensure an equal and open internet for all.[1] In practice, this means that ISPs should not be able to move some data (for example, certain applications or streaming services) into "fast lanes" while blocking, slowing, or limiting in some fashion other data. In other words, ISPs (such as AT&T Internet Services, Cox Communications, Comcast and Verizon) should not be able to block a user from accessing a service such as Skype, Zoom, or slow down Netflix or Roku, in order to encourage the user to keep a cable package or buy a different video-streaming service.

A core issue to net neutrality is how ISPs should be classified under the Communications Act of 1934, if they should be Title I "information services" or Title II "telecommunications or common carrier services." The classification affects the Federal Communications Commission's (FCC) authority over ISPs. As Title II common carriers, the FCC would have significant ability to regulate ISPs, but not if they are classified as Title I. Title I information services are regulated by the Federal Trade Commission (FTC or Commission). In layman's terms, "common carrier services" move data from one place of the customer's choosing to another, and "information services" provide processing or storage services for that data. The debate over Title I vs. Title II classification continues even today.

The FCC regulates interstate and international communications by radio, television, wire, satellite, and cable in all 50 states, the District of Columbia and U.S. territories. An independent U.S. government agency overseen by Congress, the FCC is the federal agency responsible for implementing and enforcing America's communications law and regulations. The makeup of the five-member FCC changes with each U.S. President, and competing interests have ultimately led to the state of net neutrality flipping back and forth over the last several decades. With regard to the FTC, the Commission is headed by five Commissioners, nominated by the President and confirmed by the U.S. Senate, each serving a seven-year term. No more than three Commissioners can be of the same political party. The President chooses one Commissioner to act as Chairman.

DISCUSSION

Federal Regulatory Activity

In the absence of any formal categorization of internet services, the FCC issued several statements regarding broadband regulation.

In 2005, the FCC adopted four principles in order to "encourage broadband deployment and preserve and promote the open and interconnected nature of public Internet."[2] The four principles

are as follows: (1) consumers are entitled to access the lawful Internet content of their choice; (2) consumers are entitled to run applications and services of their choice, subject to the needs of law enforcement; (3) consumers are entitled to connect their choice of legal devices that do not harm the network; and (4) consumers are entitled to competition among network providers, application and service providers, and content providers.[3] At that time, the FCC stated it would consider these principles during "policymaking activities."

In 2010, the Open Internet Order was passed by the FCC. The goal of the Open Internet Order was to "preserve the Internet as an open platform for innovation, investment, job creation, economic growth, competition, and free expression," which ultimately revolved around three basic tenets:[4]

- *Transparency*. Fixed and mobile broadband providers must disclose the network management practices, performance characteristics, and terms and conditions of their broadband services;[5]
- *No blocking*. Fixed broadband providers may not block lawful content, applications, services, or non-harmful devices; mobile broadband providers may not block lawful websites, or block applications that compete with their voice or video telephony services; and
- *No unreasonable discrimination.* Fixed broadband providers may not unreasonably discriminate in transmitting lawful network traffic.

According to the FCC, broadband providers invested $212 billion in the three years following adoption of the rules—from 2011 to 2013—more than in any three-year period since 2002.[6]

Between 2005 and 2012, there were several Congressional attempts to pass legislation containing limitations on net neutrality. These attempts failed, largely due to the argument that the legislation would have benefited industry instead of consumers.

The FCC in its February 26, 2015, open meeting voted 3-2, along party lines, to adopt new open internet rules and released these rules via an Open Internet Report and Order on Remand on March 12, 2015.

One of the most controversial aspects of the rules was the decision to reclassify broadband internet access service (BIAS) as telecommunications service under Title II, thereby subjecting ISPs to a more stringent regulatory framework. The FCC Order reclassifying ISPs as Title II services gave the FCC authority to enforce net neutrality. Specifically, the FCC's 2015 Open Internet Order banned each of the following: Blocking, Throttling, and Paid Prioritization—applying the same rules to both fixed and mobile broadband Internet access service.[7]

- *No Blocking*. The FCC noted at that time that "consumers who subscribe to a retail broadband Internet access service must get what they have paid for—access to all (lawful) destinations on the Internet."[8] Thus, the Order adopted a straightforward ban:
  - A person engaged in the provision of broadband Internet access service, insofar as such person is so engaged, shall not block lawful content, applications, services, or nonharmful devices, subject to reasonable network management.
- *No Throttling*. The FCC noted that "the 2010 rule against blocking contained an ancillary prohibition against the degradation of lawful content, applications, services, and devices, on the ground that such degradation would be tantamount to blocking.[9] The 2015 Order created a separate rule to guard against degradation targeted at specific uses of a customer's broadband connection:
  - A person engaged in the provision of broadband Internet access service, insofar as such person is so engaged, shall not impair or degrade lawful Internet traffic on the basis of

Internet content, application, or service, or use of a non-harmful device, subject to reasonable network management.

- *No Paid Prioritization*. Paid prioritization occurs when a broadband provider accepts payment (monetary or otherwise) to manage its network in a way that benefits particular content, applications, services, or devices.[10] To protect against "fast lanes," the 2015 Order adopted a rule that establishes that:
  - A person engaged in the provision of broadband Internet access service, insofar as such person is so engaged, shall not engage in paid prioritization.

In 2017, with a new Administration at the helm, the FCC proposed reclassifying ISPs as Title I services, effectively repealing the previously established neutrality policies and discarding millions of comments submitted by the public to the FCC. On June 11, 2018, the FCC's Restoring Internet Freedom Order took effect, despite attempts by Congress to stay the Order.[11] The new Order, among other things, reverses the 2015 classification of BIAS as a telecommunications service under Title II of the Communications Act, shifts much of the oversight from the FCC to the FTC and the U.S. Department of Justice, and provides for a less regulated approach.[12] Specifically, the FCC's framework for protecting Internet freedom under this new Order has three key parts: 1) Consumer Protection; 2) Transparency; and 3) Removes Unnecessary Regulations to Promote Broadband Investment.[13]

- *Consumer Protection*. The Federal Trade Commission will police and take action against Internet service providers for anticompetitive acts or unfair and deceptive practices.
- *Transparency*. Internet service providers must publicly disclose information regarding their network management practices, performance, and commercial terms of service. These disclosures must be made via a publicly available, easily accessible company website or through the FCC's website.
- *Removes Unnecessary Regulations to Promote Broadband Investment*. Removes Title II regulations.

The COVID-19 Pandemic and the Dramatic Surge in Internet Usage

According to a Pew Research Center survey conducted in 2019, approximately two-thirds of rural Americans (63 percent) say they have a broadband internet connection at home, up from about a third (35 percent) in 2007.[14] While encouraging, this is far from ideal—particularly as the nation battles the COVID-19 pandemic. Businesses, K-12 schools, colleges and universities, and health providers across the U.S. have been forced to pivot to a new normal built around telework, eLearning, and telehealth. More than 300 million people were under stay-at-home orders when the national public health emergency was declared, resulting in the use of, and need for, a dramatically increased level of internet access through their home connections.[15] The pandemic has pushed regulators and politicians at all levels of government to reevaluate current policies related to bandwidth, traffic and network neutrality.

The massive surge in Internet usage during the COVID-19 crisis will play a major role in the debate over what the appropriate regulatory framework should be for broadband access. For those that have high-speed internet connectivity, the internet has withstood the unimaginable increase of online video-calling, telehealth, teleworking, distance learning and leisure television show and movie bingeing. As people in rural areas and underserved urban areas seek to telework, learn remotely, and access telehealth services, the digital divide in the U.S. becomes even more glaring. Broadband availability has been at the heart of the digital divide long before the pandemic hit, with an estimated 21.3 million people lacking a connection of at least 25 Mbps/3 Mbps (the FCC's

current benchmark) by the end of 2017, according to the FCC. And although this is a decrease from the prior year of 26.1 million people, the U.S. has much work ahead to close the gap.[16]

Current Congressional Activity

In early 2019, federal legislation was introduced that would address the net neutrality debate. However, only one such bill has progressed. The "Save the Internet Act of 2019", H.R. 1644/S. 682 would repeal the Declaratory Ruling, Report and Order, and Order in the matter of restoring internet freedom that was adopted by the Commission on December 14, 2017 (FCC 17–166) and restore the 2015 Order. H.R. 1644 passed (232-190) the House on April 10, 2019 and has been sent to the Senate for consideration.

Republicans in Congress contend that the increased Internet use as a result of shelter-in-place orders is proof positive that the net neutrality rules were unnecessary. Democrats in Congress have turned their focus to the FCC's various Internet connection programs to make sure people at all income levels, in all geographic areas across the U.S. have access to broadband. As a result of the changing Internet landscape due to the pandemic, it is likely that congressional leaders from both parties moving forward will increase their focus on bolstering broadband infrastructure across the country, as this endeavor has bipartisan support, rather than focusing on net neutrality policies specifically.

The Expansion of Telehealth Services as a Result of the COVID-19 Pandemic

Congress appropriated $200 million to the FCC for the Telehealth Program as part of the Coronavirus Aid, Relief, and Economic Security (CARES) Act, to help health care providers provide connected care services to patients at their homes or mobile locations in response to the novel Coronavirus 2019 disease (COVID-19) pandemic.[17] The COVID-19 Telehealth Program will provide immediate support to eligible health care providers responding to the COVID-19 pandemic by fully funding their telecommunications services, information services, and devices necessary to provide critical connected care services until the program's funds have been expended or the COVID-19 pandemic has ended. The COVID-19 Telehealth Program is limited to nonprofit and public eligible health care providers.[18]

As of May 20, 2020, the FCC's COVID-19 Telehealth Program has approved funding for 132 health care providers in 33 states plus Washington, DC for a total of just over $50 million in funding.[19] The FCC is continuing to evaluate COVID-19 Telehealth Program applications and distribute additional funding on a rolling basis.

The FCC's Office of Managing Director and Wireline Competition Bureau (WCB) also is waiving the FCC's red light rule[20] for COVID-19 Telehealth Program applicants to facilitate prompt review and processing of the maximum number of applications to the Program. The "red light" rule normally prevents the FCC from taking action on applications and other requests by entities with delinquent debts with the agency. While the FCC found good cause existed to waive the "red light" rule, the agency was clear that the waiver solely applied to the COVID-19 Telehealth Program and did not affect the agency's ability to take collection action against delinquent debtors.

In addition, on May 22, 2020, U.S. Senators Brian Schatz (D-Hawaii), Lisa Murkowski (R-Alaska), John Boozman (R-Ark.), Angus King (I-Maine), Gary Peters (D-Mich.), Dan Sullivan (R-Alaska), Kevin Cramer (R-N.D.), and Ed Markey (D-Mass.) introduced the Health Care Broadband Expansion During COVID-19 Act. The bipartisan bill would direct $2 billion to help

health care providers increase their broadband capacity and expand telehealth services during the current public health crisis.[21]

AMA POLICY

Existing AMA policy generally promotes increasing patient access to electronic health data, encouraging innovation and competition amongst technology vendors, and removing barriers to internet-based care. In 2020 the AMA developed and published a guidance document containing privacy principles.[22]

Policy H-478.980, "Increasing Access to Broadband Internet to Reduce Health Disparities"
Our AMA will advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas of the U.S. while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services.
Citation: Res. 208, I-18;

Policy D-478.979, "Promoting Internet-Based Electronic Health Records and Personal Health Records" Our American Medical Association will advocate for the Centers for Medicare & Medicaid Services (CMS) to evaluate the barriers and best practices for those physicians who elect to use a patient portal or interface to a personal health record (PHR) and will work with CMS to educate physicians about the barriers to PHR implementation, how to best minimize risks associated with PHR use and implementation, and best practices for physician use of a patient portal or interface to a PHR.
Citation: (BOT Rep. 11, I-11)

CONCLUSION

The essential nature of broadband communication services that has been highlighted by the COVID-19 pandemic makes it clear that without affordable and high-quality broadband services, workforce participation, commerce, education, and telehealth usage, are drastically curtailed. Additionally, access to broadband is a social determinant of health—both in and of itself and in light of its intersection between education and employment opportunities—and therefore an important component of discussions around health equity.[23] The digital divide was already negatively affecting millions of Americans, but the COVID-19 crisis has placed an increased level of stress on an already fragile system especially in rural and underserved areas. Some argue that the surge in internet usage as a result of stay-at-home orders simply confirms that the FCC's existing policies and programs, combined with low levels of broadband competition, are not meeting the basic needs of Americans. While others contend that the U.S. has fared well during this dramatic surge in internet use as a result of shelter in place orders, much better than some European countries,[24] and regulators and Congress should re-focus their efforts on expanding infrastructure. Given the bolstering of the FCC's COVID-19 Telehealth Program funding and the expansion of telehealth policy through the Centers for Medicare & Medicaid Services[25,26] as a result of the pandemic, our AMA believes that we too should pivot and re-focus our efforts on advocating for the expansion of broadband infrastructure in rural and underserved urban communities across America. Our AMA believes that as these opportunities to expand broadband access and telehealth are adopted and implemented successfully during this health crisis, both Congress and the Administration will be hard pressed to roll these advances back post-pandemic.

RECCOMENDATIONS

The Board of Trustees recommends that Resolution 211-I-19, "Effects of Net Neutrality on Public Health," and Resolution 208-I-19, "Net Neutrality and Public Health," not be adopted and that the remainder of the report be filed.

Fiscal Note: None

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16. https://docs.fcc.gov/public/attachments/FCC-19-44A1.pdf
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18. 42 USC 254(h)(7)(B). "(B)Health care provider --- The term "health care provider" means— (i)post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools; (ii)community health centers or health centers providing health care to migrants; (iii)local health departments or agencies; (iv)community mental health centers; (v)not-for-profit hospitals; (vi)rural health clinics; (vii)skilled nursing facilities (as defined in section 395i–3(a) of title 42); and (viii)consortia of health care providers consisting of one or more entities described in clauses (i) through (vii)."
19. https://docs.fcc.gov/public/attachments/DOC-364481A1.pdf
20. https://docs.fcc.gov/public/attachments/DA-20-436A1.pdf
21. https://www.schatz.senate.gov/press-releases/schatz-murkowski-senators-introduce-bipartisan-bill-to-expand-telehealth-help-more-people-receive-health-care
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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 201
(N-21)

Introduced by: South Carolina, Alabama, Florida, Mississippi, New Jersey, Oklahoma, West Virginia, Arkansas, North Carolina

Subject: Protection of Peer-Review Process

Referred to: Reference Committee B

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1 Whereas, Peer review is the task of self-monitoring and maintaining the administration of patient
2 safety and quality of care, consistent with optimal standards of practice; and
3
4 Whereas, It is the mechanism by which the medical profession fulfills its obligation to ensure
5 that its members are able to provide safe and effective care; and
6
7 Whereas, It is a mechanism for assuring the quality, safety, and appropriateness of hospital
8 services. The duties of peer review are: addressing the standard of care, preventing patient
9 harm, evaluating patient safety and quality of care, and ensuring that the design of systems or
10 settings of care support safety and high quality care; and
11
12 Whereas, Proceedings include all of the activities and information and records of a peer review
13 committee. Proceedings are not subject to discovery and no person who was in attendance at a
14 meeting of a peer review organization shall be permitted or required to testify in any such civil
15 action as to any evidence or other matters produced or presented during the proceedings of
16 such organization or as to any findings, recommendations, evaluations, opinions, or other
17 actions of such organization or any members thereof; and
18
19 Whereas, The proceedings, records, findings, and recommendations of a peer review
20 organization are not subject to discovery. Information gathered by a committee is protected.
21 Purely factual information, such as the time and dates of meetings and identities of any peer
22 review committee attendees is protected. Peer review information otherwise discoverable from
23 "original sources" cannot be obtained from the peer review committee itself; and
24
25 Whereas, A U.S. Senate Oversight Committee in investigating UNOS (United Network for
26 Organ Sharing) has subpoenaed “all relevant materials to include peer-review related
27 materials”; therefore be it
28
29 RESOLVED, That our American Medical Association use its full ability and influence to oppose
30 any new attempt(s) to make peer review proceedings, regardless of the venue, discoverable,
31 even if by the U.S. Congress or other U.S. governmental entity. (Directive to Take Action)

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

Received: 06/21/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution should be considered by our AMA House of Delegates as an URGENT resolution because of the on-going attempts by Oversight Committees of the US Congress to obtain peer-reviewed data which would include information by transplant surgeons as well as other physicians involved in the life-saving task of organ transplantation. There can be no guarantee that protected information would not be released in violation of the spirit of peer-reviewed procedures.

RELEVANT AMA POLICY

Legal Protections for Peer Review H-375.962
Definition and Purpose of Peer Review
Peer review is the task of self-monitoring and maintaining the administration of patient safety and quality of care, consistent with optimal standards of practice. It is the mechanism by which the medical profession fulfills its obligation to ensure that its members are able to provide safe and effective care. The responsibility assigned to and scope of peer review is the practice of medicine; ie, professional services administered by a physician and the portion of care under a physician's direction. Therefore, elements of medical care, which describe the knowledge, skills, attitudes, and educational experiences of physicians and provide the foundation of physician activities, are subject to peer review and its protections. Those elements include, but are not limited to the following: patient care, medical knowledge, interpersonal and communication skills, practice-based learning and improvement, and systems-based practice. Activities that comprise medical care are subject to the scope and rigor of peer review and entitled to the protections and privileges afforded by peer review law.
Peer review goes beyond individual review of instances or events; it is a mechanism for assuring the quality, safety, and appropriateness of hospital services. The duties of peer review are: addressing the standard of care, preventing patient harm, evaluating patient safety and quality of care, and ensuring that the design of systems or settings of care support safety and high quality care. Accountability to patients and their care, to the medical profession and colleagues, and to the institution granting privileges is inherent to the peer review process.
Composition of the Peer Review Committee
Peer review is conducted in good faith by physicians who are within the same geographic area or jurisdiction and medical specialty of the physician subject to review to ensure that all physicians consistently maintain optimal standards of competency to practice medicine. Physicians outside of the organization that is convening peer review may participate in that organization's peer review of a physician if the reviewing physician is within the same geographic area or jurisdiction and medical specialty as the physician who is the subject of peer review.
Definitions
Good Faith Peer Review. Peer review conducted with honest intentions that assess appropriateness and medical necessity to assure safe, high-quality medical care is good faith peer review. Misfeasance (i.e., abuse of authority during the peer review process to achieve a desired result other than improved patient care), or misuse of the peer review process, or peer review that is politically motivated, manipulated to achieve economic gains, or due to personal vendetta is not considered a good faith peer review.
Medical Peer Review Organizations. Any panel, committee, or organization that is composed of physicians or formed from a medical staff or formed by statute, such as physician wellness peer review boards, which engages in or utilizes peer reviews concerning the care and treatment of patients for the purposes of self-monitoring and maintaining the administration of patient safety and quality of care consistent with optimal standards of practice is a medical peer review organization. The responsibility of a medical peer review organization is to ensure: (1) that all physicians consistently maintain optimal standards of competency to practice medicine; and (2) the quality, safety, and appropriateness of patient care services. The medical peer review committee's obligations include review of allegations of infirmity (e.g., fitness to practice medicine), negligent treatment, and intentional misconduct. Peer review protections and privilege should extend to investigation and subsequent correction of negligent treatment and intentional misconduct.
Proceedings. Proceedings include all of the activities and information and records of a peer review committee. Proceedings are not subject to discovery and no person who was in attendance at a meeting

of a peer review organization shall be permitted or required to testify in any such civil action as to any evidence or other matters produced or presented during the proceedings of such organization or as to any findings, recommendations, evaluations, opinions, or other actions of such organization or any members thereof. However, information, documents, or records otherwise available from original sources are not to be construed as immune from discovery or use in any such civil action merely because they were presented during proceedings of a peer review organization, nor should any person who testifies before a peer review organization or who is a member of a peer review organization be prevented from testifying as to matters within his/her knowledge; but such witness cannot be asked about his/her testimony before a peer review organization or about opinions formed by him/her as a result of the peer review organization hearings.

Peer Review Activity. Peer review activity means the procedure by which peer review committees or quality assessment and assurance committees monitor, evaluate, and recommend actions to improve and ensure the delivery and quality of services within the committees' respective facilities, agencies, and professions, including recommendations, consideration of recommendations, actions with regard to recommendations, and implementation of actions.

Peer Review Records. Peer review records mean all complaint files, investigation files, reports, and other investigative information relating to the monitoring, evaluation, and recommendation of actions to improve the delivery and quality of health care services, licensee discipline, or professional competence in the possession of a peer review committee or an employee of a peer review committee.

Privilege. The proceedings, records, findings, and recommendations of a peer review organization are not subject to discovery. Information gathered by a committee is protected. Purely factual information, such as the time and dates of meetings and identities of any peer review committee attendees is protected. Peer review information otherwise discoverable from "original sources" cannot be obtained from the peer review committee itself. In medical liability actions, the privilege protects reviews of the defendant physician's specific treatment of the plaintiff and extends to reviews of treatment the physician has provided to patients other than the plaintiff.

Confidentiality. Peer review records and deliberations are confidential and may not be disclosed outside of the judicial process.

Peer Review Immunity and Protection from Retaliation. To encourage physician participation and ensure effective peer review, entities and participants engaged in good faith peer review activities should be immune from civil damages, injunctive or equitable relief, and criminal liability, and should be afforded all available protections from any retaliatory actions that might be taken against such entities or participants because of their involvement in peer review activities.

Citation: BOT Rep. 10, A-09; Reaffirmed: BOT Rep. 13, I-11; Modified: BOT Rep. 05, I-17

Peer Reviewer Immunity D-375.997

Our AMA will: (1) recommend medical staffs adopt/implement staff by laws that are consistent with HCQIA and AMA policy by communicating the guidelines from AMA policy H-375.983 widely through appropriate media to the relevant organizations and institutions, including a direct mailing to all medical staff presidents in the United States, indicating that compliance is required to conform to HCQIA and related court decisions; (2) monitor legal and regulatory challenges to peer review immunity and non discoverability of peer review records/proceedings and continue to advocate for adherence to AMA policy, reporting challenges to peer review protections to the House of Delegates and produce an additional report with recommendations that will protect patients and physicians in the event of misdirected or negligent peer review at the local level while retaining peer review immunity for the process; and (3) continue to work to provide peer review protection under federal law.

Citation: (BOT Rep.8, I-01; Reaffirmation A-05; Modified: CCB/CLRPD Rep. 2, A-14)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 203
(N-21)

Introduced by: Medical Student Section

Subject: Poverty-Level Wages and Health

Referred to: Reference Committee B

Whereas, Poverty has been shown to be an independent predictor of both physical and mental health in adults and children, in addition to causing a decreased life expectancy[1–12]; and

Whereas, People living in poverty are more likely to skip medical visits, medication doses, and meals, compounding the health inequities they experience[4,13]; and

Whereas, In 2019, 34 million people in the United States were living in poverty, and the U.S. poverty rate exceeded that of most peer or developed countries[14–16]; and

Whereas, The federal minimum wage was instituted in 1938 to create a minimum standard of living and to protect the health and well-being of employees[17,18]; and

Whereas, The federal U.S. minimum wage has not increased since 2009, while average yearly inflation increased steadily during that time, such that the real value of the minimum wage is now 17% less than it was in 2009 and 31% less than it was in 1968[19–21]; and

Whereas, An American family with two children and two adults working full-time jobs at the federal minimum wage would be roughly at the U.S. poverty level, and furthermore any single parent working a full-time job at the federal minimum wage would be below the federal poverty level[22]; and

Whereas, Due to longstanding systemic and structural discrimination, Black, Indigenous, Latinx, and other people of color, women, LGBTQ+ individuals, and people with disabilities are more likely to be vulnerable to poverty and to be working jobs that make only minimum wage[21,23–29]; and

Whereas, Researchers have documented associations between increased wages and decreases in suicide mortality, decreases in hypertension and heart disease, better birth outcomes, decreased teen birthrates, lower rates of sexually-transmitted infections among women, lower rates of new HIV infection, improvement in self-reported health and fewer days with functional limitations, decreases in smoking prevalence, decreases in youth binge drinking, and increased life expectancy[30–43]; and

Whereas, A low minimum wage results in an increased number of patients relying on Medicaid, resulting in lower overall reimbursements for physicians[44,45]; and

Whereas, The numerous states and localities that have raised their minimum wage above the federal minimum have not incurred adverse impacts on their rates of employment[46–49]; and

Whereas, Multiple bills aimed at raising the federal minimum wage have been proposed and debated in recent years[50]; and

Whereas, Our AMA recognizes the importance and impact of social determinants on health (H-165.822), recognizes health is a basic human right and that the provision of healthcare services is an obligation of an ethical civil society (H-65.960), and encourages screening for social and economic risk factors (H-160.909), but has no policy supporting federal minimum wage regulation for the betterment of individual and public health; therefore be it

RESOLVED, That our American Medical Association support federal minimum wage regulation such that the minimum wage increases at least with inflation in order to prevent full-time workers from experiencing the adverse health effects of poverty. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Poverty's impact upon health has become especially pressing during the COVID-19 pandemic. Poverty and economic stress have been highly correlated with poor health outcomes, as the pandemic reveals the depths of the economic divide that separates the well and well-cared-for from the sick and oft-ignored in America. As we as a nation begin to try to recover from the pandemic, it is imperative that we also try to resolve this long-standing social ill, so that the next national disaster is not so horrifically devastating among society's more vulnerable members and at large. Poverty-level wages, which keep a full-time worker under the poverty line, are massively detrimental to an individual's health. It is unconscionable that a full-time worker in the U.S. may not make enough to keep them alive, much less well, and the effects of this inequity have been made inescapable as the pandemic continues to cause devastation. Further, increasing the minimum wage has been a topic under federal governmental consideration, making this issue highly timely and relevant. Our AMA should act decisively to combat these harms now, to give our pandemic recovery the greatest chance of succeeding for all.

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RELEVANT AMA POLICY

Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems D-440.922

Our AMA will: (1) champion the betterment of public health by enhancing advocacy and support for programs and initiatives that strengthen public health systems, to address pandemic threats, health inequities and social determinants of health outcomes; and (2) study the most efficacious manner by which our AMA can continue to achieve its mission of the betterment of public health by recommending ways in which to strengthen the health and public health system infrastructure.
Res. 407, I-20

Health, In All Its Dimensions, Is a Basic Right H-65.960

Our AMA acknowledges: (1) that enjoyment of the highest attainable standard of health, in all its dimensions, including health care is a basic human right; and (2) that the provision of health care services as well as optimizing the social determinants of health is an ethical obligation of a civil society.
Res. 021, A-19

Health Plan Initiatives Addressing Social Determinants of Health H-165.822

Our AMA:
1. recognizing that social determinants of health encompass more than health care, encourages new and continued partnerships among all levels of government, the private sector, philanthropic organizations, and community- and faith-based organizations to address non-medical, yet critical health needs and the underlying social determinants of health;
2. supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs;
3. encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health, including through such mechanisms as professional development and other training;
4. supports mechanisms, including the establishment of incentives, to improve the acquisition of data related to social determinants of health, while minimizing burdens on patients and physicians;
5. supports research to determine how best to integrate and finance non-medical services as part of health insurance benefit design, and the impact of covering non-medical benefits on health care and societal costs; and
6. encourages coverage pilots to test the impacts of addressing certain non-medical, yet critical health needs, for which sufficient data and evidence are not available, on health outcomes and health care costs.
CMS Rep. 7, I-20

Poverty Screening as a Clinical Tool for Improving Health Outcomes H-160.909

Our AMA encourages screening for social and economic risk factors in order to improve care plans and direct patients to appropriate resources.
Res. 404, A-13; Reaffirmed: BOT Rep. 39, A-18

Racism as a Public Health Threat H-65.952

1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA will identify a set of current, best practices for healthcare institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, providers, international medical graduates, and populations.
4. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
5. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
6. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.
Res. 5, I-20

Discriminatory Policies that Create Inequities in Health Care H-65.963
Our AMA will: (1) speak against policies that are discriminatory and create even greater health disparities in medicine; and (2) be a voice for our most vulnerable populations, including sexual, gender, racial and ethnic minorities, who will suffer the most under such policies, further widening the gaps that exist in health and wellness in our nation.
Res. 001, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 204
(N-21)

Introduced by: Medical Student Section

Subject: Supporting Collection of Data on Medical Repatriation

Referred to: Reference Committee B

Whereas, Forced medical repatriation is the involuntary return of civilians in need of medical treatment to their country of origin by healthcare professionals[1]; and

Whereas, Forced medical repatriation results in an involuntary transfer of a patient to a foreign country, provoking an unwarranted intersection between immigration enforcement and the healthcare system[2]; and

Whereas, Of the estimated 10.5 million undocumented immigrants in the United States in 2017, a study found expenditures on immigrants in 2016 accounted for less than 10% of the overall healthcare spending in a population with the highest risk of being uninsured among the non-elderly population[2-4]; and

Whereas, Under the Emergency Medical Treatment and Labor Act of 1986 (EMTALA), federally funded health institutions with emergency care capabilities are mandated to treat all patients with emergent medical conditions who present to their facility until deemed stable, regardless of their insurance coverage or financial status[5]; and

Whereas, Once deemed stable, medical centers must consider medical repatriation if no long-term care alternative is available to the patient as a cost-saving mechanism[6]; and

Whereas, Care centers like St. Joseph's Hospital and Medical Center in Phoenix, Arizona, partake in forced medical repatriation for undocumented immigrant patients and a Florida patient experienced involuntary deportation prior to the completion of their appeal or asylum verdict[7-9]; and

Whereas, Forced medical repatriation has led to serious medical consequences for patients, including the exacerbation of existing medical conditions[10,11]; and

Whereas, Patients experienced a lapse and deterioration of care due to the inability of the patient's country of origin to provide adequate treatment and concurrent separation from their community in the U.S. during a time which may require emotional, physical and financial support[6,7,9,12]; and

Whereas, Hospitals fail to inform patients, or their guardians of potential adverse medical consequences related to repatriation[7,13]; and

Whereas, Forced medical repatriation increases health disparities among migrant communities and deters immigrants from seeking necessary medical services[14,15];and

Whereas, Forced medical repatriation often violates the Centers for Medicare and Medicaid Services' Conditions of Participation regulation which commits hospitals to ensure patients have the right to conduct informed decisions regarding their care[16,17]; and

Whereas, Forced medical repatriation violates the patient's constitutional right to due process, especially if the patient is able to claim asylum[18]; and

Whereas, The *AMA Journal of Ethics* encourages health care systems to seek routes of care to avoid forced medical repatriation and the *AMA Code of Ethics* Opinion 1.1.8 states that "physicians should resist any discharge requests that are likely to compromise a patient's safety" and that the "discharge plan should be developed without regard to socioeconomic status, immigration status, or other clinically irrelevant considerations" [2,19,20]; and

Whereas, The AMA is pursuing policy focused on alternative routes for immigrant healthcare through Health Care Payment for Undocumented Persons (D-440.985) and Federal Funding for Safety Net Care for Undocumented Aliens (H-160.956)[21,22]; and

Whereas, Data on repatriation of civilians is not reported through any government agency or otherwise, and there is a lack of documentation[7,23]; therefore be it

RESOLVED, That our American Medical Association ask the Department of Health and Human Services to collect and de-identify any and all instances of medical repatriations from the United States to other countries by medical centers to further identify the harms of this practice (Directive to Take Action); and be it further

RESOLVED, That our AMA denounce the practice of forced medical repatriation. (New HOD Policy)

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

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

This resolution denounces the practice of forced medical repatriations. Forced medical repatriations are an important ethical dilemma and public health crisis, impacting vulnerable immigrant communities. Further, this issue has become acutely, highly important during the current pandemic, as we currently have no data on how medical repatriations are decided or enacted and what their outcomes and downstream impacts may be. Without data collection on medical repatriations, we have no way to know whether they are being used in a discriminatory fashion, or what the outcomes are for patients, their healthcare teams, the countries to which the patients are repatriated, the people with whom they travel, and so on. Our AMA currently has no policy on medical repatriation and under the current political climate revolving immigrant health, we feel that this obviously unethical practice urgently needs to be researched and denounced by our AMA. By advocating for data collection and documentation of repatriation cases, this resolution demands transparency on an issue that has been rendered invisible by a lack of data. This resolution represents an urgent and necessary step forward during a time when the health of vulnerable immigrant populations is particularly at risk.

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RELEVANT AMA POLICY

EMTALA -- Major Regulatory and Legislative Developments D-130.982

Our AMA: (1) continue to work diligently to clarify and streamline the EMTALA requirements to which physicians are subject; (2) continue to work diligently with the Department of Health and Human Services (HHS) to further limit the scope of EMTALA, address the underlying problems of emergency care, and provide appropriate compensation and adequate funding for physicians providing EMTALA-mandated services; (3) communicate to physicians its understanding that following inpatient admission of a patient initially evaluated in an emergency department and stabilized, care will not be governed by the EMTALA regulations; and (4) continue strongly advocating to the Federal government that, following inpatient admission of a patient evaluated in an emergency department, where a patient is not yet stable, EMTALA regulations shall not apply.
BOT Rep. 17, I-02, Reaffirmation: A-07, Modified: BOT Rep. 22, A-17

Access to Emergency Services H-130.970

1. Our AMA supports the following principles regarding access to emergency services; and these principles will form the basis for continued AMA legislative and private sector advocacy efforts to assure appropriate patient access to emergency services:
(A) Emergency services should be defined as those health care services that are provided in a hospital emergency facility 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.
CMS Rep. A, A-89, Modified: CMS Rep. 6, I-95, Reaffirmation: A-97, Reaffirmed: Sub. Res. 707, A-98, Reaffirmed: Res. 705, A-99, Reaffirmed: CMS Rep. 3, I-99, Reaffirmation: A-00, Reaffirmed: Sub. Res. 706, I-00, Amended: Res. 229, A-01, Reaffirmation and Reaffirmed: Res. 708, A-02, Reaffirmed: CMS Rep. 4, A-12, Reaffirmed: CMS Rep. 07, A-16, Appended: Res. 128, A-17, Reaffirmation: A-18, Reaffirmed in lieu of: Res. 807, I-18

Emergency Medical Treatment and Active Labor Act (EMTALA) H-130.950
Our AMA: (1) will seek revisions to the Emergency Medical Treatment and Active Labor Act ((EMTALA)) and its implementing regulations that will provide increased due process protections to physicians before sanctions are imposed under (EMTALA); (2) expeditiously identify solutions to the patient care and legal problems created by current Emergency Medical Treatment and Active Labor Act ((EMTALA)) rules and regulations; (3) urgently seeks return to the original congressional intent of (EMTALA) to prevent hospitals with emergency departments from turning away or transferring patients without health insurance; and (4) strongly opposes any regulatory or legislative changes that would further increase liability for failure to comply with ambiguous (EMTALA) requirements.
Sub. Res. 214, A-97, Reaffirmation: I-98, Reaffirmation: A-99, Appended: Sub. Res. 235 and Reaffirmation A-00, Reaffirmation: A-07, Reaffirmed: BOT Rep. 22, A-17)

Emergency Transfer Responsibilities H-130.957
Our AMA supports seeking amendments to Section 1867 of the Social Security Act, pertaining to patient transfer, to:

(1) require that the Office of the Inspector General (IG) request and receive the review of the Quality Improvement Organization (QIO) prior to imposing sanctions;
(2) make the QIO determination in alleged patient transfer violations binding upon the IG;
(3) expand the scope of QIO review to include a determination on whether the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweighed the potential risks;
(4) restore the knowing standard of proof for physician violation;
(5) recognize appropriate referral of patients from emergency departments to physician offices;
(6) clarify ambiguous terms such as emergency medical transfer and stabilized transfer;
(7) clarify ambiguous provisions regarding the extent of services which must be provided in examining/treating a patient;
(8) clarify the appropriate role of the on-call specialist, including situations where the on-call specialist may be treating other patients; and
(9) clarify that a discharge from an emergency department is not a transfer within the meaning of the act.
Sub. Res. 78, A-91, Reaffirmation: A-00, Reaffirmed: BOT Rep. 6, A-10; Modified: BOT Rep. 04, A-20

Repeal of COBRA Anti-Physician Provisions H-130.959
It is the policy of the AMA (1) to seek legal or legislative opportunities to clarify that Section 1867 of the Social Security Act applies only to inappropriate transfers from hospital emergency departments and not to issues of malpractice; and (2) to continue to seek appropriate modifications of Section 1867 of the Social Security Act to preclude liability for discharges from the hospital, including emergency department and outpatient facility.
Sub. Res. 145, I-90, Reaffirmed: Sunset Report, I-00, Reaffirmed: BOT Rep. 6, A-10; Reaffirmed: BOT Rep. 04, A-20

Health Care Payment for Undocumented Persons D-440.985
Our AMA shall assist states on the issue of the lack of reimbursement for care given to undocumented immigrants in an attempt to solve this problem on a national level.
Res. 148, A-02, Reaffirmation: A-07, Reaffirmed: CMS Rep. 1, A-17, Reaffirmation: A-19; Reaffirmation: I-19

Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients H-440.876
1. Our AMA: (a) opposes any policies, regulations or legislation that would criminalize or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants; (b) opposes any policies, regulations, or legislation requiring physicians and other health care providers to collect and report data regarding an individual patient's legal resident status; and (c) opposes proof of citizenship as a condition of providing health care. 2. Our AMA will work with local and state medical societies to immediately, actively and publicly oppose any legislative proposals that would criminalize the provision of health care to undocumented residents.
Res. 920, I-06, Reaffirmed and Appended: Res. 140, A-07, Modified: CCB/CLRPD, Rep. 2, A-14

Federal Funding for Safety Net Care for Undocumented Aliens H-160.956
Our AMA will lobby Congress to adequately appropriate and dispense funds for the current programs that provide reimbursement for the health care of undocumented aliens.
Sub. Res. 207, A-93, Reaffirmed: BOT Rep. 17, I-94, Reaffirmed: Ref Com B, A-96, Reaffirmation: A-02, Reaffirmation: A-07, Reaffirmed: BOT Rep. 22, A-17, Reaffirmation: A-19; Reaffirmation: I-19

Presence and Enforcement Actions of Immigration and Customs Enforcement (ICE) in Healthcare D-160.921
Our AMA: (1) advocates for and supports legislative efforts to designate healthcare facilities as sensitive locations by law; (2) will work with appropriate stakeholders to educate medical providers on the rights of undocumented patients while receiving medical care, and the designation of healthcare facilities as sensitive locations where U.S. Immigration and Customs Enforcement (ICE) enforcement actions should not occur; (3) encourages healthcare facilities to clearly demonstrate and promote their status as sensitive locations; and (4) opposes the presence of ICE enforcement at healthcare facilities.
Res. 232, I-17)

Addressing Immigrant Health Disparities H-350.957
1. Our American Medical Association recognizes the unique health needs of refugees and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.
2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.
3. Our AMA will call for asylum seekers to receive all medically appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.
Res. 804, I-09, Appended: Res. 409, A-15, Reaffirmation: A-19, Appended: Res. 423, A-19; Reaffirmation: I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 205
(N-21)

Introduced by: Medical Student Section

Subject: Reducing the Prevalence of Sexual Assault by Testing Sexual Assault Evidence Kits

Referred to: Reference Committee B

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1 Whereas, Rape and/or sexual assault is common in the United States, with between 135,755
2 and 393,980 rapes and/or sexual assaults committed in 2017 alone[1,2]; and
3
4 Whereas, 43.6% of women and 24.8% of men have experienced some form of sexual violence,
5 including unwanted sexual contact of any kind, in their lifetimes[3]; and
6
7 Whereas, Rape and sexual assault are associated with a wide range of medical and
8 psychological sequelae, including direct physical trauma, PTSD, depression, social phobias,
9 mood regulation deficiencies, impaired sexual function, anxiety, self-harm, suicidal ideation and
10 suicide attempts[4-14]; and
11
12 Whereas, Data suggests that a significant proportion of rapes and/or sexual assaults are
13 committed by serial offenders[15-19]; and
14
15 Whereas, Identification and incarceration of perpetrators of violent sexual crimes reduces the
16 incidence of future sexual violence committed by these serial offenders[17-23]; and
17
18 Whereas, Sexual assault evidence kits (SAEKs), which refer to kits used to collect and store
19 evidence from a victim of sexual assault during a sexual assault forensic examination, are
20 extremely useful in the identification and prosecution of perpetrators of violent sexual crime and
21 are positively associated with successful prosecutions[17,19,22,23-27]; and
22
23 Whereas, Even when suspects cannot be immediately identified on the basis of the DNA
24 signature derived from a SAEK, law enforcement officials can upload the DNA profile to the
25 Federal Bureau of Investigation's Combined DNA Index System (CODIS), which can assist in
26 the later identification of the perpetrator[28]; and
27
28 Whereas, Despite the obvious utility of testing SAEKs, many remain untested and stored in law
29 enforcement evidence warehouses ("backlogged"), with estimates placing the number of
30 backlogged kits as high as 200,000 nationwide[19,29]; and
31
32 Whereas, The cause of backlogged SAEKs have been attributed to lack of standardized policies
33 and procedures, including federal guidelines, inadequate training of law enforcement officers,
34 outdated laboratory policies and lack of resources, such as funding[30]; and
35
36 Whereas, The United States Department of Justice's Violence Against Women Act of 1994
37 (VAWA) and its subsequent reauthorizations provides grants to programs offering medical
38 services to sexual assault survivors contingent on those programs incurring the full cost of
39 forensic medical exams through the offices of State Attorney's General[31-33]; and

Whereas, Standardized insurance billing procedures that include copays and other cost-sharing payments cause victims of sexual assault to be billed for part of the cost of testing forensic evidence, notwithstanding federal mandates like VAWA[34,35]; and

Whereas, The Bureau of Justice Assistance in the US Department of Justice administers the Sexual Assault Kit Initiative (SAKI), a grant program that assists police departments in testing backlogged SAEKs, has resulted in the disbursement of $43 million and the testing of 50,500 kits[40-42]; and

Whereas, Counties that have voluntarily worked to test all backlogged SAEKs in their possession have been extraordinarily successful in solving previously unsolved rapes and sexual assaults[17,19,21,22,36-40]; and

Whereas, Many of these SAEKs, if tested earlier, would have led to the identification and incarceration of serial offenders that would have prevented later assaults[17,19-22,36-38]; and

Whereas, The $9.6 million SAEK testing initiative in Cuyahoga County, Ohio financed new forensic examinations in addition to comprehensive coverage of investigations on backlogged kits with a net estimated savings of $38.7 million, highlighting the cost effectiveness of testing SAEKs[41,42]; and

Whereas, Existing AMA Policy H-80.999 outlines the rights of sexual assault victims but neither explicitly describes the right to have collected medical forensic evidence be tested in a timely manner nor addresses the backlog of untested sexual assault evidence kits; therefore be it

RESOLVED, That our American Medical Association amend Policy H-80.999, "Sexual Assault Survivors," by addition to read as follows:

H-80.999 – SEXUAL ASSAULT SURVIVORS

1. Our AMA supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing physicians involved in providing care to sexual assault survivors.
2. Our AMA advocates for the legal protection of sexual assault survivors' rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (a) receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing, treatment of injuries, and collection of forensic evidence; (b) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitations (c) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (d) be informed of these rights and the policies governing the sexual assault evidence kit; and (e) access to emergency contraception information and treatment for pregnancy prevention.
3. Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016.
4. Our AMA will advocate for increased post-pubertal patient access to Sexual Assault Nurse Examiners, and other trained and qualified clinicians, in the emergency department for medical forensic examinations.
5. <u>Our AMA will advocate at the state and federal level for (a) the immediate processing of all "backlogged" and new sexual assault examination kits; and (b) additional funding to facilitate the immediate testing of sexual assault evidence kits.</u> (Modify Current HOD Policy)

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

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Every year, hundreds of thousands of women are victims of sexual assault, and go on to suffer long-term physical, mental, and financial sequelae as a result. One of the leading tools law enforcement has to identify and track down perpetrators of this horrific act are sexual assault evidence kits (SAEKs), which can provide DNA evidence that links the attacker to DNA signatures in a variety of already-extant government databases. These kits have been shown to be extremely effective in solving sexual assaults. Their collection is very invasive and causes assault victims further stress, but victims frequently choose to undergo this stress, under the impression that the kit will help identify the perpetrator. However, there are almost no laws or regulations that mandate that SAEKs must be tested after collection. Hundreds of thousands of untested SAEKs from hundreds of thousands of sexual assaults languish in the so-called backlog, stored in police warehouses until the statute of limitations has expired. With every passing year, more SAEKs expire, their data becomes inadmissible in court, and more perpetrators of sexual assault are allowed to go free and potentially repeat their crimes. By advocating for mandates that would require all SAEKs, both those in the backlog and those collected in the future, to be fully tested and additional funding for police departments to facilitate those requirements, our AMA can help reduce the prevalence of sexual assault and advance the cause of justice. There is no time to waste.

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RELEVANT AMA POLICY

Sexual Assault Survivors H-80.999

1. Our AMA supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing physicians involved in providing care to sexual assault survivors.
2. Our AMA advocates for the legal protection of sexual assault survivors' rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (a) receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing, treatment of injuries, and collection of forensic evidence; (b) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (c) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (d) be informed of these rights and the policies governing the sexual assault evidence kit; and (e) access to emergency contraception information and treatment for pregnancy prevention.

3. Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016.
4. Our AMA will advocate for increased post-pubertal patient access to Sexual Assault Nurse Examiners, and other trained and qualified clinicians, in the emergency department for medical forensic examinations.
Sub. Res. 101, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: Res. 202, I-17; Appended: Res. 902, I-18

Sexual Assault Survivor Services H-80.998
Our AMA supports the function and efficacy of sexual assault survivor services, supports state adoption of the sexual assault survivor rights established in the Survivors' Bill of Rights Act of 2016, encourages sexual assault crisis centers to continue working with local police to help sexual assault survivors, and encourages physicians to support the option of having a counselor present while the sexual assault survivor is receiving medical care.
Res. 56, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: Res. 202, I-17

Addressing Sexual Assault on College Campuses H-515.956
Our AMA: (1) supports universities' implementation of evidence-driven sexual assault prevention programs that specifically address the needs of college students and the unique challenges of the collegiate setting; (2) will work with relevant stakeholders to address the issues of rape, sexual abuse, and physical abuse on college campuses; and (2) will strongly express our concerns about the problems of rape, sexual abuse, and physical abuse on college campuses.
Res. 402, A-16; Appended: Res. 424, A-18

HIV, Sexual Assault and Violence H-20.900
Our AMA: (1) believes that HIV testing and Post-Exposure Prophylaxis (PEP) should be offered to all survivors of sexual assault who present within 72 hours of a substantial exposure risk, that these survivors should be encouraged to be retested in six months if the initial test is negative, and that strict confidentiality of test results be maintained; and (2) supports: (a) education of physicians about the effective use of HIV Post-Exposure Prophylaxis (PEP) and the U.S. PEP Clinical Practice Guidelines, and (b) increased access to, and coverage for, PEP for HIV, as well as enhanced public education on its effective use.
CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13; Modified: Res. 905, I-18

Access to Emergency Contraception H-75.985
It is the policy of our AMA: (1) that physicians and other health care professionals should be encouraged to play a more active role in providing education about emergency contraception, including access and informed consent issues, by discussing it as part of routine family planning and contraceptive counseling; (2) to enhance efforts to expand access to emergency contraception, including making emergency contraception pills more readily available through pharmacies, hospitals, clinics, emergency rooms, acute care centers, and physicians' offices; (3) to recognize that information about emergency contraception is part of the comprehensive information to be provided as part of the emergency treatment of sexual assault victims; (4) to support educational programs for physicians and patients regarding treatment options for the emergency treatment of sexual assault victims, including information about emergency contraception; and (5) to encourage writing advance prescriptions for these pills as requested by their patients until the pills are available over-the-counter.
CMS Rep. 1, I-00; Appended: Res. 408, A-02; Modified: Res. 443, A-04; Reaffirmed: CSAPH Rep. 1, A-14

Insurance Discrimination Against Victims of Domestic Violence H-185.976
Our AMA: (1) opposes the denial of insurance coverage to victims of domestic violence and abuse and seeks federal legislation to prohibit such discrimination; and (2) advocates for equitable coverage and appropriate reimbursement for all health care, including mental health care, related to family and intimate partner violence.
Res. 814, I-94; Appended: Res. 419, I-00; Reaffirmation A-09; Reaffirmed: CMS Rep. 01, A-19

AMA Code of Medical Ethics 8.10 Preventing, Identifying and Treating Violence and Abuse
All patients may be at risk for interpersonal violence and abuse, which may adversely affect their health or ability to adhere to medical recommendations. In light of their obligation to promote the well-being of patients, physicians have an ethical obligation to take appropriate action to avert the harms caused by violence and abuse.
To protect patients' well-being, physicians individually should:
(a) Become familiar with:
(i) how to detect violence or abuse, including cultural variations in response to abuse;
(ii) community and health resources available to abused or vulnerable persons;
(iii) public health measures that are effective in preventing violence and abuse;
(iv) legal requirements for reporting violence or abuse.
(b) Consider abuse as a possible factor in the presentation of medical complaints.
(c) Routinely inquire about physical, sexual, and psychological abuse as part of the medical history.
(d) Not allow diagnosis or treatment to be influenced by misconceptions about abuse, including beliefs that abuse is rare, does not occur in "normal" families, is a private matter best resolved without outside interference, or is caused by victims' own actions.
(e) Treat the immediate symptoms and sequelae of violence and abuse and provide ongoing care for patients to address long-term consequences that may arise from being exposed to violence and abuse.
(f) Discuss any suspicion of abuse sensitively with the patient, whether or not reporting is legally mandated, and direct the patient to appropriate community resources.
(g) Report suspected violence and abuse in keeping with applicable requirements. Before doing so, physicians should:
(i) inform patients about requirements to report;
(ii) obtain the patient's informed consent when reporting is not required by law. Exceptions can be made if a physician reasonably believes that a patient's refusal to authorize reporting is coerced and therefore does not constitute a valid informed treatment decision.
(h) Protect patient privacy when reporting by disclosing only the minimum necessary information.
Collectively, physicians should:
(i) Advocate for comprehensive training in matters pertaining to violence and abuse across the continuum of professional education.
(j) Provide leadership in raising awareness about the need to assess and identify signs of abuse, including advocating for guidelines and policies to reduce the volume of unidentified cases and help ensure that all patients are appropriately assessed.
(k) Advocate for mechanisms to direct physicians to community or private resources that might be available to aid their patients.
(l) Support research in the prevention of violence and abuse and collaborate with public health and community organizations to reduce violence and abuse.
(m) Advocate for change in mandatory reporting laws if evidence indicates that such reporting is not in the best interests of patients.
Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 206
(N-21)

Introduced by: Medical Student Section

Subject: Updating Policy on Immigration Laws, Rules, Legislation, and Health Disparities to Better Address National Crises

Referred to: Reference Committee B

Whereas, The 2018 American Community Survey (ACS) reported that about 10.6 million undocumented immigrants were living the United States[1]; and

Whereas, Since the beginning of the COVID-19 pandemic, there have been at least 48 immigration policy changes that have not only affected international travel, student visas, and immigration, and asylum processes, but also caused significant confusion for immigration lawyers[2-4]; and

Whereas, The suspension of the United States Custom and Immigration Services (USCIS) during the COVID-19 pandemic has led to a back-up in the processing of necessary documentation, which has left many unable to access certain benefits necessary for work, receiving healthcare, and accessing public benefits[5]; and

Whereas, The Executive Office for Immigration Review (EOIR) suspended all hearings for non-detained individuals on March 18, 2020, which delayed the processing of asylum seekers enrolled in the Migrant Protection Protocols and left them to remain in Mexico in unsanitary conditions that promotes the spread of the virus[5]; and

Whereas, The federal government used statutes and the Tariff Act of 1930 in order to create rules from the Centers for Disease Control and Prevention (CDC) and CBP that restricted both entry at the northern and southern borders and barred asylum seekers from entering the country due to public health threats, despite evidence suggesting that such restrictions are ineffective and may even divert resources from other interventions[5]; and

Whereas, Immigration courts closed at the beginning of the COVID-19 pandemic and postponed hearings for detained people, prolonging their stay in detention centers[4,5]; and

Whereas, The relief packages that were provided by the government during the pandemic either provided little or no coverage to immigrants and their families, leaving them with few options for testing and treatment[5,7]; and

Whereas, The Families First Coronavirus Response Act (FFCRA) failed to make COVID-19 related services available under emergency Medicaid, which means that immigrants are unable to access these services since they cannot apply for non-emergency Medicaid due to immigration eligibility criteria[1,5,8]; and

Whereas, Undocumented immigrants typically work low-earning jobs and are unable to receive unemployment insurance or government stimulus checks during national crises[5,9]; and

Whereas, The Coronavirus Aid, Relief, and Economic Security (CARES) act limited the ability to receive a stimulus payment to individuals with a social security number, which limits many immigrants who file taxes using Individual Taxpayer Identification Numbers (ITIN)[1,5,8]; and

Whereas, Lapses in work authorization due to slowed processing times and suspension of required processing services may result in immigrants being unemployed or losing benefits offered by their employer[5,8]; and

Whereas, Both the FFCRA and the CARES act expanded Unemployment Insurance (UI) programs, but due to lapses in work authorizations, many immigrants may either not qualify or lose access to this vital benefit[1]; and

Whereas, Previous immigration law changes, such as the February 2020 Public Charge rule, penalized immigrants for using non-cash public assistance like Medicaid, the Supplemental Nutrition Assistance Program (SNAP), the Children's Health Insurance Program (CHIP), several housing programs, and federal poverty level determination by threatening inadmissibility or inability to be granted legal permanent residency in the United States[10,11]; and

Whereas, These changes not only discourage use of publicly funded healthcare and welfare services even among immigrant families to which the rule does not technically apply due to fear and confusion, but also mislead countless immigrant parents to remove their U.S. citizen children from health care insurance, likely leading to unnecessary child morbidity and mortality[10,12-15]; and

Whereas, Decreased participation in public benefit programs would contribute to a greater uninsured population, a decrease in the use of both preventive and curative health services, and negatively affect the health outcomes and financial stability of nearly 22 million noncitizens currently residing in the U.S.[10,16,17]; and

Whereas, On March 27, 2020, the USCIS announced that testing or treatment related to the COVID-19 pandemic would not count as a public charge[18,19]; and

Whereas, Although two filed lawsuits have prevented this ruling from being enacted further, there remains a concern on the potential for future immigration policy to discriminate based on poverty level, housing status, and the need for public benefits[17-19]; and

Whereas, Increased fear of deportation among families, even if only one family member is a non-citizen immigrant, not only causes decreased health care utilization but also causes increased behavioral issues in children[17]; and

Whereas, The 3rd AMA Principle of Medical Ethics states, "A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient" [10]; and

Whereas, Our AMA is opposed to any 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 (AMA Policy D-440.927); and

Whereas, Our AMA joined other health care organizations in submission of amicus briefs and comment letters opposing the new public charge regulations, stating “there is no evidence that chilling the use of health and nutrition benefits will result in an increase in income, employment or educational status of immigrants... These sweeping and detrimental changes will ultimately result in far greater costs to the public’s health than any purported benefit offered by DHS” [11]; and

Whereas, Our AMA has set policy precedent to act on behalf of the health of immigrants, refugees, migrant workers, and asylum seekers (AMA Policy H-350.957), and has joined other health care organizations in submitting amicus briefs and comment letters opposing the new public charge regulations, stating “there is no evidence that chilling the use of health and nutrition benefits will result in an increase in income, employment or educational status of immigrants... These sweeping and detrimental changes will ultimately result in far greater costs to the public’s health than any purported benefit offered by DHS”[11]; therefore be it

RESOLVED, That our American Medical Association, in order to prioritize the unique health needs of immigrants, asylees, refugees, and migrant workers during national crises, such as a pandemic:

(1) oppose the slowing or halting of the release of individuals and families that are currently part of the immigration process; and
(2) oppose continual detention when the health of these groups is at risk and supports releasing immigrants on recognizance, community support, bonding, or a formal monitoring program during national crises that impose a health risk; and
(3) support the extension or reauthorization of visas that were valid prior to a national crisis if the crisis causes the halting of immigration processing; and
(4) oppose utilizing public health concerns to deny of significantly hinder eligibility for asylum status to immigrants, refugees, or migrant workers without a viable, medically sound alternative solution (New HOD Policy); and be it further

RESOLVED, That our AMA amend H-350.957, "Addressing Immigrant Health Disparities," by addition as follows:

Addressing Immigrant and Refugee Health Disparities H-350.957

1. Our American Medical Association recognizes the unique health needs of immigrants and refugees and encourages the exploration of issues related to immigrant and refugee health and supports legislation and policies that address the unique health needs of immigrants and refugees.

2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.

3. Our AMA will call for asylum seekers to receive all medically appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.

4. Our AMA opposes any rule, regulation, or policy that would worsen health disparities among refugee or immigrant populations by forcing them to choose between health care or future lawful residency status. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

The recent horrific treatment of Haitian refugees at the border, proposal, and implementation of actions like asylum seeker bans, refugee entry suspensions, and postponing of Migration Protection Protocol hearings clearly demonstrate the need for a strong stance on immigrant protections during states of national emergency. Our delegation considers immigrant health and protections to be our strongest priority and ranked this resolution accordingly. To ensure our asks are actionable, the language of our resolution was crafted with the assistance of AMA advocacy staff.

This resolution strengthens AMA policy on legal immigrants' right to health care. It also broadens current policy so the AMA can continue to engage in conversations on immigration policy and their impact on immigrant health. The AAP has released several policy statements on the treatment of immigrant and refugee children, especially as it pertains to the use of detention centers and family separation policies, demonstrating that it is appropriate for our AMA to update existing policies on these issues.

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RELEVANT AMA POLICY

Impact of Immigration Barriers on the Nation's Health D-255.980

1. Our AMA recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.

Alt. Res. 308, A-17; Modified: CME Rep. 01, A-18; Reaffirmation: A-19; Reaffirmed: CME Rep. 4, A-21

Patient and Physician Rights Regarding Immigration Status H-315.966

Our AMA supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented.
Res. 018, A-17

Opposing the Detention of Migrant Children H-60.906
Our AMA: (1) opposes the separation of migrant children from their families and any effort to end or weaken the Flores Settlement that requires the United States Government to release undocumented children "without unnecessary delay" when detention is not required for the protection or safety of that child and that those children that remain in custody must be placed in the "least restrictive setting" possible, such as emergency foster care; (2) supports the humane treatment of all undocumented children, whether with families or not, by advocating for regular, unannounced, auditing of the medical conditions and services provided at all detention facilities by a non-governmental, third party with medical expertise in the care of vulnerable children; and (3) urges continuity of care for migrant children released from detention facilities.
Res. 004, I-18

Addressing Immigrant Health Disparities H-350.957
1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.
2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.
3. Our AMA will call for asylum seekers to receive all medically-appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.
Res. 804, I-09 Appended: Res. 409, A-15; Reaffirmation: A-19; Appended: Res. 423, A-19; Reaffirmation: I-19

HIV, Immigration, and Travel Restrictions H-20.901
Our AMA recommends that: (1) decisions on testing and exclusion of immigrants to the United States be made only by the U.S. Public Health Service, based on the best available medical, scientific, and public health information; (2) non- immigrant travel into the United States not be restricted because of HIV status; and (3) confidential medical information, such as HIV status, not be indicated on a passport or visa document without a valid medical purpose.
CSA Rep. 4, A-03; Modified: Res. 2, I-10; Modified: Res. 254, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 207
(N-21)

Introduced by: Medical Student Section

Subject: Authority to Grant Vaccine Exemptions

Referred to: Reference Committee B

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1 Whereas, Vaccination has been a key tool in the public health armory for the past century,
2 eliminating and nearly eliminating the incidence of several previously very burdensome
3 diseases in the United States and worldwide[1-4]; and
4
5 Whereas, In regard to infectious pathogens, immunization of a large portion of the population
6 can lead to vaccine-induced "herd immunity", a marked decrease in transmissibility because of
7 the paucity of viable disease hosts, that can eliminate a pathogen from circulation in a
8 population or protect those who are to be immunized for medical reasons, and increasing
9 vaccine uptake enough to achieve herd immunity requires that the vast majority of jurisdictions
10 have imposed vaccination mandates[3,4]; and
11
12 Whereas, All jurisdictions offer medical contraindication exemptions to mandates, defined as an
13 exemption due to "a medical condition that prevents them from receiving a vaccine," and some
14 also offer personal belief or religious exemptions to mandates[5,6]; and
15
16 Whereas, The process for obtaining a medical vaccine exemption differs from state to state,
17 with some states allowing any healthcare practitioner to provide a medical exemption, and some
18 specifying who qualifies as a healthcare provider, which may include medical doctors, nurse
19 practitioners, or physician assistants[4]; and
20
21 Whereas, In light of increasing medical exemptions for vaccines, in 2019 California enacted
22 Senate Bill 276 which called for an electronic, standardized medical exemption form that allows
23 only licensed physicians, surgeons, and registered nurses to prescribe medical exemptions for
24 vaccines, after which the California Department of Public Health would determine whether these
25 medical exemptions are in compliance with the Centers for Disease Control and Prevention
26 guidelines[7]; and
27
28 Whereas, Under California law, naturopathic providers (who have also been called naturopathic
29 practitioners, naturopathic doctors, or naturopathic physicians) are not considered "licensed
30 physicians" and are not allowed to grant medical exemptions, while other states, such as
31 Washington, allow naturopathic providers to provide medical vaccine exemptions[8-12]; and
32
33 Whereas, Although AMA policy defines physicians as those with MD or DO degrees
34 (H-160.949), in states allowing naturopathic providers to approve medical exemptions,
35 naturopathic providers are allowed to provide vaccine exemptions due to the states' definition of
36 medical authority; and
37
38 Whereas, Naturopathic providers do not have a nationally regulated definition of scope of
39 practice or training required, and the definitions, terms used, and requirements vary greatly
40 between states, and recent surveys have found that at most only 20% of naturopathic

practitioners actively recommend vaccination, and as many as 7% of naturopathic practitioners actively recommend against vaccination, raising concerns around allowing their access to writing vaccine exemptions[10,13,14]; and

Whereas, Given that some states have already re-defined “medical authority” to include naturopathic providers, it is possible that there may be further revisions naming other providers as “medical authorities” allowed to give vaccine exemptions, and other complementary or alternative medicine providers, like chiropractors and homeopaths, have documented similar or higher rates of reluctance to recommend vaccination or recommending against vaccination[14]; and

Whereas, This issue has become even more timely and urgent given the ongoing COVID-19 pandemic and the misinformation being spread about available, safe, and effective vaccines that can prevent SARS-CoV-2 infection; therefore be it

RESOLVED, That our American Medical Association oppose medical vaccine exemptions by non-physicians by amending Policy H-440.970, “Nonmedical Exemptions from Immunizations,” by addition to read as follows:

Nonmedical Exemptions from Immunizations, H-440.970

1. Our AMA believes that nonmedical (religious, philosophic, or personal belief) exemptions from immunizations endanger the health of the unvaccinated individual and the health of those in his or her group and the community at large.
Therefore, our AMA: (a) supports the immunization recommendations of the Advisory Committee on Immunization Practices (ACIP) for all individuals without medical contraindications; (b) supports legislation eliminating nonmedical exemptions from immunization; (c) encourages state medical associations to seek removal of nonmedical exemptions in statutes requiring mandatory immunizations, including for childcare and school attendance; (d) encourages physicians to grant vaccine exemption requests only when medical contraindications are present; (e) encourages state and local medical associations to work with public health officials to develop contingency plans for controlling outbreaks in medically-exempt populations and to intensify efforts to achieve high immunization rates in communities where nonmedical exemptions are common; and (f) recommends that states have in place: (i) an established mechanism, which includes the involvement of qualified public health physicians, of determining which vaccines will be mandatory for admission to school and other identified public venues (based upon the recommendations of the ACIP); and (ii) policies that permit immunization exemptions for medical reasons only.
2. Our AMA will actively advocate for legislation, regulations, programs, and policies that incentivize states to: <u>(a)</u> eliminate non-medical exemptions from mandated pediatric immunizations; <u>and (b) limit medical vaccine exemption authority to only licensed physicians</u>. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Anti-vaccinations stances have been on the rise for the greater part of the 21st century, resulting in outbreaks of diseases once thought almost eradicated such as measles. This issue has become critical as vaccine hesitancy is now prolonging a deadly pandemic, and lack of uptake of the extremely effective COVID-19 vaccines has led to heart wrenching, unnecessary, and entirely preventable losses of life and function. With vaccine mandates becoming more common, some individuals may look to receive unwarranted vaccine exemptions. Some states have a broad definition of "medical authority" which is now allowing alternative practitioners, such as naturopathic providers, to write vaccine exemptions. Naturopathic providers and other alternative medicine providers (like homeopaths and chiropractors) have been shown, through surveys, to be disinclined to recommend vaccines or even to recommend against vaccines. AMA policy does not offer directives or restrictions on who should be allowed to write medical vaccine exemptions, a gap this policy fills. Given the current dire situation of the pandemic and the urgent need to increase vaccination rates, we urge that this policy be considered at the November 2021 meeting, to arm our AMA with another tool in the fight against this ongoing pandemic.

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RELEVANT AMA POLICY

Nonmedical Exemptions from Immunizations H-440.970

1. Our AMA believes that nonmedical (religious, philosophic, or personal belief) exemptions from immunizations endanger the health of the unvaccinated individual and the health of those in his or her group and the community at large.

Therefore, our AMA (a) supports the immunization recommendations of the Advisory Committee on Immunization Practices (ACIP) for all individuals without medical contraindications; (b) supports legislation eliminating nonmedical exemptions from immunization; (c) encourages state medical associations to seek removal of nonmedical exemptions in statutes requiring mandatory immunizations, including for childcare and school attendance; (d) encourages physicians to grant vaccine exemption requests only when medical contraindications are present; (e) encourages state and local medical associations to work with public health officials to develop

contingency plans for controlling outbreaks in medically-exempt populations and to intensify efforts to achieve high immunization rates in communities where nonmedical exemptions are common; and (f) recommends that states have in place: (i) an established mechanism, which includes the involvement of qualified public health physicians, of determining which vaccines will be mandatory for admission to school and other identified public venues (based upon the recommendations of the ACIP); and (ii) policies that permit immunization exemptions for medical reasons only.
2. Our AMA will actively advocate for legislation, regulations, programs, and policies that incentivize states to eliminate non-medical exemptions from mandated pediatric immunizations.
CSA Rep. B, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: Res. 10, A-15; Modified: CSAPH Rep. 1, I-15; Appended: Res. 416, A-19

Practicing Medicine by Non-Physicians H-160.949
Our AMA: (1) urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional pattern of practice in which the physician directs and supervises the care given;
(2) continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers;
(3) continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;
(4) continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;
(5) through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine; and
(6) opposes special licensing pathways for “assistant physicians” (i.e., those who are not currently enrolled in an Accreditation Council for Graduate Medical Education training program, or have not completed at least one year of accredited graduate medical education in the U.S).
Res. 317, I-94; Modified by Res. 501, A-97; Appended: Res. 321, I-98; Reaffirmation: A-99; Appended: Res. 240, Reaffirmed: Res. 708 and Reaffirmation A-00; Reaffirmed: CME Rep. 1, I-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: Res. 208, I-10; Reaffirmed: Res. 224, A-11; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Res. 107, A-14; Appended: Res. 324, A-14; Modified: CME Rep. 2, A-21

National Immunization Program H-440.992
Our AMA believes the following principles are required components of a national immunization program and should be given high priority by the medical profession and all other segments of society interested and/or involved in the prevention and control of communicable disease: (1) All US children should receive recommended vaccines against diseases in a continuing and ongoing program.

(2) An immunization program should be designed to encourage administration of vaccines as part of a total preventive health care program, so as to provide effective entry into a continuous and comprehensive primary care system.

(3) There should be no financial barrier to immunization of children.

(4) Existing systems of reimbursement for the costs of administering vaccines and follow-up care should be utilized.

(5) Any immunization program should be either (a) part of a continuing physician/patient relationship or (b) the introductory link to a continuing physician/patient relationship wherever possible.

(6) Professionals and allied health personnel who administer vaccines and manufacturers should be held harmless for adverse reactions occurring through no fault of the procedure.

(7) Provision should be made for a sustained, multi-media promotional campaign designed to educate and motivate the medical profession and the public to expect and demand immunizations for children and share responsibility for their completion.

(8) An efficient immunization record-keeping system should be instituted.
Res. 44, A-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Res. 501, A-09; Reaffirmation: I-10; Reaffirmed: CSAPH Rep. 01, A-20

Distribution and Administration of Vaccines H-440.877
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.
Sub Res. 512, A-06; Reaffirmed: BOT Rep. 26, A-07; BOT Action in response to referred for decision, Res. 902, I-08; Modified: CSAPH Rep. 4, I-14; Appended: Res. 404, A-16; Reaffirmed: CMS Rep. 07, A-17; Reaffirmed: CMS Rep. 6, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 208
(N-21)

Introduced by: Medical Student Section

Subject: Protections for Incarcerated Mothers in the Perinatal Period

Referred to: Reference Committee B

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1 Whereas, Almost 4% of women newly admitted to U.S. prisons are pregnant, and 92% of
2 pregnancy outcomes in prisons resulted in live births[1,2]; and
3
4 Whereas, Twenty-five percent of justice juvenile residential facilities house at least one pregnant
5 youth[3]; and
6
7 Whereas, Limited data is available regarding health outcomes of incarcerated pregnant people
8 despite the high frequency of pre-existing health conditions in incarcerated populations and the
9 established relationship between incarceration and exacerbation of pre-existing medical
10 conditions[4-7]; and
11
12 Whereas, State and federal Maternal Mortality Review Committees and the CDC's surveillance
13 reports on maternal mortality and morbidity already use data from surveillance of perinatal
14 outcomes to improve understanding of disparities among racial groups and inform the
15 development of policies and initiatives aimed at meeting the needs of high-risk populations, but
16 data on incarceration status is not included in this surveillance[6-18]; and
17
18 Whereas, Quality improvement research can improve care for vulnerable populations, and data
19 from surveillance of perinatal outcomes and studies regarding the accessibility and quality of
20 healthcare available to pregnant incarcerated people would expand the current knowledge of
21 disparities within this particularly vulnerable group[19-22]; and
22
23 Whereas, There are currently no standard methodologies or requirements for collecting data on
24 incarcerated pregnant people and, prior to 2016, had been no organized review of pregnancy
25 outcomes of incarcerated people in the United States[23]; and
26
27 Whereas, Incarcerated pregnant people are often deprived of prenatal care, adequate nutrition,
28 access to appropriate accommodations, and timely medical care, all of which are known to
29 contribute to poor health outcomes[5,6,24-29]; and
30
31 Whereas, The American College of Obstetricians and Gynecologists (ACOG) has established
32 guidelines on prenatal and postnatal care for incarcerated women, including assessing
33 pregnancy risk, providing medication-assisted treatment for opioid use disorder in pregnant
34 people, and avoiding the use of restraints on people that are pregnant or within six weeks of
35 postpartum, but data have shown that many incarcerated women do not receive care in
36 accordance with these guidelines[6,23,30]; and
37
38 Whereas, Complications during pregnancy and delivery, such as preeclampsia, intrauterine
39 growth restriction, and intrauterine fetal death, are more likely to occur in women that have an
40 opioid addiction and do not receive adequate withdrawal treatment[31]; and

Whereas, Only a small number of states, including Pennsylvania, North Carolina, and Oklahoma, have explicit standards of care for incarcerated pregnant mothers, such as specific lab tests, frequency of prenatal visits with an obstetrician, and screening for high-risk pregnancies[32-34]; and

Whereas, The US Government Accountability Office reported in 2021 that the US Marshals Service and Bureau of Prisons' Detention Standards and Policies either do not align or only partially align with national guidance recommendations on the treatment and care of pregnant people, and the US Bureau of Prisons and most state correctional facilities do not require specific or explicit guidelines for perinatal care or nutrition[35,36]; and

Whereas, The American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) recommend exclusive breastfeeding for the first six months of a baby's life[37,38]; and

Whereas, Breast milk has established benefits for the baby, including reduced risks of infection, such as otitis media and pneumonia; other health conditions, such as obesity, type 1 and type 2 diabetes mellitus, asthma, and sudden infant death syndrome (SIDS); as well as established benefits of breastfeeding and breast milk expression for the mother, including reduced risk of breast and ovarian cancer, type 2 diabetes mellitus, and hypertension[37-40]; and

Whereas, Breastfeeding has been associated with improved cognitive and emotional abilities, increased brain development in children, and improved mother-child relationship[41]; and

Whereas, The cost of infant formula is up to $1,500 per year; alternatively, feeding a baby with pasteurized donor human milk costs an average of $4.50 per ounce, and further, the cost of healthcare in a breastfed baby's first year of life is, on average, $331 less than a formula-fed baby[42-46]; and

Whereas, Pumping breast milk can promote a greater maternal-infant bond and improve the health of both the mother and infant[47]; and

Whereas, A woman's right to breastfeed or express breast milk in any private or public location is protected by law in all 50 states of the United States; however, for mothers in prison, there are significant barriers to expressing and storing breast milk, such as requiring presence of a prison guard, time restrictions, and insufficient equipment[48,49]; and

Whereas, Most women who give birth while incarcerated are separated from their child after hospital discharge and usually without sufficient education on breastfeeding[50]; and

Whereas, Restricting mothers from breastfeeding and/or expressing breast milk while incarcerated will decrease their milk supply, hindering their ability to directly breastfeed[51]; and

Whereas, In 2017, the National Commission on Correctional Health Care called on correctional facilities to support programs for incarcerated women to breastfeed their babies directly or pump breast milk and store it for later delivery to the infant[52]; and

Whereas, The protections for incarcerated mothers to express milk may be established on a state-by-state basis, but only California, Connecticut, New Mexico, New York, and Washington have laws offering protections, although still with limitations[48,53-58]; and

Whereas, Our AMA acknowledges the importance of access to healthcare for incarcerated individuals (D-430.997, H-430.986, H-430.997), has supported standards to improve the safety of pregnant incarcerated people (H-420.957), and our AMA has policies in support of breastfeeding (H-245.982) and bonding programs for women prisoners and their newborn children (H-430.990), though these policies do not specify protecting an incarcerated mother's right to express milk; therefore be it

RESOLVED, That our American Medical Association encourage research efforts to characterize the health needs for pregnant inmates, including efforts that utilize data acquisition directly from pregnant inmates (New HOD Policy); and be it further

RESOLVED, That our AMA support legislation requiring all correctional facilities, including those that are privately-owned, to collect and report pregnancy-related healthcare statistics with transparency in the data collection process (New HOD Policy); and be it further

RESOLVED, That our AMA amend policy H-430.990 by addition to read as follows:

> Bonding Programs for Women Prisoners and their Newborn Children H-430.990
> Because there are insufficient data at this time to draw conclusions about the long-term effects of prison nursery programs on mothers and their children, the AMA supports and encourages further research on the impact of infant bonding programs on incarcerated women and their children. <u>However, since there are established benefits of breast milk for infants and breast milk expression for mothers, the AMA advocates for policy and legislation that extends the right to breastfeed and/or pump and store breast milk to include incarcerated mothers.</u> The AMA recognizes the prevalence of mental health and substance abuse problems among incarcerated women and continues to support access to appropriate services for women in prisons. The AMA recognizes that a large majority of incarcerated females who may not have developed appropriate parenting skills are mothers of children under the age of 18. The AMA encourages correctional facilities to provide parenting skills <u>and breastfeeding/breast pumping</u> training to all female inmates in preparation for their release from prison and return to their children. The AMA supports and encourages further investigation into the long-term effects of prison nurseries on mothers and their children. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

The COVID-19 pandemic has laid bare some of the vast health injustices for people who are incarcerated, making it clear this is a population in urgent need of better protections for their rights, health, and safety. Almost 4% of women are pregnant at the time of prison or jail admission in the U.S. However, there are currently no standard methodologies or requirements for collecting data on incarcerated pregnant people. ACOG has established guidelines on the pre- and postnatal care of incarcerated women, but data have shown that many incarcerated women do not receive care in accordance with these guidelines. Further, although the right to breastfeed in public and the workplace is protected by law in all 50 states, these laws fail to protect those who are incarcerated. There is often a lack of resources or education to support breast pumping and storage practices in jails and prisons, resulting in essentially a lack of adequate access to the important practice of breastfeeding for these women and their babies. We need to fill this AMA policy gap by advocating for the rights and safety of incarcerated persons in the perinatal period and their children. As the voice of America's physicians, it is vital that we take a stand for this vulnerable population whose health is so disproportionately affected in the ongoing pandemic, and this resolution represents a concrete, urgent, and impactful way we can do that.

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RELEVANT AMA POLICY

Support for Health Care Services to Incarcerated Persons D-430.997

Our AMA will:
(1) express its support of the National Commission on Correctional Health Care Standards that improve the quality of health care services, including mental health services, delivered to the nation's correctional facilities; (2) encourage all correctional systems to support NCCHC accreditation; (3) encourage the NCCHC and its AMA representative to work with departments of corrections and public officials to find cost effective and efficient methods to increase correctional health services funding; (4) continue support for the programs and goals of the NCCHC through continued support for the travel expenses of the AMA representative to the NCCHC, with this decision to be reconsidered every two years in light of other AMA financial commitments, organizational memberships, and programmatic priorities;(5) work with an accrediting organization, such as National Commission on Correctional Health Care (NCCHC) in developing a strategy to accredit all correctional, detention and juvenile facilities and will advocate that all correctional, detention and juvenile facilities be accredited by the NCCHC no later than 2025 and will support funding for correctional facilities to assist in this effort; and (6) support an incarcerated person’s right to: (a) accessible, comprehensive, evidence-based contraception education; (b) access to reversible contraceptive methods; and (c) autonomy over the decision-making process without coercion.
Res. 440, A-04; Amended: BOT Action in response to referred for decision; Res. 602, A-00; Reaffirmation I-09; Reaffirmation A-11; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: CMS Rep, 02, I-16; Appended: Res. 421, A-19; Appended: Res. 426, A-19

Health Care While Incarcerated H-430.986

1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA supports partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. That our AMA encourage state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.

5. Our AMA encourages states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal justice system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA urges Congress, the Centers for Medicare & Medicaid Services (CMS), and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from adult and juvenile correctional facilities in order to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism.
7. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of incarcerated women and adolescent females, including gynecological care and obstetrics care for pregnant and postpartum women.
8. Our AMA will collaborate with state medical societies and federal regulators to emphasize the importance of hygiene and health literacy information sessions for both inmates and staff in correctional facilities.
9. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance abuse disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; and (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community.
CMS Rep. 02, I-16; Appended: Res. 417, A-19; Appended: Res. 420, A-19; Modified: Res. 216, I-19; Reaffirmed: Res. 229, A-21

Shackling of Pregnant Women in Labor H-420.957
1. Our AMA supports language recently adopted by the New Mexico legislature that "an adult or juvenile correctional facility, detention center or local jail shall use the least restrictive restraints necessary when the facility has actual or constructive knowledge that an inmate is in the 2nd or 3rd trimester of pregnancy. No restraints of any kind shall be used on an inmate who is in labor, delivering her baby or recuperating from the delivery unless there are compelling grounds to believe that the inmate presents:
- An immediate and serious threat of harm to herself, staff or others; or
- A substantial flight risk and cannot be reasonably contained by other means.
If an inmate who is in labor or who is delivering her baby is restrained, only the least restrictive restraints necessary to ensure safety and security shall be used."
2. Our AMA will develop model state legislation prohibiting the use of shackles on pregnant women unless flight or safety concerns exist.
Res. 203, A-10; Reaffirmed: BOT Rep. 04, A-20

Bonding Programs for Women Prisoners and their Newborn Children H-430.990
Because there are insufficient data at this time to draw conclusions about the long-term effects of prison nursery programs on mothers and their children, the AMA supports and encourages further research on the impact of infant bonding programs on incarcerated women and their children. The AMA recognizes the prevalence of mental health and substance abuse problems among incarcerated women and continues to support access to appropriate services for women in prisons. The AMA recognizes that a large majority of female inmates who may not have developed appropriate parenting skills are mothers of children under the age of 18. The AMA encourages correctional facilities to provide parenting skills training to all female inmates in preparation for their release from prison and return to their children. The AMA supports and encourages further investigation into the long-term effects of prison nurseries on mothers and their children.
CSA Rep. 3, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17

Standards of Care for Inmates of Correctional Facilities H-430.997
Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance misuse care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism.
Res. 60, A-84; Reaffirmed by CLRPD Rep. 3, I-94; Amended: Res. 416, I-99; Reaffirmed: CEJA Rep. 8, A-09; Reaffirmation: I-09; Modified in lieu of Res. 502, A-12; Reaffirmation: I-12

Support for Breastfeeding H-245.982
1. Our AMA: (a) recognizes that breastfeeding is the optimal form of nutrition for most infants; (b) endorses the 2012 policy statement of American Academy of Pediatrics on Breastfeeding and the use of Human Milk, which delineates various ways in which physicians and hospitals can promote, protect, and support breastfeeding practices; (c) supports working with other interested organizations in actively seeking to promote increased breastfeeding by Supplemental Nutrition Program for Women, Infants, and Children (WIC Program) recipients, without reduction in other benefits; (d) supports the availability and appropriate use of breast pumps as a cost-effective tool to promote breast feeding; and (e) encourages public facilities to provide designated areas for breastfeeding and breast pumping; mothers nursing babies should not be singled out and discouraged from nursing their infants in public places.
2. Our AMA: (a) promotes education on breastfeeding in undergraduate, graduate, and continuing medical education curricula; (b) encourages all medical schools and graduate Resolution RS-056 (I-20) Page 5 of 6 medical education programs to support all residents, medical students and faculty who provide breast milk for their infants, including appropriate time and facilities to express and store breast milk during the working day; (c) encourages the education of patients during prenatal care on the benefits of breastfeeding; (d) supports breastfeeding in the health care system by encouraging hospitals to provide written breastfeeding policy that is communicated to health care staff; (e) encourages hospitals to train staff in the skills needed to implement written breastfeeding policy, to educate pregnant women about the benefits and management of breastfeeding, to attempt early initiation of breastfeeding, to practice "rooming-in," to educate mothers on how to breastfeed and maintain lactation, and to foster breastfeeding support groups and services; (f) supports curtailing formula promotional practices by encouraging perinatal care providers and hospitals to ensure that physicians or other appropriately trained medical personnel authorize distribution of infant formula as a medical sample only after appropriate infant feeding education, to specifically include education of parents about the medical benefits of breastfeeding and encouragement of its practice, and education of parents about formula and bottle-feeding options; and (g) supports the concept that the parent's decision to use infant formula, as well as the choice of which formula, should be preceded by consultation with a physician.
3. Our AMA: (a) supports the implementation of the WHO/UNICEF Ten Steps to Successful Breastfeeding at all birthing facilities; (b) endorses implementation of the Joint Commission Perinatal Care Core Measures Set for Exclusive Breast Milk Feeding for all maternity care facilities in the US as measures of breastfeeding initiation, exclusivity and continuation which should be continuously tracked by the nation, and social and demographic disparities should be addressed and eliminated; (c) recommends exclusive breastfeeding for about six months, followed by continued breastfeeding as complementary food are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant; (d) recommends the adoption of employer programs which support breastfeeding mothers so that they may safely and privately express breast milk at work or take time to feed their infants; and (e) encourages employers in all fields of healthcare to serve as role models to improve the public health by supporting mothers providing breast milk to their infants beyond the postpartum period.

4. Our AMA supports the evaluation and grading of primary care interventions to support breastfeeding, as developed by the United States Preventive Services Task Force (USPSTF).
5. Our AMA's Opioid Task Force promotes educational resources for mothers who are breastfeeding on the benefits and risks of using opioids or medication-assisted therapy for opioid use disorder, based on the most recent guidelines.
CSA Rep. 2, A-05; Res. 325, A-05; Reaffirmation A-07; Reaffirmation A-12;
Modified in lieu of Res. 409, A-12 and Res. 410, A-12; Appended: Res. 410, A-16; Appended: Res. 906, I-17; Reaffirmation: I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 209
(N-21)

Introduced by: Medical Student Section

Subject: Increasing Access to Hygiene and Menstrual Products

Referred to: Reference Committee B

Disclaimer: We acknowledge that not all persons who experience menstrual bleeding and need menstrual hygiene products are women, and that the following applies to all individuals who experience menstrual bleeding and require these products.

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

Whereas, In 2018, the estimated average life-time cost of menstrual products for an individual in the United States was $1,773.33[3]; and

Whereas, Two-thirds of low-income women in the United States of America were unable to afford menstrual products in 2018, and low-income women who are food insecure are more likely to struggle with the choice to either buy food or menstrual hygiene products due to financial strain, and often make the choice for the former[4,5] and

Whereas, The FDA advises that tampons should never be used for more than 8 hours at a time due to risks of bacterial growth that could result in toxic shock syndrome and because unhygienic menstruation practices are a risk factor for secondary infertility[6,7]; and

Whereas, One study showed that one third of low-income women in St. Louis, Missouri used unhygienic menstrual practices such as “strips of cloth, rags, tissues, or toilet paper” due to menstrual hygiene product inaccessibility, and other studies have shown that such practices, including using reusable cloths and insufficient changing of menstrual napkins, increase the likelihood of contracting reproductive and urinary tract infections[5,8,9] and

Whereas, Women who cannot afford menstrual hygiene products are more likely to suffer from moderate/severe depression[10]; and

Whereas, Studies have shown that low-income women are concerned about the high cost of menstrual hygiene products, and are frustrated that their benefits from the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) cannot be used to purchase menstrual hygiene supplies, even though these are necessities for women[5]; and

Whereas, Organizations including the United Nations and Human Rights Watch have classified menstrual hygiene as a human rights issue[11]; and

Whereas, School-aged children in the United States who are unprepared for menarche have increased rates of depression, substance abuse, delinquency, and school dropout[12]; and

Whereas, One in five school-aged girls in the United States have left school early or missed an entire day of school due to lack of access to menstrual products, and roughly three out of four working women have left work early to obtain needed menstrual products[13,14]; and

Whereas, OSHA requires employers to provide all workers with sanitary and immediately-available toilet facilities (restrooms) according to sanitation standards 29 CFR 1910.141, 29 CFR 1926.51 and 29 CFR 1928.110[15]; and

Whereas, Like toilets and toilet paper, menstrual hygiene products are necessary to effectively and sanitarily manage natural and unavoidable bodily functions[16]; and

Whereas, Similar to menstrual product shortages, families may experience diaper need, and families experiencing diaper need may provide fewer diaper changes, increasing the risk for pediatric urinary tract infections and diaper dermatitis, as well as more frequent pediatric care visits, and diaper need is associated with maternal stress and depression[17,18]; and

Whereas, A sufficient supply of diapers costs an average of $936 a year per child, and in a survey of pregnant women, almost 30% reported diaper need[17]; and

Whereas, Currently five states (California, Georgia, Illinois, New York, and New Hampshire) have implemented legislation to provide free menstrual products (i.e., tampons, sanitary napkins) in public school restrooms[19-23]; and

Whereas, Oregon recently introduced State Senate Bill 717 which, if passed, would require an additional $10 per month to SNAP recipients specifically for personal hygiene products, and in 2019, H.R.1882 (Menstrual Equity for All Act of 2019), introduced to the United States House of Representatives, proposed that Medicaid cover the cost of feminine hygiene products[18,19] and HB 4874 has been brought forth to the Illinois House of Representatives and requires the Department of Human Services to permit the coverage of feminine hygiene products under SNAP, WIC, and the Temporary Assistance for Needy Families[24]; and

Whereas, Multiple pieces of legislation have highlighted the movement towards menstrual equity for all by calling for free and accessible menstrual products in public schools, establishing menstrual hygiene products as medical necessities, and allowing purchases for menstrual care products to be eligible for reimbursement through Health Flexible Spending Arrangements and Health Reimbursement Arrangements[25,26]; and

Whereas, Our AMA urges continued adequate funding of WIC (H-245.979, H-245.989), supports feminine hygiene products as a medical necessity (H-525.974), supports legislation to remove all sales tax on feminine hygiene products (H-270.953), and affirms local medical societies establishing relationships with schools to aid in health education, particularly in personal hygiene (H-170.996); therefore be it

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

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

RESOLVED, That our AMA advocate for federal legislation and work with state medical societies to increase access to menstrual hygiene products, especially for recipients of public assistance (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage public and private institutions as well as places of work and education to provide free, readily available menstrual care products to workers, patrons, and students (New HOD Policy); and be it further

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

> CONSIDERING FEMININE HYGIENE PRODUCTS AS MEDICAL NECESSITIES, H-525.974
> Our AMA will: (1) encourage the Internal Revenue Service to classify feminine hygiene products as medical necessities; ~~and~~ (2) work with federal, state, and specialty medical societies to advocate for the removal of barriers to feminine hygiene products in state and local prisons and correctional institutions to ensure incarcerated women be provided free of charge, the appropriate type and quantity of feminine hygiene products including tampons for their needs~~.~~; and (3) encourage the American National Standards Institute, the Occupational Safety and Health Administration, and other relevant stakeholders to establish and enforce a standard of practice for providing free, readily available menstrual care products to meet the needs of workers. (Modify Current HOD Policy)

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

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

"Period poverty" refers to the financial burden on menstruating people who struggle to pay the additional costs of menstrual hygiene products. Low-income women, who often must choose between buying food and buying menstrual hygiene products. Without proper hygiene products, women sustain infections, injuries, or embarrassment. Women who can afford to buy menstrual products still report high rates of having had to miss work since menstrual products are not available publicly, and girls report high rates of having had to miss school for the same reason. This is even more important given how gender inequities deepened in the pandemic, with women disproportionately missing time at work, and all students missing a great deal of time in school, so that women and children now facing pandemic-induced setbacks. Additionally, the pandemic has exacerbated period poverty, leading the US government to classify period products as necessary medical expenses eligible for FSA and HSA reimbursement in the COVID-19 stimulus bill. It is important for the AMA to take a stance on this issue due to the timeliness, considering the amount of legislation on this issue making its way through legislatures. This resolution combats gender inequities and period poverty by making hygiene products available in public spaces, including schools, and incorporating these products in supplemental nutrition programs (WIC/SNAP).

Now is the time for the AMA to take a stance on this issue and provide a voice in the national movement for greater menstrual equity.

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RELEVANT AMA POLICY

Improvements to Supplemental Nutrition Programs H-150.937

1. Our AMA supports: (a) improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity; (b) efforts to decrease the price gap between calorie-dense, nutrition-poor foods and naturally nutrition-dense foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrollment, of existing programs that seek to improve nutrition and reduce obesity, such as the Farmer's Market Nutrition Program as a part of the Women, Infants, and Children program; and (c) the novel application of the Farmer's Market Nutrition Program to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize

the consumption of naturally nutrition-dense foods in wider food distribution venues than solely farmer's markets as part of the Women, Infants, and Children program.
2. Our AMA will request that the federal government support SNAP initiatives to (a) incentivize healthful foods and disincentivize or eliminate unhealthful foods and (b) harmonize SNAP food offerings with those of WIC.
3. Our AMA will actively lobby Congress to preserve and protect the Supplemental Nutrition Assistance Program through the reauthorization of the 2018 Farm Bill in order for Americans to live healthy and productive lives.
Res. 414, A-10; Reaffirmation: A-12; Reaffirmation: A-13; Appended: CSAPH Rep. 1, I-13; Reaffirmation: A-14; Reaffirmation: I-14; Reaffirmation: A-15; Appended: Res. 407, A-17; Appended: Res. 233, A-18

Opposition to Proposed Budget Cuts in WIC and Head Start H-245.979
The AMA opposes reductions in funding for WIC and Head Start and other programs that significantly impact child and infant health and education.
Res. 246, I-94; Reaffirmed: BOT Rep. 29, A-04; Reaffirmed: BOT Rep. 19, A-14

Adequate Funding of the WIC Program H-245.989
Our AMA urges the U.S. Congress to investigate recent increases in the cost of infant formula, as well as insure that WIC programs receive adequate funds to provide infant formula and foods for eligible children.
Res. 269, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep.1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Considering Feminine Hygiene Products as Medical Necessities H-525.974
Our AMA will: (1) encourage the Internal Revenue Service to classify feminine hygiene products as medical necessities; and (2) work with federal, state, and specialty medical societies to advocate for the removal of barriers to feminine hygiene products in state and local prisons and correctional institutions to ensure incarcerated women be provided free of charge, the appropriate type and quantity of feminine hygiene products including tampons for their needs.
Res. 218, A-18

Tax Exemptions for Feminine Hygiene Products H-270.953
Our AMA supports legislation to remove all sales tax on feminine hygiene products.
Res. 215, A-16

Establishing Active Liaison with Schools and Colleges H-170.996
Our AMA encourages state and local societies to establish liaison relationships with schools to provide appropriate assistance in health education, particularly personal hygiene, substance misuse, smoking, sexually transmitted disease, quackery, and the role of the physician in maintaining good health.
Res. 72, A-71; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 210
(N-21)

Introduced by: Medical Student Section

Subject: Advocating for the Amendment of Chronic Nuisance Ordinances

Referred to: Reference Committee B

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1 Whereas, Chronic nuisance ordinances (CNOs) are municipal laws that aim to lower the crime
2 rate taking place on rental properties by penalizing property owners if repeated incidents of
3 nuisance activity occur over a set period of time (typically, 12 months)[1]; and
4
5 Whereas, CNOs are part of a phenomenon called "third-party policing," through which cities
6 require private citizens – in this case property owners – to address criminal or otherwise
7 undesirable behaviors[1]; and
8
9 Whereas, Punishments for violating CNOs may range from warning letters and fines to evictions
10 and building closures, and often involve a "nuisance point system" where a certain number of
11 accumulated points will result in eviction and other actions[1]; and
12
13 Whereas, What qualifies as nuisance activity can vary widely between municipalities, though
14 commonly defined as the amount of contact with emergency services, first responders, and
15 police, for criminal behavior that occurs on or near the property, or "alleged nuisance conduct"
16 (assault, harassment, stalking, disorderly conduct, city code violations, noise violations, and
17 others)[2]; and
18
19 Whereas, CNOs have been enacted by an estimated 2,000 municipalities across 44 states as of
20 2014 [3]; and
21
22 Whereas, Nuisance ordinances often apply even when a resident was the victim, and not the
23 source, of the nuisance activity[3,17]; and
24
25 Whereas, CNOs punish tenants who require police and emergency medical assistance by
26 making eviction a consequence of police responses to their homes[1]; and
27
28 Whereas, The reason for calling the police is not taken into account by most CNOs, so people
29 who experience mental health crises may be deemed perpetrators of nuisance activity for
30 seeking emergency medical assistance at a frequency beyond the threshold established in the
31 CNO and may be threatened with eviction by their landlords[1]; and
32
33 Whereas, Cities have fined group homes (organizations that provide community-based
34 residences for people with disabilities) after staff sought police or emergency services
35 assistance responding to their residents' medical emergencies[15]; and
36
37 Whereas, Health crises that can count as a CNO violation include drug overdoses: public
38 records from a sample of Northeast Ohio cities found that 10-40% of applications of CNOs are
39 related to a person experiencing a drug overdose, many of which explicitly include violations of
40 criminal drug abuse laws as nuisance[15]; and

Whereas, CNO nuisance behavior can include the aesthetic appearance of property, such as litter, an un-mowed lawn, or an "unsightly" yard, which can be applied against residents whose physical, mental, or health-related disabilities prevent them from meeting their municipality's maintenance standards[1]; and

Whereas, In June 2017, an appellate court struck down the Village of Groton's nuisance law as unconstitutional under the First Amendment, the reasoning being that it deterred tenants from seeking police assistance, and discouraged people, including domestic violence victims, from reaching out for help[4]; and

Whereas, Surveys of nuisance ordinance enforcement from across the country suggest that chronic nuisance ordinances disproportionately impact people of color[2]; and

Whereas, Between 2012 and 2018, the city of Rochester, NY issued nearly five times as many nuisance enforcement actions in the quarter of the city with the highest concentration of people of color as it did in the quarter with the lowest concentration of people of color[2]; and

Whereas, A lawsuit filed in August 2017 by a fair housing organization in Peoria, Illinois revealed that properties in predominantly black neighborhoods were more than twice as likely to be cited under the city's nuisance ordinance as white neighborhoods[5]; and

Whereas, A two-year study of Milwaukee, Wisconsin found that properties in predominantly black neighborhoods were over two and a half times as likely to receive a nuisance citation as properties in predominantly white neighborhoods, even when the neighborhoods made similar numbers of calls[6]; and

Whereas, Women with disabilities have a 40% greater chance of experiencing domestic violence than women without disabilities[8]; and

Whereas, There are an estimated 1.3 million women who are the victims of assault by an intimate partner annually, and women have a 25% lifetime risk of intimate partner violence[7]; and

Whereas, Congress acknowledges that "women and families across the country are being discriminated against, denied access to, and even evicted from public and subsidized housing because of their status as victims of domestic violence" [7]; and

Whereas, Domestic violence advocates' efforts in the past decades have been focused on educating law enforcement on how to approach and aid victims in escaping the cycle of domestic violence while maintaining their housing[3]; and

Whereas, This initiative is directly being threatened by CNOs, as calls about domestic disturbances can result in the eviction of everyone in the household[3,10-13]; and

Whereas, Nuisance ordinances frequently fail to make exceptions for police calls made by residents experiencing domestic violence even in cases where exceptions exist, calls placed by survivors of domestic violence are regularly miscategorized and the tenants are punished under the CNO regardless[9]; and

Whereas, Such punishment of domestic violence-related calls for police and medical services discourages victims of domestic violence from seeking help in future assaults[10]; and

Whereas, The use of CNOs may contribute to the “double victimization” of domestic violence victims, who may be evicted because of allegations of disturbing other tenants or property damage caused by their abusers, and thus are more likely to hide the abuse rather than seek help like emergency services[11]; and

Whereas, The data on whether CNOs are effective at accomplishing their goals of reducing nuisance activity is limited[6,9,12]; and

Whereas, Even though Cincinnati reported an overall 22% decrease in nuisance calls from 2006-2010, it is unknown whether this drop is due to underreporting or actual decreases in such behavior[12]; and

Whereas, Housing instability and eviction is associated with a higher risk of depression, anxiety, and even suicide[14,18]; and

Whereas, Individuals who lost legal rights to their housing and whose landlords applied for eviction proceedings were four times more likely to commit suicide (OR = 4.42) compared to individuals who had not experienced eviction[16]; and

Whereas, The disproportionate impact of CNOs on people of color, with disabilities, and/or victims of domestic violence limit the opportunities for these tenants to find affordable housing in the future, regardless of the circumstances in which they occurred[13]; therefore be it

RESOLVED, That our American Medical Association advocate for amendments to chronic nuisance ordinances that ensure calls made for safety or emergency services are not counted towards nuisance designations (Directive to Take Action); and be it further

RESOLVED, That our AMA support initiatives to: (a) gather data on chronic nuisance ordinance enforcement; and (b) make that data publicly available to enable easier identification of disparities. (New HOD Policy)

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

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

This resolution seeks to advocate for changes in procedure to Chronic Nuisance Ordinances (CNOs) and to support initiatives that increase the data available on CNOs. The COVID-19 pandemic has particularly highlighted the struggles many individuals face in regard to housing. Loss of housing has serious detrimental health effects. Vulnerable populations, like those with mental illness or substance use disorders and victims of domestic violence, are further particularly vulnerable to loss of housing due to eviction for CNOs.

Cities across 44 states in the US have enacted CNOs, which are municipal laws that penalize landowners and tenants when emergency services or law enforcement are called frequently to the premises. Importantly, CNOs in many municipalities do not distinguish between victims and perpetrators of nuisance activities. Numerous health crises can count as a CNO violation including drug overdoses, domestic or partner violence, and even mental health crises. As a consequence, tenants who require frequent police or emergency medical assistance may face threats of eviction and encounter discrimination when applying to housing. Thus, the enforcement of CNOs can penalize callers to the police and emergency services for assistance regardless of the situational context. CNOs are a serious detriment to our mission as physicians to “do no harm”. Our AMA should advocate for the amendment of CNOs to ensure that residents are not reprimanded in situations where they are victims.

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RELEVANT AMA POLICY

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.
Res. 401, A-15; Appended: Res. 416, A-18; Modified: BOT Rep. 11, A-18; Appended: BOT Rep. 16, A-19; Appended: BOT Rep. 28, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 211
(N-21)

Introduced by: Medical Student Section

Subject: Support for Mental Health Courts

Referred to: Reference Committee B

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1 Whereas, "Mental health courts" are correctional diversion and rehabilitation programs used by
2 state and local courts to support individuals with mental illness in the justice system[1-7]; and
3
4 Whereas, Mental health courts connect individuals with mental illness to mental health
5 treatment, as an alternative to incarceration or other legal sentences and penalties[1-7]; and
6
7 Whereas, Two pieces of federal Congressional legislation, the America's Law Enforcement and
8 Mental Health Project of 2000 and the Mentally Ill Offender Treatment and Crime Reduction Act
9 of 2004 (MIOTCRA), were enacted to improve the use of mental health personnel and
10 resources in the justice system and to establish grants to fund mental health court programs[8-9];
11 and
12
13 Whereas, The continued funding of MIOTCRA programs over the last two decades has been
14 dependent on Congressional appropriations[10]; and
15
16 Whereas, The US Substance Abuse and Mental Health Services Administration (SAMHSA) in
17 the Department of Health and Human Services and the US Bureau of Justice Assistance (BJA)
18 in the Department of Justice administer grants to fund state and local mental health courts[11,12];
19 and
20
21 Whereas, Research demonstrates that mental health courts appear to be associated with
22 reductions in recidivism, length of incarceration, severity of charges, risk of violence, and
23 rehospitalization among individuals with mental illness in the justice system[3,13-26]; and
24
25 Whereas, SAMHSA published a 2015 report noting that because "the vast majority of individuals
26 who come into contact with the criminal justice system appear" before municipal courts and
27 "many of these individuals have mental illness and co-occurring substance use disorders,"
28 municipal courts may be an especially effective "and often overlooked" method of diversion of
29 individuals with mental illness from the justice system[26]; and
30
31 Whereas, In addition to SAMHSA and BJA, several nonprofit advocacy organizations, including
32 Mental Health America, the National Alliance on Mental Illness, the Treatment Advocacy Center,
33 the National Sheriffs' Association, the Council on State Governments, and the National Center
34 for State Courts, support the use of mental health courts[2,27-32]; and
35
36 Whereas, While several hundred mental health courts exist across all 50 states, mental health
37 courts do not exist in all counties and localities, indicating that these programs may not be
38 accessible or available to all individuals who could benefit from them[4]; and

Whereas, Because mental health courts are dependent on participation from national, state, and local governmental agencies, justice systems, and mental health service organizations and on the appropriation of public funds, including federal monies for MIOTCRA programs and grants administered by SAMHSA and BJA[10-12], the AMA can play a role in advocating for the continued support and funding of mental health courts by policymakers; and

Whereas, Courts that connect individuals with mental illness to treatment as an alternative to incarceration exist under many different names, with each focused on different types of mental illness, including "mental health courts" (for mental illness in general), "drug courts" (for substance use disorders), and "sobriety" or "sober courts" (for alcohol use disorder and sometimes certain other substance use disorders)[32-35]; and AMA policy should be inclusive of all these different types; and

Whereas, Existing AMA Policy H-100.955 (passed at A-12) established support for drug courts, which are similar in function to mental health courts but narrower in scope, "for individuals with addictive disease who are convicted of nonviolent crimes"; and

Whereas, Existing AMA Policy H-510.979 (passed at I-19) established support for veteran courts, which are similar in function to mental health courts but narrower in scope, "for veterans who commit criminal offenses that may be related to a neurological or psychiatric disorder"; and

Whereas, At I-19, HOD Reference Committee B originally recommended amending Resolution 202 on veteran courts to limit their use to only nonviolent offenses, to be consistent with previous Policy H-100.955 on drug courts[36-37]; and

Whereas, At I-19, despite the Reference Committee B recommendation, Resolution 202 was extracted in our HOD to remove the restriction on only using veteran courts for nonviolent offenses, and our HOD ultimately passed Policy H-510.979 such that veteran courts could potentially be used for criminal offenses in general and not only for nonviolent offenses[36]; and

Whereas, To be consistent with our HOD's most recent debate on this matter, Policy H-100.955 on drug courts and any future AMA policy on alternatives to incarceration for individuals with mental illness should not be limited to only nonviolent offenses; therefore be it

RESOLVED, That American Medical Association Policy H-100.955, "Support for Drug Courts," be amended by addition and deletion to read as follows:

Support for Mental Health ~~Drug~~ Courts, H-100.955
Our AMA: (1) supports the establishment and use of mental health ~~drug~~ courts, including drug courts and sobriety courts, as an effective method of intervention for individuals with mental illness involved in the justice system within a comprehensive system of community-based services and supports ~~addictive disease who are convicted of nonviolent crimes~~; (2) encourages legislators to establish mental health ~~drug~~ courts at the state and local level in the United States; and (3) encourages mental health ~~drug~~ courts to rely upon evidence-based models of care for those who the judge or court determine would benefit from intervention rather than incarceration. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Half of all people incarcerated have mental illness, with 1 in 6 experiencing serious mental illness. Incarceration exacerbates mental illness, and deeply concerning racial inequities are also well documented. These problems are acutely urgent during this pandemic, as incarcerated populations have been at drastically higher risk of SARS-CoV-2 infection and of poor outcomes from COVID-19.

This resolution expands existing AMA policy supporting the use of drug courts to support more generalized mental health courts. This better advocates for patients at risk of incarceration with a range of mental illnesses beyond substance use disorders. These special diversion programs are comprised of physicians, judges, attorneys, and case managers with mental health expertise who offer treatment as an alternative to incarceration and other penalties. Too many of our patients with mental illness unjustly suffer the physical, mental, and social detriments of incarceration and punitive measures, when community-based treatment is often the more humane, effective, and feasible pathway to achieve true rehabilitation. Studies show that recidivism, violence, and hospitalization all decrease when mental health courts are used, improving both health and community outcomes better than incarceration.

Our AMA has been a force in advancing health equity. Mental illness is treatable and manageable, and no one should be incarcerated due to lack of diagnosis, inability to see a psychiatrist, or problems paying for or managing their medication. This resolution ensures that we are pursuing equity and preventing harm, all while increasing access to treatment for our patients and better strengthening and protecting our communities.

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RELEVANT AMA POLICY

Support for Drug Courts H-100.955
Our AMA: (1) supports the establishment of drug courts as an effective method of intervention for individuals with addictive disease who are convicted of nonviolent crimes; (2) encourages legislators to establish drug courts at the state and local level in the United States; and (3) encourages drug courts to rely upon evidence-based models of care for those who the judge or court determine would benefit from intervention rather than incarceration.
Res. 201, A-12; Appended: BOT Rep. 09, I-19

Support for Veterans Courts H-510.979
Our AMA supports the use of Veterans Courts as a method of intervention for veterans who commit criminal offenses that may be related to a neurological or psychiatric disorder.
Res. 202, I-19

Maintaining Mental Health Services by States H-345.975
Our AMA:
1. supports maintaining essential mental health services at the state level, to include maintaining state inpatient and outpatient mental hospitals, community mental health centers, addiction treatment centers, and other state-supported psychiatric services;
2. supports state responsibility to develop programs that rapidly identify and refer individuals with significant mental illness for treatment, to avoid repeated psychiatric hospitalizations and repeated interactions with the law, primarily as a result of untreated mental conditions;
3. supports increased funding for state Mobile Crisis Teams to locate and treat homeless individuals with mental illness;
4. supports enforcement of the Mental Health Parity Act at the federal and state level; and
5. will take these resolves into consideration when developing policy on essential benefit services.
Res. 116, A-12; Reaffirmation A-15

Support for Justice Reinvestment Initiatives, H-95.931
Our AMA supports justice reinvestment initiatives aimed at improving risk assessment tools for screening and assessing individuals for substance use disorders and mental health issues, expanding jail diversion and jail alternative programs, and increasing access to reentry and treatment programs.
Res. 205, A-16

Prevention of Impaired Driving H-30.936
Our AMA: (1) acknowledges that all alcohol consumption, even at low levels, has a negative impact on driver skills, perceptions, abilities, and performance and poses significant health and safety risks; (2) supports 0.04 percent blood-alcohol level as per se illegal for driving, and urges incorporation of that provision in all state drunk driving laws; and (3) supports 21 as the legal drinking age, strong penalties for providing alcohol to persons younger than 21, and stronger penalties for providing alcohol to drivers younger than 21.
Education: Our AMA: (1) favors public information and education against any drinking by drivers; (2) supports efforts to educate physicians, the public, and policy makers about this issue and urges national, state, and local medical associations and societies, together with public health, transportation safety, insurance, and alcohol beverage industry professionals to renew and strengthen their commitment to preventing alcohol-impaired driving; (3) encourages physicians to participate in educating patients and the public about the hazards of chemically impaired driving; (4) urges public education messages that now use the phrase "drunk driving," or make reference to the amount one might drink without fear of arrest, be replaced with messages that indicate that "all alcohol use, even at low levels, impairs driving performance and

poses significant health and safety risks;" (5) encourages state medical associations to participate in educational activities related to eliminating alcohol use by adolescents; and (6) supports and encourages programs in elementary, middle, and secondary schools, which provide information on the dangers of driving while under the influence of alcohol, and which emphasize that teenagers who drive should drink no alcoholic beverages whatsoever; and will continue to work with private and civic groups such as Mothers Against Drunk Driving (MADD) to achieve those goals.

Legislation: Our AMA: (1) supports the development of model legislation which would provide for school education programs to teach adolescents about the dangers of drinking and driving and which would mandate the following penalties when a driver under age 21 drives with any blood alcohol level (except for minimal blood alcohol levels, such as less than .02 percent, only from medications or religious practices): (a) for the first offense - mandatory revocation of the driver's license for one year and (b) for the second offense - mandatory revocation of the driver's license for two years or until age 21, whichever is greater; (2) urges state medical associations to seek enactment of the legislation in their legislatures; (3) urges all states to pass legislation mandating all drivers convicted of first and multiple DUI offenses be screened for alcoholism and provided with referral and treatment when indicated; (4) urges adoption by all states of legislation calling for administrative suspension or revocation of driver licenses after conviction for driving under the influence, and mandatory revocation after a specified number of repeat offenses; and (5) encourages passage of state traffic safety legislation that mandates screening for substance use disorder for all DUI offenders, with those who are identified with substance use disorder being strongly encouraged and assisted in obtaining treatment from qualified physicians and through state and medically certified facilities.

Treatment: Our AMA: (1) encourages that treatment of all convicted DUI offenders, when medically indicated, be mandated and provided but in the case of first-time DUI convictions, should not replace other sanctions which courts may levy in such a way as to remove from the record the occurrence of that offense; and (2) encourages that treatment of repeat DUI offenders, when medically indicated, be mandated and provided but should not replace other sanctions which courts may levy. In all cases where treatment is provided to a DUI offender, it is also recommended that appropriate adjunct services should be provided to or encouraged among the family members actively involved in the offender's life;

Repeat Offenders: Our AMA: (1) recommends the following measures be taken to reduce repeat DUI offenses: (a) aggressive measures be applied to first-time DUI offenders (e.g., license suspension and administrative license revocation), (b) stronger penalties be leveled against repeat offenders, including second-time offenders, (c) such legal sanctions must be linked, for all offenders, to substance abuse assessment and treatment services, to prevent future deaths in alcohol-related crashes and multiple DUI offenses; and (2) calls upon the states to coordinate law enforcement, court system, and motor vehicle departments to implement forceful and swift penalties for second-time DUI convictions to send the message that those who drink and drive might receive a second chance but not a third.

On-board devices: Our AMA: (1) supports further testing of on-board devices to prevent the use of motor vehicles by intoxicated drivers; this testing should take place among the general population of drivers, as well as among drivers having alcohol-related problems; (2) encourages motor vehicle manufacturers and the U.S. Department of Transportation to monitor the development of ignition interlock technology, and plan for use of such systems by the general population, when a consensus of informed persons and studies in the scientific literature indicate the systems are effective, acceptable, reasonable in cost, and safe; and (3) supports continued research and testing of devices which may incapacitate vehicles owned or operated by DUI offenders without needlessly penalizing the offender's family members.

CCB/CLRPD Rep. 3, A-14

Court-Initiated Medical Treatment in Criminal Cases, E-9.7.2
Court-initiated medical treatments raise important questions as to the rights of prisoners, the powers of judges, and the ethical obligations of physicians. Although convicted criminals have fewer rights and protections than other citizens, being convicted of a crime does not deprive an offender of all protections under the law. Court-ordered medical treatments raise the question whether professional ethics permits physicians to cooperate in administering and overseeing such treatment. Physicians have civic duties, but medical ethics do not require a physician to carry out civic duties that contradict fundamental principles of medical ethics, such as the duty to avoid doing harm.
In limited circumstances physicians can ethically participate in court-initiated medical treatments. Individual physicians who provide care under court order should:
(a) Participate only if the procedure being mandated is therapeutically efficacious and is therefore undoubtedly not a form of punishment or solely a mechanism of social control.
(b) Treat patients based on sound medical diagnoses, not court-defined behaviors. While a court has the authority to identify criminal behavior, a court does not have the ability to make a medical diagnosis or to determine the type of treatment that will be administered. When the treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, the physician's diagnosis must be confirmed by an independent physician or a panel of physicians not responsible to the state. A second opinion is not necessary in cases of court-ordered counseling or referrals for psychiatric evaluations.
(c) Decline to provide treatment that is not scientifically validated and consistent with nationally accepted guidelines for clinical practice.
(d) Be able to conclude, in good conscience and to the best of his or her professional judgment, that to the extent possible the patient voluntarily gave his or her informed consent, recognizing that an element of coercion that is inevitably present. When treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, an independent physician or a panel of physicians not responsible to the state should confirm that voluntary consent was given.
AMA Principles of Medical Ethics: I,III (Code of Medical Ethics Opinion, Issued: 2016

Decisions for Adult Patients Who Lack Capacity, E-2.1.2
Respect for patient autonomy is central to professional ethics and physicians should involve patients in health care decisions commensurate with the patient's decision-making capacity. Even when a medical condition or disorder impairs a patient's decision-making capacity, the patient may still be able to participate in some aspects of decision making. Physicians should engage patients whose capacity is impaired in decisions involving their own care to the greatest extent possible, including when the patient has previously designated a surrogate to make decisions on his or her behalf.
When a patient lacks decision-making capacity, the physician has an ethical responsibility to:
(a) Identify an appropriate surrogate to make decisions on the patient's behalf:
(i) the person the patient designated as surrogate through a durable power of attorney for health care or other mechanism; or
(ii) a family member or other intimate associate, in keeping with applicable law and policy if the patient has not previously designated a surrogate.
(b) Recognize that the patient's surrogate is entitled to the same respect as the patient.
(c) Provide advice, guidance, and support to the surrogate.
(d) Assist the surrogate to make decisions in keeping with the standard of substituted judgment, basing decisions on:
(i) the patient's preferences (if any) as expressed in an advance directive or as documented in the medical record;
(ii) the patient's views about life and how it should be lived;

(iii) how the patient constructed his or her life story; and
(iv) the patient's attitudes toward sickness, suffering, and certain medical procedures.
(e) Assist the surrogate to make decisions in keeping with the best interest standard when the patient's preferences and values are not known and cannot reasonably be inferred, such as when the patient has not previously expressed preferences or has never had decision-making capacity. Best interest decisions should be based on:
(i) the pain and suffering associated with the intervention;
(ii) the degree of and potential for benefit;
(iii) impairments that may result from the intervention;
(iv) quality of life as experienced by the patient.
(f) Consult an ethics committee or other institutional resource when:
(i) no surrogate is available or there is ongoing disagreement about who is the appropriate surrogate;
(ii) ongoing disagreement about a treatment decision cannot be resolved; or
(iii) the physician judges that the surrogate's decision:
a. is clearly not what the patient would have decided when the patient's preferences are known or can be inferred;
b. could not reasonably be judged to be in the patient's best interest; or
c. primarily serves the interests of the surrogate or other third party rather than the patient.
AMA Principles of Medical Ethics: I,III,VIII (Code of Medical Ethics Opinion, Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 212
(N-21)

Introduced by: Association for Clinical Oncology, American College of Rheumatology

Subject: Sequestration

Referred to: Reference Committee B

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1 Whereas, Current relief from application of the sequester to Medicare provided by Congress
2 during the still ongoing COVID-19 pandemic expires at the end of 2021.
3
4 Whereas, Additional threats to Medicare, including PAYGO, will create a perfect storm in
5 January 2022 as some practices face a total of 9.75% cuts to their Medicare reimbursement.
6
7 Whereas, Practices have not yet recovered from the financial strain of the COVID-19 pandemic.
8
9 RESOLVED, That our American Medical Association prioritize strong advocacy in opposition to
10 the application of sequestration to Medicare, including to drugs administered under Medicare
11 Part B. (Directive to Take Action)

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

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

Expiration of Medicare sequestration relief is fast approaching, with the 2 percent sequester set to take effect on January 1, 2022. With additional cuts, including PAYGO, commencing on the same date, some practices face a total of 9.75% cuts to their Medicare reimbursement. These upcoming cuts place an unreasonable burden on practices and severely impact patient access to care as many practices will struggle to keep their doors open. With the COVID-19 pandemic ongoing and practices still not recovered from the financial strain placed on them during the pandemic, it is essential that our AMA act before the end of the year and prioritize strong advocacy in opposition to the application of sequestration to Medicare, including to drugs administered under Medicare Part B.

RELEVANT AMA POLICY

Exempt Physician-Administered Drugs from Medicare Sequestration H-330.888
Our AMA supports passage of federal legislation 1) exempting payments for biologics and other drugs provided under Medicare Part B from sequestration cuts, and 2) reimbursing providers for reductions in payments for biologics and other drugs furnished under Medicare Part B on or after April 1, 2013.
Citation: (Res. 235, A-13; Reaffirmation A-15)

Sequestration Budget Cuts D-165.941
1. Our AMA will urge Congress to develop a fiscally responsible alternative that would prevent the automatic budget sequestration cuts that would endanger critical programs related to

medical research, public health, workforce, food and drug safety, and health care for uniformed service members, as well as trigger cuts in Medicare payments to graduate medical education programs, hospitals, and physicians that will endanger access to care and training of physicians.

2. Our AMA will take all necessary legislative and administrative steps to prevent extended or deeper sequester cuts in Medicare payments.

Citation: (Res. 215, I-12; Appended: Res. 222, A-15)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 213
(N-21)

Introduced by: Ohio

Subject: Eliminating Unfunded or Unproven Mandates and Regulations

Referred to: Reference Committee B

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1 Whereas, Beginning in 2020, Centers for Medicare and Medicaid Services (CMS) will be
2 demanding that “providers” utilize approved “technology” using practice guidelines when
3 ordering imaging studies; and
4
5 Whereas, Such guidelines represent an unfunded mandate for physicians already struggling
6 with massive governmental regulatory burden and underpayment; and
7
8 Whereas, These technologies or “Augmented Intelligence,” are limited in their ability to apply
9 clinical context, thus limiting a physician’s ability to order appropriate testing under unique
10 circumstances and stagnating their work-flow, placing patients at risk; and
11
12 Whereas, The technology required for this mandatory decision support is extremely expensive,
13 especially for smaller and independent physician practices; therefore be it
14
15 RESOLVED, That our American Medical Association advocate for policies that allow for
16 physician judgment and documented medical decision-making to supersede government
17 regulation--including the utilization of Augmented Intelligence--in instances of disputes in patient
18 care (Directive to Take Action); and be it further
19
20 RESOLVED, That our AMA advocate for policies that require “proof of concept,” in the form of
21 independently demonstrated quality improvement, prior to the implementation of any
22 government, insurance company or other third party mandate or regulation on patient care and
23 the physician-patient relationship (Directive to Take Action); and be it further
24
25 RESOLVED, That our AMA advocate for policies requiring government, insurance company or
26 other third party entities to fully fund any mandates or regulations imposed on patient care and
27 the physician-patient relationship. (Directive to Take Action)

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

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

This issue affects many physicians and/or their patients because this affects physicians that order advanced diagnostic imaging services and physicians, practitioners and facilities that furnish advanced diagnostic imaging services.
It is consistent with our mission and strategic plan

It is a time sensitive issue and the call for action is likely to have meaningful impact. The appropriate use criteria Program is set to be fully implemented on January 1, 2022. those ordering advanced diagnostic imaging will be required to consult a qualified Clinical Decision Support Mechanism (CDSM). CDSMs are electronic portals through which appropriate use criteria (AUC) is accessed. Claims that fail to append this information will not be paid.

Such programs must not be unproven or unfunded and that expectation must be clearly made NOW.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 214
(N-21)

Introduced by: American College of Rheumatology, American Academy of Allergy, Asthma & Immunology, American Academy of Dermatology, American Academy of Ophthalmology, American Society of Dermatopathology, Association for Clinical Oncology, Society for Investigative Dermatology

Subject: Stakeholder Engagement in Medicare Administrative Contractor Policy Processes

Referred to: Reference Committee B

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1 Whereas, Contractor Advisory Committees (CACs) and other stakeholders have played an
2 important role in review of policy changes put forth by Medicare Administrative Contractors
3 (MACs); and
4
5 Whereas, The Local Coverage Determination (LCD) process historically has considered
6 comment and input from a Contractor Advisory Committee, and, in most cases, LCDs require a
7 45-day comment period; and
8
9 Whereas, Our AMA has strong policy in support of robust MAC processes for transparency and
10 stakeholder engagement, including engagement of CACs, in reviewing Local Coverage
11 Determinations (LCDs), and in support of local Medicare CACs in their role as policy advisers;
12 and
13
14 Whereas, The 21st Century Cures Act included provisions intended to modernize and strengthen
15 the LCD review process and ensure transparency and stakeholder engagement in MACs'
16 decision making processes, and the Medicare Program Integrity Manual Chapter 13 finalized
17 requirements of the LCD modernization process; and
18
19 Whereas, The 21st Century Cures Act and related regulations demonstrate the intent of
20 Congress and CMS to ensure processes for meaningful stakeholder review and input for
21 substantive policy changes; and
22
23 Whereas, Some MACs have used Local Coverage Articles (LCAs) to unilaterally issue policy
24 changes that might have the effect of restricting coverage or access, without an attached,
25 supportive LCD, arguing they are only providing billing instructions, when in reality changes
26 could reasonably be expected to have the effect of restricting coverage. In most cases LCAs are
27 coupled with LCDs or a National Coverage Determination (NCD), and the LCA only provides
28 such additional coding/billing or other information as may be needed to implement the coverage
29 policy determined in the LCD or NCD; and
30
31 Whereas, MACs issuing changes in coverage policy through LCAs without issuing a proposed
32 LCD are circumventing the notice-and-comment period required of LCDs and other substantive
33 rulemaking, bypassing the stakeholder engagement and transparency in decision making that
34 was intended by Congress; and

Whereas, By issuing LCAs without associated LCDs these MACs are denying stakeholders a meaningful opportunity to review data and decision making criteria, and to provide feedback on proposed changes in coverage policy, and are bypassing consultation with healthcare professional experts and professional societies; and

Whereas, The evidentiary requirements of LCDs are not required in an LCA, and LCAs unilaterally issued without LCDs lack transparency and also do not allow stakeholders to review data or decision criteria, or to submit formal requests for reconsideration of the coverage policy; and

Whereas, These actions by MACs are counter to and not in the spirit of the transparency and increased stakeholder engagement and review intended by Congress in revising the LCD process by way of the 21st Century Cures Act, nor of CMS' improvements to the LCD process following stakeholder feedback to its Request for Information (RFI) in the CY 2018 Physician Fee Schedule; and

Whereas, The significant changes to LCD procedures stemming from the 21st Century Cures Act also allow MACs to change their engagement with traditional CACs, and CACs are no longer being engaged by MACs to function in their roles in reviewing and commenting on proposed policy changes and therefore no longer have a meaningful function; therefore be it

RESOLVED, That our American Medical Association oppose Medicare Administrative Contractors (MACs) issuing Local Coverage Articles (LCAs) that could have the effect of restricting coverage or access without providing data and evidentiary review or without issuing associated Local Coverage Determinations (LCDs) and following required stakeholder processes (New HOD Policy); and be it further

RESOLVED, That our AMA advocate and work with the Centers for Medicare and Medicaid Services (CMS) to ensure no LCAs that could have the effect of restricting coverage or access are issued by MACs without the MAC providing public data, decision criteria, and evidentiary review and allowing comment, or without an associated LCD and the required LCD stakeholder review and input processes, through the modernization requirement of the 21st Century Cures Act (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate to CMS that the agency immediately invalidate any LCAs that it identifies as potentially restricting coverage or access and that were issued without the MACs providing public data, decision criteria, and evidentiary review, or that were issued without an associated LCD and the required stakeholder processes, and that CMS require MACs to restart those processes taking any such proposed changes through LCDs and associated requirements for stakeholder engagement, public data, and evidentiary review (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that Congress consider clarifying legislative language that reinstates a role for local Contractor Advisory Committees in review processes going forward, addressing unintended outcomes of changes in 21st Century Cures Act that allowed local CACs to be left without a voice or purpose. (Directive to Take Action)

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

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

Recent reforms to Local Coverage Determination (LCD) processes used by Medicare Administrative Contractors (MACs) have increased transparency, clarity, and responsiveness to local clinical and coverage policy concerns. However, MACs are still able to utilize Local Coverage Articles (LCAs) to unilaterally issue policy changes that may have the effect of restricting coverage or access, arguing they are only providing billing instructions when instead the changes could reasonably be expected to have the effect of restricting coverage or access.

Unlike with LCDs, by relying on LCAs the MACs can make significant changes without any requirement that they provide data, scientific justification, or evidentiary review related to the decisions, any notice-and-comment period for stakeholder input, nor any opportunity for reconsideration.

One example is MACs' decisions to reimburse administration of certain highly complex biologics at Medicare's simple therapeutic administration rate, without having to provide stakeholders any scientific explanation of why only the simple therapeutic code is being allowed for those drugs and which decision criteria and data are being used by MACs, and providing no opportunity for reconsideration, despite evidence-based considerations showing how these drugs' high complexity and safety risks meet the definitions for reimbursement under the complex chemotherapy codes. These changes have significant repercussions for practices' ability to provide treatment access to patients.

Decisions like this are happening now without data or evidentiary review being provided and without reconsideration available to physicians. Urgent action is required to further reform these processes in order to protect physician practices and patient access to care.

RELEVANT AMA POLICY

Improving the Local Coverage Determination Process D-330.908

1. Our AMA will advocate through legislative and/or regulatory efforts as follows: A. When Medicare Administrative Contractors (MACs) propose new or revised Local Coverage Determinations (LCDs) said Contractors must: (1) Ensure that Carrier Advisory Committee meeting minutes are recorded and posted to the Contractor's website; and (2) Disclose the rationale for the LCD, including the evidence upon which it is based when releasing an approved LCD; B. That the Centers for Medicare and Medicaid Services adopt a new LCD reconsideration process that allows for an independent review of a MAC's payment policies by a third-party, with appropriate medical and specialty expertise, empowered to make recommendations to the Secretary of Health and Human Services that said policies should be withdrawn or revised; and C. That MACs shall be prohibited from adopting another MAC's LCD without first undertaking a full and independent review of the underlying science and necessity of such LCD in their jurisdiction.

2. Our AMA will work with interested state medical and national specialty societies to develop model legislation or regulations requiring commercial insurance companies, state Medicaid agencies, or third party payers to: A. Publish all edits that are to be used in their claims processing in a manner that is freely accessible and downloadable to physicians; and B. Participate in a transparent process that allows for review, challenge, and deletion of unfair edits.

Res. 807, I-15

Support for Maintaining the Medicare Carrier Advisory Committee and Carrier Medical Director D-330.974
Our AMA will: (1) continue its efforts in urging the Centers for Medicare and Medicaid Services (CMS) management to retain and support local Medicare Carrier Advisory Committees and Medical Directors in their role as policy advisers; and (2) urge the CMS to seek input from the AMA and all interested medical societies before proposing any further changes to the Medicare Carrier Advisory Committee (CAC) framework or to the roles and responsibilities of carrier medical directors.
Res. 121, I-01Reaffirmed: CMS Rep. 5, A-10Reaffirmed: CMS Rep. 01, A-20

Changes to the Medical Profession Resulting from Medicare Administrative Contracting Reforms H-390.851
1. Our AMA will review and monitor the impacts of Medicare Administrative Contracting reforms with periodic reports to the House of Delegates, to include at a minimum: (a) growth, nature and outcomes of actions against physicians by Payment Safeguard Contractors, Zone Program Integrity Contractors, and Recovery Audit Contractors; (b) changes in structure and/or function of Contractor Advisory Committees; and (c) changes in access to Medicare Administrative Contractor Medical Directors and other Medicare Administrative Contractor personnel.
2. All information gathered by our AMA regarding the impact of Medicare administrative contracting reforms will be shared in a timely manner with all state and national medical specialty societies.
Res. 710, I-07Modified: CMS Rep. 01, A-17

Uniformity of Operations of Medicare Administrative Contractors H-390.921
It is the policy of the AMA (1) to use its influence and resources to bring about uniformity of business policies and procedures among the Medicare Administrative Contractors, and (2) to investigate and monitor the differing policies and procedures among the Medicare Administrative Contractors with respect to physician reimbursement.
Res. 154, A-90Reaffirmed: Sunset Report, I-00Modified: CMS Rep. 6, A-10Reaffirmed: CMS Rep. 4, I-15

Medicare Part B Contractor Changes D-335.984
1. Our AMA will: (a) register a formal public complaint to the Centers for Medicare & Medicaid Services (CMS) about the need to accept physician input as part of future contract decisions; (b) ask CMS to require that the local Medicare Administrative Contractor and clearinghouse quickly rectify problems, including having more prompt and effective communication with providers; and (c) advocate for legislation or agency policy changes that provide additional resources to be allocated to the Centers for Medicare and Medicaid Services for the specific purpose of enhancing Part B contractor customer service and accountability in billing and enrollment matters.
2. If CMS and the local Medicare Administrative Contractor and clearinghouse fail to effectively address the problems physicians are facing, our AMA will notify elected officials and the public of these failures and the need for redress.
Res. 218, I-08Reaffirmed: CMS Rep. 01, A-18

Physician Input in MAC Contracting Process D-330.943
1. Our AMA will work with other interested members of the Federation to develop mechanisms with the Centers for Medicare and Medicaid Services that meaningful input from physicians and physician associations may be received and appropriately considered in the Medicare Administrative Contractor contracting processes, both those now underway and those in the future, including input on specific potential contract bidders.

2. Our AMA: (a) encourages the Federation to continue to report problems with Medicare Administrative Contractors (MACs), or other Medicare contractors, to the AMA; (b) will advocate that the Centers for Medicare and Medicaid Services (CMS) ensure that MACs are adequately staffed to handle enrollment, claims review, appeals and other functions in a timely and accurate manner; (c) will advocate that CMS increase training of MAC personnel to ensure they can respond efficiently and effectively to provider inquiries; (d) will advocate that CMS provide sufficient time between announcement and implementation of policy changes to allow contractors to thoroughly understand and adequately prepare to communicate with physicians and other providers about the changes; (e) will urge CMS to publish on its Web site the list of performance standards against which MACs are measured, and a report of each MAC's rating on those performance standards; (f) encourages state medical societies to educate their members regarding MAC performance standards, and to actively petition CMS regarding underperforming MACs; and (g) will advocate that the Centers for Medicare and Medicaid Services impose monetary penalties on MACs that fail to process and pay claims in a timely manner.
Res. 714, I-05Appended: CMS Rep. 5, A-10Reaffirmed: CMS Rep. 01, A-20

Review of Self-Administered Drug List Alterations Under Medicare Part B D-335.983
Our AMA will seek regulatory or legislative changes to require that any alterations to Self-Administered Drug lists made by Medicare Administrative Contractors shall be subject to Carrier Advisory Committee review and advisement.
Res. 811, I-13

Parity of Payment for Administering Biologic Medications H-330.883
Our AMA supports and encourages interested national medical specialty societies and other stakeholders to submit a request to Medicare for a national coverage determination directing Medicare Administrative Contractors to consider all biologics as complex injections or infusions.
CMS Rep. 4, I-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 215
(N-21)

Introduced by: American College of Rheumatology, Association for Clinical Oncology

Subject: Pharmacy Benefit Manager Reform as a State Legislative Priority

Referred to: Reference Committee B

Whereas, Pharmacy Benefit Managers (PBMs) are third-parties that are contracted by payers to create and manage drug formularies; and

Whereas, PBMs are middle men in the drug supply chain and act in a way that lacks transparency and can create perverse incentives that increase drug prices; and

Whereas, Our AMA has existing policy supporting the regulation of PBMs by state legislatures and insurance commissioners[i]; and

Whereas, Our AMA has not updated its Health Care Reform Objectives or the AMA Vision for Health System Reform to reflect this policy; and

Whereas, Our AMA has not placed PBM reform among its highest state legislative priorities; and

Whereas, The Supreme Court decision in Rutledge v. PCMA has given states greater authority to regulate the activities of PBMs; and

Whereas, It is imperative that states use this broadened authority to regulate abusive PBM practices, therefore be it

RESOLVED, That our American Medical Association make Pharmacy Benefit Manager (PBM) reform a state legislative priority (Directive to Take Action); and be it further

RESOLVED, That our AMA draft model PBM legislation or adopt model legislation from other organizations (Directive to Take Action); and be it further

RESOLVED, That our AMA actively advocate for the passage of PBM reform in state legislatures across the country (Directive to Take Action); and be it further

RESOLVED, That our AMA update its Health Care Reform Objectives and the AMA Vision for Health System Reform to reflect this priority change and the importance of effective PBM regulation. (Directive to Take Action)

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

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

Abusive pharmacy benefit manager (PBM) practices continue to plague both providers and patients. Over the last few years, we have seen the rate of state-level PBM reform slow. However, in light of the recent Supreme Court decision in Rutledge v. PCMA, states now have greater authority to regulate PBMs. It is imperative that states use this broadened authority to regulate abusive PBM practices.
During the pandemic we have seen more aggressive tactics by PBMs, with exclusionary formularies, mandatory drug switching, copay accumulator policies, and white bagging becoming more common. These policies pose dangers to patients and threaten the integrity of the provider/patient relationship. While PBM transparency will not solve these problems, it will provide policymakers and regulators with more insight into the motivations behind these policies.
Additionally, due to the ongoing COVID-19 pandemic, patients are more vulnerable than ever to the economic pressures associated with higher prescription drug prices. It is imperative that policymakers have the tools to analyze the role that PBMs play in increasing drug prices, particularly the perverse incentives created by the rebate system. It is imperative that our AMA leads on this issue to ensure that the interests of physicians are represented in future state-level PBM legislation.

RELEVANT AMA POLICY

The Impact of Pharmacy Benefit Managers on Patients and Physicians D-110.987
1. Our AMA supports the active regulation of pharmacy benefit managers (PBMs) under state departments of insurance.
2. Our AMA will develop model state legislation addressing the state regulation of PBMs, which shall include provisions to maximize the number of PBMs under state regulatory oversight.
3. Our AMA supports requiring the application of manufacturer rebates and pharmacy price concessions, including direct and indirect remuneration (DIR) fees, to drug prices at the point-of-sale.
4. Our AMA supports efforts to ensure that PBMs are subject to state and federal laws that prevent discrimination against patients, including those related to discriminatory benefit design and mental health and substance use disorder parity.
5. Our AMA supports improved transparency of PBM operations, including disclosing:
- Utilization information;
- Rebate and discount information;
- Financial incentive information;
- Pharmacy and therapeutics (P&T) committee information, including records describing why a medication is chosen for or removed in the P&T committee's formulary, whether P&T committee members have a financial or other conflict of interest, and decisions related to tiering, prior authorization and step therapy;
- Formulary information, specifically information as to whether certain drugs are preferred over others and patient cost-sharing responsibilities, made available to patients and to prescribers at the point-of-care in electronic health records;
- Methodology and sources utilized to determine drug classification and multiple source generic pricing; and
- Percentage of sole source contracts awarded annually.
6. Our AMA encourages increased transparency in how DIR fees are determined and calculated.
CMS Rep. 05, A-19; Reaffirmed: CMS Rep. 6, I-20

[i] American Medical Association Policy Finder: The Impact of Pharmacy Benefit Managers on Patients and Physicians D-110.987

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 216
(N-21)

Introduced by: Resident and Fellow Section

Subject: Preserving Appropriate Physician Supervision of Midlevel Providers and Ensuring Patient Awareness of the Qualifications of Physicians vs. Midlevel Providers

Referred to: Reference Committee B

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1 Whereas, Patients are often not explicitly informed when seeking medical care what the
2 qualifications are of the person treating them[1]; and
3
4 Whereas, Physicians are being forced or coerced into “supervising” midlevel providers either
5 directly or indirectly, by using it as a requirement for physician employment[1]; and
6
7 Whereas, Physicians are being asked to “supervise,” in name only, unreasonably high numbers
8 of midlevel providers opening them up to liability issues[1]; and
9
10 Whereas, There have been instances where physicians’ licenses have been used, unbeknownst
11 to the physician, to document “supervision” of midlevel providers and also instances where
12 midlevel providers do not even know the identity of their documented “supervising” physician[1];
13 and
14
15 Whereas, Midlevel providers/non-physicians have pushed for changes in legislation requiring
16 “supervision” by physicians be changed to “collaboration” with physicians in effort to equate their
17 training[1]; therefore be it
18
19 RESOLVED, That our American Medical Association reaffirm Policies H-160.947 and
20 H-160.950 (Reaffirm HOD Policy); and be it further
21
22 RESOLVED, That our AMA work with relevant regulatory agencies to ensure physicians are
23 notified in writing when their license is being used to “supervise” midlevel providers (Directive to
24 Take Action); and be it further
25
26 RESOLVED, That our AMA oppose mandatory physician supervision of midlevel providers as a
27 condition for physician employment and in physician employment contracts, especially when
28 physicians are not provided adequate resources and time for this responsibility (New HOD
29 Policy); and be it further
30
31 RESOLVED, That our AMA advocate for the right of physicians to deny “supervision” to any
32 midlevel provider whom they deem a danger to patient safety and the ability to report unsafe
33 care provided by mid-levels to the appropriate regulatory board with whistleblower protections
34 for physician employment. (Directive to Take Action)

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

Received: 10/21/12

AUTHORS STATEMENT OF PRIORITY

Physicians, as leaders of the health care team, are often called on to supervise other members, including midlevel providers. However, physicians should be notified explicitly when their license is being used to supervise midlevel providers, not be forced to do so as a condition of employment and be able to advocate for the safety of their patients by reporting midlevel providers who are deemed a danger to patients to the appropriate regulatory board.

References:
1. Al-Agba, Niran, and Rebekah Bernard. *Patients at Risk: the Rise of the Nurse Practitioner and Physician Assistant in Healthcare*. Universal-Publishers, Inc., 2020

RELEVANT AMA POLICY

Physician Assistants and Nurse Practitioners H-160.947

Our AMA will develop a plan to assist the state and local medical societies in identifying and lobbying against laws that allow advanced practice nurses to provide medical care without the supervision of a physician.
The suggested Guidelines for Physician/Physician Assistant Practice are adopted to read as follows (these guidelines shall be used in their entirety):
(1) The physician is responsible for managing the health care of patients in all settings.
(2) Health care services delivered by physicians and physician assistants must be within the scope of each practitioner's authorized practice, as defined by state law.
(3) The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients.
(4) The physician is responsible for the supervision of the physician assistant in all settings.
(5) The role of the physician assistant in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the physician assistant and based on the physician's delegatory style.
(6) The physician must be available for consultation with the physician assistant at all times, either in person or through telecommunication systems or other means.
(7) The extent of the involvement by the physician assistant in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the physician assistant, as adjudged by the physician.
(8) Patients should be made clearly aware at all times whether they are being cared for by a physician or a physician assistant.
(9) The physician and physician assistant together should review all delegated patient services on a regular basis, as well as the mutually agreed upon guidelines for practice.
(10) The physician is responsible for clarifying and familiarizing the physician assistant with his/her supervising methods and style of delegating patient care.
Citation: BOT Rep. 6, A-95; Reaffirmed: Res 240 and Reaffirmation A-00; Reaffirmed: Res. 213, A-02; Modified: CLRPD Rep. 1, A-03; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13

Guidelines for Integrated Practice of Physician and Nurse Practitioner H-160.950

Our AMA endorses the following guidelines and recommends that these guidelines be considered and quoted only in their entirety when referenced in any discussion of the roles and responsibilities of nurse practitioners: (1) The physician is responsible for the supervision of nurse practitioners and other advanced practice nurses in all settings.
(2) The physician is responsible for managing the health care of patients in all practice settings.
(3) Health care services delivered in an integrated practice must be within the scope of each

practitioner's professional license, as defined by state law.
(4) In an integrated practice with a nurse practitioner, the physician is responsible for supervising and coordinating care and, with the appropriate input of the nurse practitioner, ensuring the quality of health care provided to patients.
(5) The extent of involvement by the nurse practitioner in initial assessment, and implementation of treatment will depend on the complexity and acuity of the patients' condition, as determined by the supervising/collaborating physician.
(6) The role of the nurse practitioner in the delivery of care in an integrated practice should be defined through mutually agreed upon written practice protocols, job descriptions, and written contracts.
(7) These practice protocols should delineate the appropriate involvement of the two professionals in the care of patients, based on the complexity and acuity of the patients' condition.
(8) At least one physician in the integrated practice must be immediately available at all times for supervision and consultation when needed by the nurse practitioner.
(9) Patients are to be made clearly aware at all times whether they are being cared for by a physician or a nurse practitioner.
(10) In an integrated practice, there should be a professional and courteous relationship between physician and nurse practitioner, with mutual acknowledgment of, and respect for each other's contributions to patient care.
(11) Physicians and nurse practitioners should review and document, on a regular basis, the care of all patients with whom the nurse practitioner is involved. Physicians and nurse practitioners must work closely enough together to become fully conversant with each other's practice patterns.
Citation: (CMS Rep. 15 - I-94; BOT Rep. 6, A-95; Reaffirmed: Res. 240, A-00; Reaffirmation A-00; Reaffirmed: BOT Rep. 28, A-09; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 217
(N-21)

Introduced by: Resident and Fellow Section

Subject: Studying Physician Supervision of Allied Health Professionals Outside of Their Fields of Graduate Medical Education

Referred to: Reference Committee B

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1 Whereas, Advanced practice providers and allied health professionals are required under the
2 laws of many states to be supervised to some degree by a physician; and
3
4 Whereas, News reports and articles note instances of thoracic surgeons and obstetrician/
5 gynecologists supervising social workers in the provision of group therapy[1] and plastic surgeons
6 supervising physician assistants who advertise themselves as "dermatologists"[2]; and
7
8 Whereas, Widely known anecdotal evidence suggests numerous advanced practice providers
9 practicing in various fields while being nominally supervised by physicians not trained in those
10 fields; and
11
12 Whereas, Physicians without appropriate training supervising advanced practice providers
13 outside of their expertise defeats the purpose of scope-of-practice laws and endangers patients;
14 therefore be it
15
16 RESOLVED, That our American Medical Association conduct a systematic study to collect and
17 analyze publicly available physician supervision data from all sources to determine how many
18 allied health professionals are being supervised by physicians in field which are not a core part
19 of those physicians' completed residencies and fellowships. (Directive to Take Action)

Fiscal Note: Estimated cost of $100,000 to implement resolution.

Received: 10/12/21

AUTHORS STATEMENT OF PRIORITY

As allied health providers have gained temporary independence and increased credit for their work during the pandemic, proactive AMA attention and adequate data regarding supervision is needed to ensure that the supervision we are advocating for is indeed being provided and being done so for the specialty and procedures the physician is qualified to perform and oversee. The results of this study will be able to better inform our advocacy efforts and identify areas where our advocacy is not aligning with the standards we are holding ourselves to and will identify if we need to better regulate ourselves.

References:
1. Ornstein C and ProPublica. Illinois leads Medicare billings for group therapy. Chicago Tribune. 13 Jul 2014. https://www.chicagotribune.com/lifestyles/health/ct-medicare-group-therapy-met-20140713-story.html. Accessed 18 Sep 2019.
2. Al-agba N. The P.A. Problem: Who You See and What You Get. The Healthcare Blog. 24 Nov 2017. https://thehealthcareblog.com/blog/2017/11/24/the-p-a-problem/. Accessed 18 Sep 2019.

RELEVANT AMA POLICY

Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice H-360.987

Our AMA endorses the following principles: (1) Physicians must retain authority for patient care in any team care arrangement, e.g., integrated practice, to assure patient safety and quality of care. (2) Medical societies should work with legislatures and licensing boards to prevent dilution of the authority of physicians to lead the health care team. (3) Exercising independent medical judgment to select the drug of choice must continue to be the responsibility only of physicians. (4) Physicians should recognize physician assistants and advanced practice nurses under physician leadership, as effective physician extenders and valued members of the health care team. (5) Physicians should encourage state medical and nursing boards to explore the feasibility of working together to coordinate their regulatory initiatives and activities. (6) Physicians must be responsible and have authority for initiating and implementing quality control programs for nonphysicians delivering medical care in integrated practices.
Citation: BOT Rep. 23, A-96; Reaffirmation A-99; Reaffirmed: Res. 240, and Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: BOT Rep. 9, I-11; Reaffirmation A-12; Reaffirmed: BOT Rep. 16, A-13

Practice Agreements Between Physicians and Advance Practice Nurses and the Physician to Advance Practice Nurse Supervisory Ratio H-35.969

Our AMA will: (1) continue to work with the Federation in developing necessary state advocacy resource tools to assist the Federation in: (a) addressing the development of practice agreements between practicing physicians and advance practice nurses, and (b) responding to or developing state legislation or regulations governing these practice agreements, and that the AMA make these tools available on the AMA Advocacy Resource Center Web site; and (2) support the development of methodologically valid research comparing physician-APRN practice agreements and their respective effectiveness.
Citation: BOT Rep. 28, A-09; Reaffirmed: BOT Rep. 09, A-19

Physician Assistants and Nurse Practitioners H-160.947

Our AMA will develop a plan to assist the state and local medical societies in identifying and lobbying against laws that allow advanced practice nurses to provide medical care without the supervision of a physician. The suggested Guidelines for Physician/Physician Assistant Practice are adopted to read as follows (these guidelines shall be used in their entirety):
(1) The physician is responsible for managing the health care of patients in all settings.
(2) Health care services delivered by physicians and physician assistants must be within the scope of each practitioner's authorized practice, as defined by state law.
(3) The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients.
(4) The physician is responsible for the supervision of the physician assistant in all settings.
(5) The role of the physician assistant in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the physician assistant and based on the physician's delegatory style.
(6) The physician must be available for consultation with the physician assistant at all times, either in person or through telecommunication systems or other means.

(7) The extent of the involvement by the physician assistant in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the physician assistant, as adjudged by the physician.
(8) Patients should be made clearly aware at all times whether they are being cared for by a physician or a physician assistant.
(9) The physician and physician assistant together should review all delegated patient services on a regular basis, as well as the mutually agreed upon guidelines for practice.
(10) The physician is responsible for clarifying and familiarizing the physician assistant with his/her supervising methods and style of delegating patient care.
Citation: BOT Rep. 6, A-95; Reaffirmed: Res 240 and Reaffirmation A-00; Reaffirmed: Res. 213, A-02; Modified: CLRPD Rep. 1, A-03; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13

Regulation of Advanced Practice Nurses H-35.964
1. AMA policy is that advanced practice registered nurses (APRNs) should be subject to the jurisdiction of state medical licensing and regulatory boards for regulation of their performance of medical acts.
2. Our AMA will develop model legislation to create a joint regulatory board composed of members of boards of medicine and nursing, with authority over APRNs.
Citation: BOT Action in response to referred for decision Amendment B-3 to Res. 233 A-17

Guidelines for Integrated Practice of Physician and Nurse Practitioner H-160.950
Our AMA endorses the following guidelines and recommends that these guidelines be considered and quoted only in their entirety when referenced in any discussion of the roles and responsibilities of nurse practitioners: (1) The physician is responsible for the supervision of nurse practitioners and other advanced practice nurses in all settings.
(2) The physician is responsible for managing the health care of patients in all practice settings.
(3) Health care services delivered in an integrated practice must be within the scope of each practitioner's professional license, as defined by state law.
(4) In an integrated practice with a nurse practitioner, the physician is responsible for supervising and coordinating care and, with the appropriate input of the nurse practitioner, ensuring the quality of health care provided to patients.
(5) The extent of involvement by the nurse practitioner in initial assessment, and implementation of treatment will depend on the complexity and acuity of the patients' condition, as determined by the supervising/collaborating physician.
(6) The role of the nurse practitioner in the delivery of care in an integrated practice should be defined through mutually agreed upon written practice protocols, job descriptions, and written contracts.
(7) These practice protocols should delineate the appropriate involvement of the two professionals in the care of patients, based on the complexity and acuity of the patients' condition.
(8) At least one physician in the integrated practice must be immediately available at all times for supervision and consultation when needed by the nurse practitioner.
(9) Patients are to be made clearly aware at all times whether they are being cared for by a physician or a nurse practitioner.
(10) In an integrated practice, there should be a professional and courteous relationship between physician and nurse practitioner, with mutual acknowledgment of, and respect for each other's contributions to patient care.
(11) Physicians and nurse practitioners should review and document, on a regular basis, the care of all patients with whom the nurse practitioner is involved. Physicians and nurse

practitioners must work closely enough together to become fully conversant with each other's practice patterns.
Citation: CMS Rep. 15 - I-94; BOT Rep. 6, A-95; Reaffirmed: Res. 240, A-00; Reaffirmation A-00; Reaffirmed: BOT Rep. 28, A-09; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13

Health Workforce H-200.994
The AMA endorses the following principle on health manpower: Both physicians and allied health professionals have legal and ethical responsibilities for patient care, even though ultimate responsibility for the individual patient's medical care rests with the physician. To assure quality patient care, the medical profession and allied health professionals should have continuing dialogue on patient care functions that may be delegated to allied health professionals consistent with their education, experience and competency. Citation: (BOT Rep. C, I-81; Reaffirmed: Sunset Report, I-98; Modified: CME Rep. 2, I-03; Reaffirmed: CME Rep. 2, A-13)

Health Care Quality Improvement Act of 1986 Amendments H-275.965
The AMA supports modification of the federal Health Care Quality Improvement Act in order to provide immunity from federal antitrust liability to those medical staffs credentialing and conducting good faith peer review for allied health professionals to the same extent that immunity applies to credentialing of physicians and dentists.
Citation: (Res. 203, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation A-05; Reaffirmed: BOT Rep. 10, A-15)The AMA supports modification of the federal Health Care Quality Improvement Act in order to provide immunity from federal antitrust liability to those medical staffs credentialing and conducting good faith peer review for allied health professionals to the same extent that immunity applies to credentialing of physicians and dentists. Citation: (Res. 203, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation A-05; Reaffirmed: BOT Rep. 10, A-15)

Protecting Physician Led Health Care H-35.966
Our American Medical Association will continue to work with state and specialty medical associations and other organizations to collect, analyze and disseminate data on the expanded use of allied health professionals, and of the impact of this practice on healthcare access (including in poor, underserved, and rural communities), quality, and cost in those states that permit independent practice of allied health professionals as compared to those that do not. This analysis should include consideration of practitioner settings and patient risk-adjustment. Citation: Res. 238, A-15; Reaffirmed: BOT Rep. 20, A-17

Education Programs Offered to, for or by Allied Health Professionals Associated with a Hospital H-35.978
The AMA encourages hospital medical staffs to have a process whereby physicians will have input to and provide review of education programs provided by their hospital for the benefit of allied health professionals working in that hospital, for the education of patients served by that hospital, and for outpatient educational programs provided by that hospital. Citation: (BOT Rep. B, A-93; Adopts Res. 317, A-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 218
(N-21)

Introduced by: Resident and Fellow Section

Subject: Physician Opposition to the Coordinated Effort by Corporations and Midlevel Providers to Undermine the Physician-Patient Relationship and Safe Quality Care

Referred to: Reference Committee B

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1 Whereas, The book *Patients at Risk: The Rise of the Nurse Practitioner and Physician Assistant*
2 *in Healthcare* by Niran Al-Agba, MD and Rebekah Bernard, MD published in 2020, seeks to
3 educate patients about the safety of the providers treating them and empower physicians to
4 regain control of the practice of medicine[1]; and
5
6 Whereas, The corporatization of medicine, at the expense of quality, safe healthcare, has led to
7 physicians being fired and replaced by midlevel providers, especially in states with legislatively
8 awarded independent practice for midlevel providers[1]; and
9
10 Whereas, The corporate practice of medicine has created a situation in which physicians are
11 expected to "train their replacements"; and
12
13 Whereas, Post-graduate programs for midlevel providers expand while physician post-graduate
14 training programs stay stagnant or close[1]; therefore be it
15
16 RESOLVED, That our American Medical Association study the impact that individual physician
17 scope of practice advocacy has had on physician employment and contract terminations
18 (Directive to Take Action); and be it further
19
20 RESOLVED, That our AMA study the views of patients on physician and non-physician care to
21 identify best practices in educating the general population on the value of physician-led care
22 (Directive to Take Action); and be it further
23
24 RESOLVED, That our AMA study the utility of a physician-reported database to track and report
25 institutions that replace physicians with midlevel providers in order to aid patients in seeking
26 physician-led medical care as opposed to care by midlevel providers practicing without
27 physician supervision. (Directive to Take Action)

Fiscal Note: Estimated cost of $250,000 to implement resolution.

Received: 10/12/21

AUTHORS STATEMENT OF PRIORITY

This policy is lower priority, but is important to resident and fellow training, especially in assessing the conflicts that may exist between for-profit corporations and providing adequate and appropriate training for trainees.

References:
1. Al-Agba, Niran, and Rebekah Bernard. *Patients at Risk: the Rise of the Nurse Practitioner and Physician Assistant in Healthcare*. Universal-Publishers, Inc., 2020

RELEVANT AMA POLICY

Practicing Medicine by Non-Physicians H-160.949

Our AMA: (1) urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional pattern of practice in which the physician directs and supervises the care given;
(2) continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers;
(3) continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;
(4) continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;
(5) through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine; and
(6) opposes special licensing pathways for physicians who are not currently enrolled in an Accreditation Council for Graduate Medical Education of American Osteopathic Association training program, or have not completed at least one year of accredited post-graduate US medical education.
Citation: Res. 317, I-94Modified by Res. 501, A-97Appended: Res. 321, I-98Reaffirmation A-99Appended: Res. 240, Reaffirmed: Res. 708 and Reaffirmation A-00Reaffirmed: CME Rep. 1, I-00Reaffirmed: CMS Rep. 6, A-10Reaffirmed: Res. 208, I-10Reaffirmed: Res. 224, A-11Reaffirmed: BOT Rep. 9, I-11Reaffirmed: Res. 107, A-14Appended: Res. 324, A-14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 219
(N-21)

Introduced by: Resident and Fellow Section

Subject: The Impact of Midlevel Providers on Medical Education

Referred to: Reference Committee B

Whereas, A survey in 2017 published in Worldviews Evidence Based Nursing revealed that a majority of the 2,300 nurse respondents did not feel competent in evidence-based practice[1]; and

Whereas, Physicians that speak out about the differences in training received by physicians vs. by mid-level providers are being fired, labeled “disrespectful” or labeled “not team players” in the interdisciplinary team treating patients[1]; and

Whereas, More non-physician post-graduate training programs are being formed across the nation; there is still no mandatory requirement for non-physicians to pursue post-graduate training[1]; and

Whereas, Physicians are expected to continue to maintain certification by proving they continue to educate themselves; mid-level providers are not held to the same standard[1]; and

Whereas, Currently mid-levels providers can switch between specialties and subspecialties of medicine and surgery without any formal or regulated training or education[1]; and

Whereas, Physicians are limited in their practice abilities by the post-graduate training they receive[1]; therefore be it

RESOLVED, That our American Medical Association study, using surveys among other tools that protect identities, how commonly bias against physician-led healthcare is experienced within undergraduate medical education and graduate medical education, interprofessional learning and team building work and publish these findings in peer-reviewed journals (Directive to Take Action); and be it further

RESOLVED, That our AMA work with the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to ensure all physician undergraduate and graduate training programs recognize and teach physicians that they are the leaders of the healthcare team and are adequately equipped to diagnose and treat patients independently only because of the intensive, regulated, and standardized education they receive (Directive to Take Action); and be it further

RESOLVED, That our AMA study the harms and benefits of establishing mandatory postgraduate clinical training for nurse practitioners and physician assistants prior to working within a specialty or subspecialty field (Directive to Take Action); and be it further

RESOLVED, That our AMA study the harms and benefits of establishing national requirements for structured and regulated continued education for nurse practitioners and physician assistants in order to maintain licensure to practice. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 10/12/21

AUTHORS STATEMENT OF PRIORITY

This policy is lower priority. As leaders of the health care team, physicians work with many different individuals as part of their clinical duties, including midlevel providers (NPs, PAs, etc.). However, these providers do not necessarily require postgraduate training in the specialty area they are working, and do not require any training before changing specialties. Study of this area, as well as the effects this has on medical trainees, is warranted by our AMA.

References:

1. Al-Agba, Niran, and Rebekah Bernard. *Patients at Risk: the Rise of the Nurse Practitioner and Physician Assistant in Healthcare*. Universal-Publishers, Inc., 2020.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 220
(N-21)

Introduced by: Resident and Fellow Section

Subject: Gonad Shields: Regulatory and Legislation Advocacy to Oppose Routine Use

Referred to: Reference Committee B

Whereas, Led by the Society of Pediatric Radiology (SPR), the Image Gently Alliance was formed in late 2006 with the goal of “changing practice by raising awareness of the opportunities to lower radiation dose in the imaging of children” (1); and

Whereas, The SPR recruited other organizations/members of the imaging team into the alliance in 2007 including the American College of Radiology (ACR), American Association of Physicists in Medicine (AAPM), and American Society of Radiologic Technologists (ASRT) (1); and

Whereas, The practice of shielding reproductive organs and in utero fetuses began in the 1950s given concerns about the long-term effects of radiation and the potential for passing on genetic mutations through genetic inheritance (2,3); and

Whereas, In response to these concerns, state and federal laws and regulations have been created requiring the use of gonad shields in medical imaging studies (4,5); and

Whereas, Through technological advances, medical physicists estimate the dose from routine diagnostic imaging to reproductive organs has been reduced by 95% without compromising diagnostic quality (2,3); and

Whereas, Technological advances and optimization have resulted in marginal hereditary risk reduction from gonad shielding ranging from 1x10-6 in women and 5x10-6 in men (6); and

Whereas, Research on radiation dosing has shown that routine diagnostic imaging does not produce harmful levels of radiation to patients and fetuses (2,3); and

Whereas, Modern mechanisms to optimize imaging parameters such as automatic exposure control (AEC) are negatively affected by shielding (7); and

Whereas, The gonad shield results in decreased activity on the detector, triggering AEC to increase radiation output, which results in increased exposure and patient dose along with the degradation of image quality (7); and

Whereas, The gonad shield produces artifacts and can obscure relevant anatomy and diagnostic information (7); and

Whereas, Non-diagnostic or obscured images may need to be repeated increasing patient dose when shields are used (7); and

Whereas, The gonad surface shield is ineffective at reducing internal scatter (7); and

Whereas, Studies have shown that gonad shields are incorrectly placed for females in 91% of radiographs and for males in 66% of radiographs, rendering them ineffective (8,9); and

Whereas, On January 12th, 2021 the National Council on Radiation Protection and Measurements (NCRP) issued a statement that the risks of utilizing gonad shields far outweigh the negligible benefits to reproductive organs and therefore they should not be routinely used (10); and

Whereas, Similar statements opposing routine or mandatory use of gonadal shields were released by the ACR and the AAPM in 2019 and by the ASRT in 2021 (11,12); therefore be it

RESOLVED, That our American Medical Association oppose mandatory use of gonad shields in medical imaging considering the risks far outweigh the benefits (New HOD Policy); and be it further

RESOLVED, That our AMA advocate that the U.S. Food and Drug Administration amend the code of federal regulations to oppose the routine use of gonad shields in medical imaging (Directive to Take Action); and be it further

RESOLVED, That our AMA, in conjunction with state medical societies, support model state and national legislation to oppose or repeal mandatory use of gonad shields in medical imaging. (New HOD Policy)

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

Received: 10/12/21

AUTHORS STATEMENT OF PRIORITY

This policy is lower priority. It will help the AMA to advocate for evidence-based medicine, and specifically work to decrease harms for our patients while allowing physicians to provide better care.

References

1. https://www.imagegently.org/About-Us/Campaign-Overview
2. https://www.aappublications.org/news/2020/03/31/xrayshields040120
3. https://www.radiologyinfo.org/en/info.cfm?pg=safety-patient-shielding
4. https://www.ecfr.gov/cgi-bin/text-idx?SID=c6fd98dfc8955d41420798f3e5357c66&mc=true&node=se21.8.1000_150&rgn=div8
5. https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfcfr/CFRSearch.cfm?fr=1000.50
6. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7005227/
7. https://www.aapm.org/org/policies/details.asp?id=468&type=PP&current=true
8. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3292647/
9. https://pubmed.ncbi.nlm.nih.gov/28437549/
10. https://ncrponline.org/wp-content/themes/ncrp/PDFs/Statement13.pdf
11. https://www.acr.org/Advocacy-and-Economics/Advocacy-News/Advocacy-News-Issues/In-the-June-8-2019-Issue/ACR-Endorses-AAPM-Position-on-Patient-Gonadal-and-Fetal-Shielding
12. https://www.asrt.org/main/news-publications/news/article/2021/01/12/asrt-statement-on-fetal-and-gonadal-shielding

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 221
(N-21)

Introduced by: Texas

Subject: Promoting Sustainability in Medicare Physician Payments

Referred to: Reference Committee B

Whereas, On Jan. 1, 2022, under current law, Medicare participating physicians will receive a 9.75% payment cut because of the expiration of the current reprieve from the 2% sequester stemming from the Budget Control Act of 2011, imposition of a 4% statutory PAYGO sequester resulting from passage of the American Rescue Plan Act of 2021, expiration of the congressionally enacted 3.75% temporary increase in the Medicare Physician Fee Schedule (MPFS) conversion factor, and a continuing statutory freeze in annual MPFS updates under the Medicare Access and CHIP Reauthorization Act (MACRA) that is scheduled to last until 2026; and

Whereas, Adjusted for inflation in practice costs, Medicare physician payment declined 22% from 2001 to 2020, or by 1.3% per year on average; and

Whereas, Medicare physician payments have remained restricted by a budget-neutral financing system in which the Centers for Medicare & Medicaid Services routinely overestimates the utilization and volume of new services, yet budget neutrality adjustments are permanently established in the fee schedule; and

Whereas, Physician and nonphysician practitioner services represent a modest portion of the overall growth in health care costs; and

Whereas, Potential penalties under the Merit-Based Incentive Payment System (MIPS), which apply to MPFS services, will increase to 9% in 2022; and

Whereas, The alternative payment model pathway for physicians under MACRA has yet to be realized, leaving the majority of practices stuck in the MIPS portion of the MACRA program; and

Whereas, Medicare patients suffer as physicians adjust to unpredictable and excessive reductions to payment that inhibit their ability to ensure beneficiaries have access to the care they need; and

Whereas, physician practices are amid the COVID-19 public health emergency, requiring continued infection control protocols that, while necessary, have increased the costs of providing care; therefore be it

RESOLVED, That our American Medical Association continue to advocate for legislation that prevents Medicare cuts from taking place prior to Jan. 1, 2022 (Directive to Take Action); and be it further

RESOLVED, That our AMA seek annual and full Medicare Economic Index updates for Medicare Part B physician payments (Directive to Take Action); and be it further

1 RESOLVED, That our AMA seek legislation that provides only for positive performance
2 incentives (Directive to Take Action); and be it further
3
4 RESOLVED, That our AMA advocate for payment policies that allow the Centers for Medicare &
5 Medicaid Services to retroactively adjust overestimates of volume of services by instituting a
6 three-year look-back period to correct Medicare conversion factor estimations. (Directive to
7 Take Action)

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

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

The 9.75 cut in Medicare physician payments scheduled to occur in 2022 impacts all physician specialties and their patients. The reduced Medicare payments are exacerbated by already low Medicare payment for physician services. Congress must immediately address the forecasted cut before the end of the year. Otherwise, patients may experience a reduced ability to access care as physicians are unable to sustain their practices.
There is an urgent need to address Medicare physician payment stability, and this fits squarely within AMA's mission and strategic plan.
While AMA does have policy on averting Medicare physician payment cuts, this resolution expands upon it by calling for:

- Annual and full MEI updates;
- legislation that provides only for positive performance incentives; and
- CMS to retroactively adjust overestimates of volume of services by instituting a three-year look-back period to correct Medicare conversion factor estimations.

Action by the AMA will have a positive impact on all physician specialties and the AMA is the most appropriate Association to tackle this issue.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 222
(N-21)

Introduced by: Texas

Subject: Opposing Federal Preemption of State Licensing Laws and Scope-of-Practice Expansion Under the Ninth Amendment to Declaration Under the PREP Act

Referred to: Reference Committee B

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1 Whereas, On March 17, 2020, the Secretary of the U.S. Department of Health and Human
2 Services declared a public health emergency caused by COVID-19; and
3
4 Whereas, This action triggered the Secretary's authority to issue certain directives relating to
5 public health under the Public Readiness and Emergency Preparedness Act (PREP Act), 42
6 U.S.C. §247d-6d; and
7
8 Whereas, The PREP Act gives broad immunity to certain covered persons from lawsuits and
9 liability under federal and state law in regard to claims for loss caused by, arising out of, relating
10 to, or resulting from the administration to or use by an individual of a covered countermeasure to
11 diseases, threats and conditions, except in the case of willful misconduct; and
12
13 Whereas, Effective Sept. 9, 2021, the secretary released the Ninth Amendment to Declaration
14 Under the Public Readiness and Emergency Preparedness Act for Medical Countermeasures
15 Against COVID-19, (herein after referred to as "the declaration"), expanding liability protection
16 and authority for certain covered persons authorized to prescribe, dispense, and administer
17 COVID-19 therapeutics that are covered countermeasures under section IV of the declaration;
18 and
19
20 Whereas, The declaration specifically expands the scope of authority for state-licensed
21 pharmacists to order and administer, and certain pharmacy technicians and pharmacy interns to
22 administer, COVID-19 therapeutics subcutaneously, intramuscularly, or orally as authorized,
23 approved, or licensed by the U.S. Food and Drug Administration; and
24
25 Whereas, The declaration states that it preempts state law that would otherwise prohibit these
26 individuals from independently prescribing, dispensing, or administering COVID-19 therapeutics
27 or other covered countermeasures; and
28
29 Whereas, It is a longstanding principle in the U.S. that the practice of medicine is regulated by
30 the state and that states determine and enforce the scope of practice for physicians and health
31 care providers practicing in their respective states; and
32
33 Whereas, State scope-of-practice laws serve an important role in protecting public health,
34 including safeguarding patients from improper care provided by individuals acting outside the
35 scope of their practice under state licensure, which is based on education, training, and
36 experience requirements that vary significantly by licensure type as well as by each state for the
37 same type of licensure; and

Whereas, Many states uphold physician-led, team-based care with proper physician delegation and supervision of medical acts performed by nonphysicians to protect patient safety; and

Whereas, The declaration places public health in jeopardy by attempting to override these state guardrails and protocols meant to protect against such variables in physician and health care provider education, training, and experience; and

Whereas, The declaration threatens to erode physician-led, team-based care and interfere with continuity of care in the patient's primary medical home; and

Whereas, For more than 30 years, the American Medical Association's state and federal advocacy has safeguarded the practice of medicine by opposing attempts to inappropriately expand nonphysicians' scope of practice; therefore be it

RESOLVED, That our American Medical Association oppose the U.S. Department of Health and Human Services Secretary's Ninth Amendment to Declaration Under the Public Readiness and Emergency Preparedness Act for Medical Countermeasures Against COVID-19 (the declaration); and be it further

RESOLVED, That our AMA specifically oppose expansion under the declaration of the scope of authority for state-licensed pharmacists to order and administer, and certain pharmacy technicians and pharmacy interns to administer, COVID-19 therapeutics subcutaneously, intramuscularly, or orally as authorized, approved, or licensed by the U.S. Food and Drug Administration (New HOD Policy); and be it further

RESOLVED, That our AMA also specifically oppose the declaration as it purports to preempt state law that otherwise would prohibit these individuals from independently prescribing, dispensing, or administering COVID-19 therapeutics or other covered countermeasures (New HOD Policy); and be it further

RESOLVED, That our AMA release a statement in opposition to the declaration and ask that it be rescinded (Directive to Take Action); and be it further

RESOLVED, That our AMA continue to advocate for legislation that prevents the federal government from preempting state scope-of-licensure laws for physicians and health care providers. (Directive to Take Action)

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

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

The Texas Medical Association (TMA) requests immediate action by the American Medical Association (AMA) to pass this attached proposed resolution opposing the federal government's recent attempt to usurp the states' powers to individually regulate the practice of medicine. This issue affects most of the nation's physicians and their patients, which is why AMA is the most appropriate organization to tackle this urgent concern

Specifically, effective September 9, 2021, the Secretary of the U.S. Department of Health and Human Services issued the Ninth Amendment to the Public Readiness and Emergency Preparedness Act Declaration (the Declaration), which purports, among other things, to unilaterally authorize state-licensed pharmacists to order and administer, and certain pharmacy technicians and pharmacy interns to administer, COVID-19 therapeutics subcutaneously, intramuscularly, or orally as authorized, approved, or licensed by the Federal Drug Administration. This Declaration states that it preempts any state laws to the contrary, thereby attempting to eviscerate state scope-of-practice laws, which are tailored based on variances in education, training, and experience. The federal government's one-size-fits-all approach threatens, not helps, address public health concerns.

TMA's proposed resolution fits squarely within AMA's advocacy efforts on scope expansion and AMA's action on this resolution will positively reflect the voices of physicians nationwide. Accordingly, we ask AMA to swiftly address this pressing scope expansion issue by immediately considering and adopting the proposed resolution submitted by TMA, which calls on AMA to publicly oppose and demand the rescission of the Declaration.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 223
(N-21)

Introduced by: Texas

Subject: Paying Physicians for Services According to the Physician Fee Schedule

Referred to: Reference Committee B

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1 Whereas, The COVID-19 public health emergency has caused a rapid adoption of telehealth;
2 and
3
4 Whereas, Patients and physicians continue to find value in the use of telemedicine when the
5 condition is appropriate for this delivery type; and
6
7 Whereas, Patients will now expect telemedicine visits when appropriate, since telemedicine is
8 about convenience for the patient, and removing telehealth services from the covered code list
9 will prove disruptive to practices and patients alike; and
10
11 Whereas, The Centers for Medicare & Medicaid Services proposes to retain 135 telehealth
12 services added to the Medicare telehealth services list on a Category 3 basis until the end of
13 2023; and
14
15 Whereas, Physicians must have the flexibility to decide whether to see their patients via
16 telehealth or in person without unnecessary and disconnected pricing incentives; and
17
18 Whereas, A physician-led and collaborative team-based approach is optimal for patient care
19 delivery and overall health care outcomes, especially when using telehealth; and
20
21 Whereas, Physician payment is determined using the resource-based relative value scale,
22 which aligns payments based on the cost and resources used to provide services using
23 physician work, practice expense, and medical liability expense; and
24
25 Whereas, Augmenting a physician's practice with telemedicine incurs additional expenses
26 different from those of delivering only in-person care, and offering telemedicine adds expenses
27 such as software, hardware, workflow adjustments, physician and staff training, and patient
28 education; therefore be it
29
30 RESOLVED, That our American Medical Association advocate for Congress to require
31 Employee Retirement Income Security Act (ERISA) self-funded employer-sponsored plans,
32 state-regulated plans, Medicare, Medicaid, and TRICARE to pay physicians appropriately for a
33 covered service provided as a telemedicine service to an enrolled patient by a contracted
34 physician at least the same as the contracted rate that would have been paid if the service were
35 provided in an in-person setting (Directive to Take Action); and be it further
36
37 RESOLVED, That our AMA support state medical board licensure requirements in the state
38 where the patient is located, but otherwise the geographic and originating site restrictions
39 should be eliminated to allow patients to receive appropriate telehealth services in their homes,
40 residential facilities, and other locations (New HOD Policy); and be it further

1 RESOLVED, That our AMA advocate that the Centers for Medicare & Medicaid Services retain
2 on a permanent basis the telehealth services added to the Medicare telehealth services list
3 during the public health emergency.(Directive to Take Action)

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

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

Despite the tragedy of the COVID-19 public health emergency, a widely recognized silver lining is the rapid adoption of telehealth which affects nearly all physicians and their patients. As such, it is important for the AMA to act at this meeting to enhance policies so that public and private payers properly pay for physician services associated with telehealth medicine. Addressing physician payment and patient access to physician services via telehealth fits squarely within the AMA mission.

To ensure that telehealth policies continue in a favorable and patient-centered manner at the conclusion of the public health emergency requires the AMA to consider and implement new policy.

While AMA has some existing policy on this topic, current policy does not explicitly call on public and private payers to appropriately pay physicians for a covered service provided as a telemedicine service to an enrolled patient by a contracted physician at least the same as the contracted rate that would have been paid if the service were provided in an in-person setting. Nor does current AMA policy explicitly support state medical board licensure requirements in the state where the patient is located

Given the rapid adoption of and policy evolvement associated with telemedicine, it is an important issue and AMA action will have a positive impact on physicians and their patients. The AMA is the most appropriate entity to tackle this issue.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 224
(N-21)

Introduced by: Florida

Subject: Improve Physician Payments

Referred to: Reference Committee B

Whereas, There are looming Medicare cuts amounting to almost 9.75% on physician practices on January 1, 2022; and

Whereas, The AMA is urging House leaders to extend the 3.75% increase to the Medicare conversion factor that Congress included in the Consolidated Appropriations Act of 2021 which provides for continued stability to the physician and provider community as it works toward broader Medicare payment reform; and

Whereas, Physicians, who have given their time, energy, expertise and in some cases their lives to protect the United States population from the current COVID 19 pandemic deserve to be recognized not by Medicare reductions but by increases; and

Whereas, Our AMA has policy that has not been acted upon in a manner to effect change for American physicians regarding payment cuts; and

Whereas, Our AMA membership of practicing physicians could be improved strengthening our organization; therefore be it

RESOLVED, That our American Medical Association make avoiding the Medicare payment cuts on physician practices a top priority (Directive to Take Action); and be it further

RESOLVED, That our AMA utilize the necessary resources to avoid the pending Medicare physician payment cuts (Directive to Take Action); and be it further

RESOLVED, That our AMA modify policy D-165.941, “Sequestration Budget Cuts,” by addition and deletion to read as follows:

Sequestration Budget Cuts D-165.941
1. Our AMA will urge Congress to develop a fiscally responsible alternative that would prevent the automatic budget sequestration cuts that would endanger critical programs related to medical research, public health, workforce, food and drug safety, and health care for uniformed service members, as well as trigger cuts in Medicare payments to graduate medical education programs, hospitals, and physicians that will endanger access to care and training of physicians.
2. Our AMA will take all necessary legislative and administrative steps to prevent extended ~~or~~ <u>and</u> deeper sequester cuts in Medicare payments <u>to physician practices using the financial means necessary to do so and make this a top priority</u>. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA reaffirm and take immediate action on policy H-330.932, "Cuts in Medicare and Medicaid Reimbursement," that:

(1) supports the concept that the Medicare and Medicaid budgets need to expand adequately to adjust for factors such as cost of living, the growing size of the Medicare population, and the cost of new technology;(calls for elimination of budget neutrality) (current policy)

(2) aggressively encourages CMS to affirm the patient's and the physician's constitutional right to privately contract for medical services; (freedom of choice for patients), (current policy)

(3) if the reimbursement is not improved, the AMA declares the Medicare reimbursement unworkable and intolerable, and seek immediate legislation to allow the physician to balance bill the patient according to their usual and customary fee; (current policy); and

(4) supports a mandatory annual "cost-of-living" or COLA increase in Medicaid, Medicare, and other appropriate health care reimbursement programs, in addition to other needed payment increases. (current policy) (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA reach out to the physicians of the United States via all possible means, to include but not be limited to email, US mail, social media, to encourage physicians to participate in the AMA campaign to improve physician payments (Directive to Take Action); and be it further

RESOLVED, That our AMA have an open and transparent dialogue with Congressional leaders and the Centers for Medicare and Medicaid Services regarding continued devaluation of the American physician and communicate such with America's physicians (both member and non-member). (Directive to Take Action)

Fiscal Note: Estimated cost to implement this resolution is $240,000.

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

This is a top priority resolution as it affects almost all physicians and if not enacted will have serious deleterious impact on practicing physicians and the AMA is the only organization that can tackle this issue. The looming cuts on physician's payments by CMS has a time certain of January 2022 and therefore, this is a top priority right now for all physicians as insurance carriers often follow Medicare changes. The AMA has been working on this for quite some time and there is policy that needs to be acted upon with urgency. This resolution, if made into policy, will strengthen our organization and show both member and non-member physicians that the AMA is focused on helping physicians take care of patients.

RELEVANT AMA POLICY

Sequestration Budget Cuts D-165.941
1. Our AMA will urge Congress to develop a fiscally responsible alternative that would prevent the automatic budget sequestration cuts that would endanger critical programs related to medical research, public health, workforce, food and drug safety, and health care for uniformed service members, as well as trigger cuts in Medicare payments to graduate medical education programs, hospitals, and physicians that will endanger access to care and training of physicians.
2. Our AMA will take all necessary legislative and administrative steps to prevent extended or deeper sequester cuts in Medicare payments.
Citation: (Res. 215, I-12; Appended: Res. 222, A-15)

Cuts in Medicare and Medicaid Reimbursement H-330.932
Our AMA:
(1) continues to oppose payment cuts in the Medicare and Medicaid budgets that may reduce patient access to care and undermine the quality of care provided to patients;
(2) supports the concept that the Medicare and Medicaid budgets need to expand adequately to adjust for factors such as cost of living, the growing size of the Medicare population, and the cost of new technology;
(3) aggressively encourages CMS to affirm the patient's and the physician's constitutional right to privately contract for medical services;
(4) if the reimbursement is not improved, the AMA declares the Medicare reimbursement unworkable and intolerable, and seek immediate legislation to allow the physician to balance bill the patient according to their usual and customary fee; and
(5) supports a mandatory annual "cost-of-living" or COLA increase in Medicaid, Medicare, and other appropriate health care reimbursement programs, in addition to other needed payment increases.
Citation: (Sub. Res. 101, A-97; Reaffirmation A-99 and Reaffirmed: Res. 127, A-99; Reffirmation A-00; Reaffirmation I-00; Reaffirmed: BOT Action in response to referred for decision Res. 215, I-00; Reaffirmation A-01; Reaffirmation and Appended: Res. 113, A-02; Reaffirmation A-05; Reaffirmed in lieu of Res. 207, A-13)

Patient Access Jeopardized By Senate Failure to Correct Medicare Payment Error D-390.988
Our AMA will: (1) aggressively promote expanded grassroots participation in the Medicare Update Campaign through the use of blast fax, e-mails and the toll-free grassroots hotline (1-800-833-6354); (2) continue to work with state and national medical specialty societies, as well as group practices, on physician surveys to measure the effect on patient access to care; (3) immediately disseminate the latest information to physicians regarding Medicare participation, non-participation and private contracting arrangements; and (4) concurrent with all of the above legislative, grassroots and targeted political actions, continue to evaluate aggressive, appropriate legal remedies through court action that could serve to rectify physician concerns about Medicare payment cuts and their impact on patient care.
Citation: (BOT Rep. 24, I-02; Modified: CCB/CLRPD Rep. 4, A-12)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 225
(N-21)

Introduced by: Florida

Subject: End Budget Neutrality

Referred to: Reference Committee B

Whereas, Federal law imposes budget neutrality requirements on revisions to RVUs under the Medicare Physician Fee Schedule (MPFS) that result in changes in federal expenditures in excess of $20 million per year[iii]; and

Whereas, Our AMA has calculated that the value of Medicare physician payments declined 22% relative to practice costs between 2001 and 2020[iii] and government officials project that the real value of the MPFS will continue to decline under current federal law[ivv]; and

Whereas, The US has an aging population[vi] which will drive Medicare enrollment growth[vii] and increase Medicare spending[viii]; and

Whereas, The 2021 MPFS Final Rule would have imposed budget neutrality cuts as high as 10% on certain specialists[ix], which made it impossible to implement the rule's appropriate and deserved payment increases for office and outpatient E&M codes without threatening access to care and endangering the economic viability of other physician practices; and

Whereas, Congress provided substantial temporary relief from these cuts[x], including a 3.75-percent across-the-board payment increase under the MPFS, this component of the relief will expire January 1st, 2022 unless further Congressional action is taken; and

Whereas, Existing budget neutrality requirements make implementing appropriate, significant RVU revisions for crucial services under the MPFS difficult or impossible to accomplish while maintaining access to care for beneficiaries who receive treatment from physicians who do not provide these services; and

Whereas, Budget neutrality cuts can create significant, arbitrary distortions in valuations for Medicare physician services and thereby generate looming access crises on a perennial basis; and

Whereas, Our AMA has taken existing stances against budget neutrality (Objects to the use of the relative values as a mechanism to preserve budget neutrality (H-400.959 -Refining and Updating the Physician Work Component of the RBRVS and 400.956-RBRVS development); therefore be it

RESOLVED, That our American Medical Association work towards the elimination of budget neutrality requirements under federal law (Directive to Take Action); and be it further

RESOLVED, That our AMA amend Policy H-385.905, "Merit-based Incentive Payment System (MIPS) Update**,"** by addition and deletion to read as follows:

Merit-based Incentive Payment System (MIPS) Update H-385.905
Our AMA will work toward creating and pursuing ~~supports~~ legislation that ensures Medicare physician payments are ~~is~~ sufficient to safeguard beneficiary access to care, ~~replaces or supplements budget~~ eliminate budget neutrality requirements within the MPFS and with respect to ~~in~~ MIPS ~~with~~ incentive payments, ~~or~~ and implements ~~positive~~ annual Medicare physician payment updates that keep pace with rising practice costs. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA reaffirm D-400.989, "Equal Pay for Equal Work," with a special emphasis on the third bullet point and work to create legislation to eliminate budget neutrality:

Our AMA: (1) shall make its first legislative priority to fix the Medicare payment update problem because this is the most immediate means of increasing Medicare payments to physicians in rural states and will have the greatest impact; (2) shall seek enactment of legislation directing the General Accounting Office to develop and recommend to Congress policy options for reducing any unjustified geographic disparities in Medicare physician payment rates and improving physician recruitment and retention in underserved rural areas; and **(3) shall advocate strongly to the current administration and Congress that additional funds must be put into the Medicare physician payment system and that continued budget neutrality is not an option.** (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA reaffirm and take action on H-400.972, "Physician Payment Reform"

H-400.972, "Physician Payment Reform
It is the policy of the AMA to (1) take all necessary legal, legislative, and other action to redress the inequities in the implementation of the RBRVS, including, but not limited to, (a) reduction of allowances for new physicians; (b) the non-payment of EKG interpretations; (c) defects in the Geographic Practice Cost Indices and area designations; (d) inappropriate Resource-Based Relative Value Units; (e) the deteriorating economic condition of physicians' practices disproportionately affected by the Medicare payment system; (f)the need for RBRVS conversion factor updates that are not subject to budget neutrality requirements; (g) the inadequacy of payment for services of assistant surgeons; and (h) the loss of surgical-tray benefit for many outpatient procedures (Reaffirmed by Rules & Credentials Cmt., A-96);
(2) seek an evaluation of (a) stress factors (i.e., intensity values) as they affect the calculation of the Medicare Payment Schedule, seeking appropriate, reasonable, and equitable adjustments; and (b) descriptors (i.e., vignettes) and other examples of services used to determine RBRVS values and payment levels and to seek adjustments so that the resulting values and payment levels appropriately pertain to the elderly and often infirm patients;
(3) evaluate the use of the RBRVS on the calculation of the work component of the Medicare Payment Schedule and to ascertain that the concept for the work component continues to be an appropriate part of a resource-based relative value system;
(4) seek to assure that all modifiers, including global descriptors, are well publicized and include adequate descriptors;
(5) seek the establishment of a reasonable and consistent interpretation of global fees, dealing specifically with preoperative office visits, concomitant office procedures, and/or future procedures;

(6) seek from CMS and/or Congress an additional comment period beginning in the Fall of 1992;
(7) seek the elimination of regulations directing patients to points of service;
(8) support further study of refinements in the practice cost component of the RBRVS to ensure better reflection of both absolute and relative costs associated with individual services, physician practices, and medical specialties, considering such issues as data adequacy, equity, and the degree of disruption likely to be associated with any policy change;
(9) take steps to assure that relative value units in the Medicare payment schedule, such as nursing home visits, are adjusted to account for increased resources needed to deliver care and comply with federal and state regulatory programs that disproportionately affect these services and that the Medicare conversion factor be adjusted and updated to reflect these increased overall costs;
(10) support the concepts of HR 4393 (the Medicare Geographic Data Accuracy Act of 1992), S 2680 (the Medicare Geographic Data Accuracy Act of 1992), and S 2683 (Medicare Geographic Data Accuracy Act) for improving the accuracy of the Medicare geographic practice costs indices (GPCIs) and work with CMS and the Congress to assure that GPCIs are updated in as timely a manner as feasible and reflect actual physician costs, including gross receipt taxes;
(11) request that CMS refine relative values for particular services on the basis of valid and reliable data and that CMS rely upon the work of the AMA/Specialty Society RVS Updating Committee (RUC) for assignment of relative work values to new or revised CPT codes and any other tasks for which the RUC can provide credible recommendations;
(12) pursue aggressively recognition and CMS adoption for Medicare payment schedule conversion factor updates of an index providing the best assurance of increases in the monetary conversion factor reflective of changes in physician practice costs, and to this end, to consider seriously the development of a "shadow" Medicare Economic Index;
(13) continue to implement and refine the Payment Reform Education Project to provide member physicians with accurate and timely information on developments in Medicare physician payment reform; and
(14) take steps to assure all relative value units contained in the Medicare Fee Schedule are adjusted as needed to comply with ever-increasing federal and state regulatory requirements. (created in 1992, reaffirmed 10 times) (Reaffirm HOD Policy)

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

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

This is a top priority resolution as it affects all physicians and AMA action will have a positive impact. The AMA has substantial policy to eliminate budget neutrality that has yet to be fully acted upon. Current budget neutrality requirements make implementing appropriate, significant RVU revisions difficult or impossible. Our aging population will drive Medicare enrollment growth and increase spending. Eliminating budget neutrality will help to ensure that Medicare physician payments are sufficient to safeguard beneficiary access to care and payment updates will keep pace with rising practice costs. This resolution, if made into policy, will strengthen our organization and show both member and non-member physicians that the AMA is focused on helping physicians take care of patients.

RELEVANT AMA POLICY

Merit-based Incentive Payment System (MIPS) Update H-385.905
Our AMA supports legislation that ensures Medicare physician payment is sufficient to safeguard beneficiary access to care, replaces or supplements budget neutrality in MIPS with incentive payments, or implements positive annual physician payment updates.
Citation: BOT Rep. 13, I-20

Equal Pay for Equal Work D-400.989
Our AMA: (1) shall make its first legislative priority to fix the Medicare payment update problem because this is the most immediate means of increasing Medicare payments to physicians in rural states and will have the greatest impact; (2) shall seek enactment of legislation directing the General Accounting Office to develop and recommend to Congress policy options for reducing any unjustified geographic disparities in Medicare physician payment rates and improving physician recruitment and retention in underserved rural areas; and (3) shall advocate strongly to the current administration and Congress that additional funds must be put into the Medicare physician payment system and that continued budget neutrality is not an option.
Citation: BOT Rep. 14, A-02; Reaffirmation A-06; Reaffirmation I-07; Reaffirmation A-08; Reaffirmed: Sub. Res. 810, I-08; Reaffirmation A-09; Reaffirmed: BOT Action in response to referred for decision Res. 212, A-09; Reaffirmed: CMS Rep. 01, A-19

Refining and Updating the Physician Work Component of the RBRVS H-400.959
The AMA: (1) supports the efforts of the CPT Editorial Panel and the AMA/Specialty Society RVS Update Committee's (RUC's) work with the American Academy of Pediatrics and other specialty societies to develop pediatric-specific CPT codes and physician work relative value units to incorporate children's services into the RBRVS; (2) supports the RUC's efforts to improve the validity of the RBRVS through development of methodologies for assessing the relative work of new technologies and for assisting CMS in a more comprehensive review and refinement of the work component of the RBRVS; and (3) continues to object to use of the relative values as a mechanism to preserve budget neutrality.
Citation: (BOT Rep. I-93-26; Reaffirmed by BOT Rep. 8 - I-94; Res. 806, I-94; Reaffirmed: Sub. Res. 816, I-99; Reaffirmed: CMS Rep. 4, I-02; Reaffirmed: BOT Rep. 14, A-08; Reaffirmed: Sub. Res. 104, A-14; Reaffirmation A-15)

RBRVS Development H-400.956
(1) That the AMA strongly advocate CMS adoption and implementation of all the RUC's recommendations for the five-year review;
(2) That the AMA closely monitor all phases in the development of resource-based practice expense relative values to ensure that studies are methodologically sound and produce valid data, that practicing physicians and organized medicine have meaningful opportunities to participate, and that any implementation plans are consistent with AMA policies;
(3) That the AMA work to ensure that the integrity of the physician work relative values is not compromised by annual budget neutrality or other adjustments that are unrelated to physician work;
(4) That the AMA encourage payers using the relative work values of the Medicare RBRVS to also incorporate the key assumptions underlying these values, such as the Medicare global periods; and
(5) That the AMA continue to pursue a favorable advisory opinion from the Federal Trade Commission regarding AMA provision of a valid RBRVS as developed by the RUC process to private payers and physicians.

Citation: (BOT Rep. 16, A-95; BOT Rep. 11, A-96; Reaffirmed: CMS Rep. 4, I-02; Reaffirmed: BOT Rep. 14, A-08; Reaffirmed: Sub. Res. 104, A-14; Reaffirmation A-15)

Physician Payment Reform H-400.972
It is the policy of the AMA to (1) take all necessary legal, legislative, and other action to redress the inequities in the implementation of the RBRVS, including, but not limited to, (a) reduction of allowances for new physicians; (b) the non-payment of EKG interpretations; (c) defects in the Geographic Practice Cost Indices and area designations; (d) inappropriate Resource-Based Relative Value Units; (e) the deteriorating economic condition of physicians' practices disproportionately affected by the Medicare payment system; (f) the need for restoration of the RBRVS conversion factor to levels consistent with the statutory requirement for budget neutrality; (g) the inadequacy of payment for services of assistant surgeons; and (h) the loss of surgical-tray benefit for many outpatient procedures (Reaffirmed by Rules & Credentials Cmt., A-96);
(2) seek an evaluation of (a) stress factors (i.e., intensity values) as they affect the calculation of the Medicare Payment Schedule, seeking appropriate, reasonable, and equitable adjustments; and (b) descriptors (i.e., vignettes) and other examples of services used to determine RBRVS values and payment levels and to seek adjustments so that the resulting values and payment levels appropriately pertain to the elderly and often infirm patients;
(3) evaluate the use of the RBRVS on the calculation of the work component of the Medicare Payment Schedule and to ascertain that the concept for the work component continues to be an appropriate part of a resource-based relative value system;
(4) seek to assure that all modifiers, including global descriptors, are well publicized and include adequate descriptors;
(5) seek the establishment of a reasonable and consistent interpretation of global fees, dealing specifically with preoperative office visits, concomitant office procedures, and/or future procedures;
(6) seek from CMS and/or Congress an additional comment period beginning in the Fall of 1992;
(7) seek the elimination of regulations directing patients to points of service;
(8) support further study of refinements in the practice cost component of the RBRVS to ensure better reflection of both absolute and relative costs associated with individual services, physician practices, and medical specialties, considering such issues as data adequacy, equity, and the degree of disruption likely to be associated with any policy change;
(9) take steps to assure that relative value units in the Medicare payment schedule, such as nursing home visits, are adjusted to account for increased resources needed to deliver care and comply with federal and state regulatory programs that disproportionately affect these services and that the Medicare conversion factor be adjusted and updated to reflect these increased overall costs;
(10) support the concepts of HR 4393 (the Medicare Geographic Data Accuracy Act of 1992), S 2680 (the Medicare Geographic Data Accuracy Act of 1992), and S 2683 (Medicare Geographic Data Accuracy Act) for improving the accuracy of the Medicare geographic practice costs indices (GPCIs) and work with CMS and the Congress to assure that GPCIs are updated in as timely a manner as feasible and reflect actual physician costs, including gross receipt taxes;
(11) request that CMS refine relative values for particular services on the basis of valid and reliable data and that CMS rely upon the work of the AMA/Specialty Society RVS Updating Committee (RUC) for assignment of relative work values to new or revised CPT codes and any other tasks for which the RUC can provide credible recommendations;
(12) pursue aggressively recognition and CMS adoption for Medicare payment schedule conversion factor updates of an index providing the best assurance of increases in the monetary conversion factor reflective of changes in physician practice costs, and to this end, to consider seriously the development of a "shadow" Medicare Economic Index;

(13) continue to implement and refine the Payment Reform Education Project to provide member physicians with accurate and timely information on developments in Medicare physician payment reform; and
(14) take steps to assure all relative value units contained in the Medicare Fee Schedule are adjusted as needed to comply with ever-increasing federal and state regulatory requirements.
Citation: Sub. Res. 109, A-92; Reaffirmed: I-92; Reaffirmed by CMS Rep. 8, A-95 and Sub. Res. 124, A-95; Reaffirmation A-99 and Reaffirmed: Res. 127, A-99; Reaffirmation A-02; Reaffirmation A-06; Reaffirmation I-07; Reaffirmed: BOT Rep. 14, A-08; Reaffirmation A-09; Reaffirmed: CMS Rep. 01, A-19;

Physician Payment Reform H-390.849
1. Our AMA will advocate for the development and adoption of physician payment reforms that adhere to the following principles:
a) promote improved patient access to high-quality, cost-effective care;
b) be designed with input from the physician community;
c) ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions;
d) not require budget neutrality within Medicare Part B;
e) be based on payment rates that are sufficient to cover the full cost of sustainable medical practice;
f) ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process;
g) make participation options available for varying practice sizes, patient mixes, specialties, and locales;
h) use adequate risk adjustment methodologies;
i) incorporate incentives large enough to merit additional investments by physicians;
j) provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols;
k) provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization;
l) attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary; and
m) include ongoing evaluation processes to monitor the success of the reforms in achieving the goals of improving patient care and increasing the value of health care services.
2. Our AMA opposes bundling of payments in ways that limit care or otherwise interfere with a physician's ability to provide high quality care to patients.
3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes, quality and risk-adjustment measures only if measures are scientifically valid, verifiable, accurate, and based on current data.
4. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.
5. Our AMA supports the development of a public-private partnership for the purpose of validating statistical models used for risk adjustment.
Citation: CMS Rep. 6, A-09; Reaffirmation A-10; Appended: Res. 829, I-10; Appended: CMS Rep. 1, A-11; Appended: CMS Rep. 4, A-11; Reaffirmed in lieu of Res. 119, A-12; Reaffirmed in lieu of Res. 122, A-12; Modified: CMS Rep. 6, A-13; Reaffirmation I-15; Reaffirmation: A-16; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmed: BOT Action in response to referred for decision: Res. 237, I-17; Reaffirmation: A-19; Reaffirmed: BOT Action in response to referred for decision Res. 111, A-19; Reaffirmed: BOT Action in response to referred for decision Res. 132, A-19

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[i] Social Security Act (see: https://www.law.cornell.edu/uscode/text/42/1395w-4 or https://www.ssa.gov/OP_Home/ssact/title18/1848.htm see Section 1848(c)(2)(B)(ii)(II))
[ii] Payment for Physician Services, Social Security Administration (https://www.ssa.gov/OP_Home/ssact/title18/1848.htm see Section 1848(c)(2)(B)(ii)(II))
[iii] AMA: WAKE UP TO FINANCIAL PERIL FACING MEDICARE PAYMENT SYSTEM (SEE HTTPS://WWW.AMA-ASSN.ORG/PRESS-CENTER/PRESS-RELEASES/AMA-WAKE-FINANCIAL-PERIL-FACING-MEDICARE-PAYMENT-SYSTEM)

[iv] 020 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS (https://www.cms.gov/files/document/2020-medicare-trustees-report.pdf see the last paragraph of page 2 of the report)
[v] Estimated Financial Effects of the Medicare Access and CHIP Reauthorization Act of 2015 (H.R. 2) https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/2015HR2a.pdf see pages 8 and 9)
[vi] Demographic Turning Points for the United States: Population Projections for 2020 to 2060, United States Census Bureau (see: https://www.census.gov/content/dam/Census/library/publications/2020/demo/p25-1144.pdf)
[vii] Medicare Payment Advisory Commission Data Book, Ju; 2010 (http://www.medpac.gov/docs/default-source/data-book/july2021_medpac_databook_sec.pdf?sfvrsn=0 see chart 2-4)
[viii] Medicare Payment Advisory Commission Data Book, Ju; 2010 (http://www.medpac.gov/docs/default-source/data-book/july2021_medpac_databook_sec.pdf?sfvrsn=0 see chart 1-5)
[ix] CMS, 2021 MPFS Final (see: https://www.govinfo.gov/content/pkg/FR-2020-12-28/pdf/2020-26815.pdf see: Rule CY 2021 PFS Table 106: CY 2021 PFS Estimated Impact on Total Allowed Charges by Specialty)
[x] CONGRESS PROVIDES RELIEF ON MEDICARE PAYMENT; PASSES SURPRISE BILLING (HTTPS://WWW.AMA-ASSN.ORG/DELIVERING-CARE/PATIENT-SUPPORT-ADVOCACY/CONGRESS-PROVIDES-RELIEF-MEDICARE-PAYMENT-PASSES-SURPRISE)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 226
(N-21)

Introduced by: Michigan

Subject: Address Adolescent Telehealth Confidentiality Concerns

Referred to: Reference Committee B

Whereas, Adolescents believe that all health care should be confidential and report it as one of the most important aspects of their health care, yet many express concerns regarding privacy and worry that their providers will tell parents about their conversations; and

Whereas, The Academy of Pediatrics recommends providing confidential and private health care to adolescents by allowing sufficient opportunities for adolescents to discuss sensitive issues with physicians without a parent present; and

Whereas, The COVID-19 pandemic has not affected adolescents' needs for confidential services, and the early shift from in-person visits to telehealth visits demonstrated that 85 percent of adolescent primary care visits occurred for sensitive issues including sexual and reproductive health, eating disorders, and substance use; and

Whereas, Recent studies report that only 38 percent of adolescents spent any time alone with a provider within the last year, yet adolescents who experience portions of their visits unaccompanied by a parent are more likely to discuss sensitive topics such as sexual and reproductive health; and

Whereas, Only 27 percent of adolescents reported that they had any alone time with their provider during recent telehealth visits, potentially limiting access to confidential services; and

Whereas, A unique challenge of providing confidential care over telehealth includes finding quiet and private spaces in adolescents' homes that are separate from other household members to discuss sensitive topics without fear of the conversation being overheard; and

Whereas, The American Academy of Pediatrics, Pediatric Health Network, Michigan Medicine, and other organizations have developed frameworks recommending that physicians continue providing confidential and private care to adolescents through telehealth; and

Whereas, The organizations above provide recommendations unique to telehealth to ensure private and confidential visits, including asking the parent to leave for part of the visit and gaining parent buy-in regarding the importance of this privacy; and

Whereas, Additional suggestions to provide confidential care to adolescents through telehealth include asking the adolescent to move to a more private area of the home, providing suggestions on unique areas that patients may go to ensure privacy, the use of headphones and chat features, the use of yes or no answers, asking the adolescent for a 360 degree video view to understand who is in the room, and having the parent and adolescent call from separate devices to easily facilitate the transition to confidential discussions; and

Whereas, AMA Policies H-60.938 and H-60.965 recommend providing confidential care to adolescent patients, but do not address the unique confidentiality concerns of adolescents and their parents accessing telehealth, nor the challenges associated with finding private spaces in an adolescent's home; therefore be it

RESOLVED, That our American Medical Association amend Policy H-60.965, "Confidential Health Services for Adolescents," by addition to read as follows:

Confidential Health Services for Adolescents H-60.965
Our AMA:
(1) reaffirms that confidential care for adolescents is critical to improving their health;
(2) encourages physicians to allow emancipated and mature minors to give informed consent for medical, psychiatric, and surgical care without parental consent and notification, in conformity with state and federal law;
(3) encourages physicians to involve parents in the medical care of the adolescent patient, when it would be in the best interest of the adolescent. When, in the opinion of the physician, parental involvement would not be beneficial, parental consent or notification should not be a barrier to care;
(4) urges physicians to discuss their policies about confidentiality with parents and the adolescent patient, as well as conditions under which confidentiality would be abrogated. This discussion should include possible arrangements for the adolescent to have independent access to health care (including financial arrangements);
(5) encourages physicians to offer adolescents an opportunity for examination and counseling apart from parent. The same confidentiality will be preserved between the adolescent patient and physician as between the parent (or responsible adult) and the physician;
(6) encourages state and county medical societies to become aware of the nature and effect of laws and regulations regarding confidential health services for adolescents in their respective jurisdictions. State medical societies should provide this information to physicians to clarify services that may be legally provided on a confidential basis;
(7) urges undergraduate and graduate medical education programs and continuing education programs to inform physicians about issues surrounding minors' consent and confidential care, including relevant law and implementation into practice;
(8) encourages health care payers to develop a method of listing of services which preserves confidentiality for adolescents; and
(9) encourages medical societies to evaluate laws on consent and confidential care for adolescents and to help eliminate laws which restrict the availability of confidential care<u>; and</u>
<u>(10) encourages physicians to recognize the unique confidentiality concerns of adolescents and their parents associated with telehealth visits; and</u>
<u>(11) encourages physicians in a telehealth setting to offer a separate examination and counseling apart from others and to ensure that the adolescent is in a private space</u>.
(Modify current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

Telehealth utilization has skyrocketed during the COVID-19 pandemic. Along with the opportunities this provides to continue ongoing patient care, come new challenges for health care professionals caring for adolescents especially regarding the ability to provide a private space that preserves the ability to engage in confidential physician-patient communications. As telehealth continues to be a viable and acceptable mode for conducting patient visits, it is critical that health care professionals, patients, and parents have guidance on how best to address confidentiality concerns.

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RELEVANT AMA POLICY

Confidential Health Services for Adolescents H-60.965

Our AMA:
(1) reaffirms that confidential care for adolescents is critical to improving their health;
(2) encourages physicians to allow emancipated and mature minors to give informed consent for medical, psychiatric, and surgical care without parental consent and notification, in conformity with state and federal law;
(3) encourages physicians to involve parents in the medical care of the adolescent patient, when it would be in the best interest of the adolescent. When, in the opinion of the physician,

parental involvement would not be beneficial, parental consent or notification should not be a barrier to care;
(4) urges physicians to discuss their policies about confidentiality with parents and the adolescent patient, as well as conditions under which confidentiality would be abrogated. This discussion should include possible arrangements for the adolescent to have independent access to health care (including financial arrangements);
(5) encourages physicians to offer adolescents an opportunity for examination and counseling apart from parents. The same confidentiality will be preserved between the adolescent patient and physician as between the parent (or responsible adult) and the physician;
(6) encourages state and county medical societies to become aware of the nature and effect of laws and regulations regarding confidential health services for adolescents in their respective jurisdictions. State medical societies should provide this information to physicians to clarify services that may be legally provided on a confidential basis;
(7) urges undergraduate and graduate medical education programs and continuing education programs to inform physicians about issues surrounding minors' consent and confidential care, including relevant law and implementation into practice;
(8) encourages health care payers to develop a method of listing of services which preserves confidentiality for adolescents; and
(9) encourages medical societies to evaluate laws on consent and confidential care for adolescents and to help eliminate laws which restrict the availability of confidential care.
Citation: (CSA Rep. A, A-92; Reaffirmed by BOT Rep. 24, A-97; Reaffirmed by BOT Rep. 9, A-98; Reaffirmed: Res. 825, I-04; Reaffirmation A-08; Reaffirmed: CMS Rep. 2, I-14)

E-1.2.12 Ethical Practice in Telemedicine
Innovation in technology, including information technology, is redefining how people perceive time and distance. It is reshaping how individuals interact with and relate to others, including when, where, and how patients and physicians engage with one another.
Telehealth and telemedicine span a continuum of technologies that offer new ways to deliver care. Yet as in any mode of care, patients need to be able to trust that physicians will place patient welfare above other interests, provide competent care, provide the information patients need to make well-considered decisions about care, respect patient privacy and confidentiality, and take steps to ensure continuity of care. Although physiciansfundamental ethical responsibilities do not change, the continuum of possible patient-physician interactions in telehealth/telemedicine give rise to differing levels of accountability for physicians.
All physicians who participate in telehealth/telemedicine have an ethical responsibility to uphold fundamental fiduciary obligations by disclosing any financial or other interests the physician has in the telehealth/telemedicine application or service and taking steps to manage or eliminate conflicts of interests. Whenever they provide health information, including health content for websites or mobile health applications, physicians must ensure that the information they provide or that is attributed to them is objective and accurate.
Similarly, all physicians who participate in telehealth/telemedicine must assure themselves that telemedicine services have appropriate protocols to prevent unauthorized access and to protect the security and integrity of patient information at the patient end of the electronic encounter, during transmission, and among all health care professionals and other personnel who participate in the telehealth/telemedicine service consistent with their individual roles.
Physicians who respond to individual health queries or provide personalized health advice electronically through a telehealth service in addition should:
(a) Inform users about the limitations of the relationship and services provided.
(b) Advise site users about how to arrange for needed care when follow-up care is indicated.
(c) Encourage users who have primary care physicians to inform their primary physicians about the online health consultation, even if in-person care is not immediately needed.

Physicians who provide clinical services through telehealth/telemedicine must uphold the standards of professionalism expected in in-person interactions, follow appropriate ethical guidelines of relevant specialty societies and adhere to applicable law governing the practice of telemedicine. In the context of telehealth/telemedicine they further should:
(d) Be proficient in the use of the relevant technologies and comfortable interacting with patients and/or surrogates electronically.
(e) Recognize the limitations of the relevant technologies and take appropriate steps to overcome those limitations. Physicians must ensure that they have the information they need to make well-grounded clinical recommendations when they cannot personally conduct a physical examination, such as by having another health care professional at the patients site conduct the exam or obtaining vital information through remote technologies.
(f) Be prudent in carrying out a diagnostic evaluation or prescribing medication by:
(i) establishing the patient's identity;
(ii) confirming that telehealth/telemedicine services are appropriate for that patients individual situation and medical needs;
(iii) evaluating the indication, appropriateness and safety of any prescription in keeping with best practice guidelines and any formulary limitations that apply to the electronic interaction; and
(iv) documenting the clinical evaluation and prescription.
(g) When the physician would otherwise be expected to obtain informed consent, tailor the informed consent process to provide information patients (or their surrogates) need about the distinctive features of telehealth/telemedicine, in addition to information about medical issues and treatment options. Patients and surrogates should have a basic understanding of how telemedicine technologies will be used in care, the limitations of those technologies, the credentials of health care professionals involved, and what will be expected of patients for using these technologies.
(h) As in any patient-physician interaction, take steps to promote continuity of care, giving consideration to how information can be preserved and accessible for future episodes of care in keeping with patients' preferences (or the decisions of their surrogates) and how follow-up care can be provided when needed. Physicians should assure themselves how information will be conveyed to the patient's primary care physician when the patient has a primary care physician and to other physicians currently caring for the patient.
Collectively, through their professional organizations and health care institutions, physicians should:
(i) Support ongoing refinement of telehealth/telemedicine technologies, and the development and implementation of clinical and technical standards to ensure the safety and quality of care.
(j) Advocate for policies and initiatives to promote access to telehealth/telemedicine services for all patients who could benefit from receiving care electronically.
(k) Routinely monitor the telehealth/telemedicine landscape to:
(i) identify and address adverse consequences as technologies and activities evolve; and
(ii) identify and encourage dissemination of both positive and negative outcomes.

AMA Principles of Medical Ethics: I,IV,VI,IX

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 227
(N-21)

Introduced by: Michigan

Subject: Medication for Opioid Use Disorder in Physician Health Programs

Referred to: Reference Committee B

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1 Whereas, Physician Health Programs (PHPs) are designed to allow physicians with potentially
2 impairing conditions who either come forward or are referred to be given the opportunity for
3 evaluation, rehabilitation, treatment, and monitoring without disciplinary action in an anonymous,
4 confidential, and respectful manner; and
5
6 Whereas, The PHP model is intended to ensure participants receive effective clinical care for
7 mental, physical, and substance abuse disorders and access to a variety of clinical interventions
8 and support; and
9
10 Whereas, Currently, physicians referred to PHPs who are diagnosed with opioid use disorder
11 (OUD) involving monitoring or sanctions may be subjected to punitive action by their respective
12 licensing boards; and
13
14 Whereas, The stigma associated with illness and impairment, particularly impairment resulting
15 from mental illness, including substance use disorders, can be a powerful obstacle to seeking
16 treatment, especially in the medical community where the presence of this stigma has been
17 described in the literature; and
18
19 Whereas, The US Food and Drug Administration recommends approved medications for the
20 treatment of opioid use disorder (MOUD) including methadone, buprenorphine, and naltrexone
21 be available to all patients; and
22
23 Whereas, MOUD has been proven to help maintain recovery and prevent death in patients with
24 opioid use disorder (OUD); and
25
26 Whereas, It is reported that patients who use MOUD remain in therapy longer than those who
27 do not, and are less likely to use illicit opioids; and
28
29 Whereas, A 2019 report from the National Academies of Sciences, Engineering, and Medicine
30 stated that “there is no scientific evidence that justifies withholding medications from OUD
31 patients in any setting” and that such practices amount to “denying appropriate medical
32 treatment,” and that such practices amount to “denying appropriate medical treatment”; and
33
34 Whereas, Clinicians should consider a patient’s preferences, past treatment history, current
35 state of illness, and treatment setting when deciding between the use of methadone,
36 buprenorphine, and naltrexone; and
37
38 Whereas, Additional considerations apply to health professionals who are actively engaged in,
39 or planning to return to, safety sensitive work; and

Whereas, Treatment programs offering the best possible outcomes are critical to ensuring a pathway to recovery and continuation of clinical practice in a safe and ethical manner with patient protection at the forefront; and

Whereas, The American Society of Addiction *Medicine's Public Policy Statement on Physicians and other Healthcare Professionals with Addiction* includes the recommendation that "Healthcare professionals should be offered the full range of evidence-based treatments, including medication for addiction, in whatever setting they receive treatment. Regulatory agencies (including state licensing boards), professional liability insurers, and credentialing bodies should not discriminate against the type of treatment an individual receives based on unjustified assumptions that certain treatments cause impairment;" therefore be it

RESOLVED, That our American Medical Association work with stakeholders including the Federation of State Medical Boards and the Federation of State Physician Health Programs to develop guidelines supporting the adoption of policies by state-based Physician Health Programs to support individualized decision-making, inclusive of all treatment options including counseling and medication for the treatment of opioid use disorder, and considerations for safety sensitive professionals, to ensure physicians receive effective clinical care to aid in their recovery and safe and ethical return to clinical practice (Directive to Take Action); and be it further

RESOLVED, That our AMA work with stakeholders including the Federation of State Medical Boards and the Federation of State Physician Health Programs to develop model legislation permitting state Boards of Medicine and Osteopathic Medicine to allow for safe-haven or non-reporting of physicians to a licensing board, and/or accept Physician Health Program compliance as an alternative to disciplinary action when public safety is not at risk, and especially for any physicians who voluntarily self-report their physical, mental, and substance use disorders and engage with a Physician Health Program and who successfully complete the terms of participation. (Directive to Take Action)

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

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

Per the December 18, 2020 article, As pandemic rages, physician wellness suffers in silence, Susan R. Bailey, MD, AMA Immediate Past President, states "the need for both physical and mental wellness within our physician community has never been more urgent than it is today." She highlights the impact of COVID-19 in exacerbating the underlying and systemic problems that contribute most directly to physician burnout. Additionally, many experts note the financial, physical, emotional, and mental toll of the pandemic on health care professionals resulting in feelings of anxiety, stress, and isolation that can trigger an unhealthy consumption of mood-altering substances. Physician Health Programs offer a confidential resource for physicians, other licensed health care professionals, or those in training suffering from addictive, psychiatric, medical, behavioral or other potentially impairing conditions. It is imperative that these programs support individualized decision-making, inclusive of all treatment options including counseling and medication for the treatment of opioid use disorder.

RELEVANT AMA POLICY

Support the Elimination of Barriers to Medication-Assisted Treatment for Substance Use Disorder D-95.968
1. Our AMA will: (a) advocate for legislation that eliminates barriers to, increases funding for, and requires access to all appropriate FDA-approved medications or therapies used by licensed drug treatment clinics or facilities; and (b) develop a public awareness campaign to increase awareness that medical treatment of substance use disorder with medication-assisted treatment is a first-line treatment for this chronic medical disease.
2. Our AMA supports further research into how primary care practices can implement medication-assisted treatment (MAT) into their practices and disseminate such research in coordination with primary care specialties.
3. The AMA Opioid Task Force will increase its evidence-based educational resources focused on methadone maintenance therapy (MMT) and publicize those resources to the Federation.
Citation: Res. 222, A-18; Appended: BOT Rep. 02, I-19

Educating Physicians About Physician Health Programs and Advocating for Standards D-405.990
Our AMA will:
(1) work closely with the Federation of State Physician Health Programs (FSPHP) to educate our members as to the availability and services of state physician health programs to continue to create opportunities to help ensure physicians and medical students are fully knowledgeable about the purpose of physician health programs and the relationship that exists between the physician health program and the licensing authority in their state or territory;
(2) continue to collaborate with relevant organizations on activities that address physician health and wellness;
(3) in conjunction with the FSPHP, develop state legislative guidelines addressing the design and implementation of physician health programs;
(4) work with FSPHP to develop messaging for all Federation members to consider regarding elimination of stigmatization of mental illness and illness in general in physicians and physicians in training;
(5) continue to work with and support FSPHP efforts already underway to design and implement the physician health program review process, Performance Enhancement and Effectiveness Review (PEER™), to improve accountability, consistency and excellence among its state member PHPs. The AMA will partner with the FSPHP to help advocate for additional national sponsors for this project; and
(6) continue to work with the FSPHP and other appropriate stakeholders on issues of affordability, cost effectiveness, and diversity of treatment options.
Citation: Res. 402, A-09; Modified: CSAPH Rep. 2, A-11; Reaffirmed in lieu of Res. 412, A-12; Appended: BOT action in response to referred for decision Res. 403, A-12; Reaffirmed: BOT Rep. 15, A-19; Modified: Res. 321, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 228
(N-21)

Introduced by: Michigan

Subject: Resentencing for Individuals Convicted of Marijuana-Based Offenses

Referred to: Reference Committee B

Whereas, Incarceration is a key issue under the domain of Social and Community Context in the Social Determinants of Health topic area of Healthy People 2020 due to numerous disparities in inmate mental and physical health compared to the population, as well as the increased rate of mental health disorders in the children of incarcerated parents; and

Whereas, There is a clear link between incarceration and health, with incarcerated individuals showing higher risk of chronic conditions such as cardiovascular disease, hypertension, and cancer compared to the general population; a study in March 2013 found that each additional year an individual spends in prison corresponds with a decline in life expectancy by two years; and

Whereas, Incarcerated populations are particularly vulnerable to the coronavirus disease 2019 (COVID-19) given the demographics of those experiencing incarceration in addition to the inability to properly "social distance", high population turnover, unsanitary living conditions, poor ventilation systems, inability or inadequacy to properly test and track COVID-19 cases and exposure which have led to an estimated 113,664 COVID-19 cases and 887 related deaths among incarcerated people as of August 2020; and

Whereas, Arrests for marijuana possession, regardless of whether the person was later convicted on these charges, have been shown to negatively impact opportunities such as finding employment, housing, and obtaining student loans, which can lead to widespread and multifactorial individual health consequences; furthermore, criminalization of drug use is associated with increased stigma and discrimination of drug users and that stigma and discrimination is also a causal factor for decreased mental and physical health; and

Whereas, Nationally, African Americans are three times more likely to be arrested for marijuana possession than Whites, a finding that cannot be explained by differences in use; and

Whereas, A 2014 report by the National Research Council found that mandatory minimum sentences for drug offenders “have few, if any, deterrent effects;” and

Whereas, Eighteen states, two territories, and the District of Columbia have legalized the use of recreational and medicinal marijuana, and in the past four years, 23 states have passed laws addressing expungement of certain marijuana convictions, pairing these laws with other policies to its decriminalization or legalization; and

Whereas, In 2018, California became the first state to enact legislation ordering its Department of Justice to conduct a review of criminal records and identify past convictions eligible for sentence dismissal or re-designation in accordance with the Adult Use of Marijuana Act; the outcomes of this legislation showed that reductions in criminal penalties for drug possession

reduce racial and ethnic disparities in the criminal justice system, allowing for improvements in health inequalities linked to social determinants of health; and

Whereas, Illinois passed a bill in May 2019, to expunge convictions for non-violent crimes of possession, manufacturing, and distribution of up to 30 grams and possession up to 500 grams, and Colorado and Massachusetts have approved legislation allowing individuals convicted for possession to petition to seal criminal records of misdemeanor offenses that are no longer considered crimes; and

Whereas, A recent study examining the impact of this type of expungement found that those who do obtain expungement have extremely low subsequent crime rates and experience a significant increase in their wage and employment trajectories and an overall positive impact on the lives of those affected; however, of those legally eligible for expungement, only 6.5 percent obtain it within five years of eligibility, findings that support the development of “automatic” expungement procedures; and

Whereas, Those who have received resentencing for past offenses, including decriminalized marijuana-based charges, have experienced an increase of 22 percent in wages on average within one year of resentencing as well as lower subsequent crime rates that compare favorably to the general population; and

Whereas, Our AMA has policy (H-95.924) supporting public health-based strategies, rather than incarceration, in the handling of individuals possessing cannabis for personal us and encouraging research on the impact of legalization and decriminalization of cannabis in an effort to promote public health and public safety; and

Whereas, Legislation has been considered at the federal level to, among other provisions, remove marijuana from the list of controlled substances under the Controlled Substances Act and create an opportunity for individuals with marijuana law convictions to petition for expungement and resentencing; therefore be it

RESOLVED, That our American Medical Association adopt policy supporting the expungement, destruction, or sealing of criminal records for marijuana offenses that would now be considered legal (New HOD Policy); and be it further

RESOLVED, That our AMA adopt policy supporting the elimination of violations or other penalties for persons under parole, probation, pre-trial, or other state or local criminal supervision for a marijuana offense that would now be considered legal. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 10/13/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution is timely for two key reasons. First, conversations about legalization of cannabis and concurrent expungement of records are currently happening, as the number of states with cannabis legalization are increasing. It is important that the AMA have a clear stance on the resentencing of persons who are currently serving a sentence for offenses for which the penalty no longer exists and to redesignate or dismiss such offenses from the criminal records of persons who have completed their sentences as set forth in this act. Second, COVID-19 pandemic and incarceration. Incarceration is a key factor due to numerous disparities in inmate mental and physical health compared to the general population. Furthermore, incarcerated populations are particularly vulnerable to COVID-19 given the demographics of those experiencing incarceration. People who are incarcerated are unable to properly "social distance," there are high population turnover, unsanitary living conditions, poor ventilation systems, and systems are unable to properly test and track COVID-19 cases. There were 398,627 cases and 2,715 deaths related to coronavirus reported among prisoners through June 2021. There are thousands of people who are incarcerated and suffering through these conditions solely due to low-level cannabis-based offenses. This resolution seeks to adopt policies that would support legislative changes that have the potential to dramatically improve the health and wellbeing of those affected.

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RELEVANT AMA POLICY

Cannabis Legalization for Adult Use (commonly referred to as recreational use) H-95.924
Our AMA: (1) believes that cannabis is a dangerous drug and as such is a serious public health concern; (2) believes that the sale of cannabis for adult use should not be legalized (with adult defined for these purposes as age 21 and older); (3) discourages cannabis use, especially by persons vulnerable to the drug's effects and in high-risk populations such as youth, pregnant women, and women who are breastfeeding; (4) believes states that have already legalized cannabis (for medical or adult use or both) should be required to take steps to regulate the product effectively in order to protect public health and safety including but not limited to: regulating retail sales, marketing, and promotion intended to encourage use; limiting the potency of cannabis extracts and concentrates; requiring packaging to convey meaningful and easily understood units of consumption, and requiring that for commercially available edibles, packaging must be child-resistant and come with messaging about the hazards about unintentional ingestion in children and youth; (5) laws and regulations related to legalized cannabis use should consistently be evaluated to determine their effectiveness; (6) encourages local, state, and federal public health agencies to improve surveillance efforts to ensure data is available on the short- and long-term health effects of cannabis, especially emergency department visits and hospitalizations, impaired driving, workplace impairment and worker-related injury and safety, and prevalence of psychiatric and addictive disorders, including cannabis use disorder; (7) supports public health based strategies, rather than incarceration, in the handling of individuals possessing cannabis for personal use; (8) encourages research on the impact of legalization and decriminalization of cannabis in an effort to promote public health and public safety; (9) encourages dissemination of information on the public health impact of legalization and decriminalization of cannabis; (10) will advocate for stronger public health messaging on the health effects of cannabis and cannabinoid inhalation and ingestion, with an emphasis on reducing initiation and frequency of cannabis use among adolescents, especially high potency products; use among women who are pregnant or contemplating pregnancy; and avoiding cannabis-impaired driving; (11) supports social equity programs to address the impacts of cannabis prohibition and enforcement policies that have disproportionately impacted marginalized and minoritized communities; and (12) will coordinate with other health organizations to develop resources on the impact of cannabis on human health and on methods for counseling and educating patients on the use cannabis and cannabinoids.
Citation: CSAPH Rep. 05, I-17; Appended: Res. 913, I-19; Modified: CSAPH Rep. 4, I-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 229
(N-21)

Introduced by: New York

Subject: CMS Administrative Requirements

Referred to: Reference Committee B

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1 Whereas, The American Medical Association (AMA) has previously affirmed that administrative
2 simplification, including automation and standardization of electronic transactions, is a high
3 priority in order to provide affordable, timely, and effective care; and
4
5 Whereas, The National Standards Group (NSG) at the Centers for Medicare/Medicaid Services
6 (CMS) Office of Burden Reduction is empowered to enforce administration simplification
7 requirements to ensure standardization throughout the ecosystem of payers, providers, and
8 clearinghouses; and
9
10 Whereas, Many insurers, including government payers, have transitioned to and mandated
11 electronic billing rather than paper claim submission; and
12
13 Whereas, Some health insurers and their claim processing subsidiaries have begun to charge a
14 processing fee for claims submitted electronically and even for the electronic payments they
15 provide to physicians and their practices; and
16
17 Whereas, Violations of administrative simplification requirements by health plans and payor
18 business associates, including clearinghouses, are prevalent and have an adverse effect on
19 healthcare practices and patients via higher costs and resulting in limited access to affordable
20 healthcare; and
21
22 Whereas, NSG at the CMS Office of Burden Reduction has stated that the enforcement
23 mechanism against health plan violations is based on the idea of ‘voluntary compliance’, the
24 only program of this type in the Federal Government where compliance is ‘voluntary’ but has
25 failed to impose any financial penalties in the past 7 years on health plans for violation of HIPAA
26 administrative simplification requirements; and
27
28 Whereas, The American Medical Association and Medical Group Managers Association have
29 advocated to HHS/CMS that existing federal laws require health insurers to offer network
30 physicians no-charge option for electronic funds transfer (EFT), but that has not stopped health
31 insurers and/or their vendors from inappropriately charging for EFT; and
32
33 Whereas, At the same time, HHS/CMS has imposed numerous financial penalties on physicians
34 and other providers in healthcare, for violations of HIPAA privacy rules which are governed by
35 the same rules as the HIPAA administrative simplification requirements, (including financial
36 penalties for failure to implement EMR, Meaningful Use (MU) and PQRS, MACRA, MIPS, “Open
37 Payments,” Sunshine Act violations, and numerous others); and

Whereas, Physicians strongly disapprove of the failure by the NSG at the CMS Office of Burden Reduction to resolve complaints related to payments via non-compliant methods including virtual credit cards and for imposing fees for receiving EFT payments by health plans and clearinghouses, therefore be it

RESOLVED, That our American Medical Association forcefully advocate that the Centers for Medicare and Medicaid Services (CMS) investigate all valid allegations of HIPAA Administrative simplification requirements thoroughly and offers transparency in its processes and decisions as required by the Administrative Procedure Act (APA) (Directive to Take Action); and be it further

RESOLVED, That our AMA forcefully advocate that the CMS resolve all complaints related to the non-compliant payment methods including opt-out virtual credit cards, charging processing fees for electronic claims and other illegal electronic funds transfer (EFT) fees (Directive to Take Action); and be it further

RESOLVED, That our AMA communicate its strong disapproval of the failure by the CMS Office of Burden Reduction to effectively enforce the HIPAA administrative simplification requirements as required by the law and its failure to impose financial penalties for non-compliance by health plans (Directive to Take Action); and be it further

RESOLVED, That our AMA, through legislation, regulation or other appropriate means, advocate for the prohibition of health insurers charging physicians and other providers to process claims and make payment. (Directive to Take Action)

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

Received: 10/11/21

AUTHORS STATEMENT OF PRIORITY

The inequity in the way that physicians are treated by CMS versus how health insurance plans are treated must stop. There are federal regulations that are supposed to prohibit health insurers from charging for electronic payments. Yet CMS has not enforced this law and as a result, there are increasing complaints of health insurers inappropriately charging for EFT. Physicians and their offices are on the front lines of patient care – the more time we must devote to administrative burdens, penalties, sorting out payment denials, deduction of processing fees from payments – is less time to see patients. The uneven enforcement of administration simplification requirements places the heaviest burden on physician offices NOT the insurance industry. This must stop, penalties must be enforced and imposed upon insurers as they are on physicians. Health insurers should be prohibited from charging fees for processing claims – the premiums paid to an insurer cover the expenses for an insured and that includes processing and paying the claim.

RELEVANT AMA POLICY

Administrative Simplification in the Physician Practice D-190.974
1. Our AMA strongly encourages vendors to increase the functionality of their practice management systems to allow physicians to send and receive electronic standard transactions directly to payers and completely automate their claims management revenue cycle and will continue to strongly encourage payers and their vendors to work with the AMA and the Federation to streamline the prior authorization process.
2. Our AMA will continue its strong leadership role in automating, standardizing and simplifying all administrative actions required for transactions between payers and providers.
3. Our AMA will continue its strong leadership role in automating, standardizing, and simplifying the claims revenue cycle for physicians in all specialties and modes of practice with all their trading partners, including, but not limited to, public and private payers, vendors, and clearinghouses.
4. Our AMA will prioritize efforts to automate, standardize and simplify the process for physicians to estimate patient and payer financial responsibility before the service is provided, and determine patient and payer financial responsibility at the point of care, especially for patients in high-deductible health plans.
5. Our AMA will continue to use its strong leadership role to support state and specialty society initiatives to simplify administrative functions.
6. Our AMA will continue its efforts to ensure that physicians are aware of the value of automating their claims cycle.
Citation: CMS Rep. 8, I-11; Appended: Res. 811, I-12; Reaffirmation A-14; Reaffirmation: A-17; Reaffirmed: BOT Action in response to referred for decision: Res. 805, I-16; Reaffirmation: I-17; Reaffirmation: A-19; Modified: CMS Rep. 09, A-19

Police, Payer and Government Access to Patient Health Information D-315.992
Our AMA will: (1) widely publicize to our patients and others, the risk of uses and disclosures of individually identifiable health information by payers and health plans, without patient consent or authorization, permitted under the final Health Insurance Portability and Accountability Act "privacy" rule; and (2) continue to aggressively advocate to Congress, and the Administration, physician's concerns with the administrative simplification provisions of HIPAA and that the AMA seek changes, including legislative relief if necessary, to reduce the administrative and cost burdens on physicians.
Citation: Res. 246, A-01; Reaffirmed: BOT Rep. 22, A-11; Reaffirmed: BOT Rep. 7, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 230
(N-21)

Introduced by: New York

Subject: Medicare Advantage Plan Mandates

Referred to: Reference Committee B

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1 Whereas, Some municipalities are requiring their retirees to change from traditional Medicare
2 health insurance coverage to Medicare Advantage plans; and
3
4 Whereas, Medicare Advantage plans may have restrictive networks; and
5
6 Whereas, Medicare Advantage plans further privatize patients' Medicare, without discussion or
7 agreement by the persons concerned, all in the interest of saving money for the employer; and
8
9 Whereas, Forcing use of Medicare Advantage plans does not consider the retiree's personal
10 health concerns, including the ability to find continued care with their own doctors or hospitals
11 with whom they may have long relationships; therefore be it
12
13 RESOLVED, That our American Medical Association advocate for federal legislation to ensure
14 that no person should be mandated to change from traditional Medicare to Medicare Advantage
15 plans. (Directive to Take Action)

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

Received: 10/11/21

AUTHORS STATEMENT OF PRIORITY

As State, city and local governments continue to be pressured by rising healthcare costs, the effort to force employees and retirees (aka, patients) to accept less expensive and less inclusive health plans will increase. This mandate has already begun in New York City. Many Medicare Advantage plans have very limited networks and would force patients to select a health plan that may not include the physicians with whom they have developed long relationships and years of care. Forcing patients into other plans interrupts continuing care across all specialties and should not be permitted. This represents the worst kind of government interference in the health of patients. AMA needs to work with CMS to ensure that no patient is forced to choose or forced to switch to Medicare Advantage plan coverage.

RELEVANT AMA POLICY

Ending Medicare Advantage Auto-Enrollment H-285.905
Our AMA will work with the Centers for Medicare and Medicaid Services and/or Congress to end the procedure of "auto-enrollment" of individuals into Medicare Advantage Plans.
Citation: Res. 216, I-16

Deemed Participation and Misleading Marketing by Medicare Advantage Private Fee for Service Plans D-330.930
Our AMA will continue its efforts to educate physicians and the general public on the implications of participating in programs offered under Medicare Advantage and educate physicians and the public about the lack of secondary coverage (Medigap policies) with Medicare Advantage plans and how this may affect enrollees.
Citation: BOT Action in response to referred for decision Res. 711, I-06; Reaffirmation A-08; Modified: CMS Rep. 01, A-19

Elimination of Subsidies to Medicare Advantage Plans D-390.967
1. Our AMA will seek to have all subsidies to private plans offering alternative coverage to Medicare beneficiaries eliminated, that these private Medicare plans compete with traditional Medicare fee-for-service plans on a financially neutral basis and have accountability to the Centers for Medicare and Medicaid Services.
2. Our AMA will seek to prohibit all private plans offering coverage to Medicare beneficiaries from deeming any physician to be a participating physician without a signed contract specific to that product, and that our AMA work with CMS to prohibit all-products clauses from applying to Medicare Advantage plans and private fee-for-service plans.
Citation: Res. 229, A-07; Modified: CMS Rep. 01, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 231
(N-21)

Introduced by: New York

Subject: Prohibit Ghost Guns

Referred to: Reference Committee B

Whereas, Homemade, difficult to trace firearms are increasingly turning up at crime scenes; and

Whereas, The most important part of a gun is the lower receiver - the 'chassis' of the weapon, the part housing vital components such as the hammer and trigger; and

Whereas, Under federal law, the lower receiver is considered a firearm - while other gun components do not require a background check for purchase; and

Whereas, Dozens of companies sell what are known as "80%" lower receivers - ones that are 80% finished, lack a serial number and can be used to make a homemade gun; and

Whereas, The Gun Control Act (1968) and the Brady Gun Violence Prevention Act (1993) allow for homemade weapons; and

Whereas, Ghost guns don't have any unique markings and therefore present black holes to police investigators; and

Whereas, Ghost guns provide an easy avenue for people banned from owning guns to obtain them; and

Whereas, According to the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) 30% of all weapons recovered by the bureau in California were homemade; and

Whereas, These weapons have been connected with mass shootings, police shootouts and arms trafficking; therefore be it

RESOLVED, That our American Medical Association support state and federal legislation and regulation that would subject homemade weapons to the same regulations and licensing requirements as traditional weapons. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

This resolution expands the current AMA policy on gun safety. Additionally, it dovetails with the recently stated objectives of the US President and Senate Majority Leader. The best solution is a national (federal) one and AMA should be a part of that as a national organization. AMA must expand its policy to include this.

RELEVANT AMA POLICY

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997
1. Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths.
Therefore, the AMA:
(A) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;
(B) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;
(C) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;
(D) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;
(E) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;
(F) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and
(G) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.
2. Our AMA will advocate for firearm safety features, including but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or misappropriation of the weapon by a non-registered user; and support legislation and regulation to standardize the use of these firearm safety features on weapons sold for non-military and non-peace officer use within the U.S.; with the aim of establishing manufacturer liability for the absence of safety features on newly manufactured firearms.
Citation: CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appended: Res. 403, I-99; Reaffirmation A-07; Reaffirmation A-13; Appended: Res. 921, I-13; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmation: A-18; Reaffirmation: I-18; Appended: Res. 405, A-19

Firearm Availability H-145.996
1. Our AMA: (a) advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.
2. Our AMA supports requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms.

3. Our AMA supports “gun violence restraining orders” for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as “red-flag” laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and “red-flag” laws, we also support the importance of due process so that individuals can petition for their rights to be restored.
Citation: Res. 140, I-87; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: BOT Rep. 12, A-16; Appended: Res. 433, A-18; Reaffirmation: I-18; Modified: BOT Rep. 11, I-18

Ban on Handguns and Automatic Repeating Weapons H-145.985
It is the policy of the AMA to:
(1) Support interventions pertaining to firearm control, especially those that occur early in the life of the weapon (e.g., at the time of manufacture or importation, as opposed to those involving possession or use). Such interventions should include but not be limited to:
(a) mandatory inclusion of safety devices on all firearms, whether manufactured or imported into the United States, including built-in locks, loading indicators, safety locks on triggers, and increases in the minimum pressure required to pull triggers;
(b) bans on the possession and use of firearms and ammunition by unsupervised youths under the age of 21;
(c) bans of sales of firearms and ammunition from licensed and unlicensed dealers to those under the age of 21 (excluding certain categories of individuals, such as military and law enforcement personnel);
(d) the imposition of significant licensing fees for firearms dealers;
(e) the imposition of federal and state surtaxes on manufacturers, dealers and purchasers of handguns and semiautomatic repeating weapons along with the ammunition used in such firearms, with the attending revenue earmarked as additional revenue for health and law enforcement activities that are directly related to the prevention and control of violence in U.S. society; and
(f) mandatory destruction of any weapons obtained in local buy-back programs.
(2) Support legislation outlawing the Black Talon and other similarly constructed bullets.
(3) Support the right of local jurisdictions to enact firearm regulations that are stricter than those that exist in state statutes and encourage state and local medical societies to evaluate and support local efforts to enact useful controls.
(4) Oppose concealed carry reciprocity federal legislation that would require all states to recognize concealed carry firearm permits granted by other states and that would allow citizens with concealed gun carry permits in one state to carry guns across state lines into states that have stricter laws.
(5) Support the concept of gun buyback programs as well as research to determine the effectiveness of the programs in reducing firearm injuries and deaths.
Citation: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-14; Appended: Res. 427, A-18; Reaffirmation: A-18; Modified: Res. 244, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 232
(N-21)

Introduced by: New York, Medical Student Section, Minority Affairs Section, GLMA: Health Professionals Advancing LGBTQ Equality, American Academy of Psychiatry and the Law, American Psychiatric Association, California, American Academy of Child and Adolescent Psychiatry, American Association of Geriatric Psychiatry

Subject: Ban the Gay/Trans (LGBTQ+) Panic Defense

Referred to: Reference Committee B

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1 Whereas, The gay/trans panic (to be more inclusive will use “LGBTQ+ panic”) defense strategy
2 is a legal strategy that uses a victim’s sexual orientation or gender identity/expression as an
3 excuse for a defendant’s violent reaction, seeking to legitimize and even to excuse violent and
4 lethal behavior (1); and
5
6 Whereas, The LGBTQ+ panic defense strategy gives defendants three options of defense: 1)
7 insanity or diminished capacity, 2) provocation, 3) self-defense (3); and
8
9 Whereas, To claim:
10
11 - insanity, defendants claim that the sexual orientation or gender of the victim is enough to
12 induce insanity (1);
13
14 - provocation, defendants claim “victim’s proposition, sometimes termed a “non-violent sexual
15 advance” was sufficiently “provocative” to induce the defendant to kill the victim”(1);
16
17 - self-defense, “defendants claim they believed that the victim, because of their sexual
18 orientation or gender identity/expression, was about to cause the defendant serious bodily
19 harm (3)”; and
20
21 Whereas, Studies have shown that jurors with higher homonegativity and religious
22 fundamentalism ratings assigned higher victim blame, lower defendant responsibility, and more
23 lenient verdicts in the “LGBTQ+ panic” conditions (5,6,7); and
24
25 Whereas, “Gay panic disorder” was removed from the DSM in 1973 because the APA
26 recognized that no such condition exists; and
27
28 Whereas, Many murder sentences have been reduced or defendants have been acquitted using
29 the LGBTQ+ panic defense strategy such as in the Matthew Shepard case, to successfully
30 mitigate a charge from murder to criminally negligent manslaughter as recently as 2018 (1); and
31
32 Whereas, The LGBTQ community makes up 3.5% of the US population yet, sexual orientation
33 is the motivator of 17% of hate crime attacks with one in four transgender people becoming the
34 victim of a hate crime in their lifetime (4, 5); and

Whereas, The LGBTQ+ panic defense has only been banned in 11 states as of February 2021, with legislation having been introduced in 12 more states (1, 2); and

Whereas, New York State passed a law in June 2019 banning the gay/trans (LGBTQ+) Panic Defense, preventing a setback in protections for LGBTQ+ people; and

Whereas, At least 44 Transgender or Gender Non-Conforming persons have been killed in the US during the year 2020, the highest total since HRC started tracking in 2013 (9); and

Whereas, There is not a race panic defense for a reason, and similar reasoning must disallow a gay/trans (LGBTQ+) panic defense; therefore be it

RESOLVED, That our American Medical Association seek a federal law banning the use of the so-called "gay/trans (LGBTQ+) panic" defense in homicide, manslaughter, physical or sexual assault cases (Directive to Take Action); and be it further

RESOLVED, That our AMA publish an issue brief and talking points on the topic of so called "gay/trans (LGBTQ+) panic" defense, that can be used by our AMA in seeking federal legislation, and can be used and adapted by state and specialty medical societies, other allies, and stakeholders as model legislation when seeking state legislation to ban the use of so-called "gay/trans (LGBTQ+) panic" defense to mitigate personal responsibility for violent crimes such as assault, rape, manslaughter, or homicide. (Directive to Take Action)

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

Received: 10/13/21

AUTHOR'S STATEMENT OF PRIORITY:

Transgender people, our patients, specifically transgender women of color, are at an extremely high risk of dying by homicide. Last year a record number of deaths were recorded in the US (46- an underestimate given the under reporting of transgender identity). By mid-April, there are 15 known homicides of transgender people as reported by HRC. If this pace continues for 2021, another record will be broken on pace for over 50 homicides this year. AMA must act now to protect transgender people, and to send a clear message to all of our transgender patients and our LGBTQ+ patients, that we see them, value them, support them, and fight for them. This resolution must be heard at the AMA – it was extracted in June from the "not for consideration list" for further consideration and is being resubmitted **with support from seven additional organizations**. This is a critically important resolution that needs to be moved forward by the AMA so that model legislation can be shared and to provide justice for transgender people.

RELEVANT AMA POLICY

Preventing Anti-Transgender Violence H-65.957
Our AMA will: (1) partner with other medical organizations and stakeholders to immediately increase efforts to educate the general public, legislators, and members of law enforcement using verified data related to the hate crimes against transgender individuals highlighting the disproportionate number of Black transgender women who have succumbed to violent deaths: (2) advocate for federal, state, and local law enforcement agencies to consistently collect and report data on hate crimes, including victim demographics, to the FBI; for the federal government to provide incentives for such reporting; and for demographic data on an

individual's birth sex and gender identity be incorporated into the National Crime Victimization Survey and the National Violent Death Reporting System, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; (3) advocate for a central law enforcement database to collect data about reported hate crimes that correctly identifies an individual's birth sex and gender identity, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; (4) advocate for stronger law enforcement policies regarding interactions with transgender individuals to prevent bias and mistreatment and increase community trust; and (5) advocate for local, state, and federal efforts that will increase access to mental health treatment and that will develop models designed to address the health disparities that LGBTQ individuals experience.
Citation: Res. 008, A-19

Access to Basic Human Services for Transgender Individuals H-65.964
Our AMA: (1) opposes policies preventing transgender individuals from accessing basic human services and public facilities in line with ones gender identity, including, but not limited to, the use of restrooms; and (2) will advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender individuals according to ones gender identity.
Citation: Res. 010, A-17

Support of Human Rights and Freedom H-65.965
Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.
Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 233
(N-21)

Introduced by: New York

Subject: Insurers and Vertical Integration

Referred to: Reference Committee B

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1 Whereas, Insurers already enjoy significant marketplace advantages, such as keeping
2 healthcare data opaque from other stakeholders, marketplace consolidation, and monopsony
3 power; and
4
5 Whereas, These advantages have not resulted in cost savings (or even stability) for
6 consumers--in fact cost increases born by consumers have been outsized and correlated with
7 consolidation; and
8
9 Whereas, Insurers have increasingly been pursuing mergers--in the name of promoting
10 efficiency; and
11
12 Whereas, These “efficiencies” rarely, if ever, benefit the consumer; and
13
14 Whereas, These combined entities (especially vertical ones) are more competitive among their
15 competitors than the uncombined ones (accelerating further consolidation); and
16
17 Whereas, The combined entities are also positioned (due to their superior access to capital) to
18 unfairly disrupt entities at other points in the supply chain such as medical practices, community
19 pharmacies, and safety net hospitals; therefore be it
20
21 RESOLVED, That our American Medical Association seek legislation and regulation to prevent
22 health payers (except non-profit HMO’s) from owning or operating other entities in the health
23 care supply chain. (Directive to Take Action)

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

Received: 10/13/21

AUTHOR’S STATEMENT OF PRIORITY

As a matter of protecting public health and reducing health payor interference in patient care delivery, it is critical that AMA continue to actively work to prevent large entities from creating these monopolies. While the AMA has taken important steps in recent years to challenge these mergers and acquisitions, existing AMA policy is four years old. The efforts on the part of health payers to absorb practices, pharmacy benefit managers, medical equipment suppliers etc. continues and will create a health care market without any competition. This will not be good for our patients nor for physicians. These entities should be controlled by nothing more than the competitive free market system. Allowing health insurers to control more and more elements of the health care supply chain will result in even greater interference in the physician-patient relationship and decrease access to care for our patients. AMA is strongly urged to take immediate action to update its policy on this subject.

RELEVANT AMA POLICY

Health Insurance Company Purchase by Pharmacy Chains D-160.920
Our AMA will: (1) continue to analyze and identify the ramifications of the proposed CVS/Aetna or other similar merger in health insurance, pharmacy benefit manager (PBM), and retail pharmacy markets and what effects that these ramifications may have on physician practices and on patient care; (2) continue to convene and activate its AMA-state medical association and national medical specialty society coalition to coordinate CVS/Aetna-related advocacy activity; (3) communicate our AMAs concerns via written statements and testimony (if applicable) to the U.S. Department of Justice (DOJ), state attorneys general and departments of insurance; (4) work to secure state level hearings on the merger; and (5) identify and work with national antitrust and other legal and industry experts and allies.
Citation: BOT Action in response to referred for decision Res. 234, I-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 234
(N-21)

Introduced by: Illinois, California, Iowa, Georgia, New Jersey, Pennsylvania, American Academy of Ophthalmology, American Society of Cataract and Refractive Surgery, American Society of Ophthalmic Plastic and Reconstructive Surgery, American Society of Retina Specialists

Subject: Permitting the Dispensing of Stock Medications for Post Discharge Patient Use and the Safe Use of Multi-dose Medications for Multiple Patients

Referred to: Reference Committee B

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1 Whereas, A topical stock-item medication is an unlabeled ointment or drop that the hospital
2 operating room (OR), or Emergency Room (ER), or Ambulatory Surgical Treatment Center
3 (ASTC) staff has on stand-by or is retrieved from a dispensing system for a specified patient for
4 use during a procedure or visit; and
5
6 Whereas, Topical stock-item agents are charged to the patient, but unused medication often
7 gets discarded when the patient is discharged, even if the medication is recommended for
8 post-discharge care to aid in the patient's healing; and
9
10 Whereas, Because regulations governing the ability to dispense the remaining portion of stock-
11 item medications for post-discharge use can be unclear or appear overly burdensome, many
12 facilities do not allow the practice; and
13
14 Whereas, Patients may need to purchase duplicate agents for post-discharge use, increasing
15 patient cost and creating medication waste; and
16
17 Whereas, Similar issues of cost inefficiencies and medical waste arise with the use of
18 medications such as multiuse eye drops that are only allowed for single-patient use, but could
19 safely be used in multiple patients; and
20
21 Whereas, The Joint Commission has previously approved specific policies and procedures
22 implemented by the Utah Valley Regional Medical Center for the use of multi dose eye drops in
23 multiple patients; therefore be it
24
25 RESOLVED, That our American Medical Association work with national specialty societies,
26 state medical societies and/or other interested parties to advocate for legislative and regulatory
27 language that permits the practice of dispensing stock-item medications to individual patients
28 upon discharge in accordance with labeling and dispensing protocols that help ensure patient
29 safety, minimize duplicated patient costs, and reduce medication waste (Directive to Take
30 Action); and be it further

1 RESOLVED, That our AMA work with the Food and Drug Administration, national specialty
2 societies, state medical societies and/or other interested parties to advocate for legislative and
3 regulatory language that permits the practice of using multi dose eye drop bottles
4 post-operatively in accordance with safe handling and dispensing protocols that help ensure
5 patient safety, minimize duplicated patient costs, and reduce medication waste. (Directive to
6 Take Action)

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

Received: 10/15/21

AUTHORS STATEMENT OF PRIORITY

This resolution reflects an issue that is urgent and affects most physicians and their patients. Health care costs are rising at an unsustainable rate, which jeopardizes access to care. There is significant medical waste associated with the disposal of certain stock medications, which patients could continue to use safely if they were dispensed to the patient upon discharge. AMA action or policy statement will have a positive impact. We should quickly pursue clarifying legislative and regulatory language that removes this barrier to the efficient and safe use of medications that would otherwise be wasted.

Reference:

Using multi dose eye drops in a health care setting: a policy and procedural approach to safe and effective treatment of patients. Jensen MK, et al. JAMA Ophthalmology 2014. https://jamanetwork.com/journals/jamaophthalmology/article-abstract/1901216

Reference Committee C

CME Report(s)

01 Guiding Principles and Appropriate Criteria for Assessing the Competency of Late Career Physicians
02 A Study to Evaluate Barriers to Medical Education for Trainees with Disabilities
03 Rural Health Physician Workforce Disparities
04 Medical Student Debt and Career Choice
05 Investigation of Existing Application Barriers for Osteopathic Medical Students Applying for Away Rotation

Resolution(s)

301 Equitable Reporting of USMLE Step 1 Scores
302 University Land Grant Status in Medical School Admissions
303 Decreasing Bias in Evaluations of Medical Student Performance
304 Reducing Complexity in the Public Service Loan Forgiveness Program
305 Increase Awareness Among Residency, Fellowship, and Academic Programs on the United States-Puerto Rico Relationship Status
306 Support for Standardized Interpreter Training
307 Support for Institutional Policies for Personal Days for Undergraduate Medical Students
308 Modifying Eligibility Criteria for Association of American Medical Colleges' Financial Assistance Program
309 Protecting Medical Student Access to Abortion Education and Training
310 Resident and Fellow Access to Fertility Preservation
311 Improving Access to Physician Health Programs for Physician Trainees
312 Accountable Organizations to Resident and Fellow Trainees
313 Establishing Minimum Standards for Parental Leave During Graduate Medical Education Training
314 Updating Current Wellness Policies and Improving Implementation
315 Reducing Overall Fees and Making Costs for Licensing, Exam Fees, Application Fees, etc. Equitable for IMGs
316* Medical Education Debt Cancellation in the Face of a Physician Shortage During the COVID-19 Pandemic
317* Creating a More Accurate Accounting of Medical Education Financial Costs
318* The Medical Student Match Mismatch

* Contained in the Handbook Addendum

REPORT 1 OF THE COUNCIL ON MEDICAL EDUCATION
Guiding Principles and Appropriate Criteria for Assessing the Competency of Late Career Physicians (CME Report 1-N-21)
(Reference Committee C)

EXECUTIVE SUMMARY

Older physicians remain an essential part of the physician workforce as they continue to practice into their 70s and 80s. Although some studies of physicians have shown decreasing practice performance with increasing years in medical practice, the effect of age on any individual physician's competence can be highly variable. The call for increased accountability by the public has led regulators and policymakers to consider implementing some form of age-based competency screening to assure safe and effective practice. In addition, some hospitals and medical systems have initiated age-based screening, but there is no national standard. Older physicians are not required to pass a health assessment or an assessment of competency or quality performance in their area or scope of practice. Physicians must lead in developing standards for monitoring and assessing their own personal competency and that of their peers. Otherwise, other entities may take action, without evidence, to implement national guidelines and a mandatory retirement age.

The Council on Medical Education studied this issue and submitted reports on this topic in 2015 and 2018. The second report, "Competency of Senior Physicians" (I-18) was referred for further study due to concerns among the House of Delegates that the AMA was advocating for a screening process for senior/late career physicians. This report is in response to that referral. Due to the impact of COVID-19, this report was deferred for business until the N-21 Meeting of the HOD.

The 2015 report led to AMA Policy D-275.956, "Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians," which charged the Council, in collaboration with the Senior Physicians Section, to identify organizations to work together to develop guidelines for screening and assessing the competency of the late career physician. The AMA Work Group on Assessment of Senior/Late Career Physicians included key stakeholders that represented physicians, medical specialty societies, accrediting and certifying organizations, hospitals and health systems, and patients' advocates as well as content experts who research physician competence and administer assessment programs.

The work group concurred that it was important to investigate the current screening practices and policies of the state medical and osteopathic boards, medical societies, large U.S. health systems, and remediation programs as well as to collect data and review the current literature to learn more about age and risk factors associated with the assessment of late career physicians in the United States and internationally. This report summarizes the activities of the work group and additional research findings on this topic.

This report does not mandate an assessment. The intent of this report is to outline a set of guiding principles that have been developed by the Council with extensive feedback from members of the work group as well as from other content experts who research physician competence and administer assessment programs. The guiding principles provide direction and serve as a reference for guidelines for screening and assessing late career physicians. The underlying assumption is that guidelines must be based on evidence and on the principles of medical ethics. Furthermore, guidelines should be relevant, supportive, fair, equitable, and transparent, and not result in undue cost or burden to physicians. The primary driver for the establishment of guidelines should be to fulfill the ethical obligation of the profession to the health of the public and patient safety.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-N-21

Subject: Guiding Principles and Appropriate Criteria for Assessing the Competency of Late Career Physicians

Presented by: Niranjan Rao, MD, Chair

Referred to: Reference Committee C

At the 2018 Interim Meeting of the American Medical Association (AMA) House of Delegates, the AMA Council on Medical Education presented Report 1-I-18, "Competency of Senior Physicians," which was in response to AMA Policy D-275.956, "Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians," which directs the AMA to: "1) identify organizations that should participate in the development of guidelines and methods of screening and assessment to assure that senior/late career physicians remain able to provide safe and effective care for patients; and 2) convene organizations identified by the AMA to work together to develop preliminary guidelines for assessment of the senior/late career physician and develop a research agenda that could guide those interested in this field and serve as the basis for guidelines more grounded in research findings."

The HOD referred the report for further study. This report is in response to that referral. Due to the impact of COVID-19, this report was deferred for business until the N-21 Meeting of the House of Delegates.

It is important to note that this report does not mandate an assessment. The intent of this report is to outline a set of guiding principles to provide direction and serve as a reference for guidelines for screening and assessing late career physicians.

BACKGROUND: SCOPE OF THE ISSUE

The total number of physicians 65 years and older has increased greatly, from 50,993 in 1975 to 343,694 in 2019.[1] Physicians 65 and older currently represent 29.8 percent of all physicians in the United States.[1] Within this age group, two-fifths (43.6 percent) are actively engaged in patient care, while nearly half (49.3 percent) are listed as inactive in the AMA Physician Masterfile. The remainder are involved in teaching, administration, medical research or non-patient care.[1] Additionally, more than a quarter of physicians practicing in rural communities are age 60 years or older.[2-3] Many physicians are hesitant to retire and may continue to practice into their 70s and 80s due to professional satisfaction, increased life expectancy, and concerns regarding financial security.[4]

There is evidence that physical health and some cognitive abilities decline with aging.[5] For example, recent studies have associated hearing loss, which is one of the most prevalent disorders of aging, with dementia and decreasing cognition.[6-7] Research also shows that cognitive dysfunction is more prevalent among older adults, although aging does not necessarily result in cognitive impairment.[8] The effect of age on any physician's competence can be highly variable, and aging is just one of several factors that may impact performance.[4,9] Other factors may influence

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clinical performance, e.g., practice setting, lack of board certification, high clinical volume, certain specialty practices, etc.[10, 11] Fatigue, stress, burnout, and health issues unrelated to aging are also risk factors that can affect clinical performance.[11] Performance also may be broadly determined by characteristics ranging from intelligence to personality.[5] However, some attributes relevant to the practice of medicine—such as wisdom, resilience, compassion, and tolerance of stress—may actually improve as a function of aging.[9, 12-15]

Although age alone may not be associated with reduced competence, the variation in cognitive abilities as physicians age suggests that the issue cannot be ignored. While physicians may retain expertise from years of experience, in some specialties (especially in procedurally oriented disciplines), the accuracy and precision of a practitioner's skills tend to deteriorate without continued practice and repeated training.[16] When a performance issue becomes apparent, the physician and health care system must ensure that the physician can demonstrate the necessary competence for practice skills or procedural expertise, retrain for the necessary skills, or retire that procedural expertise from their practice.[16-17]

There are a limited number of validated tools for measuring competence/performance, but these tools are primarily used when a physician is "referred for cause." In addition, physicians' practices vary throughout the United States and from specialty to specialty. A few hospitals have introduced mandatory age-based evaluations, but there is no national standard.[18-19] Furthermore, there is cultural resistance among physicians to externally imposed assessment approaches and concern about discriminatory policies and procedures.

Knowing when to give up practice remains an important decision for most doctors and a critically difficult decision for some.[20] Older physicians have decades of experience and contributions to medicine and to their patients. So, as they experience health changes that may or may not allow continued clinical practice, they deserve the same sensitivity and respect afforded their patients.[21] Shifting away from procedural work, allocating more time with individual patients, using memory aids, and seeking input from professional colleagues may help physicians successfully adjust to the cognitive changes that accompany aging yet continue providing valuable health care services for years to come.[9, 20]

PHYSICIANS' PROFESSIONAL RESPONSIBILITIES

Council on Ethical and Judicial Affairs (CEJA) Report 1-I-19, "Competence, Self-Assessment and Self-Awareness" notes that, "to fulfill their ethical responsibility of competence, physicians at all stages in their professional lives should cultivate and exercise skills of self-awareness and active self-observation; take advantage of tools for self-assessment that are appropriate to their practice settings and patient populations; and be attentive to environmental and other factors that may compromise their ability to bring their best skills to the care of individual patients." In its report, CEJA recommends that "individual physicians and physicians in training should strive to: recognize that different points of transition in professional life can make different demands on competence; and maintain their own health, in collaboration with a personal physician, in keeping with ethics guidance on physician health and wellness."

The AMA *Code of Medical Ethics* has always stated that physicians of all ages must maintain their health and wellness, and, if a health issue arises, they must seek appropriate help from a personal physician whose objectivity is not compromised to honestly assess their ability to continue practicing safely.[22] The prohibition of self-treatment is imperative. However, a recent review of studies associated with self-diagnosis, self-referral, and self-treatment among physicians showed that self-treatment is strongly embedded within the culture of physicians and medical students as an

accepted way to enhance/buffer work performance.[23] This may be due to a culture in medicine that physicians do not expect themselves or their colleagues to be sick.[23] In response, many hospitals are beginning to establish health and wellness committees to confidentially address concerns regarding practitioners' health.

It is also in physicians' best interest to proactively address issues related to aging in order to maintain professional self-regulation. Since its adoption at the founding meeting of the AMA in 1847, the AMA *Code of Medical Ethics* has articulated the values to which physicians commit themselves as members of the medical profession. Chapter 9, Opinions on Professional Self-Regulation, states, "Society permits medicine to set standards of ethical and professional conduct for physicians. In return, medicine is expected to hold physicians accountable for meeting those standards and to address lapses in professional conduct when they occur."[24] Self-regulation is an important aspect of medical professionalism, and helping colleagues recognize their declining skills is an important part of self-regulation.[25] Furthermore, contemporary methods of self-regulation (e.g., clinical performance measurement; continuing professional development requirements, including novel performance improvement continuing medical education programs; and continuing board certification programs) have been created by the profession to meet shared obligations for quality assurance and patient safety.

From a public protection perspective, the objective assessment option seems like an important intervention, given the strong impact of aging on performance, the extreme variability of cognitive function among older physicians, and the well-documented inability of physicians to self-assess—particularly among those physicians who are less competent.[26] In the literature, Eva advised caution regarding the above interventions, with significant resource and administrative implications; they should not be universally mandated but implemented through a case-by-case, assessment-driven process, given the extreme variability of cognitive findings among older physicians.[27] External, objective assessment also seems essential, given that non-analytic processes may be even less accessible to critical self-appraisal than the more conscious analytical processes.

The Joint Commission's Requirements

Health care entities that credential or employ physicians have an obligation to assess physicians' health in the hiring and privileging process. The Joint Commission standard MS.11.01.01 is specifically written to encourage medical staff to identify and manage matters of individual health for licensed independent practitioners which are separate from actions taken for disciplinary purposes. The standard focuses on the education of physicians to recognize issues in others and encourages self-referral to facilitate confidential diagnosis, treatment, and rehabilitation by assisting a practitioner to retain and regain optimal professional functioning consistent with the protection of patients. If it is determined, however, that a physician is unable to practice safely, The Joint Commission standard calls for the matter to be reported to the medical staff leadership for appropriate corrective action.[28]

WORK GROUP MEETINGS

To fulfill the directive of Policy D-275.956, the Council on Medical Education, in collaboration with the Senior Physicians Section, identified organizations to participate in a joint effort to develop guidelines for screening and assessing the late career physician. As summarized below, a work group meeting and two conference calls were convened to develop a research agenda that could guide those interested in this field and serve as the basis for guidelines supported by research.

March 16, 2016 Work Group Meeting

The work group meeting, held March 16, 2016, brought together key stakeholders that represented physicians, medical specialty societies, accrediting and certifying organizations, hospitals and other health care institutions, and patient advocates as well as content experts who research physician competence and administer assessment programs. Work group participants concurred that this first meeting raised important issues related to the rationale for developing guidelines to screen and assess the competence and practice performance of late career physicians, which is challenging for a number of reasons. Discussion centered around the evidence and factors related to competency and aging physicians, existing and needed policies, screening and assessment approaches, and legal requirements and challenges. Although current evidence and initial research pointed toward the need for developing guidelines, most work group participants felt that additional information/data should be gathered on aging physicians' competence and practice performance. In addition, the participants felt that a set of guiding principles should be developed to reflect the values and beliefs underlying any guidelines that may be developed for screening and assessing late career physicians.

July 19, 2016, Work Group Conference Call

The purpose of this conference call was to convene a smaller group of participants to develop guiding principles to support the guidelines to screen and assess late career physicians. During the call, the conversation focused upon the thresholds at which screening/assessment should be required. Although physicians of all ages can be assessed "for cause," the group discussed whether age alone is a sufficient rationale for monitoring beyond what is typical for all physicians. Other factors discussed included the influence of practice setting and medical specialty, as well as the metrics and standards for different settings that would have to be developed to determine at "what age" and "how do you test," etc. The need for surveillance, associated risk factors, and the ability to take appropriate corrective steps, if needed, were also discussed. It was noted that there is a need to be able to fairly and equitably identify physicians who may need help while assuring patient safety. It was also noted that very few hospitals have specific age guidelines, and evidence shows that the number of disciplinary actions increases between ages 65 and 70. The cost of and who will pay for screening/assessments were also discussed.

The group felt that more information and data were needed before the guiding principles could be finalized and agreed to reconvene after gathering more information and studying evidence-based data from the United States and other countries related to age and risk factors.

December 15, 2017, Work Group Conference Call

The purpose of this conference call was to reconvene the same smaller group of participants to review the literature and data that had been gathered and finalize guiding principles to support the guidelines to screen and assess late career physicians. Background information to help guide the guiding principles included:

1. Results from a survey of members of the Federation of State Medical Boards (FSMB), Council of Medical Specialty Societies (CMSS), and International Association of Medical Regulatory Authorities (IAMRA) regarding the screening and assessment of late career physicians.

2. A literature review of available data related to late career physician screening and assessment, focusing on international work in this area.

3. Data from large health systems regarding their screening and assessment policies and procedures.

Survey Results Related to Screening and Assessing Late Career Physicians

To support the development of guiding principles, data were gathered through surveys of professional associations (CMSS), state medical boards (FSMB), and international regulatory authorities (IAMRA). The goal was to learn if these organizations had processes in place to screen and assess late career physicians for clinical or cognitive competence and, if not, whether they had considered developing such processes.

The survey data showed that most respondents were not screening or assessing late career physicians, although a slightly larger number of respondents have thought about the issues around doing so.

Most respondents did not have clinical or cognitive screening/competence assessment policies in place. In addition, most did not know (42, or 46.7 percent) or were unsure (26, or 28.9 percent) whether other organizations had age-based screening in place. Regarding whether age-based screening should be included within physician wellness programs, only 28 (32.9 percent) said yes and nine (10.6 percent) no, while more than half, or 48 (56.5 percent) were unsure.

Respondents were asked if their organizations/boards offered educational resources regarding the effects of age on physician practice; eight (9.2 percent) said yes, 72 (82.8 percent) said no, and seven (8.0 percent) were unsure. The survey also asked organizations if they were interested in resources that promoted physician awareness of screening aging physicians in practice. Very few groups offered these types of resources, but 100 percent (11) of IAMRA respondents, 60.8 percent (31) of FSMB respondents, and 25 percent (3) of CMSS respondents were interested in offering them.

HIGHLIGHTS FROM THE LITERATURE REVIEW

As summarized below, the current literature on age and risk factors associated with the assessment of late career physicians (in the United States and internationally) is significant and offers some direction for appropriate solutions to this challenge.

Recently published peer-reviewed studies focus on institutional policies related to cognitive assessment of late career physicians. Dellinger et al. concluded that as physicians age, a required cognitive evaluation combined with a confidential, anonymous feedback evaluation by peers and coworkers, including a focus on wellness and competence, would be beneficial both to physicians and their patients.[29] The authors also recommended that large professional organizations identify a range of acceptable policies to address the aging physician, while leaving institutions the flexibility to customize the approach.[29] Hickson et al. suggested that evaluation tools be integrated into an evidence-based longitudinal assessment of cognitive and behavioral skills that allows for reliable determination of a physician's ability to practice.[30] However, the process of identification of physicians with declining cognitive and clinical skills must be done with an awareness of laws protecting colleagues from discrimination.[30] Institutions such as Cooper University Health Care in Camden, New Jersey, are developing late career practitioner policies that include cognitive assessment along with peer review and medical assessment to assure both the hospital and physicians that physician competency is present and that physicians can continue to practice with confidence.[31]

Studies related to the utility of professionalism, self-reporting, and peer review in heading off competency issues indicate that these methods are not always reliable. For example, DesRoches et al. found that more than one-third of physicians were not clear on their obligation to report a colleague who is impaired or incompetent, one-third were unprepared to deal with such colleagues, and many appeared to not take action. Among the 17% of physicians who reported being aware of an impaired or incompetent colleague, one-third said that they did not report that individual.[25, 32, 33] Since early "red flags" of cognitive impairment may include prescription errors, billing mistakes, irrational business decisions, skill deficits, patient complaints, office staff observations, unsatisfactory peer review, patient injuries, or lawsuits, Soonsawat et al. encouraged improved reporting of impaired physicians by patients, peers, and office staff.[4]

A study that utilized the national Patient Advocacy Report System (PARS®) database showed that patients may provide an important source of information for health care organizations interested in identifying professionals with evidence of cognitive impairment.[34] LoboPrabhu et al. suggested that either screening for cognitive impairment be implemented at a certain age or that rigorous evaluation after lapses in standard of care be the norm, regardless of age.[35]

Any screening process needs to achieve a balance between protecting patients from harm due to substandard practice while ensuring fairness to physicians and avoiding any unnecessary reductions in workforce.[5] A recent study of U.S. late career surgeons showed that a steady proportion of surgeons, even in the oldest age group (>65), are still learning new surgical innovations and participating in challenging cases.[36] Individual and institutional considerations require a dialogue among the interested parties to optimize the benefits while minimizing the risks for both.[37-38]

In 2018, the Society of Surgical Chairs (SCS) conducted an anonymous survey of its membership. The survey respondents defined an age for an aging surgeon as follows: 25 (53 percent) selected 65 years of age and 14 (30 percent) selected 70 years of age, while none believed that surgeons younger than 60 years would be considered an aging surgeon.[39] These results are consistent with a 2013 Report from the Coalition for Physician Enhancement Conference in which 72 percent of their respondents recommended screening beginning at ages 65 to 70 years.[9, 39] In 2019, the SCS released transition recommendations for the senior surgeon which include mandatory cognitive and psychomotor testing of surgeons by age 65, possibly as part of regular professional practice evaluations; discussions with surgeons about career transition starting early in their careers; careful consideration of the financial needs, work commitments, and various concerns of retiring surgeons; and creation of opportunities for senior surgeons in modified clinical or nonclinical roles (e.g., teaching, mentoring, or coaching and/or administrative).[72]

The international community continues to address this topic. In Canada, the aging medical workforce presents a challenge for medical regulatory authorities charged with protecting the public from unsafe practice. However, Adler and Constantinou argued that normal aging is associated with some cognitive decline as part of the aging process, but physicians, as highly educated individuals with advanced degrees, may be less at risk.[20]

A review of the aging psychiatric workforce in Australia showed how specific cognitive and other skills required for the practice of psychiatry vary from those applied by procedural specialists.[40] In 2017, the Medical Board of Australia proposed requiring physicians to undergo peer review and health checks at age 70 and every three years thereafter.[41] There is some uniformity in the way that Australian regulatory bodies deal with impairment that supports the dual goals of protecting the public and rehabilitating the physician.[42] However, there are no agreed-upon guidelines to help medical boards decide what level of cognitive impairment in a physician may put the public at risk.[20] In Australia, the primary approach to dealing with older physicians (age 55 and older) is

individualized and multi-level, beginning with assessment, and followed by rehabilitation where appropriate; secondary measures proposed for older impaired physicians include early notification and facilitation of career planning and timely retirement.[42]

It is the responsibility of licensing bodies in New Zealand, Canada, and the United Kingdom to use reasonable methods to determine whether performance remains acceptable.[43] For example, the College of Physicians and Surgeons of Ontario (Canada) assesses all practicing physicians not assessed in the last five years at age 70 and then every five years as long as they are in active practice, via chart review.[44, 45] However, high performance by all physicians throughout their careers cannot be fully ensured, and so it is not clear that an age threshold is the best method of assessment

A better understanding of physician aging and cognition can inform more effective approaches to continuous professional development and lifelong learning in medicine—a critical need in a global economy, where changing technology can quickly render knowledge and skills obsolete.[8] The development of continuing board certification programs provides an opportunity to study the knowledge base across the professional lifespan of physicians.[46, 47] For example, a recent study of initial certification and recertification examinees in the subspecialty of forensic psychiatry, using a common item test question bank, compared two examinee groups' performance and demonstrated that performance for those 60 and older was similar to that of those younger than 50. Diplomates recertifying for the second time outperformed those doing so for the first time.[48]

The Royal Australasian College of Surgeons developed strategies to support late career surgeons over 65 years of age (expected to be about 25 percent of surgeons by 2050). It also wrote a position statement that provides clear guidelines to aging surgeons, with a focus on continuing professional development.[49, 50] An assessment of the competence of practicing physicians in New Zealand, Canada, and the United Kingdom showed that maintenance of professional standards by continuing education did not identify the poorly performing physician; rather, assessment of clinical performance was needed.[43] Therefore, the most common approach to assessment may be responsive—following a complaint—or periodic, either for all physicians or for an identified high-risk group. However, a single, valid, reliable, and practical screening tool is not available.[43]

A review of the European literature to explore the effects of aging on surgeons' performance and to identify current practical methods for transitioning surgeons out of practice at the appropriate time and age was completed. The reviewers suggested that competence should be assessed at an individual level, focusing on functional ability over chronological age; this may inform retirement policies for surgeons, which differ worldwide.[36] Research conducted in Canada suggested that some interventions (external support, deliberate practice, and education and testing) might prove successful in remediating older physicians, who should be tested more thoroughly.[27]

Careful planning, innovative thinking, and the incorporation of new patterns of medical practice are all part of this complex transition into retirement in the United States.[37, 51] A literature review that looked at retirement ages for doctors in different countries found that most countries had no mandatory retirement age for doctors.[52] Anecdotal reports published in the *British Medical Journal* suggested that the decision to retire is getting harder for some physicians because requirements for reappraisal and other barriers are discouraging some from considering part-time work after retirement.[53, 54] In Canada, Ireland, and India, the retirement age (65) is limited to public sectors only, but older physicians can continue to practice in the private sector.[52] In Russia and China, the mandated retirement age is 60 for men and 55 for women.[52]

Studies show that doctors can mitigate the impact of cognitive decline by ceasing procedural work, allocating more time to each patient, using memory aids, seeking advice from trusted colleagues, and seeking second opinions.[20] Peisah et al. (Australia) proposed a range of secondary and primary prevention measures for dealing with the challenge of the older impaired doctor; these included educating the medical community, encouraging early notification, and facilitating career planning and timely retirement of older doctors.[42] Racine (Canada) suggested that physicians retire before health or competency issues arise.[55] Lee (Canada) suggested that older practicing physicians consider slowing down in aspects of practice that require rapid cognitive processing and listen carefully to the concerns of colleagues, patients, friends, and family.[56] The University of Toronto, Department of Surgery, has developed Guidelines for Late Career Transitions that require each full-time faculty surgeon to undergo an annual assessment of academic and surgical activity and productivity. As surgeons age, the University creates individual plans for a decrease in on-call surgical responsibilities and encourages late career surgeons to engage in greater levels of teaching, research, and administration.[57]

How Some U.S. Organizations Are Addressing the Screening and Assessment of Competency of Late Career Physicians

The public call for increased accountability led regulators and policymakers to consider implementing some form of age-based competency screening to assure safe and effective practice.[9] The work group concurred that it was important to investigate existing screening practices and policies of state medical and osteopathic boards, medical societies, large U.S. health systems, and remediation programs. Some of the more significant findings are summarized below.

All physicians must meet state licensure requirements to practice medicine in the United States. In addition, some hospitals and medical systems have initiated age-based screening,[18, 19] but there is no national standard. In many instances, older physicians are not required to pass a health assessment or an assessment of competency or quality performance in their area or scope of practice.

The American College of Surgeons (ACS) explored the challenges of assessing aging surgeons. Recognizing that the average age of the practicing surgeon is rising and approximately one-third of all practicing surgeons are 55 and older, the ACS was concerned that advanced age may influence competency and occupational performance. In January 2016, the ACS Board of Governors' Physician Competency and Health Workgroup published a statement that emphasized the importance of high-quality and safe surgical care.[56] The statement recognized that surgeons are not immune to age-related decline in physical and cognitive skills and stressed the importance of a healthy lifestyle. The ACS recommended that, starting at ages 65 to 70, surgeons undergo a voluntary and confidential baseline medical examination and visual testing for overall health assessment, with regular reevaluation thereafter. In addition, the ACS encouraged surgeons to voluntarily assess their neurocognitive function using confidential online tools and asserted a professional obligation to disclose any concerning findings, as well as inclusion of peer review reports, in the recredentialing process.[58]

The American College of Obstetricians and Gynecologists (ACOG) recommends that when evaluating an aging physician, focus should be placed on the quality of patient care.[59] ACOG's recommendations regarding the late career obstetrician-gynecologist also state that: 1) it is important to establish systems-based competency assessments to monitor and address physicians' health and the effect age has on performance and outcomes; 2) workplace adaptations should be adopted to help obstetrician-gynecologists transition and age well in their practice and throughout their careers; and 3) to avoid the potential for legal challenges, hospitals should address the

provisions of the Age Discrimination in Employment Act, making sure that assessments are equitably applied to all physicians, regardless of age.[59]

At Kaiser Permanente, within its federation of contracted Permanente Medical Groups, physicians are classified as "in partnership" or "incorporated" based on how the Permanente Medical Group in the applicable geographic region has been established as a legal entity. In a region where a partnership exists, such as Southern California, the normal retirement age as a partner is at the end of the calendar year when one turns 65.

The University of California, San Diego, Physician Assessment and Clinical Education (PACE) Program is the largest assessment and remediation program for health care professionals in the country. Recently, PACE conducted a pilot screening project to assess physicians. Thirty volunteer physicians, aged 50 to 83, were recruited to participate in the screening regimen. Preliminary data analysis showed that some late career physicians performed less than optimally (seven of 30 participants). However, the pilot study did not have sufficient power to reach significance. Also, it did not include enough participants to provide a breakdown on specialties.[60]

How Some Hospitals are Addressing the Screening and Assessment of Competency of Late Career Physicians

Studies show that a more proactive and physician-friendly approach for evaluating physicians of all ages is to utilize multisource feedback or 360-degree survey screenings, either routinely as part of the recredentialling process or, alternatively, when significant risk factors occur, such as adverse events or patient complaints.[17, 61-67] For the 360-degree screening, physicians are invited to select raters such as colleagues and staff with whom they work, and the chief/leader of the department "validates" the list by ensuring the final rater pool is a comprehensive and representative sample. A 360-degree survey, validated against quality indicators such as malpractice claims and patient satisfaction, is sent to the selected raters so they can provide qualitative and quantitative feedback to the physician. Finally, comments and/or questions associated with cognitive impairment (e.g., seems forgetful about important information), irritability or compromised communication (e.g., overreacts to small mistakes), and competence (e.g., has sound clinical judgment) are scored and compared against national benchmarks for the physician's specialty. Physicians scoring in outlying ranges are referred for a second-line assessment, such as discussions with the clinical supervisor, peer review, practice evaluation, and/or cognitive screening. If that assessment is positive for significant findings, the physician may be referred for a third-line evaluation, including physical or mental health testing and/or a comprehensive neurocognitive assessment. The Medical Staff Peer Review Committee assesses the findings in terms of the potential to impair the physician's quality of care and makes a recommendation to the credentials committee. The assessed physician is encouraged to review the survey results with a trained coach.

Multiple studies show that a very small percentage (2 percent to 8 percent) of clinicians are associated with patterns of unprofessional behavior and performance. Of those physicians who receive awareness interventions, most respond (>75 percent), but some who do not change may be affected by some form of cognitive impairment.[30] The 360-degree survey process is currently used at hospitals such as Massachusetts General Hospital, Brigham and Women's Hospital, and University of Michigan to assess physicians on various core competencies.[67]

The Medical Executive Committee at Yale New Haven (Connecticut) Hospital elected to require a neurologic and ophthalmologic examination of all applicants for reappointment to the medical staff who are aged 70 years and older.[68, 69] From October 2017 through January 2019, 141 clinicians underwent a neuropsychological assessment. After completion of screening and/or full

neuropsychological testing, the hospital's Medical Staff Review Committee determined that 18 (12.7 percent) of the clinicians were found to have impaired cognition, raising concerns about their clinical abilities.[68] None of these 18 clinicians had previously been brought to the attention of medical staff leadership because of performance problems.[68] These 18 clinicians elected to discontinue their practice or moved into a closely proctored environment. All of these physicians agreed to make changes in their practice voluntarily.[68] In early 2020, a lawsuit was filed by the U.S. Equal Employment Opportunity Commission (EEOC) on behalf of the medical staff alleging that Yale New Haven Hospital violated federal law by adopting and implementing a discriminatory "Late Career Practitioner Policy".[70]

Another lawsuit was filed by the Equal Employment Opportunity Commission (EEOC) against Hennepin Healthcare System, Inc., a healthcare provider in Hennepin County, Minnesota, to resolve investigations conducted by the EEOC under the Age Discrimination in Employment Act of 1967, as amended (ADEA), and the Americans with Disabilities Act of 1990, as amended (ADA). The EEOC investigation determined Hennepin's "Late Career Practitioner Policy" discriminated against practitioners aged 70 and older which required them to participate in age-related screenings. In January 2021, the EEOC announced a settlement which will provide monetary relief to affected staff for out-of-pocket costs not covered by insurance. For the next three years, Hennepin must report to the EEOC on formal complaints related to age discrimination, unlawful medical inquiries, and/or any such retaliations, and notify its employees of the resolution.[71]

PROPOSED GUIDING PRINCIPLES

The Council on Medical Education proposes a set of guiding principles as a basis for developing guidelines for the screening and assessment of late career physicians. The underlying assumption is that guidelines must be based on evidence and on the principles of medical ethics. Furthermore, guidelines should be relevant, supportive, fair, equitable, and transparent, and not result in undue cost or burden to late career physicians. The primary driver for the establishment of guidelines should be to fulfill the ethical obligation of the profession to the health of the public and patient safety.

The Council developed the following eight guiding principles with extensive feedback from members of the AMA Work Group on Assessment of Senior/Late Career Physicians, as well as feedback from other content experts who research physician competence and administer screening and assessment programs.

1. *Evidence-based:* Guidelines for assessing and screening late career physicians should be based on evidence of the importance of cognitive changes associated with aging that are relevant to physician performance. Some physicians may suffer from declines in practice performance with advancing age. Research also suggests that the effects of age on an individual physician's competency can be highly variable, and since wide variations are seen in cognitive performance with aging, age alone should not be a precipitating factor.

2. *Ethical:* Guidelines should be based on the principles of medical ethics. Self-regulation is an important aspect of medical professionalism. Physicians should be involved in the development of guidelines/standards for monitoring and assessing both their own and their colleagues' competency.

3. *Relevant:* Guidelines, procedures, or methods of assessment should be relevant to physician practices to inform judgments and provide feedback regarding physicians' ability to perform the tasks specifically required in their practice environment.

4. *Accountable:* The ethical obligation of the profession to the health of the public and patient safety should be the primary driver for establishing guidelines and informing decision making about physician screening and assessment results.

5. *Fair and equitable:* The goal of screening and assessment is to optimize physician competency and performance through education and modifications to a physician's practice environment or scope. Unless public health or patient safety is directly threatened, physicians should retain the right to modify their practice environment to allow them to continue to provide safe and effective care.

6. *Transparent:* Guidelines, procedures, or methods of screening and assessment should be transparent to all parties, including the public. Physicians should be aware of the specific methods used, performance expectations and standards against which performance will be judged, and the possible outcomes of the screening or assessment.

7. *Supportive:* Education and/or remediation practices that result from screening and /or assessment procedures should be supportive of physician wellness, ongoing, and proactive.

8. *Cost conscious:* Procedures and screening mechanisms that are distinctly different from "for cause" assessments should not result in undue cost or burden to late career physicians providing patient care. Hospitals and health care systems should provide easily accessible screening assessments for their employed late career physicians. Similar procedures and screening mechanisms should be available to late career physicians who are not employed by hospitals and health care systems.

AMA POLICY

AMA policy urges members of the profession to discover and rehabilitate if possible or exclude if necessary, physicians whose practices are incompetent and to fulfill their responsibility to the public and to their profession by reporting to the appropriate authority those physicians who, by being impaired, are in need of help or whose practices are incompetent (H-275.998). AMA policy urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions that impair a physician's current ability to practice medicine (H-275.978[6]). AMA policy also reaffirms that it is the professional responsibility of every physician to participate in voluntary quality assurance, peer review, and CME activities (H-300.973 and H-275.996). These and other related policies are shown in the Appendix.

SUMMARY AND RECOMMENDATIONS

The Council on Medical Education concurs that physicians should be allowed to remain in practice as long as patient safety is not endangered and they are providing appropriate and effective care. However, data and anecdotal information support guidelines for the screening and assessment of late career physicians. The variations in cognitive skills as physicians age, as well as the changing demographics of the physician workforce, are key factors contributing to this need. Physicians must lead in developing standards for monitoring and assessing the competency of themselves and their peers; otherwise, other entities, may move for nationally implemented guidelines and a

mandatory retirement age that lack a solid evidence base. The guiding principles outlined in this report provide direction and serve as a reference for setting priorities and standards for further action.

It is important to note that this report does not mandate an assessment. Its intent, rather, is to outline a set of guiding principles to provide direction and serve as a reference for guidelines for screening and assessing late career physicians.

The Council on Medical Education therefore recommends that the following recommendations be adopted and that the remainder of the report be filed.

1. That our American Medical Association (AMA) support the following Guiding Principles on the Assessment of Late Career Physicians:

    a) Evidence-based: Guidelines for assessing and screening late career physicians should be based on evidence of the importance of cognitive changes associated with aging that are relevant to physician performance. Some physicians may suffer from declines in practice performance with advancing age. Research also suggests that the effect of age on an individual physician's competency can be highly variable; and since wide variations are seen in cognitive performance with aging, age alone should not be a precipitating factor.

    b) Ethical: Guidelines should be based on the principles of medical ethics. Self-regulation is an important aspect of medical professionalism. Physicians should be involved in the development of guidelines/standards for monitoring and assessing both their own and their colleagues' competency.

    c) Relevant: Guidelines, procedures, or methods of assessment should be relevant to physician practices to inform judgments and provide feedback regarding physicians' ability to perform the tasks specifically required in their practice environment.

    d) Accountable: The ethical obligation of the profession to the health of the public and patient safety should be the primary driver for establishing guidelines and informing decision making about physician screening and assessment results.

    e) Fair and equitable: The goal of screening and assessment is to optimize physician competency and performance through education, remediation, and modifications to a physician's practice environment or scope. Unless public health or patient safety is directly threatened, physicians should retain the right to modify their practice environment to allow them to continue to provide safe and effective care.

    f) Transparent: Guidelines, procedures, or methods of screening and assessment should be transparent to all parties, including the public. Physicians should be aware of the specific methods used, performance expectations, and standards against which performance will be judged and the possible outcomes of the screening or assessment.

    g) Supportive: Education and/or remediation practices that result from screening and /or assessment procedures should be supportive of physician wellness, ongoing, and proactive.

    h) Cost conscious: Procedures and screening mechanisms that are distinctly different from "for cause" assessments should not result in undue cost or burden to late career physicians providing patient care. Hospitals and health care systems should provide easily accessible

screening assessments for their employed late career physicians. Similar procedures and screening mechanisms should be available to late career physicians who are not employed by hospitals and health care systems. (Directive to Take Action)

2. That our AMA encourage the Council of Medical Specialty Societies and other interested organizations to develop educational materials on the effects of age on physician practice. (Directive to Take Action)

3. That Policy D-275.956, "Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians," be rescinded, as having been fulfilled by this report. (Rescind HOD Policy)

Fiscal note: $1,000.

APPENDIX: AMA POLICIES

D-275.956, "Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians"

Our American Medical Association: (1) will identify organizations that should participate in the development of guidelines and methods of screening and assessment to assure that senior/late career physicians remain able to provide safe and effective care for patients; and (2) will convene organizations identified by the AMA to work together to develop preliminary guidelines for assessment of the senior/late career physician and develop a research agenda that could guide those interested in this field and serve as the basis for guidelines more grounded in research findings. (CME Rep. 5, A-15)

H-275.936, "Mechanisms to Measure Physician Competency"

Our AMA: (1) continues to work with the American Board of Medical Specialties and other relevant organizations to explore alternative evidence-based methods of determining ongoing clinical competency; (2) reviews and proposes improvements for assuring continued physician competence, including but not limited to performance indicators, board certification and recertification, professional experience, continuing medical education, and teaching experience; and (3) opposes the development and/or use of "Medical Competency Examination" and establishment of oversight boards for current state medical boards as proposed in the fall 1998 Report on Professional Licensure of the Pew Health Professions Commission, as an additional measure of physician competency.
(Res. 320, I-98 Amended: Res. 817, A-99 Reaffirmed: CME Rep. 7, A-02 Reaffirmed: CME Rep. 7, A-07 Reaffirmed: CME Rep. 16, A-09 Reaffirmed in lieu of Res. 313, A-12 Modified: Res. 309, I-16)

H-275.996, "Physician Competence"

Our AMA: (1) urges the American Board of Medical Specialties and its constituent boards to reconsider their positions regarding recertification as a mandatory requirement rather than as a voluntarily sought and achieved validation of excellence; (2) urges the Federation of State Medical Boards and its constituent state boards to reconsider and reverse their position urging and accepting specialty board certification as evidence of continuing competence for the purpose of re-registration of licensure; and (3) favors continued efforts to improve voluntary continuing medical education programs, to maintain the peer review process within the profession, and to develop better techniques for establishing the necessary patient care data base. (CME Rep. J, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09; Reaffirmed in lieu of Res. 302, A-10; Reaffirmed in lieu of Res. 320, A-14)

H-275.998, "Physician Competence"

Our AMA urges: (1) The members of the profession of medicine to discover and rehabilitate if possible, or to exclude if necessary, the physicians whose practices are incompetent. (2) All physicians to fulfill their responsibility to the public and to their profession by reporting to the appropriate authority those physicians who, by being impaired, need help, or whose practices are incompetent. (3) The appropriate committees or boards of the medical staffs of hospitals which have the responsibility to do so, to restrict or remove the privileges of physicians whose practices are known to be incompetent, or whose capabilities are impaired, and to restore such physicians to limited or full privileges as appropriate when corrective or rehabilitative measures have been

successful. (4) State governments to provide to their state medical licensing boards resources adequate to the proper discharge of their responsibilities and duties in the recognition and maintenance of competent practitioners of medicine. (5) State medical licensing boards to discipline physicians whose practices have been found to be incompetent. (6) State medical licensing boards to report all disciplinary actions promptly to the Federation of State Medical Boards and to the AMA Physician Masterfile. (Failure to do so simply allows the incompetent or impaired physician to migrate to another state, even after disciplinary action has been taken against him, and to continue to practice in a different jurisdiction but with the same hazards to the public.) (CME Rep. G, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmation I-03; Reaffirmed: CME Rep. 2, A-13)

H-275.978, "Medical Licensure"

The AMA: (1) urges directors of accredited residency training programs to certify the clinical competence of graduates of foreign medical schools after completion of the first year of residency training; however, program directors must not provide certification until they are satisfied that the resident is clinically competent;
(2) encourages licensing boards to require a certificate of competence for full and unrestricted licensure;
(3) urges licensing boards to review the details of application for initial licensure to assure that procedures are not unnecessarily cumbersome and that inappropriate information is not required. Accurate identification of documents and applicants is critical. It is recommended that boards continue to work cooperatively with the Federation of State Medical Boards to these ends;
(4) will continue to provide information to licensing boards and other health organizations in an effort to prevent the use of fraudulent credentials for entry to medical practice;
(5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses. It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public;
(6) urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions which impair a physician's current ability to practice medicine. (BOT Rep. I-93-13; CME Rep. 10 - I-94);
(7) urges licensing boards to maintain strict confidentiality of reported information;
(8) urges that the evaluation of information collected by licensing boards be undertaken only by persons experienced in medical licensure and competent to make judgments about physician competence. It is recommended that decisions concerning medical competence and discipline be made with the participation of physician members of the board;
(9) recommends that if confidential information is improperly released by a licensing board about a physician, the board take appropriate and immediate steps to correct any adverse consequences to the physician;
(10) urges all physicians to participate in continuing medical education as a professional obligation;
(11) urges licensing boards not to require mandatory reporting of continuing medical education as part of the process of reregistering the license to practice medicine;
(12) opposes the use of written cognitive examinations of medical knowledge at the time of reregistration except when there is reason to believe that a physician's knowledge of medicine is deficient;
(13) supports working with the Federation of State Medical Boards to develop mechanisms to evaluate the competence of physicians who do not have hospital privileges and who are not subject to peer review;

(14) believes that licensing laws should relate only to requirements for admission to the practice of medicine and to assuring the continuing competence of physicians, and opposes efforts to achieve a variety of socioeconomic objectives through medical licensure regulation;
(15) urges licensing jurisdictions to pass laws and adopt regulations facilitating the movement of licensed physicians between licensing jurisdictions; licensing jurisdictions should limit physician movement only for reasons related to protecting the health, safety and welfare of the public;
(16) encourages the Federation of State Medical Boards and the individual medical licensing boards to continue to pursue the development of uniformity in the acceptance of examination scores on the Federation Licensing Examination and in other requirements for endorsement of medical licenses;
(17) urges licensing boards not to place time limits on the acceptability of National Board certification or on scores on the United State Medical Licensing Examination for endorsement of licenses;
(18) urges licensing boards to base endorsement on an assessment of physician competence and not on passing a written examination of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination;
(19) urges licensing boards to accept an initial license provided by another board to a graduate of a US medical school as proof of completion of acceptable medical education;
(20) urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other licensing boards for review in connection with an application for licensure by endorsement;
(21) urges licensing boards to consider the completion of specialty training and evidence of competent and honorable practice of medicine in reviewing applications for licensure by endorsement; and
(22) encourages national specialty boards to reconsider their practice of decertifying physicians who are capable of competently practicing medicine with a limited license.
(CME Rep. A, A-87 Modified: Sunset Report, I-97 Reaffirmation A-04 Reaffirmed: CME Rep. 3, A-10 Reaffirmation I-10 Reaffirmed: CME Rep. 6, A-12 Appended: Res. 305, A-13 Reaffirmed: BOT Rep. 3, I-14)

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REPORT 2 OF THE COUNCIL ON MEDICAL EDUCATION (November 2021)
A Study to Evaluate Barriers to Medical Education for Trainees with Disabilities
(Reference Committee C)

EXECUTIVE SUMMARY

The Americans with Disabilities Act (ADA), which was enacted in 1990 and amended in 2008, protects people with disabilities from discrimination; works to provide fair access to goods, services, and education; and promotes equal opportunity. The ADA was amended to specify and expand on who is considered disabled and lowered the burden of proof to establish oneself as a person with a disability. An impairment or disability does not need to prevent or significantly restrict a major life activity to be considered as substantially limiting, and not every impairment will qualify as a disability. An individualized assessment is required to determine if the individual's impairment substantially limits a major life activity as compared to most people in the general population.

Among the employed U.S. adult population (ages 16 and older), 5.8 percent report some sort of disability (that is, difficulties with hearing, vision, cognition, mobility, selfcare, and independent living). Recent data indicate that 4.6 percent of enrolled medical students have requested an accommodation for a disability, a percentage that has grown recently. Attention deficit hyperactivity disorder was the most commonly reported disability, followed by psychological disability and learning disability. Considerably less is known of the prevalence of disabilities in residents and fellows in graduate medical education (GME). Results from a recent national survey suggest that approximately 3 percent of practicing physicians have a disability.

Medical schools maintain technical standards that inform a prospective or current medical student what a school's expectations are for cognitive, sensory, and mobility abilities. GME institutions are required to have policy regarding accommodations for disabilities consistent with all applicable laws and regulations. Students and residents with disabilities may encounter two types of barriers—structural and cultural. Structural barriers may include restrictive and outdated policies and procedures, the inability to locate or correctly interpret the technical standards for a given institution, poor understanding of clinical accommodations, a lack of disability and wellness support services, and a physical environment that limits accessibility. Cultural barriers include the attitudes, beliefs, and values of the medical community.

Learners with disabilities require access to information to make informed decisions about whether an educational environment has the appropriate resources and institutional culture to support necessary accommodations. Institutions should review and evaluate their technical standards to ensure that they embrace the functional capabilities of individual learners. Standards should emphasize what the learner can do rather than what they cannot do. Institutions, both undergraduate and graduate, should have readily available designated disability service providers who are expert in the ADA and aware of current resources and strategies to best process accommodation requests. Research on which accommodations are most effective in clinical learning environments will assist in determining future strategies for creating a safe and inclusive medical workforce.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 2-N-21

Subject: A Study to Evaluate Barriers to Medical Education for Trainees with Disabilities

Presented by: Niranjan Rao, MD, Chair

Referred to: Reference Committee C

American Medical Association (AMA) Policy D-295.929, "A Study to Evaluate Barriers to Medical Education for Trainees with Disabilities," directs our AMA to "work with relevant stakeholders to study available data on: (1) medical trainees with disabilities and consider revision of technical standards for medical education programs; and (2) medical graduates with disabilities and challenges to employment after training."

This report, which is in response to this directive, includes: 1) a brief summary of the Americans with Disabilities Act and its later amendment, as well as a summary of Section 504 of the Rehabilitation Act of 1973; 2) a review of available data on the prevalence of disabilities among medical students, residents, and physicians; 3) examples of accommodations made for medical learners and physicians as well as types of barriers; and 4) a discussion of proposed recommendations.

BACKGROUND

The Americans with Disabilities Act (ADA), which was enacted in 1990 and amended in 2008, protects people with disabilities from discrimination; works to provide fair access to goods, services, and education; and promotes equal opportunity. The ADA was amended to specify and expand on who is considered disabled and lowered the burden of proof to establish oneself as a person with a disability. The law requires an interactive process between a job applicant (or employee or student) and the employer (or educational program) to share information about the nature of the disability and limitations that may affect the individual's ability to perform essential duties. The employer (or educational program), in turn, must engage in a flexible dialogue that addresses the employee's specific disability and investigate reasonable accommodations that allow equal access to the work (or educational) environment.[1] Section 504 of the Rehabilitation Act of 1973 works with the ADA, in that it prohibits discrimination against an otherwise qualified person with a disability in programs or activities that receive federal funding.[2,3]

In the amended ADA, a disability is defined as a "physical or mental impairment that substantially limits one or more life activities; a record (or past history) of such an impairment; or being regarded as having a disability."[4] This contrasts with an impairment, which is a loss of function that results from some cause, injury, or body part. An impairment does not need to significantly restrict a major life activity to be considered as substantially limiting and not every impairment will qualify as a disability. An individualized assessment is required to determine if an individual's impairment substantially limits a major life activity as compared to most people in the general population. With the exception of eyeglasses or contact lenses, a determination of whether an impairment substantially limits a major life activity is made without regard to improvement resulting from mitigating factors, such as medication or hearing aids. Non-ameliorative effects also

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may be considered when determining if an impairment is substantially limiting, including negative side effects of medication or burdens associated with following a particular treatment regimen.[4,5]

Medical School Accreditation Standards Regarding Student Disabilities

The Liaison Committee on Medical Education (LCME) accredits medical education programs leading to the MD degree in the United States. Requirements concerning medical students with disabilities are addressed in Standard 10.5: A medical school develops and publishes technical standards for the admission, retention, and graduation of applicants or medical students in accordance with legal requirements. Element 10.5 provides further detail:

> Element 10.5: Technical standards for the admission, retention, and graduation of applicants or medical students: A statement by a medical school of the: 1) essential academic and non-academic abilities, attributes, and characteristics in the areas of intellectual-conceptual, integrative, and quantitative abilities; 2) observational skills; 3) physical abilities; 4) motor functioning; 5) emotional stability; 6) behavioral and social skills; and 7) ethics and professionalism that a medical school applicant or enrolled medical student must possess or be able to acquire, with or without reasonable accommodation, in order to be admitted to, be retained in, and graduate from that school's medical educational program.[6]

In addition, schools are to communicate Standard 10.5 in hard copy and/or online in a manner that is easily available to and accessible by the public.

In assessing compliance with Standard 10.5, the LCME survey team during the site visit (typically occurring every eight years) will ask the school to provide the following information:[7]

1. How does the medical school disseminate its technical standards for admission, retention, and graduation to potential and actual applicants, enrolled medical students, faculty, and others?

2. How are medical school applicants and/or medical students expected to document that they are familiar with and capable of meeting the technical standards, with or without accommodation (e.g., by formally indicating that they have received and reviewed the standards)?

In addition, Element 3.4, Anti-Discrimination Policy, requires that a medical school has policy in place to ensure that it does not discriminate on the basis of age, disability, gender identity, national origin, race, religion, sex, sexual orientation, or any basis protected by federal law. This language, revised by the LCME in October 2019, is in effect for schools in the academic year 2021-2022. Schools will be asked to describe how their anti-discrimination policy is made known to members of the medical education community.

The American Osteopathic Association's Commission on Osteopathic College Accreditation (COCA) accredits medical education programs leading to the DO degree in the United States. Element 9.1 addresses admissions policies for a college of osteopathic medicine (COM):

> A COM must establish and publish, to the public, admission requirements for potential applicants to the osteopathic medical education program and must use effective policies and procedures for osteopathic medical student selection for admission and enrollment, including technical standards for admissions. A COM must tie all admissions to the COM mission.

Submission 9.1: Admission Policy

1. Provide all admission requirements and policies and procedures for osteopathic medical student selection and enrollment.
2. Provide a copy of the technical standards required of matriculants.
3. Provide a public link to where the documents are published.

In addition, Element 1.5 addresses non-discrimination:

> A COM must demonstrate non-discrimination in the selection of administrative personnel, faculty and staff, and students based on race, ethnicity, color, sex, sexual orientation, gender, gender identity, national origin, age or disabilities, and religion.[8]

Furthermore, the Educational Council on Osteopathic Principles (ECOP) has recommended non-academic criteria for admission and continued program participation for osteopathic medical students enrolled in DO programs. A "Technical Standards Document," made available through ECOP and distributed by the American Association of Colleges of Osteopathic Medicine (AACOM) defines the reasonable expectations of osteopathic medical students and physicians in performing common and important functions of the osteopathic physician.[9]

Residency/Fellowship Program Accreditation Standards Regarding Trainee Disabilities

The Accreditation Council for Graduate Medical Education (ACGME) accredits residency and fellowship programs and sets requirements for programs as well as the institutions in which training occurs.

The ACGME's Common Program Requirements (CPRs) outline resources that must be provided to residents and fellows.[10] The program, with its sponsoring institution, must ensure a healthy and safe learning and working environment that, among other things, provides "accommodations for residents with disabilities consistent with the Sponsoring Institution's policy." [I.D.2.e]. In addition, the program director and the leadership team must "ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination" [II.A.4.a).(13)]. Finally, the learning environment must be a "professional, equitable, respectful, and civil environment that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, residents, faculty, and staff" [VI.B.6.].

The ACGME's Institutional Requirements delineate the responsibility of the sponsoring institution regarding graduate medical education (GME). Among other services provided to trainees, such as behavioral health counseling, the institution "must have a policy, not necessarily GME-specific, regarding accommodations for disabilities consistent with all applicable laws and regulations." [IV.H.4.][11]

In all situations for UME and GME, accommodations for an individual with a disability are expected, provided that the accommodation does not fundamentally alter the program, service, or activity associated with the job function or if it would impose undue financial or administrative burden upon the program or institution.

PREVALENCE OF DISABILITIES AMONG MEDICAL STUDENTS, RESIDENTS/FELLOWS, AND PHYSICIANS

Among the employed U.S. adult population (ages 16 and older), 5.8 percent report some sort of disability (that is, difficulties with hearing, vision, cognition, mobility, self-care, and independent living). The most commonly reported disability for employed adults is mobility (2.0 percent), followed by hearing (1.8 percent), cognitive (1.7 percent), vision (1.3 percent), independent living (1.0 percent), and self-care (0.4 percent).[12]

Two major surveys have been conducted to assess the prevalence and categories of disabilities among students of MD-granting medical schools. Medical school staff responsible for assisting students with implementing accommodations for their disabilities were surveyed in 2016.[13] Complete data were provided by 89 of 133 schools surveyed. Disabilities were reported for 2.7 percent of total enrollment, ranging from 0 percent to 12 percent. Attention deficit hyperactivity disorder (ADHD) was the most prevalent disability (33.7 percent), followed by learning disabilities (21.5 percent); psychological disabilities, such as depression or anxiety (20.0 percent); chronic health issues (13.1 percent); other functional impairment (3.9 percent); visual impairment (3.0 percent); mobility disability (2.5 percent); and deafness (2.2 percent).

A follow-up survey in 2019 allows a comparison across time for the same schools.[14] Overall, the 87 schools that responded in 2019 with complete data reported that 2,600 students had a disability, representing 4.6 percent of enrollment, a 69 percent increase compared to 2016. Data for the 64 schools that responded to both surveys is presented in the table.

Number of MD students (percent) with a disability, 2016 and 2019		
	2016	*2019*
ADHD	369 (32.3)	617 (30.4)
Learning disability	245 (21.4)	371 (18.3)
Psychological disability	233 (20.4)	655 (32.3)
Chronic health disabilities	152 (13.3)	365 (18.0)
Mobility disability	38 (3.3)	74 (3.6)
Visual disabilities	34 (3.0)	46 (2.3)
Deaf or hard of hearing	20 (1.8)	25 (1.2)
Other functional impairment	51 (4.5)	49 (2.4)
Overall disabilities	1,142 (2.7)	2,028 (4.6)

The increase overall, and the changes in the reported type of disability, may represent more students with disabilities being admitted to medical school, more existing students reporting a disability, more complete reporting by the schools, more psychological disability presenting during medical school (the largest difference between years), or a combination of these factors.[14]

A third survey has documented the prevalence and categories of disabilities among students of DO-granting medical schools.[15] Using the same techniques as the surveys of MD-granting schools, 32 eligible DO medical schools were surveyed, and 24 responded. Similar to MD schools, ADHD, psychological disabilities, and chronic health disabilities were most frequently reported. Compared to the total 2019 MD data (not shown), DO-granting schools reported significantly higher rates of ADHD (33.5 percent) among those students with a disability than MD-granting programs (29.1 percent), and lower rates of psychological disability (23.7 percent vs 32.3 percent). Other disabilities were reported at similar rates.

Less is known about the prevalence of disabilities in residents and fellows in GME. A recent survey of academic family medicine departments (n=191) concerning prevalence of residents with disabilities as well as residency program processes for accommodation, found relatively few department chairs reporting having residents in the preceding five years who had a disability. Fifty percent of the 66 respondents reported no resident with a disability, 16.7 percent reported one resident, and 33.3 percent reported two to five residents.[16] There are more than 700 family medicine GME programs in the United States, so these findings may not be representative of family medicine residency programs overall.

The GME environment, in which the learner is also an employee, may discourage trainees from disclosing disabilities, either during the interview for a residency position or after joining the program.[17] Furthermore, the difference in administrative structure in GME, compared to medical school, may challenge residents/fellows seeking accommodation, and thus deter them from reporting a disability.[18] Nonetheless, it can be assumed that disabilities reported in medical school will continue to be experienced by trainees in GME.

Information on the prevalence of disabilities among practicing physicians is also relatively scarce. One survey distributed in 2014 to 148 family medicine department chairs found that 31 (of the 88 respondents) reported faculty with a physical or sensory disability.[19] The most common disabilities reported for the 50 faculty members were mobility, hearing, and mental health problems. Only seven of the department chairs knew of these disabilities at hiring. A similar survey conducted in 2019 found fewer family medicine department chairs reporting faculty members with disabilities (21 chairs reporting out of 68 respondents).[16] Both surveys had low response rates, and it is likely that disability among faculty physicians is under-reported. A national survey of physicians in 2019 included questions regarding disabilities. Of 6,000 physicians (a representative sample), 178 (3.1 percent of the weighted sample) self-identified as having a disability. The most commonly reported disability was a chronic health condition (30.1 percent), followed by psychological (14.2 percent), other disabilities (e.g., essential tremors) (13.4 percent), hearing (12.1 percent), ADHD (10.4 percent), visual (7.8 percent), and learning (2.6 percent). Multiple disabilities were reported by 15.7 percent.[20] The proportion of physicians reporting a disability is considerably lower than that reported by the employed adult population overall[12] and may reflect under-reporting and/or that the profession of medicine is perceived as inhospitable and discouraging to those with disabilities.

EXAMPLES OF ACCOMMODATION

Similar to data on the prevalence of disabilities, information on the types of accommodations provided is more common for medical students than for physicians. The most frequent accommodations reported in 2016 by medical schools for students with disabilities include the following:

- Testing, such as providing extra time and/or low distraction environments (97.8 percent)
- Facilitated learning, such as note takers and/or recorded lectures (69.7 percent)
- Assistive technologies, such as text-to-speech (42.7 percent)
- Clinical, such as leaves of absence and/or relief from overnight call (34.8 percent)
- Housing, such as single rooms and reserved parking (23.6 percent)
- Hearing-related, such as employing a transcriptionist or sign language interpreter (18.0 percent)
- Ergonomic (15.7 percent)[13]

In the follow-up survey in 2019, questions about accommodations were divided into didactic and clinical environments and results were similar. Testing accommodations were most often reported in the didactic years (100 percent of schools), but 75 percent of schools reported this

accommodation for the clinical years as well. Facilitated learning was reported only for didactic years by 77.4 percent of schools, as were ergonomic accommodations (35.7 percent). Accommodations in the clinical environment were reported by 68.7 percent of schools.[14] In the similar study of DO-granting schools, all DO students disclosing disability received a form of didactic or clinical accommodations, compared to 93.3 percent of MD students. Accommodations to the clinical environment, such as a decelerated clinical year or release from overnight call, were more frequently provided in MD-granting programs when compared to DO-granting programs (68.7 percent vs 21.7 percent).[15]

New and existing technologies allow trainees to meet standards and work within a clinical setting. For example, amplified and visual stethoscopes, standing wheelchairs, dictation software, and Communication Access Real-Time Translation have allowed students and physicians with disabilities, such as hearing/visual impairment or spinal cord injuries, to earn their medical degrees and enter practice. Intermediaries can also be used in the clinical setting, in which students or physicians direct trained professionals to perform actions that the disabled individuals cannot conduct themselves.[21] An example of an adaptive environment for a deaf medical student in a one-month visiting rotation in emergency medicine has been described in which a designated health care interpreter, captioning added to instructional videos in online learning platforms, an adaptive headset, and specialized medical sign language developed for the rotation (for terms not in American Sign Language) were successfully integrated into the rotation.[1]

In a study of family medicine faculty, the most commonly reported accommodations provided for faculty with disabilities were adjusting the work schedule and providing additional time to complete tasks. Also common was the use of assistive technology and durable equipment.[19]

In a review of medical school technical standards, found online or available upon request, roughly 40 percent of schools provided information on types of accommodations allowed for hearing, vision, and mobility disabilities. Of those, 97 percent allowed auxiliary aids for all three types of disabilities. A slightly smaller number of schools (approximately 85 percent) provided information on whether intermediaries (such as interpreters) were allowed as accommodations; few schools allowed them (approximately 15 percent).[3]

BARRIERS FACED BY TRAINEES

A recent report by the Association of American Medical Colleges (AAMC), "Accessibility, Inclusion, and Action in Medical Education: Lived Experiences of Learners and Physicians with Disabilities,"[18] represents the culmination of in-depth interviews with students, residents, and physicians with disabilities. Several of the report's many recommendations are highlighted below.

The report describes two types of barriers confronting students and residents with disabilities—structural and cultural. Structural barriers include restrictive and outdated policies and procedures, poor understanding of clinical accommodations, a lack of disability and wellness support services, and a physical environment that limits accessibility. These barriers can have immediate and practical implications for trainees.[21] Cultural barriers include the attitudes, beliefs, and values of the medical community.

Medical School Technical Standards and Facilitating Access

The technical standards (TS) that a medical school publishes are used to inform a prospective or current medical student about a school's expectations are for cognitive, sensory, and mobility abilities. The AAMC has released guidelines for TS and a handbook on students with disabilities,

but it is up to schools to develop their own standards.[22] There is great variability between schools, with some using inclusive, detailed language and identifying possible accommodations, such as interpreters and transcriptionists. Other schools state, for example, that students need to hear "adequately" for communication and that an intermediary is not appropriate, or that "significant" disabilities must be disclosed. Leaving the definition of "adequately" and "significant" up to a prospective student may deter those with disabilities from applying.[22]

Clear, easily obtainable TS are important for prospective students with disabilities in ascertaining which schools may be welcoming and supportive. In 2016 Zazove et al. published the results of a study to determine the availability of TS in medical schools and evaluated the language used in TS relative to the ADA.[3] Their research covered the years 2012-2014 and included all MD- and DO-granting schools. They found that 84 percent of all schools had TS available on their websites. Ten percent of MD schools and six percent of DO schools did not have TS on their websites or make their TS available even after two inquiries. One-third of schools used language that expressed a willingness to provide accommodations for disabilities, 49 percent used equivocal language, five percent used unsupportive language, and 14 percent did not provide information on accommodations. One-third of schools required full function of hearing, 26 percent required full function of vision, and 24 percent required full mobility functionality. Roughly 10 percent did not provide information on function level required. Overall, schools with language in the TS that expressed a willingness to accommodate students with disabilities were also more likely to allow reasonable accommodations, assume responsibility for providing those accommodations (rather than the student), accept auxiliary aides, and accept intermediaries. Additional study is required to determine any changes in the number of schools making available their TS and their willingness to provide accommodations.

A criticism leveled at many TS is that there may be a focus on deficits rather than on the ability to perform the work.[23] An "organic" standard requires students to demonstrate physical, cognitive, behavioral, and sensory abilities without assistance. For example, students are expected to have hearing ability at a particular decibel level without assistance. A "functional" standard focuses on the student's abilities, with or without assistive technology or accommodation, and may state that students must be able to obtain the necessary information by hearing or other means. McKee et al.[23] discuss how organic TS are based on three assumptions that are not derived from empirical evidence: 1) accommodations pose patient safety risks; 2) accommodations are costly; and 3) graduates, even those with disabilities, should be able to pass licensure exams without accommodation.

Concerning patient safety, no legal case has been found to demonstrate harm to a patient based on an accommodation provided to a physician with a disability. Physicians and students with disabilities typically are aware of their limitations and develop strategies to adapt to the environment. The costs of accommodation vary greatly. The ADA does not allow cost to justify discrimination toward students or physicians with disabilities. Medical schools, residency/fellowship programs, and employers are ultimately responsible for paying for reasonable accommodations. Assistive technologies rapidly change, and appropriate, cost-effective accommodations can be found on industry and government websites. The ADA requires licensure examinations to provide appropriate accommodations such as sign language interpreters and extended test time. The incorporation of accommodation into the testing environment thus mimics the learning and practicing environment of the student or physician, and the examination assesses performance more accurately than if the disabled test taker were denied accommodation.[23]

The Association of Academic Physiatrists has addressed the issue of updating medical school TS.[24] Stating that a functional approach to TS promotes inclusivity by emphasizing abilities rather than

limitations, its report describes standards that allow students to use accommodations and permit incorporation of technological and medical advances as they become available. Functional TS describe what skills the student must master—e.g., effective communication with patients and the care team—but not the manner in which the student must achieve them (e.g., must use vision, etc.). Changes in medical practice and medical education coincide with an increased use of assistive technology, for all health professionals regardless of limitations. Team-based care, new information management skills, and an emphasis on problem-solving skills rather than memorization of facts combined with competency-based education can allow for performance assessment of students with disabilities using reasonable accommodations. Students can demonstrate mastery of skills through alternative methods.

Entry to GME

Students in or graduates from MD-granting medical schools who are applying to U.S. residency programs generally must pass or at least have taken USMLE® Step 1 and Step 2 to be offered an interview invitation from a residency program. The National Board of Medical Examiners® (NBME), which co-owns the USMLE with the Federation of State Medical Boards, provides a process through which a prospective exam taker can request disability accommodations for the examinations. Extensive documentation of the disability as well as evidence of previous educational examination and educational accommodations is required. The NBME requests at least 60 days to process a request. Applicants who have applied for and received accommodations for Step 1 must apply again for accommodations for Step 2.[25] Medical schools provide timelines for students who may seek accommodation from the NBME and advise a minimum of 6 months to include document preparation, submission, and review by the NBME plus additional time in case of an appeal.[26,27] Students, however, have anecdotally reported lengthier response times from the NBME, resulting in delays in taking the exam(s), which have in turn impacted application to and acceptance into residency programs.

Similarly, students in or graduates from DO-granting institutions who are applying to U.S. residency programs generally must pass or at least have taken COMLEX-USA Examination Level 1 and Level 2 to be offered an interview invitation from a residency program. The National Board of Osteopathic Medical Examiners® (NBOME) provides a process through which a prospective exam taker can request disability accommodations for the examinations. Documentation of the disability and a completed application is required. The NBOME states that the process may require 90 days from receipt of a completed application to process a request, though additional time may be necessary prior to rendering a decision.[28]

Once in GME, similar to the undergraduate environment, structural barriers for disabled learners include an absence of 1) clearly defined policies and processes; 2) a knowledgeable and responsible point person for facilitating accessibility requests; and 3) an understanding of legal requirements under the ADA.[18]

The ACGME requires that sponsoring institutions have policy regarding accommodations for disabilities and that GME programs both provide accommodations for residents with disabilities consistent with the employing sponsoring institution as well as comply with that institution's policy on employment and nondiscrimination. Unlike medical school TS, there is no requirement as to where or how an applicant to a training program can find that information. A recent review was conducted of institutional policies of the 50 largest training institutions to assess compliance with the ACGME's Common Program Requirements and Institutional Requirements (I.D.2.e, and IV.H.4., respectively) concerning disability.[29] The review also analyzed GME policy in terms of alignment with recommendations included in the AAMC's report (mentioned above) on disability.

The majority of institutions maintained a GME policy online (76 percent) or provided one upon request (18 percent). Of the 47 institutions with GME policy available, 32 (68 percent) contained a statement on disability in compliance with ACGME requirements, 23 with the statement found online. Of those institutions with a disability policy, 12 (38 percent) included language that encouraged disability disclosure, 17 (53 percent) provided a statement regarding the confidential nature of documentation regarding accommodation, and 19 (59 percent) described a procedure for disclosing disabilities and requesting accommodation. The AAMC report on accessibility and inclusion in medical education recommends institutions have on staff a designated point person(s) for disability concerns, through which accommodation requests should pass. Of the institutions with policy reviewed, only 5 reported such a process. Over half of the 32 institutions required residents to disclose a disability to program directors (some to program directors and a member of human resources), not in line with AAMC recommendations. In addition, findings from the survey of chairs of family medicine departments found that while 56.3 percent of chairs reported they had a written policy for disability disclosure, 36.6 percent did not know if they had one, and seven percent reported no written policy available. As found in the above study of institutions, over half of family medicine department chairs confirmed that the program director was the contact for disability disclosure, which can be a conflict of interest and against recommendations.[16]

Clearly stated and easily found accommodation policies can help applicants determine if a program and its institution are willing to work with the resident to maximize the learning environment. Ambiguous or absent policies may lead an applicant to assume that the program will not make accommodations, which will discourage applying to the program, or, if accepted, may prevent the resident from seeking assistance with a disability.[30] Students are encouraged to discuss accommodations with a program immediately after matching into the program to ensure ample time for implementing schedule changes or accommodations; however, students may be reluctant to do so if they perceive that a disability will be seen as a liability.[18, 30]

It is possible that some disabilities may be less apparent in virtual versus live interviews (e.g., physical disabilities). A review of the literature on best practices for virtual interviews for residency did not include a discussion on the impact of virtual interviews may have on disability disclosure.[31]

A designated, qualified person responsible for processing requests for accommodation and managing disability services is essential to ensure that residents are confident that the process is administered professionally and confidentially. A disabilities service provider may be within the human resources department or a part of an institution-wide disabilities committee. The provider or committee will be aware of the legal obligations of the ADA, unlike program directors or program staff, who may not be.[30] A program may offer accommodations to residents with apparent disabilities; residents with non- or less-apparent disabilities, but who are uncomfortable disclosing disabilities to program directors, may not receive an offer. Without clearly stated policy and an expert to manage the interactive process of determining reasonable accommodations, residents may fruitlessly disclose their disabilities to staff who are without knowledge or authority to assist and may experience delays in obtaining accommodations.[30]

BALANCE WITH PATIENT SAFETY

Melnick cautions that the laudable goal of increasing inclusion must be balanced against the medical profession's responsibility to place the interests of patients "above the interests of aspiring students."[32] Furthermore, the profession has done little to develop consensus on what accommodations would fundamentally alter the formation and assessment of a physician. Medical schools employ TS to provide guidance, but GME lacks similar standards. A goal of current

medical education is to prepare a physician who can demonstrate proficiency in the undifferentiated practice of medicine. State licensing authorities lack consensus on what comprises essential physical and cognitive capabilities for physicians. Melnick proposes discussion and research on what those essential abilities are, so that individual learners with disabilities can be supported in a way that does not alter the profession's ability to teach and assess those essential abilities. Meeks et al.[21] also propose an ecological study to measure the performance path of learners with disabilities, identify what assistance and accommodations are best suited to various disabilities, track the employment experiences of physicians with disabilities, and examine the effect of those physicians on patient care. Little is known about the process by which physicians with disabilities find employment, although it is assumed that they are guided by past experience with the ADA process and responses of various educational and institutional administrations.

CURRENT AMA POLICY

AMA policies related to this topic are listed in the Appendix.

SUMMARY AND RECOMMENDATIONS

The medical education community should accelerate the pace of inclusion of physicians with disabilities for several reasons. The ADA stipulation that institutions cannot discriminate against a qualified individual on the basis of disability and requires institutions to make reasonable accommodations to allow the individual equal opportunity to participate in the institution's programs (or employment). Second, in 2016 the U.S. population was estimated to have a disability rate of 12.8 percent (some estimates are higher), increasing by 7.6 percent since 2010.[11] The rate at which medical students present with disabilities is also growing—specifically, 4.6 percent of students enrolled in 2019 compared to 2.7 percent in 2016. Although the number of physicians with disabilities in the health care workforce is small, estimated at 3.1 percent, it is believed that these physicians can better understand and empathize with patients with disabilities. A more diverse population of medical students and physicians, including those with disabilities, can introduce new approaches to care, both for patients with and without disabilities.[23] Improved education about disability coupled with the opportunity to learn directly from peers with disabilities in the medical education setting can challenge existing beliefs about disabilities and increase awareness of the potential of both patients and physicians with disabilities.[22]

To increase access to medical education for learners with disabilities, it is important that applicants, either to medical schools or residency programs, have ready access to the information necessary to make an informed decision about whether that educational environment has the appropriate resources and institutional culture to support necessary accommodations. Institutions should review and evaluate their technical standards to remove restrictive "organic" standards and replace them with "functional" standards that emphasize what learners can do rather than what they cannot do. Institutions, undergraduate and graduate, should have readily available designated disability service providers who are knowledgeable about the ADA and aware of current resources and strategies to best process accommodation requests. Providers of high-stakes examinations need to remain responsive and flexible in reviewing and approving accommodations, especially if the number of exam takers with disabilities increases. Research on which accommodations are most effective in the patient care and learning environment will assist in determining future strategies for creating a safe and inclusive medical workforce. Future study may be warranted to examine challenges to employment after training for individuals with disabilities, as there are limited data available on physicians with disabilities in the workforce.

The Council on Medical Education therefore recommends that the following recommendations be adopted and the remainder of this report be filed:

1. That our American Medical Association (AMA) urge that all medical schools and graduate medical education (GME) institutions and programs create, review, and revise technical standards, concentrating on replacing "organic" standards with "functional" standards that emphasize abilities rather than limitations, and that those institutions also disseminate these standards and information on how to request accommodations for disabilities in a prominent and easily found location on their websites. (Directive to Take Action)

2. That our AMA urge all medical schools and GME institutions to a) make available to students and trainees a designated, qualified person or committee knowledgeable of the Americans with Disabilities Act and available support services and b) encourage students and trainees to avail themselves of support services. (Directive to Take Action)

3. That our AMA encourage the National Board of Medical Examiners and National Board of Osteopathic Medical Examiners to evaluate and enhance their processes for reviewing requests for accommodations from applicants with disabilities in order to reduce delays in completion of the USMLE and COMLEX, including an assessment of the experience of those applicants and the development of a transparent communication process that keeps applicants informed about the expected timeline to address their requests. (Directive to Take Action)

4. That our AMA encourage research and broad dissemination of results in the area of disabilities accommodation in the medical environment that includes: the efficacy of established accommodations; innovative accommodation models that either reduce barriers or provide educational approaches to facilitate the avoidance of barriers; impact of disabled learners and physicians on the delivery of health care to patients with disabilities; and research on the safety of established and potential accommodations for use in clinical programs and practice. (Directive to Take Action)

5. That our AMA rescind Policy D-295.929, "A Study to Evaluate Barriers to Medical Education for Trainees with Disabilities," as having been fulfilled by this report. (Rescind HOD Policy)

Fiscal note: $2,500.

APPENDIX: RELEVANT AMA POLICY

D-90.991, "Advocacy for Physicians with Disabilities"

1. Our AMA will study and report back on eliminating stigmatization and enhancing inclusion of physicians with disabilities including but not limited to: (a) enhancing representation of physicians with disabilities within the AMA, and (b) examining support groups, education, legal resources and any other means to increase the inclusion of physicians with disabilities in the AMA.
2. Our AMA will identify medical, professional and social rehabilitation, education, vocational training and rehabilitation, aid, counseling, placement services and other services which will enable physicians with disabilities to develop their capabilities and skills to the maximum and will hasten the processes of their social and professional integration or reintegration.
3. Our AMA supports physicians and physicians-in-training education programs about legal rights related to accommodation and freedom from discrimination for physicians, patients, and employees with disabilities.

H-65.965, "Support of Human Rights and Freedom"

Our AMA:
(1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; 3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.
Work Plan for Maintaining Privacy of Physician Medical Information D-180.991
The AMA shall recommend that medical staffs, managed care organizations and other credentialing and licensing bodies adopt credentialing processes that are compliant with the Americans with Disabilities Act and communicate this recommendation to all appropriate entities.

H-90.987, "Equal Access for Physically Challenged Physicians"

Our AMA supports equal access to all hospital facilities for physically challenged physicians as part of the Americans with Disabilities Act.

H-200.951, "Strategies for Enhancing Diversity in the Physician Workforce"

Our AMA (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities; (2) commends the Institute of Medicine for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; and (3) encourages medical schools, health care institutions, managed care and other appropriate groups to develop policies articulating the value and importance of diversity as a goal that benefits all participants, and strategies to accomplish that goal.

9.5.4, "Civil Rights & Medical Professionals"

Opportunities in medical society activities or membership, medical education and training, employment and remuneration, academic medicine and all other aspects of professional endeavors must not be denied to any physician or medical trainee because of race, color, religion, creed, ethnic affiliation, national origin, gender or gender identity, sexual orientation, age, family status, or disability or for any other reason unrelated to character, competence, ethics, professional status, or professional activities.

AMA Principles of Medical Ethics: IV: Balance with patient safety

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REPORT 3 OF THE COUNCIL ON MEDICAL EDUCATION (N-21)
Rural Health Physician Workforce Disparities
(Reference Committee C)

EXECUTIVE SUMMARY

The supply of practicing physicians in rural settings in the United States has been insufficient to meet the demand for health care services of the rural population. Physician shortages in rural settings have been an enduring and widespread concern, with only 12 percent of primary care physicians working in rural areas (and only eight percent in other specialties). The impact of these numbers is real. Rural communities most likely to suffer from a shortage of physicians can be characterized by low population density, extreme poverty, and high proportions of racial and ethnic minoritized, as well as a lack of physical and cultural amenities.

According to the 2010 Census, nearly 60 million people live in rural communities, and 20 percent of people in the U.S. are rural residents. The size of this population has been stable for several decades. Additionally, more than 15 percent of these rural residents are members of racial/ethnic minoritized groups, and this percentage is growing. In 2002, seven national family medicine organizations adopted a new model of practice that established a reasonable physician-to-population ratio at 1:1,200. In 2014, the primary care physician-to-population ratio was 1:1,300 in the United States as a whole, versus a 1:1,910 ratio in rural areas.

A recent decline in the percentage of students who report an interest in practicing in small towns and rural communities is cause for concern as these communities struggle to sustain their access to health care. A multitude of factors may contribute to this decline, including inadequate exposure to rural medicine as a career pathway, lack of pathway programs targeting rural students, and limited resources to support preparation for medical school and residency for rural students.

The federal government has established several programs to recruit and retain a diverse workforce and encourage physicians to practice in shortage specialties and underserved communities such as rural settings. These programs include the National Health Service Corps (NHSC), Title VII of the Public Health Service Act, the Conrad 30 Waiver, and Area Health Education Centers (AHECs).

Additionally, there have been other efforts to recruit and retain physicians in rural areas such as 3RNet, the Community Apgar Project, Rural Training Tracks, the Columbia-Bassett Program, and the California Oregon Medical Partnership to Address Disparities in Rural Education and Health (COMPADRE) Project. The utilization of telehealth has also provided opportunities for physicians to consult with specialists and increase access to physicians, specialists, and other health care professionals for patients in rural areas.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 3-N-21

Subject: Rural Health Physician Workforce Disparities

Presented by: Niranjan Rao, MD, Chair

Referred to: Reference Committee C

INTRODUCTION

American Medical Association (AMA) Policy H-465.988 (2,3,4), "Educational Strategies for Meeting Rural Health Physician Shortage," directs our AMA to:

> 2. work with state and specialty societies, medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education (ACGME), the Centers for Medicare and Medicaid Services (CMS) and other interested stakeholders to identify, encourage and incentivize qualified rural physicians to serve as preceptors and volunteer faculty for rural rotations in residency.
>
> 3. (a) work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates; and (b) work with interested stakeholders to formulate an actionable plan of advocacy with the goal of increasing residency training in rural areas.
>
> 4. undertake a study of issues regarding rural physician workforce shortages, including federal payment policy issues, and other causes and potential remedies (such as telehealth) to alleviate rural physician workforce shortages.

This report, which is in response to this directive, builds on information from a previous Council on Medical Education report to the House of Delegates on this topic [Report 7-A-14, "Physician Workforce Shortage: Approaches to GME Financing"] and addresses the policy above by providing information on:

1. The current state of the rural physician workforce;
2. The impact of closing rural hospitals and critical access hospitals on the rural physician shortage;
3. Current efforts to address the rural physician workforce shortage; and
4. Current AMA policy.

CURRENT STATE OF THE RURAL PHYSICIAN WORKFORCE

There is broad recognition that the United States is facing a physician workforce shortage. In 2020, the Association of American Medical Colleges (AAMC) reported that the nation "could see an estimated shortage of between 54,100 and 139,000 physicians, including shortfalls in both primary and specialty care, by 2033" as demand for physicians continues to grow faster than supply.[1] The major factor driving demand for physicians continues to be a growing, aging population. According

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to the U.S. Census Bureau, the nation's population is estimated to grow by more than 10 percent by 2032, with those over age 65 increasing by 48 percent. Additionally, the aging population will affect physician supply, since one-third of all currently active doctors will be older than 65 in the next decade. The retirement of these physicians could have a significant impact on supply.[2]

The supply of practicing physicians in rural settings in the United States has been insufficient to meet the demand for health care services of the rural population. Physician shortages in rural settings have been an enduring and widespread concern, with only 12 percent of primary care physicians, and eight percent in other specialties, working in rural areas.[2] According to the 2010 Census, nearly 60 million people live in rural communities, and 20 percent of people in the U.S. are rural residents. The size of this population measured as a percent has been stable for several decades.[3] Additionally, more than 15 percent of these rural residents are members of racial/ethnic minoritized groups, and this percentage is growing.[4]

In response to growing frustrations regarding continued inequities and inefficiencies in the U.S. health care system, the leadership of seven national family medicine organizations initiated the Future of Family Medicine (FFM) project in 2002. Through this project, a new model of practice was adopted, proposing that a reasonable physician-to-population ration be 1:1,200.[5] In 2014, the primary care physician-to-population ratio was 1:1,300 persons in the United States as a whole, versus a 1:1,910 ratio in rural areas.[6] In 2019, the Federation of State Medical Boards reported there were 985,026 physicians with Doctor of Medicine (MD) and Doctor of Osteopathic Medicine (DO) degrees licensed to practice medicine in the United States and the District of Columbia and available to serve a U.S. national population of 327,167,434.[7] Of these physicians, only 11 percent (108,353) practiced in rural counties serving 14 percent (46.1 million) of the U.S. population.[8,9]

The impact of these numbers is real. Rural communities most likely to suffer from a shortage of physicians can be characterized as communities that have low population density, extreme poverty, and high proportions of racial and ethnic minorities, as well as a lack of physical and cultural amenities.[10] These circumstances contribute to the difficulty in recruiting physicians to practice in these areas. Additionally, most of medical education is based in metropolitan areas limiting future physicians' exposure to medical practice in rural settings contributing to challenges in recruiting future physicians to train and practice in rural communities.

Studies have found that students who grew up in rural areas, as well as individuals who are racial and ethnic minorities and/or non-U.S.-citizen international medical graduates, are most likely to practice in medically underserved areas such as rural communities.[11,12] Pathman found that physicians who felt better prepared both medically and socially for practice in a rural environment stayed longer than those who felt unprepared or who were initially unaware of the special characteristics of rural practice.[13] Additional factors associated with increased likelihood that a physician will choose a rural practice include training at a medical school with a mission to train rural physicians, training at an osteopathic medical school, or training that includes rural components such as rural rotations.[14]

While medical students from rural backgrounds are more likely to practice in rural settings compared to students from non-rural areas, there was a recent 28 percent decline in rural medical school matriculants. This decline occurred between 2002 and 2017 when the overall number of medical school matriculants increased by 30 percent. In 2016 and 2017, students from rural backgrounds made up only 4.3% of the incoming medical student body.[8] That said, a recent decline in the percentage of rural medical students who report an interest in practicing in small towns and rural communities is cause for concern as these communities struggle to sustain their access to health care. A multitude of factors may contribute to this decline, including inadequate exposure to

rural medicine as a career pathway for both students in rural and nonrural environments, lack of pathway programs targeting rural students, and limited resources to support preparation for medical school and residency for rural students. The increasing number of rural hospital closures may also negatively impact medical student interest in pursuing a career in rural health.

According to the U.S. Government Accountability Office (GAO), 101 rural hospitals closed in the United States between 2013 and 2020. When rural hospitals closed, people living in areas who received health care from them had to travel farther to get the same health care services—about 20 miles farther for common services like inpatient care. People had to travel even farther—about 40 miles—for less common services like substance use disorder treatment. Before rural hospitals closed, counties where these hospitals were located had fewer doctors than counties without any closures. The number of doctors further decreased when hospitals closed.[15] Germack et al. found that rural hospital closures were associated with immediate and persistent decreases in the supply of physicians across multiple specialties.[16] For example, the percent of all rural counties in the U.S. without hospital obstetric services increased from 46 percent in 2004 to 55 percent in 2014.[17] In the period of 2004-2014, the closure of 14 rural hospitals with obstetrics units and the closure of 165 obstetric units within otherwise open hospitals, left the counties where they were located with no available obstetric services.[18]

Hospitals located in rural areas have been closing their doors more frequently and at higher rates than urban facilities in recent years—and a pattern of increasing financial distress suggests that more are likely to falter.[19] A February 2019 study found that 21 percent of U.S. rural hospitals remain at high risk of closing unless their financial situations improve. One factor driving the overall negative financial performance of rural hospitals is the losses they incur on reimbursement for Medicare patients. Excluding critical access hospitals, rural hospitals have an approximately negative 8.2 percent operating margin on Medicare patients, creating a dependence on commercial patients and employers to make up the difference.[20] Concurrently, a 2019 study of final-year medical residents found that "geographic location was their number one priority when considering a practice opportunity and 91 percent prefer to be an employee of a hospital, medical group or other facility than to be in private practice.[21] If the trend of rural hospital closures continues, physicians may be increasingly hesitant to accept positions at rural hospitals due to concerns about the financial viability of these institutions.

LEGISLATIVE PRINCIPLES TO REDUCE RURAL HEALTH DISPARITIES RELATED TO PHYSICIAN SHORTAGES

There are several current initiatives in Congress that seek to reduce the physician shortage. This includes efforts to increase Medicare support for GME, including increasing the number of Medicare-supported medical resident training positions as well as the number of physicians trained in pain management, addiction medicine, or addiction psychiatry. Another effort seeks to address the cap on full-time equivalent residents for purposes of payment for graduate medical education costs under the Medicare program for certain hospitals that have established a shortage specialty program. There are efforts underway to expand access to telehealth by waiving restrictions on Medicare payment for telehealth services. There are also efforts to examine strategies for increasing health professional workforce diversity.[1]

Current Graduate Medical Education Financing Structure

When considering health care workforce, it is important to "follow the money." The federal government is the largest contributor to physician training, through its funding of graduate medical education (GME), which exceeds $15 billion per year.[22] Funding for GME stems from both public

and private sources as well as federal mandatory and discretionary appropriations. The payroll tax funds Medicare Part A, while insurance premiums and federal mandatory appropriations fund Medicare Part B. Insurance premiums also fund private payers. The federal mandatory appropriations fund provides money to states through the federal Medicaid match and the Health Resources and Services Administration (HRSA). Meanwhile, the federal discretionary appropriations fund GME at the Department of Defense (DoD) and Veterans Health Administration (VHA). While most states support GME through their Medicaid program, some also provide GME support through state-based programs such as loan repayment incentives to address health workforce shortages.[23] Figure 1 below outlines the flow of GME funding.

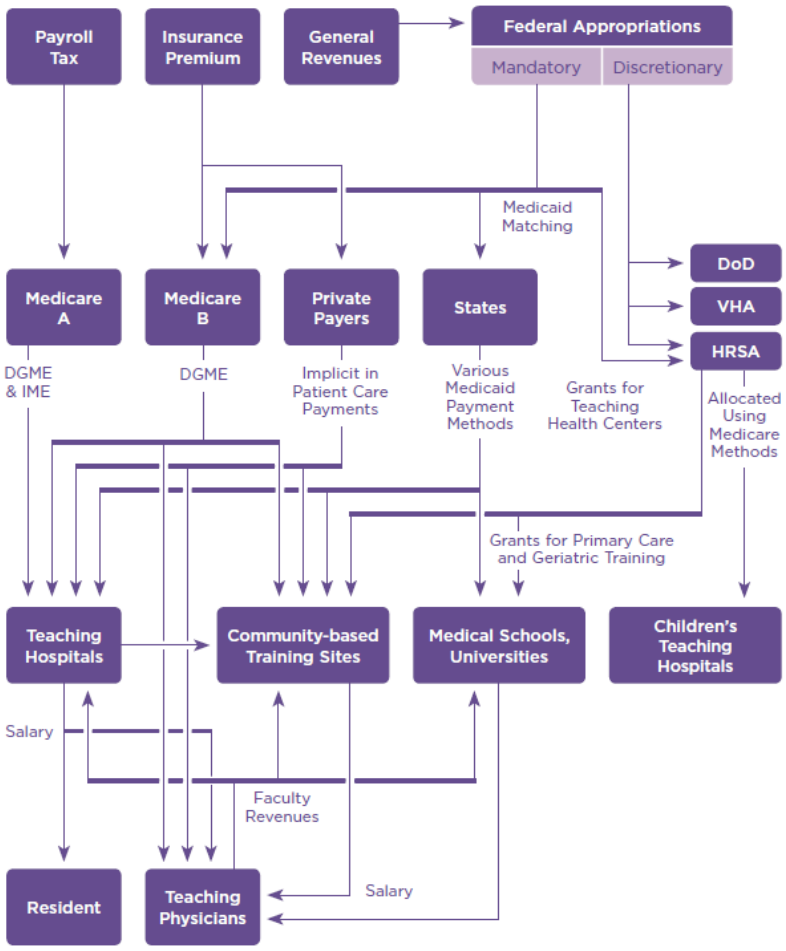

Figure 1: Flow of GME funding.

Note: DGME = direct graduate medical education; DoD = Department of Defense; HRSA = Health Resources and Services Administration; IME = indirect medical education.

Adapted from Wynn, 2012 (Committee of Interns and Residents Policy and Education Initiative White Paper, "Implementing the 2009 Institute of Medicine recommendations on resident physician work hours, supervision, and safety")

The most recent available estimates of GME funding by source indicate that Medicare is the single largest contributor to GME. A 2013 study by Henderson found that of the top three public contributors to GME, Medicare contributed $9.7 billion (~64 percent); Medicaid $3.9 billion (~26 percent); and the VHA $1.4 billion (~10 percent). Private funding for GME is difficult to quantify.

Private insurers support GME by paying higher rates to teaching institutions and health systems. Hospitals, universities, physicians' organizations, and faculty practice plans also support residencies and fellowships. In addition, private philanthropy as well as gifts and grants from industry provide GME support.[24]

When Medicare began funding GME in 1965, payments to teaching hospitals were based solely on hospitals' costs. With the arrival of the Medicare prospective payment system (PPS) for acute care hospitals in 1983, Medicare established two GME funding streams for teaching hospitals: Direct Graduate Medical Education (DGME) funding to cover the direct expenses related to residency training and Indirect Medical Education (IME) funding to help offset the additional costs of providing patient care thought to be associated with sponsoring residency programs.[25] Medicare GME was never intended to cover teaching costs for non-Medicare patients, and distribution of Medicare DGME and IME funds is governed by strict statutory formulas. Both the DGME and the IME formulas include variables that tie payment to a teaching institution's volume of Medicare patients. The DGME payment for an individual institution is calculated by multiplying three factors: weighted resident count, per-resident count, and Medicare day ratio. The weighted resident count is the rolling average of hospital's weighted number of full-time equivalent (FTE) residents in accredited programs in the most recent three-year reporting period. The per-resident amount is calculated by dividing the individual hospital's base year DGME costs by the weighted residents count, which is adjusted for geographic differences and inflation. The Medicare day ratio is the hospital's Medicare inpatient days to total inpatient days to approximate Medicare's share of training costs.[26] These formulas are not designed to account for differences in costs resulting from training residents of different specialties. The Department of Veterans Affairs, Medicaid, and the Children's Health Insurance Program are other federal sources of GME funding of varying levels. In addition, the Army, Navy, and Air Force support their own in-house residencies and fellowships to provide for the future physician workforce needs of those services. Figure 2 below highlights the breakdown of both mandatory and discretionary GME funding including the total funding, the number of trainees and cost per trainee.

Federal Funding for Graduate Medical Education (CRS, 2018)

Program Name *Control over trainees*	**Total Funding**	**Number of Trainees**	**Cost Per Trainee**
MANDATORY FUNDING			
Medicare GME Payments *The number of Medicare-supported residents and per-resident payment amount is capped for each hospital, but hospitals determine staffing needs and types of residents with the exception of certain primary care residents.*	FY2015 (est.): $10.3 - $12.5 billion	FY2015 (est.): 85,712 - 87,980 FTE (DGME) slots 85,578 - 88,416 FTE (IME) slots	FY2015 (est. average): $112,000 - 129,000 per FTE
Medicaid GME Payment *States are permitted to make these payments using their own criteria to determine which providers are eligible for payments.*	N/A.	N/A The Medicaid program does not require states to report these data.	N/A. The Medicaid program does not require states to report these data.
Teaching Health Centers GME Payment Program *Funding to applicant teaching health centers that meet the program's eligibility requirements.*	FY2018: $126.5 million (est.)	AY2016-AY2017: 742 FTE slots 771 total residents trained	N/A.
DISCRETIONARY FUNDING			
Veterans Affairs GME Payments *VA facilities determine their staffing needs and the number and type of residents supported.*	FY2017: $1.78 billion	AY2016-AY2017: 11,000 FTE slots and > 43,565 residents spent part of their training at a VA facility	FY2015 (est.): $137,792/resident

Children's Hospital GME Payment Program *Grant funding awarded to applicant children's hospitals that meet the program's eligibility requirements.*	FY2019: $325bmillion	FY2016-FY2017 58 hospitals received payments to support 7,164 FTE slots	N/A
Department of Defense GME Payments *Divisions of the armed forces determine their staffing needs and the number and type of residents supported.*	FY2012: $16.5 million	FY2017: 3,983 FTE residents	N/A

Source: CRS analysis of agency data, including review of various agency budget justification and The Robert Graham Center program data sourced from CMS Medicare hospital cost report data, and GAO report, *Physician Workforce: HHS Needs Better Information to Comprehensively Evaluate Graduate Medical Education Funding* (GAO-18-240, 2018).

Notes: AY = Academic year; Academic year 2016-2017 began on July 1, 2016, and concluded on June 30, 2017. DGME = direct graduate medical education. est. = estimate. FTE = full time equivalent. FY = fiscal year. IME = Indirect Medical Education. N/A = not available. VA = the Department of Veterans Affairs.

A key factor that may impact the physician workforce is the cap placed on Medicare GME funding more than two decades ago. The Balanced Budget Act (BBA) of 1997 (P.L.105-33) limited the number of medical residents at an institution that could be counted for purposes of calculating DGME and IME payments to the number of trainees as of 1996. This limitation effectively prohibits existing teaching hospitals from receiving Medicare support for any medical residency positions added after 1996. As medical school enrollment continues to grow in attempts to address the physician shortage, which has increased 30 percent since 2002, the Medicare GME cap has made it difficult for the number of medical residency slots to keep pace, resulting in a bottleneck in physician training.[1] Between 2005 and 2015, the number of residents grew by 22 percent. Additionally, it should be noted that the Balanced Budget Act of 1999 (P.L. 106-113) increased the resident cap for rural hospitals to 130 percent of its 1996 level, thereby mitigating somewhat the full impact of the Medicare GME cap.

LEGISLATION TO ADDRESS THE PHYSICIAN SHORTAGE

The recent Consolidated Appropriation Act of 2021 included several efforts to address the physician shortage.

Promoting Rural Hospital GME Funding Opportunity

This section makes changes to the Medicare graduate medical education (GME) Rural Training Tracks (RTT) program to provide greater flexibility for hospitals not located in a rural area that established or establish a medical residency training program (or rural tracks) in a rural area. The program also provides flexibility for hospitals that establish an accredited program where greater than 50 percent of the program occurs in a rural area to partner with rural hospitals and address the physician workforce needs of rural areas.

Medicare GME treatment of hospitals establishing new medical residency training programs after hosting medical resident rotators for short durations

This section allows hospitals to host a limited number of residents for short-term rotations without being negatively impacted by a set permanent full time equivalent (FTE) resident cap or a Per Resident Amount (PRA). A hospital must report full-time equivalent residents on its cost report for a cost reporting period if the hospital trains at least 1.0 full-time-equivalent resident in an approved medical residency training program or programs in such period.

Health Workforce

Health Resources and Services Administration (HRSA) will make $50,000,000 available for grants to public institutions of higher education to expand or support graduate education for physicians provided by such institutions. Priority will be given to public institutions located in states with a projected primary care physician shortage in 2025 and are limited to public institutions in states in the top quintile of states with a projected primary care physician shortage in 2025.

Distribution of additional residency positions

This section supports Medicare physician workforce development by providing for the distribution of 1,000 additional Medicare-funded graduate medical education (GME) residency positions. Not less than 10 percent of the aggregate number of these new positions will be given to each of the following categories: rural hospitals, hospitals that are already above their Medicare cap for residency positions, hospitals in states with new medical schools or new locations and branch campuses, and hospitals that serve Health Professional Shortage Areas. However, a hospital may not receive more than 25 additional full-time equivalent residency positions.[27]

Council on Medical Education Report 7-A-14, "Physician Workforce Shortage: Approaches to GME Financing," outlined the impact of Congressional actions and the Affordable Care Act on expansion of GME, as well as a summary of state-level funding models for GME. Since that time, a number of legislative efforts have been proposed and/or passed to support expansion of GME, including the following two examples.

Rural Residency Planning and Development Grants

In 2019, HRSA awarded approximately $20 million to recipients across 21 states for a three-year period to develop new rural residency programs while achieving program accreditation through the Accreditation Council for Graduate Medical Education. The program is intended to expand the physician workforce in rural areas by developing new, sustainable residencies in family medicine, internal medicine, and psychiatry. Award recipients included rural hospitals; community health centers; health centers operated by the Indian Health Service, Native American tribes or tribal organizations; and schools of medicine. The awards are intended to help recipients address challenges in securing sustainable financing and faculty support.[17]

PROGRAMS TO ADDRESS RURAL PHYSICIAN WORKFORCE SHORTAGES

Federal Efforts to Recruit and Retain Rural Health Physicians

The federal government has established several programs to recruit and retain a diverse workforce and encourage physicians to practice in shortage specialties and underserved communities such as rural settings. These programs include the National Health Service Corps (NHSC), Title VII of the Public Health Service Act, the Conrad 30 Waiver, and Area Health Education Centers (AHECs).

<u>National Health Service Corps (NHSC)</u>

Funded by HRSA, the NHSC awards scholarships and loan repayment to primary care physicians in eligible disciplines. The Consolidated Appropriation Act of 2021 provided an extension for community health centers, the National Health Service Corps, and teaching health centers that operate GME programs. This includes $4 billion in funding from 2019-2023 for community health centers and the National Health Service Corps and provides $310 million in additional funding

from 2021-2023 for the National Health Service Corps. It also provides additional funding, until 2023, for teaching health centers that operate graduate medical education programs. In FY 2019, the NHSC received $319 million in award funding to recruit, retain, and support clinicians serving in high-need areas. These funds were used to pay tuition, eligible fees, other reasonable educational costs, and a living stipend in exchange for a service commitment to work at an NHSC-approved site in a high-need urban, rural, or frontier community for at least two years. Frontier areas are the most remote and sparsely populated places along the rural-urban continuum and are often thought of in terms of population density and distance in minutes and miles to population centers and other resources, such as hospitals. In 2019, the NHSC placed more than 1,750 primary care clinicians in NHSC-approved sites in rural and frontier areas.[28] The NHSC recently implemented the Rural Community Loan Repayment Program (LRP) for physicians working to combat the opioid epidemic in the nation's rural communities. The recent expansion of the NHSC is cause for optimism as more than 75 percent of clinicians in the NHSC report that they plan to stay in the practice where they fulfilled their commitment for loan repayment.[29]

Title VII of the Public Health Service Act

Title VII funding supports rural physician training grants by recruiting students who are most likely to practice medicine in underserved rural communities. Eligible entities are nationally accredited or Secretary of Health and Human Services-approved schools of allopathic or osteopathic medicine or any combination or consortium of such schools. Priority is given to entities that demonstrate (1) an established record of rural community institutional partnerships; (2) having successfully trained students who practice medicine in underserved rural communities; and (3) having a high percentage of graduates from an existing program who practice medicine in underserved rural communities.[30]

Conrad 30 Waiver program

The Conrad 30 Waiver program allows physicians who have completed the J-1 exchange visitor program to apply for a waiver from the two-year residence requirement upon completing their training. J-1 visa physicians can stay in the United States after their training if they get a waiver and practice for three years in an underserved area. These physicians provide the majority of primary care services in underserved rural communities.[31] Legislation is needed to reauthorize and improve the Conrad 30 waiver program to protect patient access to care in medically underserved areas such as rural communities.

Area Health Education Centers (AHECs)

Developed by Congress in 1971, Area Health Education Centers (AHECs) were established to recruit, train, and retain a health professions workforce committed to treating underserved populations. In 1972, Congress initially awarded funds to establish AHEC programs in 11 states. The AHEC program helps bring the resources of academic medicine to address local community health needs. AHECs have a continual focus on improving the health care system by working with academic institutions, health care settings (including community health centers), behavioral health practices, and community-based organizations. Through these long-standing partnerships, AHECs employ traditional and innovative approaches to develop and train a diverse health care workforce prepared to deliver culturally appropriate, high-quality, team-based care, with an emphasis on primary care for rural and underserved communities. Presently, 235 centers across 56 AHEC programs are in operation in almost every state and the District of Columbia.[32] The national AHEC network consists of more than 300 AHEC program offices and centers, serving over 85 percent of the counties in the United States.[33]

Health Professional Shortage Area Physician Bonus Program

To offer an incentive to physicians who work in Medicare Health Professional Shortage Areas (HPSAs), CMS established the Health Professional Shortage Area Physician Bonus Program. The program provides a 10 percent bonus for Medicare-covered services to beneficiaries in a geographic HPSA. Paid quarterly, the bonus is based on the amount paid for professional services.

Additional Efforts to Recruit and Retain Physicians in Rural Areas

Grassroots organizations such as 3RNet have also established resources to support health care recruitment and retention efforts for rural communities. Founded in 1995, 3RNet's mission is to improve rural and underserved communities' access to quality health care through the recruitment and retention of physicians and other health care professionals, development of community-based recruitment and retention activities, and national advocacy on rural and underserved health care workforce issues. To achieve this mission, 3RNet developed a website (https://www.3rnet.org/), which serves as a clearinghouse for its members. Each member maintains state and regional pages within the 3RNet website, providing information about communities, available opportunities for physician employment, and loan repayment programs. Members and health care facilities can post opportunities directly to the website and members can access a candidate database. Notable members include both the Department of Veterans Affairs and the Indian Health Service. 3RNet has also collaborated with the NHSC on recruitment and retention trainings.[34]

The University of North Dakota School of Medicine and Health Sciences Center for Rural Health utilizes the Community Apgar Project (CAP) to assist rural hospitals in North Dakota in identifying strengths and challenges related to recruiting family medicine physicians through a research-validated questionnaire. The CAP was developed by the family medicine residency of Idaho and Boise State University. The University of North Dakota School of Medicine and Health Sciences Department of Family and Community Medicine, the North Dakota Center for Rural Health, and the North Dakota AHEC are currently utilizing the CAP process and methodology to examine what makes a community health care facility a good training environment for health professions education through a new tool called Health Professions Education in Rural Communities (HPERC). HPERC will provide data that can help determine site readiness for developing an educational campus for health professions students.[35]

Rural Training Tracks (RTT) were first established by Providence Northwest Washington Medical Group in 1986 in response to the lack of rural physicians produced by family medicine residency programs. The original "1-2" model provides for one year in an urban sponsoring institution, followed by two years in a more rural location. The initial programs experienced significant hardship due to a lack of funding and a general decline in student interest in family medicine. In response, a federally funded consortium of individuals and programs established the RTT Technical Assistance program (RTT TA) in 2010 to sustain the 1-2 RTT as a national strategy in training physicians for rural practice. While the project ended in August 2016, the RTT TA program was responsible for the creation of the RTT Collaborative, which currently works to sustain health professions education in rural places through mutual encouragement, peer learning, practice improvement, and the delivery of technical expertise, all in support of a quality rural workforce. In addition to providing technical assistance, the RTT Collaborative convenes an annual meeting, which is hosted by a participating program, to provide a collaborative forum for problem solving and innovation for the education of medical professionals in rural areas. A 2013 study found that at least half of RTT graduates reside in rural areas after graduation, two to three times the proportion of family medicine graduates overall, thereby demonstrating that RTTs are beneficial to increasing the supply of rural physicians.[36] A 2016 report found that among RTT

graduates tracked after graduation (2008-2015), more than 35 percent of graduates were practicing in rural areas during most of that time, about twice the proportion of family medicine residency graduates overall. Rural practice choices were also persistent over time. Furthermore, the study found that 56 percent of RTT graduates provided health care in primary care Health Professional Shortage Areas (HPSAs) one year post-graduation, and by seven years post-graduation, 50 percent were still in primary care HPSAs. These findings suggest that graduates of RTT programs provide care to rural and underserved populations at higher proportions than family medicine residency graduates overall, and these practice choices persist over time.[37] Opportunities to cultivate the RTT Collaborative could be explored, as this collaborative provides a pathway to identify, encourage, and incentivize qualified rural physicians to serve as preceptors and volunteer faculty for rural rotations during residency. However, it should also be noted that several ACGME Review Committees are now placing restrictions on distant sites that may impact the ability of urban centers to offer rural rotations.

In 2008, the University of Washington School of Medicine: Washington, Wyoming, Alaska, Montana, and Idaho (WWAMI) Program developed the Targeted Rural Underserved Track (TRUST) initiative to ensure access to health care in rural and underserved areas. TRUST utilizes an innovative four-year rural and underserved medical school curriculum that matches incoming students with a mentor and a community in a rural environment that they will continue to connect with during their four years of medical school. The goal of the TRUST program is to select students with rural and underserved backgrounds who are most likely to return to these areas. The students are also encouraged to choose specialties that serve those areas, generally a primary care specialty such as family medicine, internal medicine, or pediatrics.

Texas Tech University Health Sciences Center School of Medicine developed a rural residency track that provides residents with experience working one on one with a family physician practicing full-spectrum care including: general and preventive medicine, operative procedures, surgical obstetrics, and Texas-Mexico “border medicine” which focuses on improving health and quality of life along the U.S.-Mexico border. The program aims to increase the number of family medicine residents and mental health fellows providing care in both Midland and Odessa as well as rural communities across West Texas and eastern New Mexico.

In 2010, Columbia University College of Physicians and Surgeons and Bassett Medical Center joined forces to launch a new model of medical training to address the severe shortage of rural physicians and train a new generation of doctors capable of leading health systems that promote both quality of practice and cost-effective delivery of care.[38] Students begin their training for 18 months in Manhattan and then head to Cooperstown for two and a half years to obtain clinical training. Students experience both an urban health care setting and a rural health care environment, while being exposed to features not typically part of the medical school curriculum, such as finance, risk management, patient safety, quality improvement, and medical informatics. In addition, every Columbia-Bassett student receives grant funding at a minimum of $30,000 per year for all four years.

In 2019, Oregon Health & Science University (OHSU) and the University of California, Davis (UC Davis) were awarded $1.8 million by the AMA Reimagining Residency grant program to create educational interventions designed to expand access to quality health care between Sacramento and Portland through a network of teaching hospitals and clinics (in mostly rural areas). OHSU and UC Davis partnered to establish a GME collaborative known as the California Oregon Medical Partnership to Address Disparities in Rural Education and Health (COMPADRE). COMPADRE places hundreds of medical students and resident physicians to train with faculty and community physicians at 10 health care systems, 16 hospitals, and a network of Federally Qualified Health

Center partners throughout Northern California and Oregon. The main goals of COMPADRE are to address health care workforce shortages in rural, tribal, urban, and other communities that lack resources; increase access to physicians; and improve the health of patients from ethnic and racial minoritized groups who are disproportionately affected by certain health conditions.[39]

Additionally, the AMA also awarded $1.8 million over five years to the University of North Carolina School of Medicine to support the significant expansion of the Fully Integrated Readiness for Service (FIRST) Program to new geographic areas of North Carolina and additional high needs specialties including family medicine, general surgery, pediatrics, and psychiatry. The FIRST Program was founded in 2015 at the University of North Carolina School of Medicine to link family medicine workforce pathways from medical school to residency and to service in rural/underserved North Carolina. Participating students have the opportunity to complete their medical degree in three years, followed by the opportunity for placement with the Family Medicine Residency program of North Carolina. FIRST scholar graduates commit to three years of service in an underserved area of North Carolina, during which time they receive ongoing support from UNC Family Medicine in partnership with the NC Office of Rural Health and Community Care, AHEC, Piedmont Health Services, and the North Carolina Academy of Family Physicians.

UTILIZATION OF TELEHEALTH TO ADDRESS RURAL PHYSICIAN WORKFORCE SHORTAGES

Telehealth broadly encompasses technology and health care fields that deliver education, health care, and medical services over a distance. Telehealth modalities for physician/patient interaction may be synchronous (live video), asynchronous (store and forward), remote patient monitoring, or mobile health. In addition, telehealth in rural areas provides the ability for physicians to consult with specialists. Telehealth allows for increased access to physicians, specialists, and other health care professionals for patients in rural areas. In July 2016, the AMA conducted a comprehensive study of physicians' motivations and requirements for the adoption of digital clinical tools. The AMA repeated the study in 2019 to determine the degree to which adoption has occurred in the past three years and to identify attitudinal shifts among physicians toward their use and adoption. The 2019 study found an increase in the number of physicians who see a definite advantage in digital tools; significant growth in the adoption of digital tools among all physicians regardless of gender, specialty, or age; increased adoption of remote care tools such as tele-visits and remote monitoring; and fairly high awareness of emerging technologies such as artificial or augmented intelligence.

Despite telehealth's promise as a means by which to alleviate the shortage of rural physicians, prior to the flexibilities provided during the COVID-19 Public Health Emergency (PHE), telehealth faced several barriers that hindered its widespread adoption in rural areas. Medicare's site of service payment differences impact payments for telehealth services. For example, the originating sites, which are based on the patient's location, were paid facility fees and the distant/receiving sites were paid according to the Medicare physician payment schedule. Additionally, infrastructure presents a challenge, in that many rural areas do not have access to adequate broadband service to allow for the use of telehealth. During the PHE, Medicare has allowed patients to receive telehealth services in their homes instead of having to go to a health care facility and has been paying for telehealth services at in-person office rates. The PHE policies are expected to continue at least through the end of 2021, and the AMA is supporting legislation that would make these flexibilities permanent.

As licensure requirements vary by state, the need for physicians to be licensed in multiple states can also present a burden and a barrier to telehealth implementation. To address this, in the past

few years licensure compacts have been implemented in medicine across state lines to allow for provision of telehealth services to patients in these jurisdictions.[40] The Interstate Medical Licensure Compact (IMLC), which the AMA supports, expedites the process for licensure in multiple states. At the time of this report, 29 states, the District of Columbia, and Guam are members of the IMLC, and six other states have introduced legislation to adopt the IMLC this year. One of the promises of the IMLC is to reduce the burden of obtaining multiple state licenses to practice telehealth, while maintaining the important state-based licensure structure.

Credentialing and privileging are also challenging in telehealth delivery in rural locations due to the costs associated with credentialing. While the Centers for Medicare & Medicaid Services (CMS) approved proxy credentialing in 2011, not all state policies align with proxy credentialing, so this will remain a challenge in some areas.[41]

Despite these challenges, innovative models of health care delivery are being developed through telehealth. For example, telehealth provider Avera eCARE partners with health care systems, rural hospitals, outpatient clinics, and long-term care facilities to reach medically underserved populations in South Dakota, North Dakota, Minnesota, Iowa, Nebraska, Montana, Wyoming, and Kansas through telehealth. Avera eCARE has also expanded to include telehealth services for intensive care, emergency departments, pharmacy, long-term care, and correctional facilities. Avera eCARE programs seek to improve efficiencies while decreasing physician burnout and turnover and keeping patients closer to home, all while improving quality of care.

Using telehealth in intensive care units (ICUs) began in 1982 when the first clinical trial was conducted by Grundy et al. In Alaska, Providence Alaska Medical Center established in 2009 the eICU system, a patient monitoring system that uses telehealth to help care for critically ill patients in multiple hospitals from a single location. It is staffed with experienced intensivists and critical care nurses who monitor patients' vital signs, medications, test results, and other data, continuously analyzing their conditions. This allows critical care specialists to alert clinical staff at the bedside to potential problems before they occur and to guide interventions. The eICU allows staff in Anchorage, Alaska to help treat patients at three other hospitals in remote locations, while also adding an extra layer of care for patients in the Anchorage ICU. It costs Providence $2 million a year to operate the system; the rural hospitals pay about $40,000 a year to connect each bed to the system. Research shows that these monies are well spent. A 2011 study in *JAMA* found that eICUs prevent deaths by helping doctors follow best clinical practices and showed that eICUs cut two days off the average length of an ICU stay.[42]

Project ECHO® (Extension for Community Healthcare Outcomes) was created in 2003 to increase chronic disease management capacity in rural New Mexico for patients with hepatitis C. To treat as many such patients as possible, Project ECHO provided a free educational model and mentored community physicians across New Mexico in how to treat patients with this condition. A 2011 study in the *New England Journal of Medicine* found that hepatitis C care provided by Project ECHO-trained community physicians was as good as care provided by specialists at a university.[43] The Project ECHO model utilizes telementoring, a guided practice model through which the participating clinician retains responsibility for managing the patient. Its principles include appropriate use of technology to leverage scarce resources, sharing best practices to reduce disparity, case-based learning to master complexity, and use of a web-based database to monitor outcomes and the program has been expanded to address other clinical needs beyond hepatitis C care.

Utilization of Technology to Enhance Educational Needs for Rural Training Programs

The PHE necessitated a sudden transition to remote learning in medical schools, and distance E-learning emerged as a new method of teaching to maintain the continuity of medical education. Distance E-Learning is defined as using computer technology to deliver training, including technology-supported learning—either online, offline, or both.[44] Distance E-learning may be beneficial in enhancing educational opportunities for trainees in rural training programs and support alignment with the ACGME Common Program Requirements for scholarship by increasing access to scholarly activities on quality improvement, population health, and teaching, in addition to more classic forms of biomedical research as the focus for scholarship.

Alternative Workforce Initiatives to Address the Physician Shortage in Rural Areas

One approach to meeting demand for primary care is a redefinition, and often expansion, of the scope of practice and licensure for non-physician practitioners, such as nurse practitioners and physician assistants. Many states have taken steps to increase the procedures, treatments, actions, processes, and authority that are permitted by law, regulation, and licensure for non-physician primary care providers. According to the AMA Advocacy Resource Center, 16 states require physician supervision or collaboration of nurse practitioners (NPs) to diagnose, treat, and prescribe; 10 states require physician supervision or collaboration of NPs to prescribe; 10 states require physician supervision or collaboration for a certain number of hours or years; and 15 states plus the District of Columbia allow NPs to practice independently.

DISCUSSION

Rural communities experience significant health disparities due to a number of institutional and structural factors, such as limited access to health care specialists and subspecialists and limited job opportunities for rural residents. According to the Centers for Disease Control and Prevention (CDC), rates for the five leading causes of death in the United States—heart disease, cancer, unintentional injury (including vehicle accidents and opioid overdoses), chronic lower respiratory disease, and stroke—are higher in rural communities.[45] This inequality is intensified as rural residents are less likely to have employer-provided health insurance coverage and, if they are poor, are often not covered by Medicaid. Unfortunately, the supply of rural physicians has not met the demand for health care services among these communities. To meet this need, investments are needed to increase the number of students from rural areas and other students committed to rural and family medicine who are enrolled in medical school and to increase resident exposure to rural practice opportunities.

The current structure of medical education is predominately based in metropolitan areas and disproportionately exposes future physicians to medical practice in urban and suburban settings.[3] While recruitment efforts have focused on strengthening the career pathways for those populations traditionally underrepresented in medicine (URM), these efforts tend to target racial and ethnic groups rather than explicitly targeting students from rural areas. Opportunities to increase rural students' exposure to careers in medicine should be explored to help expand rural physician pathways. Additionally, medical schools should consider rural background as an important component of a diverse student body. Medical schools should consider widespread adoption of holistic admissions practices that value a broad set of life and leadership experiences among applicants.

Beyond educational interventions, efforts should be made to decrease rural hospital closures, as physicians are not likely to practice in an area that is remote from a hospital. There is a symbiotic

relationship between physicians and hospitals; research has found that rural hospital closures are associated with long-term decreases in the supply of rural physicians. Rural hospitals in states that had expanded Medicaid as of April 2018 were less likely to close compared to rural hospitals in states that had not expanded Medicaid. At the time this report was drafted, the North Carolina Rural Health Research Program had identified 163 rural hospital closures, 35 percent of which have occurred since 2016. In its 2018 report, the GAO found that from 2013 through 2017 rural hospitals located in the U.S. South represented 77 percent of rural hospital closures; Medicare Dependent Hospitals accounted for 25 percent; and for-profit rural hospitals 36 percent.

Addressing this issue is essential to ensuring an adequate supply of physicians for rural areas. The Association of State and Territorial Health Officials (ASTHO) reports that states are using a variety of measures to prevent rural hospital closures, including tax incentives, technical assistance, and increased Medicaid reimbursement rates. States are also working to improve rural health care access by creating new licensure options, reducing regulatory barriers for clinics that serve rural populations, and exploring legislation that would recruit and train a rural health workforce.[46]

RELEVANT AMA POLICY

Our AMA has numerous existing policies and directives that are relevant to the topic of rural health; these are shown in the appendix.

SUMMARY AND RECOMMENDATIONS

Addressing the gap of rural health services in the U.S. requires a multifaceted approach. In its role as convener of key organizations and stakeholders, our AMA continues to work to help identify ways to encourage and incentivize qualified physicians to practice in our nation's underserved areas. In addition, our AMA continues to advocate for state and national legislative action and other efforts that (1) expand the health careers pathways for Americans in rural areas and others interested in serving these populations; (2) fund residency training in rural areas; (3) promote telehealth and training in telehealth as a promising paradigm to bridge the gaps in care in rural areas; and (4) address the rising tide of rural hospital closures that threatens to further weaken the health care infrastructure in the rural U.S.

The Council on Medical Education therefore recommends that the following recommendation be adopted and the remainder of this report be filed:

1. That our AMA amend Policy H-465.988, "Educational Strategies for Meeting Rural Health Physician Shortage," by addition and deletion to read as follows: ~~Our AMA will undertake a study of issues regarding rural physician workforce shortages, including federal payment policy issues, and other causes and potential remedies (such as telehealth) to alleviate rural physician workforce shortages.~~ (4) Our AMA will encourage ACGME review committees to consider adding exposure to rural medicine as appropriate, to encourage the development of rural program tracks in training programs and increase physician awareness of the conditions that pose challenges and lack of resources in rural areas. (5) Our AMA will encourage adding educational webinars, workshops and other didactics via remote learning formats to enhance the educational needs of smaller training programs. (Modify Current HOD Policy)

2. That our AMA monitor the status and outcomes of the 2020 Census to assess the impact of physician supply and patient demand in rural communities. (Directive to Take Action)

3. That our AMA amend Policy H-200.954, "US Physician Shortage," by addition to read as follows: "(13) will monitor the impact of initiatives to address rural physician workforce shortages." (Modify Current HOD Policy)

4. That our AMA reaffirm Policy H-465.988, "Educational Strategies for Meeting Rural Health Physician Shortage," which states, in part "(1.a) Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents. (1.b) Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians." (Reaffirm HOD Policy).

Fiscal note: $500.

APPENDIX: RELEVANT AMA POLICY

D-305.967, "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education"

1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.

14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.
20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.
21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.
22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Health care Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and health care workforce policy and advice to the nation and provide data that support the value of GME to the nation.
23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.
24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.
25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.
26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.

27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.
28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.
29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.
30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.
31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of Cap-Flexibility and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.
32. Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates rates of placement into GME as well as GME completion.
33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation’s health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.

D-400.985, “Geographic Practice Cost Index”

Our AMA will: (1) use the AMA Physician Practice Information Survey to determine actual differences in rural vs. urban practice expenses; (2) seek Congressional authorization of a detailed study of the way rents are reflected in the Geographic Practice Cost Index (GPCI); (3) advocate that payments under physician quality improvement initiatives not be subject to existing geographic variation adjustments (i.e., GPCIs); and (4) provide annual updates on the Centers for Medicare and Medicaid Services efforts to improve the accuracy of Medicare Economic Index weights and geographic adjustments and their impact on the physician payment schedule, and AMA advocacy efforts on these issues.

D-400.989, "Equal Pay for Equal Work"

Our AMA: (1) shall make its first legislative priority to fix the Medicare payment update problem because this is the most immediate means of increasing Medicare payments to physicians in rural states and will have the greatest impact; (2) shall seek enactment of legislation directing the General Accounting Office to develop and recommend to Congress policy options for reducing any unjustified geographic disparities in Medicare physician payment rates and improving physician recruitment and retention in underserved rural areas; and (3) shall advocate strongly to the current administration and Congress that additional funds must be put into the Medicare physician payment system and that continued budget neutrality is not an option.

H-200.949, Principles of and Actions to Address Primary Care Workforce

1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation's current and projected demand for health care services.
2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).
3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.
4. Admissions and recruitment: The medical school admissions process should reflect the specific institution's mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.
5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.
6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.
7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.
8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.

9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.
10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.
11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.
12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.
13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).
14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.
15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.
16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.
17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.
18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-

centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.
19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.
20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.
21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.
22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.
23. Practicing physicians in other specialties--particularly those practicing in underserved urban or rural areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.
24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.
25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.

H-200.954, "US Physician Shortage"

Our AMA:
(1) explicitly recognizes the existing shortage of physicians in many specialties and areas of the US;
(2) supports efforts to quantify the geographic maldistribution and physician shortage in many specialties;
(3) supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US;
(4) encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations;
(5) encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations;
(6) encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates' eventual practice in underserved areas and with underserved populations;
(7) will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas;

(8) will continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification;
(9) will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need;
(10) continues to work with the Association of American Medical Colleges (AAMC) and other relevant groups to monitor the outcomes of the National Resident Matching Program; and
(11) continues to work with the AAMC and other relevant groups to develop strategies to address the current and potential shortages in clinical training sites for medical students.
(12) will: (a) promote greater awareness and implementation of the Project ECHO (Extension for Community Health care Outcomes) and Child Psychiatry Access Project models among academic health centers and community-based primary care physicians; (b) work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States; and (c) monitor whether health care payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in programs such as Project ECHO and the Child Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians.

H-200.972, "Primary Care Physicians in Underserved Areas"

1. Our AMA should pursue the following plan to improve the recruitment and retention of physicians in underserved areas:
(a) Encourage the creation and pilot-testing of school-based, faith-based, and community-based urban/rural family health clinics, with an emphasis on health education, prevention, primary care, and prenatal care.
(b) Encourage the affiliation of these family health clinics with local medical schools and teaching hospitals.
(c) Advocate for the implementation of AMA policy that supports extension of the rural health clinic concept to urban areas with appropriate federal agencies.
(d) Encourage the AMA Senior Physicians Section to consider the involvement of retired physicians in underserved settings, with appropriate mechanisms to ensure their competence.
(e) Urge hospitals and medical societies to develop opportunities for physicians to work part-time to staff health clinics that help meet the needs of underserved patient populations.
(f) Encourage the AMA and state medical associations to incorporate into state and federal health system reform legislative relief or immunity from professional liability for senior, part-time, or other physicians who help meet the needs of underserved patient populations.
(g) Urge hospitals and medical centers to seek out the use of available military health care resources and personnel, which can be used to help meet the needs of underserved patient populations.
2. Our AMA supports efforts to: (a) expand opportunities to retain international medical graduates after the expiration of allocated periods under current law; and (b) increase the recruitment and retention of physicians practicing in federally designated health professional shortage areas.

H. 240.971, "Elimination of Payment Differentials Between Urban and Rural Medical Care"

Our AMA (1) supports elimination of Medicare reimbursement differentials between urban and rural medical care; and (2) supports efforts to inform the Congress of the impact of such programs on the rural population.

H-400.988, "Medicare Reimbursement, Geographical Differences"

The AMA reaffirms its policy that geographic variations under a Medicare payment schedule should reflect only valid and demonstrable differences in physician practice costs, especially liability premiums, with other non-geographic practice cost index (GPCI) -based adjustments as needed to remedy demonstrable access problems in specific geographic areas.
(Sub. Res. 82, A-89 Reaffirmed: BOT Rep. DD, I-92 Reaffirmed: CMS Rep. 10, A-03 Reaffirmation A-06 Reaffirmation I-07 Reaffirmation A-08 Reaffirmation A-09 Reaffirmed: BOT Action in response to referred for decision Res. 212, A-09 Modified: CMS Rep. 4, A-11 Reaffirmed: CMS Rep. 1, I-11 Reaffirmed in lieu of Res. 122, A-12 Reaffirmed in lieu of Res. 113, A-13)

H-465.979, "Economic Viability of Rural Sole Community Hospitals"

Our AMA: (1) recognizes that economically viable small rural hospitals are critical to preserving patient access to high-quality care and provider sustainability in rural communities; and (2) supports the efforts of organizations advocating directly on behalf of small rural hospitals provided that the efforts are consistent with AMA policy.

H-465.980, "Rural Community Health Networks"

AMA policy is that development of rural community health networks be organized using the following principles: (1) Local delivery systems should be organized around the physical, mental and social needs of the community; (2) Clinical decision-making and financial management should reside within the community health network whenever feasible with physicians retaining responsibility for a network's medical, quality and utilization management; (3) Savings generated by community health networks should be reinvested in the local health care delivery system, rather than redirected elsewhere, since rural health systems and economies are fundamentally intertwined; (4) Patients should retain access to the spectrum of local health services, thereby preserving patient-physician relationships and continuity of care; and (5) Participation in rural community health networks should be voluntary, but open to all qualified rural physicians and other health care providers wishing to participate.

H-465.981, "Enhancing Rural Physician Practices"

The AMA: (1) supports legislation to extend the 10% Medicare payment bonus to physicians practicing in rural counties and other areas where the poverty rate exceeds a certain threshold, regardless of the areas' Health Professional Shortage Area (HPSA) status; (2) encourages federal and state governments to make available low interest loans and other financial assistance to assist physicians with shortage area practices in defraying their costs of compliance with requirements of the Occupational Safety and Health Administration, Americans with Disabilities Act and other national or state regulatory requirements; (3) will explore the feasibility of supporting the legislative and/or regulatory changes necessary to establish a waiver process through which shortage area practices can seek exemption from specific elements of regulatory requirements when improved access, without significant detriment to quality, will result; and (4) supports legislation that would allow shortage area physician practices to qualify as Rural Health Clinics without the need to employ one or more physician extenders.

H-465.982, "Rural Health"

The AMA: (1) encourages state medical associations to study the relevance of managed competition proposals to meeting health care needs of their rural populations; (2) encourages state associations to work with their respective state governments to implement rural health demonstration projects; and (3) will provide all adequate resources to assist state associations in dealing with managed competition in rural areas.

H-465.989, "Rural Health"

It is the policy of the AMA that: (1) the AMA closely monitor the impact of balance billing restrictions mandated by the Budget Reconciliation legislation on reimbursement levels and access to care in rural areas, and take action as needed to moderate that impact; (2) the AMA closely monitor implementation of the legislation establishing essential access community hospitals and rural primary care hospitals, to ensure that this program is implemented in a manner conducive to high quality of patient care and consistent with Association policy concerning the functions and supervision of physician assistants and nurse practitioners; (3) state medical associations be encouraged to monitor similarly and to influence any legislation or regulations governing the development and operation of such limited service rural hospital facilities in their own jurisdictions; and (4) the AMA establish liaison with the American Hospital Association, Congress and the Centers for Medicare & Medicaid Services regarding any further development of essential access community hospitals and rural primary care hospitals grants.

H-465.990, "Closing of Small Rural Hospitals"

Our AMA encourages legislation to reduce the financial constraints on small rural hospitals in order to improve access to health care.

H-465.994, "Improving Rural Health"

1. Our AMA (a) supports continued and intensified efforts to develop and implement proposals for improving rural health care, (b) urges physicians practicing in rural areas to be actively involved in these efforts, and (c) advocates widely publicizing AMA's policies and proposals for improving rural health care to the profession, other concerned groups, and the public.

2. Our AMA will work with other entities and organizations interested in public health to:
- Identify and disseminate concrete examples of administrative leadership and funding structures that support and optimize local, community-based rural public health.
- Develop an actionable advocacy plan to positively impact local, community-based rural public health including but not limited to the development of rural public health networks, training of current and future rural physicians in core public health techniques and novel funding mechanisms to support public health initiatives that are led and managed by local public health authorities.
- Study efforts to optimize rural public health.

H.465.997, "Access to and Quality of Rural Health Care"

(1) Our AMA believes that solutions to access problems in rural areas should be developed through the efforts of voluntary local health planning groups, coordinated at the regional or state level by a similar voluntary health planning entity. Regional or statewide coordination of local efforts will not only help to remedy a particular community's problems, but will

also help to avoid and, if necessary, resolve existing duplication of health care resources. (2) In addition to local solutions, our AMA believes that on a national level, the implementation of Association policy for providing the uninsured and underinsured with adequate protection against health care expense would be an effective way to help maintain and improve access to care for residents of economically depressed rural areas who lack adequate health insurance coverage. Efforts to place National Health Service Corps physicians in underserved areas of the country should also be continued.

D-255.985, "Conrad 30 - J-1 Visa Waivers"

1. Our AMA will: (A) lobby for the reauthorization of the Conrad 30 J-1 Visa Waiver Program; (B) advocate that the J-1 Visa waiver slots be increased from 30 to 50 per state; (C) advocate for expansion of the J-1 Visa Waiver Program to allow IMGs to serve on the faculty of medical schools and residency programs in geographic areas or specialties with workforce shortages; (D) publish on its website J-1 visa waiver (Conrad 30) statistics and information provided by state Conrad 30 administrators along with a frequently asked questions (FAQs) document about the Conrad 30 program; (E) advocate for solutions to expand the J-1 Visa Waiver Program to increase the overall number of waiver positions in the US in order to increase the number of IMGs who are willing to work in underserved areas to alleviate the physician workforce shortage; (F) work with the Educational Commission for Foreign Medical Graduates and other stakeholders to facilitate better communication and information sharing among Conrad 30 administrators, IMGs, US Citizenship and Immigration Services and the State Department; and (G) continue to communicate with the Conrad 30 administrators and IMGS members to share information and best practices in order to fully utilize and expand the Conrad 30 program.
2. Our AMA will continue to monitor legislation and provide support for improvements to the J-1 Visa Waiver program.
3. Our AMA will continue to promote its educational or other relevant resources to IMGs participating or considering participating in J-1 Visa waiver programs.
4. As a benefit of membership, our AMA will provide advice and information on Federation and other resources (but not legal opinions or representation), as appropriate to IMGs in matters pertaining to work-related abuses.
5. Our AMA encourages IMGs to consult with their state medical society and consider requesting that their state society ask for assistance by the AMA Litigation Center, if it meets the Litigation Center's established case selection criteria.

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REPORT 4 OF THE COUNCIL ON MEDICAL EDUCATION (November 2021)
Medical Student Debt and Career Choice
(Reference Committee C)

EXECUTIVE SUMMARY

American Medical Association (AMA) Policy H-305.925 (22), "Principles of and Actions to Address Medical Education Costs and Student Debt," asks our AMA to:

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

To implement the policy, the Council on Medical Education developed a task force comprising representatives of AMA member sections as well as the National Association of Advisors for the Health Professions. The task force held two calls, in April and July, to review the literature on this topic, discuss the issues and potential solutions, and develop recommendations for consideration by the Council on Medical Education.

The task force reflected on a multitude of issues related to medical student career choice and the influence of debt; these include trends in medical student debt, gaps in financial literacy among medical students, the potential role of debt on diversity of the medical profession, and the impact of loan forgiveness programs and free medical school tuition.

Although high levels of medical school debt are a personal concern from a financial perspective for many medical students, trainees, and physicians, the ultimate impact of debt on career choice is variable and is not strongly associated with specialty selection. The Council on Medical Education will continue to monitor the literature and data regarding the influence of medical education debt on the physician workforce, especially with regard to the potentially intersecting impacts of race/ethnicity, socioeconomic status, and other key sociodemographic factors.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 4-N-21

Subject: Medical Student Debt and Career Choice

Presented by: Niranjan Rao, MD, Chair

Referred to: Reference Committee C

American Medical Association (AMA) Policy H-305.925 (22), "Principles of and Actions to Address Medical Education Costs and Student Debt," asks our AMA to:

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

During the 2019 Annual Meeting of the AMA House of Delegates (HOD), testimony before Reference Committee C was in support of this addition to policy. Indeed, education debt continues to be a significant burden on medical students, residents, and physicians. The AMA has numerous policies on this topic and advocates to legislators for mechanisms to alleviate or eliminate education debt. Similarly, the AMA continues to call for improved workforce planning, to ensure access to health care services nationwide, particularly in underserved rural and urban areas and in specific fields of need (e.g., primary care).

DEVELOPMENT OF THE TASK FORCE

To implement the policy, the Council on Medical Education assigned the chair of its 2019-2020 undergraduate medical education committee (Robert Goldberg, DO) as lead for the task force, which comprised representatives of the following AMA sections, along with the National Association of Advisors for the Health Professions (NAAHP):

• Medical Student Section	Faith Crittenden
• Resident and Fellow Section	Gunjan Malhotra, MD
• Young Physicians Section	Hilary Fairbrother, MD, MPH
• Academic Physicians Section	Hal B. Jenson, MD, MBA
• Women Physicians Section	Anita Ravi, MD, MPH, MSHP
• Minority Affairs Section	Frank Clark, MD
• Senior Physicians Section	Louis Weinstein, MD
• NAAHP	Francie Cuffney, PhD

The task force held two teleconferences, in April and July; appointed representatives contributed the expertise and unique perspectives of their specific demographic groups to the background and recommendations of this report.

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TRENDS IN MEDICAL STUDENT DEBT

As with tuition and expenses across higher education, data on medical student debt reflect a continuing upward trend. The Association of American Medical Colleges (AAMC) reports that median medical school debt in 2019 was $200,000, which increased from $195,000 in 2018.[1] Data for osteopathic medical school programs reflect a similar upward trend, according to the American Association of Colleges of Osteopathic Medicine (AACOM), with an overall median expected debt for matriculants in 2019 at $192,000—up nine percent over the previous two years.[2] AACOM data also show that median expected debt for entering students at private osteopathic schools is $200,000, versus $160,000 for those in public osteopathic schools.

These data show a significant and growing debt burden on medical students in aggregate but may disguise the actual debt load that many individual students face, due to a sizeable and growing cross-section of students who report no medical student debt. The proportion of those reporting no debt has been increasing and appears concentrated in students from wealthy backgrounds. The reported percentage of 2015 medical school graduates who graduated with no medical school debt was 21.5 percent; this figure grew to 28.7 percent for 2019 graduates.[1] Although this trend may at first glance seem positive, report Grischkan et al., it may have negative consequences both for the diversity of the physician workforce and physician distribution across medical specialties, in that "primary care-oriented fields seem to have less of an increase in graduates without debt."[3] In fact, as Grischkan et al. note, six specialties are experiencing the largest absolute increase in no debt; radiology, dermatology, neurology, obstetrics and gynecology, ophthalmology, and pathology—many of which are competitive choices for careers among medical school graduates seeking to match into a residency program. In short, it appears that higher overall debt is concentrated among a smaller number of individuals. This underscores the potential misinterpretations that may arise from viewing these data in aggregate, which may cloud the overall picture, as a significant subset of students have outside funding sources to offset debt, including personal or family wealth, scholarships, debt relief through military service, and loan forgiveness due to future service in an underserved urban and rural area.

One of the largest contributors to medical school debt is rising tuition. According to the AAMC, the cost of allopathic medical education has been increasing steadily for both public and private institutions, as shown in Table 1, with a 20 percent to 23 percent increase in less than a decade.[4] Similar data from the AACOM (see Table 2) show a 30 percent to 34 percent increase over 11 years.[5]

Table 1. Average tuition, U.S. allopathic medical school programs (public and private)

	2012-2013		2019-2020	
	In-state	Out of state	In-state	Out of state
Public	$23,954	$45,047	$32,520	$56,001
Private	$42,407	$43,943	$55,337	$56,946

Table 2. Mean tuition, U.S. osteopathic medical school programs (public and private aggregated)

2008-2009		2019-2020	
In-state	Out of state	In-state	Out of state
$33,420	$38,683	$50,563	$55,853

It is important to note that while tuition has been steadily increasing, it has not discouraged applications to medical school; this number as well as overall enrollments have continued to increase over the last decade for both allopathic[6] and osteopathic[7] medical school programs. These increases in tuition could influence specialty choice among graduates of public versus private medical schools in different ways. Phillips et al. reported that high educational debt deters graduates of public medical schools from choosing primary care but does not appear to influence private school graduates in the same way. They note that "[r]educing debt of selected medical students may be effective in promoting a larger primary care physician workforce."[8]

GAPS IN FINANCIAL LITERACY AMONG MEDICAL STUDENTS

While the increase in medical school costs is a significant factor in rising medical student debt, it is also important to consider the relative lack of financial education among medical students as a concern.

A study of first- and fourth-year medical students by Jayakumar et al. found low levels of financial literacy and lack of preparedness for managing personal finances, including strategies for effective saving and investing and practice management.[9] Equally concerning, the study's authors describe the lack of improvement in financial literacy between entering and graduating medical students, regardless of whether their medical school offered such education. They conclude that reform efforts in undergraduate medical education by institutions and policymakers should encompass improvements to existing curricula to fill this gap in medical students' knowledge, and ensure that financial counseling is tailored to meet students' needs and occurs before key personal finance decisions are made.

The Liaison Committee on Medical Education, which accredits medical school programs in the U.S. leading to the MD (allopathic) degree, includes as part of its accreditation standards a requirement that programs provide the following services to students:

> *12.1 Financial Aid/Debt Management Counseling/Student Educational Debt*
>
> *A medical school provides its medical students with effective financial aid and debt management counseling and has mechanisms in place to minimize the impact of direct educational expenses (i.e., tuition, fees, books, supplies) on medical student indebtedness.*

Similarly, the Commission on Osteopathic College Accreditation, the accrediting body for osteopathic medical school programs, has the following requirements related to debt counseling and student debt outcomes:

> *Element 9.7: Financial Aid and Debt Management Counseling*
>
> *A COM [college of medicine] must provide its students with counseling to assist them with financial aid applications and debt management.*
>
> > *Submission 9.7: Financial Aid and Debt Management Counseling*
> >
> > > *1. Provide a description of all financial aid and debt counseling sessions provided to its students, including:*
> > > > *a. When the financial aid and debt counseling sessions are/were provided to the students;*
> > > > *b. The OMS year during which students are required to receive these sessions;*

c. A roster of students that received financial aid and debt counseling.

Element 11.3: Student Debt Outcomes

A COM and/or its parent institution must collect and publish data on the debt load and student loan default rates of its students in such a way that applicants can be aware of the information.

Submission 11.3: Student Debt Outcomes

1. Provide the current average debt for the last four years of students.
2. Provide a public link to where the information is published.
3. For each of the four academic years preceding the submission of this information, provide the student loan default rate for all federal financial aid obtained under the Higher Education Act of 1965 (HEA), as amended, including financial aid provided under Title IV of the HEA.

DEBT AND DIVERSITY

In considering the connections between career choice and medical student debt, it is imperative to examine the differences in financial circumstances and barriers that exist for subsets of medical graduates.

Data regarding debt that account for racial/ethnic diversity of medical students and physicians demonstrate that Black/African American and Hispanic/Latina/o/x medical students graduate with higher levels of medical school debt compared to the overall population. According to AACOM, 91 percent of Black/African American and 88 percent of Hispanic/Latina/o/x entering students expect to graduate with medical education debt—versus 77 percent of Asian entering students and 86 percent of white students.[10] These trends have been supported by other studies that report higher debt burden in Black medical students compared to other races/ethnicities. A study by Dugger et al. found that 77.3 percent of Black medical students anticipated debt in excess of $150,000 upon graduation, versus White (65.1 percent), Hispanic (57.2 percent), and Asian students (50.2 percent).[11] These findings are supported by Jolly[12] and Phillips et al.[13] (Dugger et al. do note that Hispanic students are a "notable exception to this general relationship," and call for research of the "relatively high matriculation and low debt of Hispanics in comparison to other minority groups.")

The literature concerning medical school debt among students from groups historically marginalized in medicine is limited, it is important to consider additional disparities that exist in medical school. While the current evidence reflects higher amounts of debt for Black/African American and Hispanic/Latina/o/x groups, students from minoritized groups also experience a higher incidence of discrimination and burnout and may have more limited access to resources compared to non-minoritized medical students. Medical student debt levels are negatively associated with mental well-being and academic outcomes, according to a review by Pisaniello et al.[14] Perceived risk of not completing an educational program creates additional burden regarding one's ability to ultimately repay educational debt. It is important to lower these hurdles for minoritized students; improved strategies and programs for decreasing and mitigating medical school debt and its impacts is only one aspect of addressing systemic disparities within medical education.

FACTORS THAT INFLUENCE MEDICAL CAREER CHOICE

It is inarguable that high levels of medical school debt are a personal concern from a financial perspective for many medical students, trainees, and physicians. Increasing evidence suggests that the impact of debt on career choice is variable and is not strongly associated with specialty selection, including the choice of primary care fields.[15,16,17,18]

In contrast, the strongest and most predictive influences of specialty choice, according to the AAMC survey of 2019 medical school graduates,[1] are the following:

Influence	Percent
Fit with personality, interests, and skills	87.2
Content of specialty	83.4
Role model influence	50.9

These data have been consistent, in that they represent the three most frequently cited influences on specialty choice by each of the past five classes of medical school graduates, from 2015 to 2019.

A recent systematic literature review and meta-analysis of 75 studies encompassing more than 880,000 individuals by Yang et al.[19] outlined the factors influencing medical students' choice of subspecialty training; as shown, student debt was cited as a factor by the fewest respondents:

Factor	Percent
Academic interests	75.3
Competencies	55.2
Controllable lifestyles or flexible work schedules	53
Patient service orientation	50
Medical teachers or mentors	46.9
Career opportunities	44
Workload or working hours	37.9
Income	34.7
Length of training	32.3
Prestige	31.2
Advice from others	28.2
Student debt	15.3

Income is certainly among the drivers of career choice; this variable is even more critical when considering lifetime earning potential. Leigh et al. reported that estimates of additional lifetime earnings for the broad categories of surgery, internal medicine, and pediatric subspecialties and other specialties over that for primary care were $1,587,722, $1,099,655, and $761,402 respectively. For 41 specific specialties, the top additional earnings compared with family medicine as reference were neurological surgery ($2,880,601), medical oncology ($2,772,665), and radiation oncology ($2,659,657). The authors conclude, "After accounting for varying residency years and discounting future earnings, primary care specialties earned roughly $1 [million to] $3 million less than other specialties."[20]

Aside from the numbers, career satisfaction continues to be complex and multifaceted. Physician career satisfaction has been linked to better health care, patient satisfaction, and improved patient outcomes. Career satisfaction and dissatisfaction vary across specialty as well as by age, income, and region. A 2002 study by Leigh et al. found a "relatively high proportion of dissatisfied physicians among those practicing certain 'procedural' specialties" (including ophthalmology,

otolaryngology, and orthopaedic surgery), which the authors deemed "puzzling" due to the high income and prestige associated with these fields. In contrast, physicians practicing some "cognitive" specialties (e.g., infectious diseases, geriatrics, and pediatrics) were unlikely to be dissatisfied. The authors conclude that the advent of recent changes wrought by managed care is responsible for the levels of dissatisfaction among these procedural fields.[21]

Several current and future events may also become relevant with regard to the impact of medical student debt upon career choice. With the transition of the United States Medical Licensing Examination® (USMLE®) Step 1 exam to pass/fail reporting, previously perceived barriers to consideration of certain specialties may become less relevant to applicants. Increasing emphasis on holistic review of applicants may also affect medical student specialty choice. In addition, given the impact of the COVID-19 pandemic, there may be significant changes in the application process resulting from necessary innovation to adapt to travel limitations. Although it would be impossible to predict the impact of the changing landscape of medical education and medical student assessment, these factors may become relevant over time and warrant continued monitoring and potential future study.

LOAN FORGIVENESS PROGRAMS AND FREE TUITION

In one study of the role of debt and loan forgiveness/repayment programs in osteopathic medical graduates' plans to enter primary care, the use of loan forgiveness programs has been associated with choosing primary care specialties. Scheckel et al. found that "Graduates with high debt burden were more likely to enter primary care fields and use loan forgiveness/repayment programs."[22] In addition, Richards et al. found a strong association between participation in loan forgiveness programs and medical service in underserved areas.[23] These programs therefore serve a dual purpose—to mitigate the impact of medical school debt on career choice and help increase the medical workforce in underserved areas.

Some, however, have questioned the value of loan forgiveness programs. In their study, Phillips et al. state that it is surprising that individuals with high debt were "significantly less likely to pursue a career with a government-owned or subsidized practice, including an FQHC [federally qualified health center], rural health clinic, the Indian Health Service, the Public Health Service, a state or local government-operated clinic, or the Department of Veterans Affairs."[8] They conclude, "Existing National Health Service Corps [NHSC] loan repayment opportunities may not offer adequate incentives to primary care physicians with high debt," and call for policy changes, including increased investment in the NHSC, reform of the Public Service Loan Forgiveness program, and federal support for academic primary care.

Similarly, Asch, Grischkan, and Nicholson comment that loan repayment programs can create "perverse incentives" and may conflict with each other, leading to a financial disincentive to enter primary care careers. They also state that loan repayment does nothing to address the underlying costs of medical education and only provides a benefit to those who pursue participation in such programs.[24]

Additionally, free tuition and full scholarships alone were also not associated with students choosing primary care, conclude Nguyen and Bounds; they posit that concerns with work environment and lifestyle may dissuade those who were initially interested in primary care from staying with that decision, aside from any tuition and scholarship assistance.[25] This finding is important, in that the number of medical schools offering free tuition is growing, with seven total as of April 2019 (although some such offerings are limited to the first few graduating classes at newly accredited medical schools).[26] An article in *AAMC News* on the increase in free medical

schools notes that such efforts are unlikely to augment the primary care workforce, although they could attract a more diverse pool of applicants and allow for graduates to pursue their passion, regardless of profit. The article highlights data from the AAMC that debt has "little influence" on choice of specialty.[27] In addition, the authors opine that efforts to enhance compensation and reimbursements for primary care medical specialties, change negative perceptions of low prestige (all too common among a subset of medical education role models and mentors), and improve the primary care practice environment for these physicians could be more fruitful as a means to increase the primary care workforce. Future research by the Council on Medical Education and other stakeholders should monitor the impact of free tuition and scholarships on specialty choice and debt, as well as workforce composition and physician satisfaction.

CONCERNS WITH THE PUBLIC SERVICE LOAN FORGIVENESS (PSLF) PROGRAM

At the June 2021 of the AMA HOD, attendees discussed the Public Service Loan Forgiveness (PSLF) program. Discussion centered around concerns about the denial rate of PSLF applications, lack of transparency of and communication about program requirements, and oversight and accountability of PSLF loan servicers. Council on Medical Education offered to incorporate discussion of the issue into this report.

A 2017 report by the Council on Medical Education, "Expansion of Public Service Loan Forgiveness," provided background on the PSLF program, a taxpayer-funded program through which debt relief is afforded individuals to work in public service careers, such as teachers and social workers, as well as medical professionals. PSLF forgives the remaining balance on Direct Loans after the individual makes 120 qualifying monthly payments under a qualifying repayment plan while working full-time for a qualifying employer. According to Federal Student Aid, an office of the U.S. Department of Education (https://studentaid.gov/manage-loans/forgiveness-cancellation/public-service), PSLF requirements specify that recipients must:

- be employed by a U.S. federal, state, local, or tribal government or not-for-profit organization;
- work full-time for that agency or organization;
- have Direct Loans (or consolidate other federal student loans into a Direct Loan);
- repay loans under an income-driven repayment plan; and
- make 120 qualifying payments.

Despite the promise of the program, it has been beset by challenges and administrative difficulties, leading to "astronomical" denial rates, as the authors of Resolution 314-J-21 deemed it. A 2019 *New York Times*' article (https://www.nytimes.com/2019/11/28/us/politics/student-loan-forgiveness.html) ascribed blame for the program's failures to "loan servicers who at best failed to inform borrowers of what was needed to qualify, to the single company in charge of the program that has been repeatedly cited for shoddy service, mismanagement and poor record keeping, to lawmakers who wrote in a baffling list of requirements, and to the Education Department, which has failed to step in and correct the problem."

A 2019 report from the Government Accountability Office (https://www.gao.gov/products/gao-19-595) calls for increased availability of information on the program and decreasing/combining the number of application steps to make PSLF less confusing for borrowers.

A contrarian viewpoint, expressed by the founder of Student Loan Planner at https://www.studentloanplanner.com/pslf-snowball-effect/, takes a more sanguine approach to the PSLF and its prospects for debt relief. He writes, "The PSLF success rate for applications will be

exponentially increasing over the next few years thanks to the 'PSLF Snowball Effect.'" For medicine in particular, he adds that, due to the timing of the development of the program, and the 10-year window for the 120-payment requirement, physicians will not be receiving PSLF "en masse" until 2024.

AMA'S FEDERAL ADVOCACY EFFORTS REGARDING STUDENT LOAN DEBT

The AMA's Advocacy Group has been active in advocating before Congress for legislation that ensures continued funding of key programs, such as loan forgiveness, that help ensure availability of physicians in specific fields of medicine and/or underserved geographic areas to satisfy the nation's health care workforce needs.

Consolidated Appropriations Act, 2021 (H.R. 133)

This legislation (see https://rules.house.gov/sites/democrats.rules.house.gov/files/BILLS-116HR133SA-RCP-116-68.pdf) encompasses extension for community health centers, the National Health Service Corps, and teaching health centers that operate graduate medical education (GME) programs. It includes $4 billion in funding from 2019-2023 for community health centers and the National Health Service Corps and provides $310 million in additional funding from 2021-2023 for the National Health Service Corps. It also provides additional funding, until 2023, for teaching health centers that operate GME programs. (Sec. 301)

Specific relevant sections of the legislation include the following:

Promoting Rural Hospital GME Funding Opportunity

This section makes changes to Medicare graduate medical education (GME) Rural Training Tracks (RTT) program to provide greater flexibility for hospitals not located in a rural area that established or establish a medical residency program (or rural tracks) in a rural area or establish an accredited program where greater than 50 percent of the program occurs in a rural area to partner with rural hospitals and address the physician workforce needs of rural areas. (Sec. 127)

Medicare GME treatment of hospitals establishing new medical residency training programs after hosting medical resident rotators for short durations

This section allows hospitals to host a limited number of residents for short-term rotations without being negatively impacted by a set permanent full time equivalent (FTE) resident cap or a Per Resident Amount (PRA). A hospital must report full-time equivalent residents on its cost report for a cost reporting period if the hospital trains at least 1.0 full-time-equivalent residents in an approved medical residency training program or programs in such period. (Sec. 131)

Student Financial Assistance

A total of $24.5 billion shall be provided for carrying out Title IV of HEA and the maximum Pell Grant that a student can be eligible for during 2021-2022 will be $5,432. (Title III)

Student Aid Administration

A total of $1.9 billion will remain available through September 30, 2022 to carry out HEA and the Public Health Service Act, allowing students to pick from multiple servicers for their student loans and providing more support and transparency for borrowers. (Title III)

Strategy to prioritize and expand educational and professional exchange programs with Mexico

The section calls for assessment of the feasibility of fostering partnerships between universities in the United States and medical school and nursing programs in Mexico to ensure that Mexican programs have accreditation standards that are in line with the Accreditation and Standards in Foreign Medical Education and Accreditation Commission For Education in Nursing, so that Mexican medical and nursing students can pass medical and nursing licensing examinations, respectively, in the United States. (Sec. 1904)

General Provisions

A total of $50 million for public service loan forgiveness under the normal terms. (Sec. 311)

Health Workforce

A total of $50 million will be available for grants to public institutions of higher education to expand or support graduate education for physicians provided by such institutions. Priority will be given to public institutions located in states with a projected primary care shortage in 2025. Grants are limited to public institutions in states in the top quintile of states with a projected primary care shortage in 2025. (Title II)

Distribution of additional residency positions

This section supports Medicare physician workforce development by providing for the distribution of 1,000 additional Medicare-funded GME residency positions. Not less than 10 percent of the aggregate number of these new positions will be given to each of the following categories: rural hospitals, hospitals that are already above their Medicare cap for residency positions, hospitals in states with new medical schools or new locations and branch campuses, and hospitals that serve Health Professional Shortage Areas. However, a hospital may not receive more than 25 additional full-time equivalent residency positions. (Sec. 126). On June, 28, 2021, the AMA provided comments about how the new 1,000 GME slots should be distributed. The AMA also signed on to a letter discussing this same issue.

Higher Education Emergency Relief Fund

Funding will be provided to defray expenses associated with COVID-19, to carry out student support activities authorized by the HEA that address needs related to COVID-19, and to provide financial aid grants to students which may be used for any component of the student's cost of attendance or for emergency costs that arise due to COVID-19, including tuition, food, housing, health care, or childcare. Additional funding will be provided for Historically Black Colleges and Universities, Tribal Colleges and Universities, Hispanic Serving Institutions, and certain other institutions. (Sec. 314)

FAFSA Simplification

This provision makes it easier to apply for federal aid and makes that aid predictable. This provision provides a formula for determining the amount of need that a student has including tuition, room and board, dependents, book stipends, transportation, and personal expenses. It also considers parents' and spouses' potential financial contributions or lack thereof. (Title VII)

Emergency Financial Aid Grants

Students receiving qualified emergency financial aid grants after March 26, 2020, will not have those grants included in their gross income for purposes of the Internal Revenue Code. (Sec. 277)

Other Loan Forgiveness Legislation

The AMA offered technical assistance toward creation of the Health Heroes 2020 Act (H.R. 6650/ S. 3634), which proposes to bolster the National Health Service Corps (NHSC) by providing an additional $25 billion for both loan repayment and scholarship programs in fiscal year 2020 to increase the number of medical professionals in underserved communities. In addition, the proposal increases the mandatory NHSC funding level from $310 million to $690 million for fiscal years 2021-2026 to increase scholarship and loan forgiveness awards and meet the nation's growing health needs.

The AMA has voiced its support for the Strengthening America's Health Care Readiness Act, which increases supplemental funding for the NHSC by $10 billion. This increased funding will be used for additional loan repayment and scholarship programs. Moreover, the bill contains a 40 percent set-aside for historically underrepresented minorities in health care and provides mentoring and early recruitment for minorities. Additionally, the bill provides $50 million for a National Disaster Medical System (NDMS) pilot program, which would bolster health emergency surge capacity.

The AMA has also supported the Student Loan Forgiveness for Frontline Health Workers Act in the 116th and the 117th Congresses and urged the U.S. House of Representatives and the U.S. Senate to quickly pass this legislation. If adopted, this act would provide total student loan forgiveness for physicians, residents, and medical students who aid in responding to the COVID-19 crisis.

The AMA also drafted a letter to Congressional leaders in 2020 regarding the "phase four" coronavirus relief package intended to confront the economic impact of the COVID-19 pandemic. For resident physicians and early graduated medical students whose debt averages over $200,000 per individual, the AMA urged Congress to provide at least $20,000 of federal student loan forgiveness or $20,000 of tuition relief. The AMA believes these benefits should also be made available to third- and fourth-year medical students who are willing, and deemed competent, to begin providing early direct patient care for patients with COVID-19, or who are making other significant contributions to the pandemic response through research, public health, and telemedicine efforts.

Other AMA advocacy in 2021 toward alleviating the medical education debt burden includes the following:

- On March 24, the AMA signed on to a letter offering support for the "Resident Physician Shortage Reduction Act." This bipartisan legislation would gradually raise the number of Medicare-supported GME positions by 2,000 per year for seven years, for a total of 14,000 new slots. A share of these positions would be given to hospitals with diverse needs including hospitals in rural areas, hospitals serving patients from health professional shortage areas (HPSAs), hospitals in states with new medical schools or branch campuses, and hospitals already training over their caps. On April 8, the AMA sent a letter supporting S. 924, the "Rural America Health Corps Act." This legislation would establish a demonstration program to provide payments on qualified loans for individuals eligible for,

but not currently participating in, the National Health Service Corps (NHSC) Loan Repayment Program who agree to a five-year period of obligated full-time service in a rural health professional shortage area.

- On May 13, the AMA sent letters supporting H.R. 2917 and S. 1443, the "Retirement Parity for Student Loans Act," which would permit 401(k), 403(b), SIMPLE, and governmental 457(b) retirement plans to make voluntary matching contributions to workers as if their student loan payments were salary reduction contributions.

- On May 18, the AMA signed on to a letter asking that federal support for physician training be included in upcoming legislative efforts to improve the nation's infrastructure, and reaffirmed our support for the "Resident Physician Shortage Reduction Act of 2021," which asks for 14,000 additional Medicare-supported GME positions.

- On May 24, the AMA sent a letter supporting H.R. 3441, the "Substance Use Disorder Workforce Act," which would provide 1,000 additional Medicare-supported graduate medical education (GME) positions in hospitals that have, or are in the process of establishing, accredited residency programs in addiction medicine, addiction psychiatry, or pain medicine.

- On May 25, the AMA sent a letter voicing support for S. 1438, the "Opioid Workforce Act of 2021," which would provide 1,000 additional Medicare-supported graduate medical education (GME) positions in hospitals that have, or are in the process of establishing, accredited residency programs in addiction medicine, addiction psychiatry, or pain medicine. This is the companion bill for the "Substance Use Disorder Workforce Act."

- On June 10, the AMA sent a letter in support of the "Doctors of Community Act" or "DOC Act." This legislation would permanently authorize the Teaching Health Center Graduate Medical Education (THCGME) program. As such, if passed, this legislation would help ensure that patients in underserved areas continue to have access to needed health care services.

- On June 23, the AMA sent a letter voicing support for the "Physician Shortage GME Cap Flex Act of 2021." This legislation would help to address the national physician workforce shortage by providing teaching hospitals an additional five years to set their Medicare GME cap if they establish residency training programs in primary care or specialties that are facing shortages. (House; Senate)

- On July 1, the AMA sent a letter supporting H.R. 4122, the "Resident Education Deferred Interest (REDI) Act," which would allow borrowers to qualify for interest-free deferment on their student loans while serving in a medical or dental internship or residency program.

Higher Education Act (HEA) Reauthorization

The HEA was last comprehensively reauthorized in 2008 by the Higher Education Opportunity Act of 2008, which authorized most HEA programs through FY2014; it was extended through FY2015, under the General Education Provisions Act (GEPA). Many HEA programs that had been due to expire at the end of FY2015 were provided additional funding under a variety of appropriations bills and continuing resolutions, because Congress has not been able to agree on comprehensive reauthorization legislation. Earlier in 2020, Congressional lawmakers were close to reaching an agreement to update the HEA, but the emergence of the pandemic put this effort on hold. Today,

with the potential growing for a long-term economic downturn related to the COVID-19 pandemic, and as more people seek to further their education as a result, the need to reauthorize the HEA is more pressing than ever, and the AMA will continue advocacy in this regard.

RELEVANT AMA POLICY

Our AMA calls for addressing and reducing the burden of medical education debt among students, residents/fellows, and physicians through the following policies:

- H-305.925, "Principles and Actions to Address Medical Education Costs and Student Debt"
- H-310.907, "Resident/Fellow Clinical and Educational Work Hours."

Similarly, the AMA backs strategies to combat rising costs for medical education:

- D-305-983, "Strategies to Combat Mid-year and Retroactive Tuition Increases"
- H-305.988, "Cost and Financing of Medical Education and Availability of First-Year Residency Positions"

The AMA supports loan forgiveness incentives and reduction in student loan interest rates for residents/fellows, physicians working in Veterans Affairs facilities, and those pursuing careers in research:

- D-305.984, "Reduction in Student Loan Interest Rates"
- D-510.990, "Fixing the VA Physician Shortage with Physicians"
- H-460.995, "Support for Careers in Research"

The AMA endorses expansion of financial incentives, aid, relief options to recruit and train primary care physicians, especially those in rural and urban underserved areas:

- H-200.949, "Principles of and Actions to Address Primary Care Workforce"
- H-465-988, "Educational Strategies for Meeting Rural Health Physician Shortage"

The AMA recommends increasing diversity in the physician workforce to address underserved areas via loan forgiveness programs and diversity pipeline programs, and improve transparency regarding tuition requirements:

- D-200.982, "Diversity in the Physician Workforce and Access to Care"
- D-200.985, "Strategies for Enhancing Diversity in the Physician Workforce"

SUMMARY AND RECOMMENDATIONS

After considering potential trends/solutions related to the connection between medical student debt and career choice and analyzing the peer-reviewed literature to ascertain whether existing data support these hypotheses, this report finds little solid evidence for a strong link between debt and career choice. This finding, however, may be limited by the lack of available data on the potentially intersecting impacts of race/ethnicity, socioeconomic status, and other key sociodemographic factors. In addressing the workforce need for primary care and other fields, a more deliberate approach to planning by federal agencies and stakeholder organizations may be helpful. The composition of the physician workforce is ultimately the result of economic and personal decisions by individual students, residents, and physicians to pursue professional satisfaction in whichever medical field, practice setting, and location that is right for them. Balancing the impact of these individual choices with society's workforce and population health needs may require new and/or improved programs (including financial incentives) that serve as inducements for those decisions that best serve the common good and ensure access to needed health care services for all Americans, now and in the future.

In addition, the AMA should closely monitor the PSLF program, particularly over the next few years, to ensure that it is a viable option for debt relief for physicians. If the denial rates for physician applicants continue to remain unacceptably high, further federal advocacy to encourage reforms to the program is recommended, as reflected in the proposed emendations to AMA policy below.

The Council on Medical Education therefore recommends that the following recommendations be adopted and the remainder of this report be filed:

1. That our American Medical Association (AMA) encourage key stakeholders to collect and disseminate data on the impacts of medical education debt on career choice, especially with regard to the potentially intersecting impacts of race/ethnicity, socioeconomic status, and other key sociodemographic factors. (New HOD Policy)

2. That our AMA monitor new policies and novel approaches to influence career choice based on the key factors that affect the decision to enter a given specialty and subspecialty. (New HOD Policy)

3. That our AMA amend Policy H-305.925 (20), "Principles of and Actions to Address Medical Education Costs and Student Debt," by addition and deletion, to read as follows:

   "Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician ~~benefits~~ participation in the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the employer's PSLF program qualifying status ~~of the employer~~; (f) Advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes; (j) Monitor the denial rates for physician applicants to the PSLF; and (k) Undertake expanded federal advocacy, in the event denial rates for physician applicants are unacceptably high, to encourage release of information on the basis for the high denial rates, increased transparency and streamlining of program requirements, consistent and accurate communication between loan servicers and borrowers, and clear expectations regarding oversight and accountability of the loan servicers responsible for the program." (Modify Current HOD Policy)

4. That our AMA rescind Policy H-305.925 (22), "Principles of and Actions to Address Medical Education Costs and Student Debt," as having been fulfilled through this report:

   "~~Formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new polices and novel approaches to prevent debt from influencing specialty and subspecialty choice~~." (Rescind HOD Policy)

Fiscal note: $1,000.

Acknowledgment: The AMA appreciates the assistance with this report of David Mata, MS, MD Candidate, Class of 2023, Stritch School of Medicine at Loyola University Chicago.

APPENDIX: RELEVANT AMA POLICY

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

The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:
1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the "20/220 pathway," and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties

that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.
13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the "cost of attendance"; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to "lock in" a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.
15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.
16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.
17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.
19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.
20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on

PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer; (f) Advocate that the profit status of a physicians training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.
21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.
22. Formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new polices and novel approaches to prevent debt from influencing specialty and subspecialty choice.

H-310.907, "Resident/Fellow Clinical and Educational Work Hours"

Our AMA adopts the following Principles of Resident/Fellow Clinical and Educational Work Hours, Patient Safety, and Quality of Physician Training:
1. Our AMA supports the 2017 Accreditation Council for Graduate Medical Education (ACGME) standards for clinical and educational work hours (previously referred to as "duty hours").
2. Our AMA will continue to monitor the enforcement and impact of clinical and educational work hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents.
3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of clinical and educational work hours, to include such topics as extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice.
4. Our AMA endorses the study of innovative models of clinical and educational work hour requirements and, pending the outcomes of ongoing and future research, should consider the evolution of specialty- and rotation-specific requirements that are evidence-based and will optimize patient safety and competency-based learning opportunities.
5. Our AMA encourages the ACGME to:
a) Decrease the barriers to reporting of both clinical and educational work hour violations and resident intimidation.
b) Ensure that readily accessible, timely and accurate information about clinical and educational work hours is not constrained by the cycle of ACGME survey visits.
c) Use, where possible, recommendations from respective specialty societies and evidence-based approaches to any future revision or introduction of clinical and educational work hour rules.
d) Broadly disseminate aggregate data from the annual ACGME survey on the educational environment of resident physicians, encompassing all aspects of clinical and educational work hours.

6. Our AMA recognizes the ACGME for its work in ensuring an appropriate balance between resident education and patient safety, and encourages the ACGME to continue to:
a) Offer incentives to programs/institutions to ensure compliance with clinical and educational work hour standards.
b) Ensure that site visits include meetings with peer-selected or randomly selected residents and that residents who are not interviewed during site visits have the opportunity to provide information directly to the site visitor.
c) Collect data on at-home call from both program directors and resident/fellow physicians; release these aggregate data annually; and develop standards to ensure that appropriate education and supervision are maintained, whether the setting is in-house or at-home.
d) Ensure that resident/fellow physicians receive education on sleep deprivation and fatigue.
7. Our AMA supports the following statements related to clinical and educational work hours:
a) Total clinical and educational work hours must not exceed 80 hours per week, averaged over a four-week period (Note: "Total clinical and educational work hours" includes providing direct patient care or supervised patient care that contributes to meeting educational goals; participating in formal educational activities; providing administrative and patient care services of limited or no educational value; and time needed to transfer the care of patients).
b) Scheduled on-call assignments should not exceed 24 hours. Residents may remain on-duty for an additional 4 hours to complete the transfer of care, patient follow-up, and education; however, residents may not be assigned new patients, cross-coverage of other providers' patients, or continuity clinic during that time.
c) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit, and on-call frequency must not exceed every third night averaged over four weeks. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.
d) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
e) Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new "off-duty period."
f) Given the different education and patient care needs of the various specialties and changes in resident responsibility as training progresses, clinical and educational work hour requirements should allow for flexibility for different disciplines and different training levels to ensure appropriate resident education and patient safety; for example, allowing exceptions for certain disciplines, as appropriate, or allowing a limited increase to the total number of clinical and educational work hours when need is demonstrated.
g) Resident physicians should be ensured a sufficient duty-free interval prior to returning to duty.
h) Clinical and educational work hour limits must not adversely impact resident physician participation in organized educational activities. Formal educational activities must be scheduled and available within total clinical and educational work hour limits for all resident physicians.
i) Scheduled time providing patient care services of limited or no educational value should be minimized.
j) Accurate, honest, and complete reporting of clinical and educational work hours is an essential element of medical professionalism and ethics.
k) The medical profession maintains the right and responsibility for self-regulation (one of the key tenets of professionalism) through the ACGME and its purview over graduate medical education, and categorically rejects involvement by the Centers for Medicare & Medicaid Services, The Joint Commission, Occupational Safety and Health Administration, and any other federal or state government bodies in the monitoring and enforcement of clinical and educational work hour regulations, and opposes any regulatory or legislative proposals to limit the work hours of practicing physicians.

l) Increased financial assistance for residents/fellows, such as subsidized child care, loan deferment, debt forgiveness, and tax credits, may help mitigate the need for moonlighting. At the same time, resident/fellow physicians in good standing with their programs should be afforded the opportunity for internal and external moonlighting that complies with ACGME policy.
m) Program directors should establish guidelines for scheduled work outside of the residency program, such as moonlighting, and must approve and monitor that work such that it does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.
n) The costs of clinical and educational work hour limits should be borne by all health care payers. Individual resident compensation and benefits must not be compromised or decreased as a result of changes in the graduate medical education system.
o) The general public should be made aware of the many contributions of resident/fellow physicians to high-quality patient care and the importance of trainees' realizing their limits (under proper supervision) so that they will be able to competently and independently practice under real-world medical situations.
8. Our AMA is in full support of the collaborative partnership between allopathic and osteopathic professional and accrediting bodies in developing a unified system of residency/fellowship accreditation for all residents and fellows, with the overall goal of ensuring patient safety.
9. Our AMA will actively participate in ongoing efforts to monitor the impact of clinical and educational work hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians, including program directors and attending physicians.

H-465.988, "Educational Strategies for Meeting Rural Health Physician Shortage"

1. In light of the data available from the current literature as well as ongoing studies being conducted by staff, the AMA recommends that:
A. Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents.
B. Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians.
C. Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians.
D. Our AMA encourage state and county medical societies and local medical schools to develop outreach and recruitment programs in rural counties to attract promising high school and college students to medicine and the other health professions.
E. Our AMA urge continued federal and state legislative support for funding of Area Health Education Centers (AHECs) for rural and other underserved areas.
F. Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships.
G. Our AMA support full funding of the new federal National Health Service Corps loan repayment program.
H. Our AMA encourage continued legislative support of the research studies being conducted by the Rural Health Research Centers funded by the National Office of Rural Health in the Department of Health and Human Services.
I. Our AMA continue its research investigation into the impact of educational programs on the supply of rural physicians.

J. Our AMA continue to conduct research and monitor other progress in development of educational strategies for alleviating rural physician shortages.
K. Our AMA reaffirm its support for legislation making interest payments on student debt tax deductible.
L. Our AMA encourage state and county medical societies to develop programs to enhance work opportunities and social support systems for spouses of rural practitioners.
2. Our AMA will work with state and specialty societies, medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education (ACGME), the Centers for Medicare and Medicaid Services (CMS) and other interested stakeholders to identify, encourage and incentivize qualified rural physicians to serve as preceptors and volunteer faculty for rural rotations in residency.
3. Our AMA will: (a) work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates; and (b) work with interested stakeholders to formulate an actionable plan of advocacy with the goal of increasing residency training in rural areas.
4. Our AMA will undertake a study of issues regarding rural physician workforce shortages, including federal payment policy issues, and other causes and potential remedies (such as telehealth) to alleviate rural physician workforce shortages.

D-305.984, "Reduction in Student Loan Interest Rates"

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

D-510.990, "Fixing the VA Physician Shortage with Physicians"

1. Our AMA will work with the VA to enhance its loan forgiveness efforts to further incentivize physician recruiting and retention and improve patient access in the Veterans Administration facilities.
2. Our AMA will call for an immediate change in the Public Service Loan Forgiveness Program to allow physicians to receive immediate loan forgiveness when they practice in a Veterans Administration facility.
3. Our AMA will work with the Veterans Administration to minimize the administrative burdens that discourage or prevent non-VA physicians without compensation (WOCs) from volunteering their time to care for veterans.
4. Our AMA will: (a) continue to support the mission of the Department of Veterans Affairs Office of Academic Affiliations for expansion of graduate medical education (GME) residency positions;

and (b) collaborate with appropriate stakeholder organizations to advocate for preservation of Veterans Health Administration funding for GME and support its efforts to expand GME residency positions in the federal budget and appropriations process.
5. Our AMA supports postgraduate medical education service obligations through programs where the expectation for service, such as military service, is reasonable and explicitly delineated in the contract with the trainee.
6. Our AMA opposes the blanket imposition of service obligations through any program where physician trainees rotate through the facility as one of many sites for their training.

H-460.995, "Support for Careers in Research"

Our AMA: (1) recognizes the serious decline in the number of physicians seeking to prepare for a career in research, which is fundamental to the advancement of the practice of medicine, and urges that: (a) medical students be made aware of the challenging and important career option of biomedical research, and (b) schools of medicine be made aware of the impending shortage and provide increased opportunities for students to participate in research; and (2) supports policies and legislation designed to increase the number of physician-investigators. Such support should include encouragement for training of physicians in careers in biomedical research and for supportive legislation to make physician-investigators eligible for forgiveness in certain government scholarship and loan programs for qualified candidates in numbers consistent with national needs.

H-200.949, "Principles of and Actions to Address Primary Care Workforce"

1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation's current and projected demand for health care services.
2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).
3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.
4. Admissions and recruitment: The medical school admissions process should reflect the specific institution's mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.
5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.

6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.
7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.
8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.
9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.
10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.
11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.
12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.
13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).
14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.
15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.
16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and

decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.
17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.
18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.
19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.
20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.
21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.
22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.
23. Practicing physicians in other specialties--particularly those practicing in underserved urban or rural areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.
24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.
25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.

D-200.982, "Diversity in the Physician Workforce and Access to Care"

Our AMA will: (1) continue to advocate for programs that promote diversity in the US medical workforce, such as pipeline programs to medical schools; (2) continue to advocate for adequate funding for federal and state programs that promote interest in practice in underserved areas, such as those under Title VII of the Public Health Service Act, scholarship and loan repayment programs under the National Health Services Corps and state programs, state Area Health Education Centers, and Conrad 30, and also encourage the development of a centralized database of scholarship and loan repayment programs; and (3) continue to study the factors that support and

those that act against the choice to practice in an underserved area, and report the findings and solutions at the 2008 Interim Meeting.

D-305.983, "Strategies to Combat Mid-year and Retroactive Tuition Increases"

Our AMA will: (1) assist state medical societies in advocacy efforts in opposition to mid-year and retroactive tuition increases, tuition taxes, and any other attendance-based taxes by any government entity at both public and private medical schools; (2) make available, upon request, the judicial precedent that would support a successful legal challenge to mid-year tuition increases; and (3) continue to encourage individual medical schools and universities, federal and state agencies, and others to expand options and opportunities for financial aid to medical students.

H-305.988, "Cost and Financing of Medical Education and Availability of First-Year Residency Positions"

Our AMA:
1. believes that medical schools should further develop an information system based on common definitions to display the costs associated with undergraduate medical education;
2. in studying the financing of medical schools, supports identification of those elements that have implications for the supply of physicians in the future;
3. believes that the primary goal of medical school is to educate students to become physicians and that despite the economies necessary to survive in an era of decreased funding, teaching functions must be maintained even if other commitments need to be reduced;
4. believes that a decrease in student enrollment in medical schools may not result in proportionate reduction of expenditures by the school if quality of education is to be maintained;
5. supports continued improvement of the AMA information system on expenditures of medical students to determine which items are included, and what the ranges of costs are;
6. supports continued study of the relationship between medical student indebtedness and career choice;
7. believes medical schools should avoid counterbalancing reductions in revenues from other sources through tuition and student fee increases that compromise their ability to attract students from diverse backgrounds;
8. supports expansion of the number of affiliations with appropriate hospitals by institutions with accredited residency programs;
9. encourages for profit-hospitals to participate in medical education and training;
10. supports AMA monitoring of trends that may lead to a reduction in compensation and benefits provided to resident physicians;
11. encourages all sponsoring institutions to make financial information available to help residents manage their educational indebtedness; and
12. will advocate that resident and fellow trainees should not be financially responsible for their training.

D-200.985, "Strategies for Enhancing Diversity in the Physician Workforce"

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups.

2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.
10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.
13. Our AMA: (a) supports the publication of a white paper chronicling health care career pipeline programs (also known as pathway programs) across the nation aimed at increasing the number of programs and promoting leadership development of underrepresented minority health care professionals in medicine and the biomedical sciences, with a focus on assisting such programs by identifying best practices and tracking participant outcomes; and (b) will work with various stakeholders, including medical and allied health professional societies, established biomedical science pipeline programs and other appropriate entities, to establish best practices for the sustainability and success of health care career pipeline programs.
14. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 5-N-21

Subject: Investigation of Existing Barriers for Osteopathic Medical Students Applying for Away Rotations

Presented by: Niranjan Rao, MD, Chair

Referred to: Reference Committee C

American Medical Association (AMA) Policy H-295.876 (3), "Equal Fees for Osteopathic and Allopathic Medical Students," asks that our AMA:

> work with relevant stakeholders to explore reasons behind application barriers that result in discrimination against osteopathic medical students when applying to elective visiting clinical rotations and generate a report with the findings by the 2020 Interim Meeting.

This report is in response to this policy.

Testimony on this topic during the 2019 Interim Meeting noted that U.S. osteopathic medical students are charged fees in excess of those charged to U.S. allopathic medical students for the same clinical rotations at some U.S. allopathic medical schools. These fees represent a financial barrier to career opportunities for osteopathic medical students in that these clinical experiences are often useful to support applications to graduate medical education (GME) programs. Testimony also noted that AMA policy "discourages discrimination against medical students by institutions and programs based on osteopathic or allopathic training…[and]…encourages equitable fees for allopathic and osteopathic medical students in access to clinical electives."

INTRODUCTION

Medical students seek elective clinical experiences at institutions other than their home institution ("away electives") for a number of reasons, including exposure to specialties and subspecialties not available at their home institutions, working with special populations, obtaining letters of reference to support residency applications, and experiencing diverse or different health care systems. Perhaps the most important reason students seek these experiences is to explore the training environment at institutions where they are considering applying for GME positions. In this regard, these away electives have the potential to benefit the student, the specialty program, and the institution hosting the elective, and potentially serve to help both learner and program achieve the best match to meet their respective objectives. Mueller et al, in a study of allopathic medical schools, found that the most common reason for a school to support a visiting medical student program was recruitment into its residency programs, and the most common reason for students to participate is to secure residency positions in those programs.[1]

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BACKGROUND

The Association of American Medical Colleges (AAMC) supports students seeking away electives through the online Visiting Student Learning Opportunities (VSLO) program, which includes a Visiting Student Application Service (VSAS) for students and host institutions.[2] Most, if not all, allopathic medical schools utilize VSAS to manage visiting student applications. The fee to use VSAS is $40 for the first three applications and $15 per application thereafter. Institutions are also charged a fee to use the system, but the institutional fee structure is not published. The VSLO website notes that participating host institutions may have their own fee structures and may charge a processing fee or tuition but specifies that only the AAMC may charge fees that are referred to as application fees. Host institutions may charge applicants processing fees, registration fees, or other types of fees, as long as these fees are not labeled as application fees. VSLO also allows host institutions to select the home institutions from which they will accept applications.

The Accreditation Council for Graduate Medical Education (ACGME) reached an agreement with the American Osteopathic Association and American Association of Colleges of Osteopathic Medicine to develop a single accreditation system for GME in early 2014. Transition to the ACGME Single Accreditation System began in 2015, and by June 2020 the transition was complete. One benefit of the Single Accreditation System is to offer all U.S. medical school graduates a uniform GME pathway, allowing them to seek admission into any residency and fellowship program. Any graduate of a college of medicine accredited by the Commission on Osteopathic College Accreditation (COCA), a medical school within the United States or Canada accredited by the Liaison Committee on Medical Education (LCME), or a medical school outside the United States or Canada that meets the established eligibility criteria is eligible to enter an ACGME-accredited program.[3]

Beginning in 2020, the National Resident Matching Program (NRMP) supported the first combined Match for allopathic and osteopathic medical students into programs accredited through the ACGME's Single Accreditation System.

THE ROLE OF ELECTIVE OPPORTUNITIES FOR VISITING MEDICAL STUDENTS IN RESIDENCY PROGRAM DECISIONS

As noted in the introduction, medical students seek away elective experiences to explore programs and make themselves known to the host programs. In this regard, the experiences are often referred to as "audition electives." The literature offers conflicting information about whether audition electives are important in securing a position. Data from the 2014 NRMP Program Director Survey showed that program directors consider the audition elective to be an important factor for deciding whom to interview and rank.[4] Some studies have demonstrated that audition electives are important in the selection of applicants,[5,6] while others have shown that audition electives have no effect on the selection of applicants.[1,7,8,9,10,11]

POTENTIAL BARRIERS IMPOSED UPON OSTEOPATHIC STUDENTS SEEKING ELECTIVE EXPERIENCES AT ALLOPATHIC SCHOOLS IMPOSE BARRIERS

To explore the concerns raised in Policy H-295.876 (3), AMA staff reviewed the websites of allopathic medical schools in six states (California, Florida, Illinois, New York, Ohio, and Texas) and 13 school websites identified by representatives of the AMA Medical Student Section. This sample represented 66 of the 144 allopathic medical schools in the United States that have graduated at least one full class of students. The websites from 15 of these schools indicated that visiting medical students must be from LCME-accredited schools, and four of the 15 explicitly

stated that osteopathic medical students would not be accepted. For 11 of the school websites, either information on visiting medical students was not included or the visiting student websites were suspended due to the COVID-19 pandemic. The remaining 39 school websites indicated that both allopathic and osteopathic medical students could participate as visiting medical students. One of the schools indicated that osteopathic students would be accepted for most, but not all, of the electives. Three schools required passage of United States Medical Licensing Examination (USMLE) Step 1. Of the 39 schools accepting both allopathic and osteopathic medical students, 23 charged a fee. For 19 of these schools, the fee was the same for both allopathic and osteopathic medical students, with a range of $25 to $300 per elective request submitted (mean = $165). The remaining four fee-charging schools in this review charged a differential fee for allopathic and osteopathic student applicants. One school's fees were listed as $125 and $295 for allopathic and osteopathic students, respectively; one school's fees were listed as $150 and $4,150 for allopathic and osteopathic students, respectively; and one school's fees were listed as $500 and $5,000 for allopathic and osteopathic students, respectively. The fourth school listed a $30 processing fee for osteopathic students and $900 per week of elective for osteopathic students, while no fees were listed for allopathic students. The review did not explore the practices of GME programs that operate independently from medical schools but may offer clinical elective experiences for medical students.

Data from an unpublished survey of 182 allopathic schools and GME programs, conducted by the Council of Osteopathic Student Government Presidents, had similar findings. That study found that 24 of the surveyed programs did not accept applications for electives from osteopathic medical students, 35 programs listed "licensing exam disparities" including inequitable class ranking requirements and minimum scores for osteopathic students compared to allopathic students, and 14 programs listed financial disparities between allopathic student applicants and osteopathic student applicants in the application process.[12] (The authors of this study have asked for the following disclaimer: "This is unofficial student-collected information that is not yet submitted for official publication or research.")

HOW SOME FEE STRUCTURES AND OTHER BARRIERS DISADVANTAGE OSTEOPATHIC MEDICAL STUDENTS

The ACGME states that the benefits of the Single Accreditation System include offering all U.S. medical graduates a uniform education pathway, increasing collaboration among the medical education community, providing consistency across all residency and fellowship programs, reducing costs, and increasing opportunities for osteopathic GME. Despite these stated benefits, surveys of allopathic schools demonstrate that osteopathic medical students continue to face barriers in applying for away rotations at allopathic institutions and programs. These barriers include: 1) outright exclusion from participation; 2) the requirement for a passing USMLE score; and 3) inequitable fees. Upon finding these barriers while considering sites for away electives, osteopathic students would be deterred from applying for an elective opportunity, thus potentially decreasing the likelihood of applying to the program for residency or decreasing the likelihood of securing a position after application. Further, the existence of these barriers implies that osteopathic medical students are less welcome, or unwelcome, at the host institution. These barriers also have implications for educational experiences, in that osteopathic medical students may not be able to participate and learn in specialty and subspecialty areas not otherwise available to them at their home institutions.

While it is difficult to determine if these financial and other barriers to away experiences have affected the competitiveness of osteopathic medical students applying for ACGME-accredited residencies, Match data suggest a possible relationship between type of training and securing a

residency position. Although NRMP data show that the match rates for senior osteopathic medical students in the United States have steadily but slowly risen from 82.7 percent in 2015 to 88.1 percent in 2019, during the same period match rates for seniors in allopathic programs were consistently higher, fluctuating between 93.9 percent and 94.3 percent. Beginning in 2020, the ACGME completed the transition to the Single Accreditation System to accredit participating osteopathic residency programs that were previously only accredited by the AOA, thereby offering all U.S. medical school graduates (allopathic and osteopathic) a uniform graduate medical education pathway and allowing them to seek admission into any residency or fellowship program. According to NRMP data for the 2020 match, 90.7 percent of osteopathic senior medical students and 93.7 percent of allopathic senior medical students matched to a PGY-1 position. However, data among specialties demonstrate notable differences between the match rates of allopathic and osteopathic senior student applicants. For example, the unmatched rate for osteopathic senior students ranking only one specialty was approximately double the unmatched rate for allopathic senior students in emergency medicine, neurological surgery, neurology, obstetrics and gynecology, orthopedic surgery, plastic surgery, and general surgery. It should be noted that it is unknown whether financial or other barriers to elective experiences played any role in these outcomes.[13]

Complicating this report are the effects of the COVID-19 pandemic, which has markedly limited away electives for all students and the effects of the increasing use of virtual interviews for residency programs and applicants. The planned conversion of USMLE Step 1 from a scored exam to pass/fail may also have future implications for this issue.

SUMMARY AND RECOMMENDATIONS

The AMA, in a joint statement with the American Osteopathic Association, has described the equivalency of training, licensure, and practice rights of allopathic and osteopathic physicians, and the vital role osteopathic physicians serve in the nation's health care delivery system.[14] Thus, it stands to reason that osteopathic medical students should have equal access to elective training opportunities.

Information collected from allopathic medical school websites indicates that barriers exist for participation of osteopathic medical students in elective experiences at some allopathic medical schools. The barriers include: 1) outright exclusion from participation; 2) the requirement for a passing USMLE score; and 3) inequitable fees. These barriers may deter osteopathic students from applying to or being accepted for a residency position. Programs that lack exposure to potential qualified osteopathic students may rank candidates disparately. These barriers on osteopathic medical students are in contradiction to the goal of the ACGME Single Accreditation System to offer all U.S. medical school graduates a uniform GME pathway.

Further, current AMA Policy H-295.876 discourages discrimination against medical students based on allopathic or osteopathic undergraduate medical education training and encourages equitable fee structures for allopathic and osteopathic medical student applicants to clinical electives.

The Council on Medical Education therefore recommends that the following recommendations be adopted and the remainder of this report be filed:

1. That our American Medical Association (AMA) amend Policy H-295.876 (2), "Equal Fees for Osteopathic and Allopathic Medical Students," by addition and deletion as shown below. (Modify Current HOD Policy)

Our AMA encourages equitable access to and equitable fees for clinical electives for allopathic and osteopathic medical students ~~in access to clinical electives~~, while respecting the rights of individual allopathic and osteopathic medical schools to set their own policies related to visiting students.

2. That our AMA encourage the Association of American Medical Colleges to request that its member institutions promote equitable access to clinical electives for allopathic and osteopathic medical students and charge equitable fees to visiting allopathic and osteopathic medical students. (New HOD Policy)

3. That our AMA encourage the Accreditation Council for Graduate Medical Education to require its accredited programs to work with their respective affiliated institutions to ensure equitable access to clinical electives for allopathic and osteopathic medical students and charge equitable fees to visiting allopathic and osteopathic medical students. (New HOD Policy)

Fiscal note: $500.

RELEVANT AMA POLICY

H-295.876, "Equal Fees for Osteopathic and Allopathic Medical Students"

3. Our AMA, in collaboration with the American Osteopathic Association, discourages discrimination against medical students by institutions and programs based on osteopathic or allopathic training.
4. Our AMA encourages equitable fees for allopathic and osteopathic medical students in access to clinical electives, while respecting the rights of individual allopathic and osteopathic medical schools to set their own policies related to visiting students.
Citation: Res. 809, I-05 Appended: CME Rep. 6, A-07 Modified: CCB/CLRPD Rep. 2, A-14

H-295.867, "Expanding the Visiting Students Application Service for Visiting Student Electives in the Fourth Year"

1. Our American Medical Association strongly encourages the Association of American Medical Colleges (AAMC) to expand eligibility for the Visiting Students Application Service (VSAS) to medical students from Commission on Osteopathic College Accreditation (COCA)-accredited medical schools.
2. Our AMA supports and encourages the AAMC in its efforts to increase the number of members and non-member programs in the VSAS, such as medical schools accredited by COCA and teaching institutions not affiliated with a medical school.
3. Our AMA encourages the AAMC to ensure that member institutions that previously accepted both allopathic and osteopathic applications for fourth year clerkships prior to VSAS implementation continue to have a mechanism for accepting such applications of osteopathic medical students.
Citation: Res. 910, I-09 Reaffirmed: CME Rep. 01, A-19

H-310.909, "ACGME Residency Program Entry Requirements"

Our AMA supports entry into Accreditation Council on Graduate Medical Education (ACGME) accredited residency and fellowship programs from either ACGME-accredited programs or American Osteopathic Association-accredited programs.
Citation: Res. 920, I-12

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 301
(N-21)

Introduced by: Medical Student Section

Subject: Equitable Reporting of USMLE Step 1 Scores

Referred to: Reference Committee C

Whereas, As a result of the slowly-increasing burden of residency applications with only 0.85 positions per applicant in 2020, program directors have become more reliant on quantitative markers for comparison and screening of residency applicants[1]; and

Whereas, The United States Medical Licensing Examination (USMLE) Step 1 exam and Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA) Level 1 are psychometric instruments utilized as a top selection criteria by residency programs[2-7]; and

Whereas, There is weak correlation between the 3-digit numerical USMLE Step 1 scores and clinical outcomes related to patient care[8-10]; and

Whereas, Due to perceived adverse impact of the current overemphasis on USMLE performance residency screening and selection, the Federation of State Medical Boards (FSMB) and the National Board of Medical Examiners (NBME) announced a change to a Pass/Fail scoring system for the USMLE Step 1 beginning as early as January of 2022[11-12]; and

Whereas, The National Board of Osteopathic Medical Examiners (NBOME) announced in December 2020 that the COMLEX-USA Level 1 exam will shift to a Pass/Fail scoring system beginning on May 1, 2022[13]; and

Whereas, An estimated 9.2% of all medical students elect to take a leave of absence or participate in dual degree programs, thus taking longer than the standard four years to graduate from undergraduate medical education[14]; and

Whereas, The timing of the change to Pass/Fail will have profound impacts on dual degree students and a significant group of other students who may have received a 3-digit numerical score on USMLE Step 1, but will be applying after the Pass/Fail scoring policy has been implemented[15-16]; and

Whereas, The USMLE announced in July 2020 that all students who have taken Step 1 with 3-digit numerical score report will continue to have this score reported on their USMLE transcript moving forward[17]; and

Whereas, In anticipation of a 3-digit numerical score being removed in favor of a Pass/Fail scoring system for USMLE Step 1, 81% of Residency Program Directors plan to shift emphasis on a scored USMLE Step 2 Clinical Knowledge (CK) following the change in score reporting of USMLE Step 1, resulting in potential inequities with some residency applicants reporting two numerical scored metrics versus some applicants reporting only one[18]; and

Whereas, This imbalance of score reporting within a pool of applicants may lead to inequitable assessment of 3-digit-scoring dual degree students against their Pass/Fail-scored peers[14,19]; therefore be it

RESOLVED, That our American Medical Association work with appropriate stakeholders to release guidance for residency and fellowship program directors on equitably comparing students who received 3-digit United States Medical Licensing Examination Step 1 or Comprehensive Osteopathic Medical Licensing Examination Level 1 scores and students who received Pass/Fail scores. (Directive to Take Action)

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

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Given that the FSMB and the NBME announced a change to a Pass/Fail scoring system for the USMLE Step 1 beginning as early as January of 2022, students applying for residency as early as the 2023 residency cycle will be impacted by imbalanced score reporting. This imbalance within a pool of applicants may lead to inequitable assessment of 3-Digit-scoring students against their Pass/Fail-scored peers. These differences in scoring systems will affect dual degree students, students who conducted a research year during their training, and students who take step 1 prior to January of 2022 but still apply during the 2023 application cycle. This is an extremely timely issue and needs to be heard soon so AMA CME has the appropriate time to report back and recommend policy to the AMA before there is a mixed-score residency cycle. Since this will take time for the CME to generate and is crucial for the cohorts of students who will be applying with 3-Digit scores alongside their Pass/Fail-scored peers, this should be heard at the November 2021 meeting.

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RELEVANT AMA POLICY

The Grading Policy for Medical Licensure Examinations H-275.953

1. Our AMA's representatives to the ACGME are instructed to promote the principle that selection of residents should be based on a broad variety of evaluative criteria, and to propose that the ACGME General Requirements state clearly that residency program directors must not use NBME or USMLE ranked passing scores as a screening criterion for residency selection.
2. Our AMA adopts the following policy on NBME or USMLE examination scoring: (a) Students receive "pass/fail" scores as soon as they are available. (If students fail the examinations, they may request their numerical scores immediately.) (b) Numerical scores are reported to the state licensing authorities upon request by the applicant for licensure. At this time, the applicant may request a copy of his or her numerical scores. (c) Scores are reported in pass/fail format for each student to the medical school. The school also receives a frequency distribution of numerical scores for the aggregate of their students.
3. Our AMA will co-convene the appropriate stakeholders to study possible mechanisms for transitioning scoring of the USMLE and COMLEX exams to a Pass/Fail system in order to avoid the inappropriate use of USMLE and COMLEX scores for screening residency applicants while still affording program directors adequate information to meaningfully and efficiently assess medical student applications, and that the recommendations of this study be made available by the 2019 Interim Meeting of the AMA House of Delegates.
4. Our AMA will: (a) promote equal acceptance of the USMLE and COMLEX at all United States residency programs; (b) work with appropriate stakeholders including but not limited to the National Board of Medical Examiners, Association of American Medical Colleges, National Board of Osteopathic Medical Examiners, Accreditation Council for Graduate Medical Education and American Osteopathic Association to educate Residency Program Directors on how to interpret and use COMLEX scores; and (c) work with Residency Program Directors to promote higher COMLEX utilization with residency program matches in light of the new single accreditation system.

CME Rep. G; Reaffirmed by Res. 310, A-98; Reaffirmed: CME Rep. 3, A-04; Reaffirmed: CME Rep. 2, A-14; Appended: Res. 309, A-17; Modified: Res. 318, A-18; Appended: Res. 955, I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 302
(N-21)

Introduced by: Medical Student Section

Subject: University Land Grant Status in Medical School Admissions

Referred to: Reference Committee C

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1 Whereas, American Indian and Alaska Natives (AI-AN) are defined as “people having origins in
2 any of the original peoples of North America, South America, and Central America, who
3 maintain tribal affiliation or community attachment”[1]; and
4
5 Whereas, The United States Department of Interior Bureau of Indian Affairs recognizes 574
6 American Indian and Alaska Native tribes and villages in the United States, with many more
7 recognized at the state level or in the process of seeking recognition[2]; and
8
9 Whereas, AI-AN communities in the U.S. continue to have lower health status and
10 disproportionate disease burden compared with other Americans, secondary to inadequate
11 education, disproportionate poverty, discrimination in the delivery of health services, and cultural
12 differences with healthcare providers[3]; and
13
14 Whereas, AI-AN individuals born today have a life expectancy that is 5.5 years less than the
15 U.S. all races population (73.0 years to 78.5 years, respectively)[3]; and
16
17 Whereas, The Government Accountability Office reports that 29% of the Indian Health Services’
18 physician positions are vacant, with some regions operating with up to 46% of their physician
19 positions vacant[4]; and
20
21 Whereas, The Association of American Medical Colleges (AAMC) recognizes that the continued
22 underrepresentation of AI-AN physicians should be viewed as a national crisis faced by all
23 medical schools[5]; and
24
25 Whereas, Only 0.56% of active physicians identify as AI-AN alone or in combination with
26 another race, far below their national representation of 2%[1,5]; and
27
28 Whereas, From 2013-2018, greater than 95% of AI-AN tribes (547 / 574) had fewer than 10
29 AI-AN applicants to medical school and 99% of AI-AN tribes (567 / 574) had fewer than 10
30 matriculants to medical school[5]; and
31
32 Whereas, AI-AN medical students are more likely to practice medicine in tribal communities,
33 and are more likely than their peers to practice in underserved areas[5]; and
34
35 Whereas, In a 2016-2017 Curriculum Inventory, the AAMC reported that only 11% of U.S.
36 MD-granting institutions (14 of 131 participating) had AI-AN health content[5]; and

Whereas, Including AI-AN health content in medical school curricula provides visibility to and acknowledges the importance of the health of [AI-AN] communities and prepares all trainees to work with AI-AN communities[5]; and

Whereas, The AAMC recommends the development of focused AI-AN medical education curricula and medical school admissions policies that consider the political identity, rather than solely the race or ethnicity, of American Indians and Alaska Natives from tribal nations[5-6]; and

Whereas, The U.S. Supreme Court has recognized that membership status in a tribe does not violate laws related to non-discrimination or equal protection under the law (i.e., anti-affirmative action laws), iterating that tribal status is distinct from race[6-7]; and

Whereas, The AAMC has recognized that anti-affirmative action laws have impacted AI-AN application and matriculation rates to medical school despite rulings from the U.S. Supreme Court[8]; and

Whereas, There are professional programs that preferentially consider tribal membership in admissions and funding awards, such as UCLA School of Law, UC San Diego, and UC Davis School of Medicine[6,9-10]; and

Whereas, Our AMA, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded to meet the needs of AI-AN communities (H-350.981); and

Whereas, Our AMA opposes legislation and other related efforts that undermine the ability of institutions to employ affirmative action to promote a diverse student population (D-200.985); and

Whereas, As tribal membership is legally distinct from race, then it follows that tribal membership can be affirmatively considered outside of holistic admissions processes, including those that have race-blind admissions (e.g., California, Washington)[5]; and

Whereas, The federal government has a unique legal and political relationship with Tribal governments established through and confirmed by the United States Constitution, treaties, federal statutes, executive orders, and judicial decisions[11]; and

Whereas, Central to this relationship is the Federal Government's trust responsibility to protect the interests of Indian Tribes and communities[11]; and

Whereas, The federal trust responsibility is a legal obligation under which the federal government "has charged itself with moral obligations of the highest responsibility and trust" toward AI-AN tribes, which include healthcare and education[12-13]; and

Whereas, The federal trust responsibility establishes the basis for a variety of federal services provided to federally recognized tribes and villages, including healthcare delivery and the provision of physicians, on the basis of tribal membership, not racial identification[14]; and

Whereas, Land-grant universities are universities built on land transferred to states from the federal government with the enactment of the Morrill Act of 1862[15-16]; and

Whereas, Land-grant universities, many of which house associated medical schools, continue to derive benefit from 10.7 million acres of land expropriated from nearly 250 tribal nations, while being federal and state government-funded entities[15-16]; and

Whereas, As a creation of the federal government and recipient of federal funding, land-grant universities therefore play a role in the fulfillment of the federal trust responsibility; and

Whereas, The rationale for this policy is supported by the following 29 health and policy-related organizations and AI-AN tribes: American Indian Studies Department, CSUSM, San Marcos, CA, American Indian Studies Department, SDSU, San Diego, CA, Association of American Indian Physicians, Oklahoma City, OK, California Consortium for Urban Indian Health, Sacramento, CA, California Democratic Party Native American Caucus, Sacramento, CA, California Indian Culture and Sovereignty Center, San Marcos, CA, California Rural Indian Health Board, Roseville, CA, Center for Native American Youth, Washington, DC, Coyote Valley Band of Pomo Indians, Redwood Valley, CA, Federated Indians of Graton Rancheria, Rohnert Park, CA, Indian Health Center of Santa Clara Valley, San Jose, CA, Indian Health Council, Valley Center, CA, La Jolla Band of Luiseño Indians, Pauma Valley, CA, Latino Medical Student Association, Chicago, IL, Mesa Grande Band of Mission Indians, Santa Ysabel, CA, National Indian Health Board, Washington, DC, Native American Health Center, Oakland, CA, Pala Band of Mission Indians, Pala, CA, Pauma Band of Luiseño Indians, Pauma Valley, CA, Rincon Band of Luiseño Indians, Valley Center, CA, Sacramento Native American Health Center, Sacramento, CA, San Diego American Indian Health Center, San Diego, CA, San Manuel Band of Mission Indians, Highland, CA, San Pasqual Band of Mission Indians, Valley Center, CA Santa Ynez Band of Chumash Indians, Santa Ynez, CA, Student National Medical Association, Washington, DC Sycuan Band of the Kumeyaay Nation, El Cajon, CA, Tolowa Dee-ni' Nation, Smith River, CA, Wilton Rancheria, Elk Grove, CA[17]; and

Whereas, Medical schools are chiefly responsible for the composition of the physician workforce and set their own admissions criteria[5]; therefore be it

RESOLVED, That our American Medical Association work with the Association of American Medical Colleges, Liaison Committee on Medical Education, Association of American Indian Physicians, and Association of Native American Medical Students to design and promulgate medical school admissions recommendations in line with the federal trust responsibility (Directive to Take Action); and be it further

RESOLVED, That our AMA amend Policy H-350.981, “AMA Support of American Indian Health Career Opportunities,” by addition to read as follows:

AMA Support of American Indian Health Career Opportunities H-350.981

AMA policy on American Indian health career opportunities is as follows:
(1) Our AMA, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded.
(2) Our AMA support the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals. <u>These efforts should include, but are not limited to, priority consideration of applicants who self-identify as American Indian or Alaska Native and can provide some form of affiliation with an American Indian or Alaska Native tribe in the United States, and robust mentorship programs that support the successful advancement of these trainees.</u>
(3) Our AMA utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and that particular emphasis be placed on the need for <u>stronger</u> <u>clinical exposure and a greater number of</u> health professionals to work among the American Indian population.
(4) Our AMA continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs, and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations.
<u>(5) Our AMA acknowledges long-standing federal precedent that membership or lineal descent from an enrolled member in a federally recognized tribe is distinct from racial identification as American Indian or Alaska Native and should be considered in medical school admissions even when restrictions on race-conscious admissions policies are in effect.</u>
<u>(6) Our AMA will engage with the Association of Native American Medical Students and Association of American Indian Physicians to design and disseminate American Indian and Alaska Native medical education curricula that prepares trainees to serve AI-AN communities.</u> (Modify Current HOD Policy)

Fiscal Note: Moderate - between $5,000 - $10,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

While there has been great interest and appropriate action taken to advance all aspects of health equity, the number of American Indian and Alaska Native physicians-in-training is actually, alarmingly, declining. Many contributing factors, from K-12 completion, lack of mentorship, steep financial barriers, and medical school admissions are at play. In 2018, the Association of American Medical Colleges charged academic medicine with examining policies and procedures that may prohibit greater workforce parity for American Indian and Alaska Native physicians. This resolution enables the relevant entities within our AMA to engage with the Association of American Indian Physicians and Association of Native American Physicians to promulgate best practices in admissions and interview considerations for American Indian and Alaska Natives. These efforts would be especially focused at land-grant allopathic and osteopathic training programs given their unique history during periods of Indigenous displacement and assimilation. Further, we direct our AMA to engage in American Indian and Alaska Native-focused medical school didactic and clinical content creation to prepare trainees from all backgrounds to serve rural and urban tribes across the United States.

This resolution aligns with our AMA's consideration of the urgent priority of advancing health equity and redressing the harms of past and present discrimination. Our delegation urges that this issue be considered by our AMA at this meeting, so that the existing and troubling health disparities may be prevented from widening.

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RELEVANT AMA POLICY

AMA Support of American Indian Health Career Opportunities H-350.981

AMA policy on American Indian health career opportunities is as follows: (1) Our AMA, and other national, state, specialty, and county medical societies recommend special programs for

the recruitment and training of American Indians in health careers at all levels and urge that these be expanded.
(2) Our AMA support the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals.
(3) Our AMA utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and that particular emphasis be placed on the need for additional health professionals to work among the American Indian population.
(4) Our AMA continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs, and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations.
CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation: A-12

Indian Health Service H-350.977
The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.
(2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative non-federal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.
(3) Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.
(4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided

under their direction, including professional consultation and involvement in society activities should be pursued.
(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.
CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation: A-12; Reaffirmed: Res. 233, A-13

Improving Health Care of American Indians H-350.976
Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens.
(2) The federal government provide sufficient funds to support needed health services for American Indians.
(3) State and local governments give special attention to the health and health-related needs of non-reservation American Indians in an effort to improve their quality of life.
(4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.
(5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.
(6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.
(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.
(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.
(9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.
(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.
(11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.
CLRPD Rep. 2, I-98; Reaffirmed: Res. 22, A-07; Reaffirmation: A-12; Reaffirmed: Res. 233, A-13

Desired Qualifications for Indian Health Service Director H-440.816
Our AMA supports the following qualifications for the Director of the Indian Health Service:
1. Health profession, preferably an MD or DO, degree and at least five years of clinical experience at an Indian Health Service medical site or facility.
2. Demonstrated long-term interest, commitment, and activity within the field of Indian Health.
3. Lived on tribal lands or rural American Indian or Alaska Native community or has interacted closely with an urban Indian community.
4. Leadership position in American Indian/Alaska Native health care or a leadership position in an academic setting with activity in American Indian/ Alaska Native health care.
5. Experience in the Indian Health Service or has worked extensively with Indian Health Service, Tribal, or Urban Indian health programs.

6. Knowledge and understanding of social and cultural issues affecting the health of American Indian and Alaska Native people.
7. Knowledge of health disparities among Native Americans / Alaska Natives, including the pathophysiological basis of the disease process and the social determinants of health that affect disparities.
8. Experience working with Indian Tribes and Nations and an understanding of the Trust Responsibility of the Federal Government for American Indian and Alaska Natives as well as an understanding of the sovereignty of American Indian and Alaska Native Nations.
9. Experience with management, budget, and federal programs.
Res. 603, I-18

Strong Opposition to Cuts in Federal Funding for the Indian Health Service D-350.987
1. Our AMA will strongly advocate that all of the facilities that serve Native Americans under the Indian Health Service be adequately funded to fulfill their mission and their obligations to patients and providers.
2. Our AMA will ask Congress to take all necessary action to immediately restore full and adequate funding to the Indian Health Service.
3. Our AMA adopts as new policy that the Indian Health Service not be treated more adversely than other health plans in the application of any across the board federal funding reduction.
4. In the event of federal inaction to restore full and adequate funding to the Indian Health Service, our AMA will consider the option of joining in legal action seeking to require the federal government to honor existing treaties, obligations, and previously established laws regarding funding of the Indian Health Service.
5. Our AMA will request that Congress: (A) amend the Indian Health Care Improvement Act to authorize Advanced Appropriations; (B) include our recommendation for the Indian Health Service (HIS) Advanced Appropriations in the Budget Resolution; and (C) include in the enacted appropriations bill IHS Advanced Appropriations.
Res. 233, A-13; Appended: Res. 229, A-14

Plan for Continued Progress Toward Health Equity H-180.944
Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.
BOT Rep. 33, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 303
(N-21)

Introduced by: Medical Student Section

Subject: Decreasing Bias in Evaluations of Medical Student Performance

Referred to: Reference Committee C

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1 Whereas, Racism, xenophobia, sexism, homophobia, transphobia, ableism, and other
2 discrimination within medical education manifests through structural, institutional, and
3 interpersonal means, which necessitates a multilevel approach in order to be addressed[1-6]; and
4
5 Whereas, The Liaison Committee on Medical Education (LCME) defines a "fair and formal
6 process for taking any action that may affect the status of a medical student" such that a
7 "...student will be assessed by individuals who have not previously formed an opinion of the
8 student's abilities, professionalism, and/or suitability to become a physician"[7]; and
9
10 Whereas, Differences by race and ethnicity have been documented in receipt of Honors in
11 various clerkships, Alpha Omega Alpha membership, Medical Student Performance Evaluation
12 (MSPE) comments, and the residency application process[8-13]; and
13
14 Whereas, Latinx and Black physicians received a disproportionate number of complaints to the
15 Medical Board of California and had greater odds of complaints escalating to investigations, and
16 Latinx physicians had a greater probability of having an investigation result in disciplinary action
17 in a study of 32,978 complaints to the Medical Board of California between 2003 and 2013[14];
18 and
19
20 Whereas, A study in which fabricated prospective students with names indicative of their gender
21 and race sent emails to professors to discuss research opportunities demonstrated that
22 professors were most responsive to students whose names indicated that they were Caucasian
23 and male, especially professors at private universities and those in more lucrative fields[15]; and
24
25 Whereas, A study of medical students in the Netherlands revealed that non-Dutch students
26 were referred to the professional behavior board at a rate 2.86 times that of Dutch students, and
27 noted that "(cultural) differences in communication styles may be a possible explanation for
28 these students' underperformance" and "more subjective grading in clinical training can lead to
29 what is called 'examiner bias', which means that examiners have a more positive view on
30 people who are similar to themselves"[16]; and
31
32 Whereas, Blinded peer review of scientific abstracts has been found to resolve statistically-
33 significant bias against non-English speaking authors, international institutions, and less
34 prestigious institutions[17]; and
35
36 Whereas, All component groups of the admissions committee of the Ohio State University
37 College of Medicine showed implicit white preference on the Black-White Implicit Association
38 Test, with men and faculty members displaying greater levels of unconscious bias than women
39 and students[18]; and

Whereas, It has been shown implicit bias in grading can be mitigated through the recruitment of diverse disciplinary and grade review committees and through implicit bias awareness training[18-23]; and

Whereas, There is existing literature on the benefits of a two-interval grading system from a wellbeing standpoint, but there are limited published studies delineating the specific impact of this grading schema for minoritized trainees in terms of residency applications and career opportunities[24-26]; and

Whereas, The tiered grading system, often using grades of honors, high pass, pass, fail, or similar, is the most commonly used system for clerkship grading in allopathic US medical schools, while the two-interval, or pass/fail, system is most often used for clerkship grading in osteopathic US medical schools although a number of US allopathic medical schools such as Harvard, University of San Francisco, the David Geffen School of Medicine at UCLA, and the Perelman School of Medicine at the University of Pennsylvania have transitioned to two-tiered systems for at least some of their required clerkships[27-29]; and

Whereas, Inequities present in the tiered grading system have been shown to cascade to subsequent levels of training, leading to the persistent underrepresentation of Black, Latinx/Hispanic, American Indian, Alaska Native, and certain Asian subgroups in medicine[30]; and

Whereas, Two-interval grading and hybrid systems that incorporate pass/fail grades may minimize the disparities in the quantitative aspects of performance evaluations; however, this does not protect from the racial biases codified in the language of medical student performance evaluations as well as other aspects of residency applications, and as such, there is not enough evidence to support or oppose two-interval grading systems for clinical clerkships at this time[31-38]; therefore be it

RESOLVED, That our American Medical Association work with appropriate stakeholders, such as the Liaison Committee on Medical Education and the Commission on Osteopathic College Accreditation to support: 1) increased diversity and implementation of implicit bias training to individuals responsible for assessing medical students' performance, including the evaluation of professionalism and investigating and ruling upon disciplinary matters involving medical students; and 2) that all reviews of medical student professionalism and academic performance be conducted in a blinded manner when doing such does not interfere with appropriate scoring (Directive to Take Action); and be it further

RESOLVED, That our AMA study the impact of two-interval clinical clerkship grading systems on residency application outcomes and clinical performance during residency. (Directive to Take Action)

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

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

The combined upheaval of the pandemic and reckoning with long-standing racial bias has led to much needed and urgent introspection within the medical community. Importantly, there has been increased recognition of the degree to which bias built into medical training is harming minoritized trainees. Differences by race and ethnicity have been documented in receipt of Honors in various clerkships, Alpha Omega Alpha membership, professionalism reviews, Medical Student Performance Evaluation (MSPE) comments, and the residency application process. These disparities impact individuals during their training and thus go on to affect the rest of their careers. If we in medicine truly aim to eliminate the racism that plagues our history and our present-day practices, we must begin addressing the inequities that arise in training. This resolution gives the AMA concrete ways to do so by giving us the position of supporting increased training for faculty who evaluate, supporting blinded reviews of students, and studying whether two-interval (pass/fail) grading for clerkships may reduce some of the racial bias evident in evaluations. It is imperative that our AMA continue to move forward in examining and alleviating the ways racism, biases, and microaggressions affect trainees' experiences and careers; to do otherwise would be to devalue the difficulties faced and hard work so many have given to overcome these inequities.

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RELEVANT AMA POLICY

E-8.5 Disparities in Health Care

Stereotypes, prejudice, or bias based on gender expectations and other arbitrary evaluations of any individual can manifest in a variety of subtle ways. Differences in treatment that are not directly related to differences in individual patients' clinical needs or preferences constitute inappropriate variations in health care. Such variations may contribute to health outcomes that are considerably worse in members of some populations than those of members of majority populations.

This represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics.

To fulfill this professional obligation in their individual practices physicians should:

(a) Provide care that meets patient needs and respects patient preferences.

(b) Avoid stereotyping patients.

(c) Examine their own practices to ensure that inappropriate considerations about race, gender identify, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment.

(d) Work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients.

(e) Encourage shared decision making.

(f) Cultivate effective communication and trust by seeking to better understand factors that can influence patients' health care decisions, such as cultural traditions, health beliefs and health literacy, language or other barriers to communication and fears or misperceptions about the health care system.

The medical profession has an ethical responsibility to:

(g) Help increase awareness of health care disparities.
(h) Strive to increase the diversity of the physician workforce as a step toward reducing health care disparities.
(i) Support research that examines health care disparities, including research on the unique health needs of all genders, ethnic groups, and medically disadvantaged populations, and the development of quality measures and resources to help reduce disparities.
Issued: 2016

Fostering Professionalism During Medical School and Residency Training D-295.983
(1) Our AMA, in consultation with other relevant medical organizations and associations, will work to develop a framework for fostering professionalism during medical school and residency training. This planning effort should include the following elements: (a) Synthesize existing goals and outcomes for professionalism into a practice-based educational framework, such as provided by the AMA's Principles of Medical Ethics.
(b) Examine and suggest revisions to the content of the medical curriculum, based on the desired goals and outcomes for teaching professionalism.
(c) Identify methods for teaching professionalism and those changes in the educational environment, including the use of role models and mentoring, which would support trainees' acquisition of professionalism.
(d) Create means to incorporate ongoing collection of feedback from trainees about factors that support and inhibit their development of professionalism.
(2) Our AMA, along with other interested groups, will continue to study the clinical training environment to identify the best methods and practices used by medical schools and residency programs to fostering the development of professionalism.
CME Rep. 3, A-01; Reaffirmation: I-09; Reaffirmed: CME Rep. 01, A-19; Modified: CME Rep. 01, A-20

11.2.1 Professionalism in Health Care Systems
Containing costs, promoting high-quality care for all patients, and sustaining physician professionalism are important goals. Models for financing and organizing the delivery of health care services often aim to promote patient safety and to improve quality and efficiency. However, they can also pose ethical challenges for physicians that could undermine the trust essential to patient-physician relationships.
Payment models and financial incentives can create conflicts of interest among patients, health care organizations, and physicians. They can encourage undertreatment and overtreatment, as well as dictate goals that are not individualized for the particular patient.
Structures that influence where and by whom care is delivered—such as accountable care organizations, group practices, health maintenance organizations, and other entities that may emerge in the future—can affect patients' choices, the patient-physician relationship, and physicians' relationships with fellow health care professionals.
Formularies, clinical practice guidelines, and other tools intended to influence decision making, may impinge on physicians' exercise of professional judgment and ability to advocate effectively for their patients, depending on how they are designed and implemented.
Physicians in leadership positions within health care organizations should ensure that practices for financing and organizing the delivery of care:
(a) Are transparent.
(b) Reflect input from key stakeholders, including physicians and patients.
(c) Recognize that over reliance on financial incentives may undermine physician professionalism.
(d) Ensure ethically acceptable incentives that:
(i) are designed in keeping with sound principles and solid scientific evidence. Financial incentives should be based on appropriate comparison groups and cost data and adjusted to

reflect complexity, case mix, and other factors that affect physician practice profiles. Practice guidelines, formularies, and other tools should be based on best available evidence and developed in keeping with ethics guidance;
(ii) are implemented fairly and do not disadvantage identifiable populations of patients or physicians or exacerbate health care disparities;
(iii) are implemented in conjunction with the infrastructure and resources needed to support high-value care and physician professionalism;
(iv) mitigate possible conflicts between physicians' financial interests and patient interests by minimizing the financial impact of patient care decisions and the overall financial risk for individual physicians.
(e) Encourage, rather than discourage, physicians (and others) to:
(i) provide care for patients with difficult to manage medical conditions;
(ii) practice at their full capacity, but not beyond.
(f) Recognize physicians' primary obligation to their patients by enabling physicians to respond to the unique needs of individual patients and providing avenues for meaningful appeal and advocacy on behalf of patients.
(g) Are routinely monitored to:
(i) identify and address adverse consequences;
(ii) identify and encourage dissemination of positive outcomes.
All physicians should:
(h) Hold physician-leaders accountable to meeting conditions for professionalism in health care systems.
(i) Advocate for changes in health care payment and delivery models to promote access to high-quality care for all patients.
Issued: 2016

Reducing Racial and Ethnic Disparities in Health Care D-350.995
Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations:
(1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.
(2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.
(3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities.
BOT Rep. 4, A-03; Reaffirmation: A-11; Reaffirmation: A-16; Reaffirmed: CMS Rep. 10, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 304
(N-21)

Introduced by: Medical Student Section

Subject: Reducing Complexity in the Public Service Loan Forgiveness Program

Referred to: Reference Committee C

Whereas, The number of student borrowers in the United States totals 44.7 million individuals with total indebtedness exceeding $1.5 trillion[1]; and

Whereas, Nearly three-fourths of medical students have financed their education with the use of loans [2-4]; and

Whereas, Median student debt upon graduation from medical school totals $200,000, and the total repayment over a physician's career can total from $365,000 to $440,000 depending on repayment plan[3-4]; and

Whereas, If the increasing trend of median student debt upon graduation from $100,000-$135,000 in 2003 to $200,000 in 2012 continues, then resident physicians could face loan payments comprising up to 50% of their monthly earnings[5-7]; and

Whereas, The majority of surgical residents believe that their loan debt is a significant financial burden and that high debt levels influence their "salary goals, perceptions of financial security, career choices, and practice location"[5]; and

Whereas, High medical school debt has been associated with several adverse outcomes including decreased quality of life, increased stress, lower test scores, and burnout[5,8]; and

Whereas, There are several repayment options for students, including standard repayment programs, income-based repayment programs, and public student loan forgiveness[9-10]; and

Whereas, The Public Service Loan Forgiveness (PSLF) Program was established under the *College Cost Reduction and Access Act of 2007* in an attempt to reduce federal student loan debt burden for indebted professionals working in the public sector[11]; and

Whereas, The Federal Student Aid (FSA) Office of the United States Department of Education introduced the Employment Certification Form (ECF) in 2012 to try and assist borrowers in assuring that their employment qualifies for the PSLF program, 31% of ECFs received were deemed ineligible[12-13]; and

Whereas, The FSA began accepting applications in the Fall of 2017 for individuals seeking to be beneficiaries of this program with 187,053 PSLF applications received and processed through May 2020[13]; and

Whereas, The overwhelming majority of these applications, 183,356 or 98.02%, were deemed ineligible due to ineligible qualifying payments (57%), missing information (24%), or no eligible loans (14%)[13]; and

Whereas, The stringent requirements for qualifying payments have disqualified over 104,000 applications for forgiveness and include that every single one of the 120 payments be under a qualifying repayment plan, be for the full amount as shown on the bill, be no later than 15 days from the due date, be made while employed full-time by a qualifying employer, and be made only during periods when you are required to make a payment[13]; and

Whereas, Missing information on PSLF applications has disqualified over 44,000 individuals from forgiveness with missing information ranging from incorrect employer address on the ECF to failure to recertify repayment plans yearly during the entirety of repayment[13-14]; and

Whereas, Over 25,000 applications were denied due to ineligible loans forcing them to consolidate into a qualifying loan and restart their 120 qualifying payments if they chose to participate in PSLF[13]; and

Whereas, The United States Department of Education sought to address these issues in part by expanding eligibility and reconsideration for loan forgiveness via the Temporary Expanded PSLF (TEPSLF) made possible by a $350-million appropriation through the *Consolidated Appropriations Act of 2018*[15-16]; and

Whereas, Under the TEPSLF program, 93.8% of applicants for forgiveness have been denied with the total amount of discharged funds to approved applicants thus far comprising only 16.1% of the total appropriation by Congress[13]; and

Whereas, AMA policy H-305.925, "Principles of and Actions to Address Medical Education Costs and Student Debt," advocates for increased medical student and physician benefits in PSLF[17], it fails to recognize the TEPSLF and does not acknowledge nor attempt to resolve the bureaucratic complexities that make properly accessing these benefits feasible; therefore be it

RESOLVED, That our American Medical Association amend Policy H-305.925, "Principles of and Actions to Address Medical Education Costs and Student Debt," by addition to read as follows:

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

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

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and

the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.

3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the “20/220 pathway,” and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and

avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.

13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the “cost of attendance”; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.
15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.
16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short- and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.
17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.
19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but

assistance should be available to those physicians who are experiencing hardship in meeting their obligations.

20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Work with the United States Department of Education to ensure that applicants of the PSLF and its supplemental extensions, such as Temporary Expanded Public Service Loan Forgiveness (TEPSLF), are provided with the necessary information to successfully complete the program(s) in a timely manner; (c) Work with the United States Department of Education to ensure individuals who would otherwise qualify for PSLF and its supplemental extensions, such as TEPSLF, are not disqualified from the program(s) due to bureaucratic complexities; (~~b~~d) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (~~c~~e) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (~~d~~f) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (~~e~~g) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer; (~~f~~h) Advocate that the profit status of a physicians training institution not be a factor for PSLF eligibility; (~~g~~i) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (~~h~~j) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (~~i~~k) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.
21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.
22. Formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new polices and novel approaches to prevent debt from influencing specialty and subspecialty choice.
23. Strongly advocate for the passage of legislation to allow medical students, residents and fellows who have education loans to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education. (Modify Current HOD Policy)

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

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

The COVID-19 pandemic has had immense impacts upon the mental health of healthcare workers. The U.S. is already suffering a physician shortage, and with the early retirements, burnout, and even deaths of physicians due to the pandemic, this shortage is only going to get worse. It is urgent that our AMA begin acting promptly and aggressively to improve conditions that lead to poor mental health and burnout. One of the most important of these is the immeasurable debt that future physicians acquire in medical school and which plagues them throughout their residency training and deep into their medical career. Studies have shown these huge debts to be associated with decreased quality of life and increased stress and burnout for physicians. The Public Service Loan Forgiveness (PSLF) Program was established in an attempt to reduce federal student loan debt burden for indebted professionals working in the public sector. However, the vast majority of applications for this program are deemed ineligible due, simply, to some missing information.

This resolution gives our AMA a tangible advocacy direction to take action to ensure that PSLF applicants have timely access and the necessary support and information to be successful in their applications to this vital tool against debt-induced burnout. Given the effects of this continuing pandemic upon the health and mental health of physicians, it is vital that our AMA commit to concrete action to better protect the rising physician workforce.

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17. Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925. AMA. 2019.

RELEVANT AMA POLICY

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

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

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the "20/220 pathway," and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
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indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.

13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.

14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the “cost of attendance”; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

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

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

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

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

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

20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer; (f) Advocate that the profit status of a physicians training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.
21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.
22. Formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new polices and novel approaches to prevent debt from influencing specialty and subspecialty choice.
23. Strongly advocate for the passage of legislation to allow medical students, residents and fellows who have education loans to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education.
CME Report 05, I-18; Appended: Res. 953, I-18; Reaffirmation: A-19; Appended: Res. 316, A-19; Appended: Res. 226, A-21; Reaffirmed in lieu of: Res. 311, A-21

Reduction in Student Loan Interest Rates D-305.984
1. Our AMA will actively lobby for legislation aimed at establishing an affordable student loan structure with a variable interest rate capped at no more than 5.0%.
2. Our AMA will work in collaboration with other health profession organizations to advocate for a reduction of the fixed interest rate of the Stafford student loan program and the Graduate PLUS loan program.
3. Our AMA will consider the total cost of loans including loan origination fees and benefits of federal loans such as tax deductibility or loan forgiveness when advocating for a reduction in student loan interest rates.
4. Our AMA will advocate for policies which lead to equal or less expensive loans (in terms of loan benefits, origination fees, and interest rates) for Grad-PLUS loans as this would change the status quo of high-borrowers paying higher interest rates and fees in addition to having a higher overall loan burden.
5. Our AMA will work with appropriate organizations, such as the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges, to collect

data and report on student indebtedness that includes total loan costs at completion of graduate medical education training.
Res. 316, A-03; Reaffirmed: BOT Rep. 28, A-13; Appended: Res. 302, A-13; Modified and Appended: 301, A-16

Fixing the VA Physician Shortage with Physicians D-510.990
1. Our AMA will work with the VA to enhance its loan forgiveness efforts to further incentivize physician recruiting and retention and improve patient access in the Veterans Administration facilities.
2. Our AMA will call for an immediate change in the Public Service Loan Forgiveness Program to allow physicians to receive immediate loan forgiveness when they practice in a Veterans Administration facility.
3. Our AMA will work with the Veterans Administration to minimize the administrative burdens that discourage or prevent non-VA physicians without compensation (WOCs) from volunteering their time to care for veterans.
4. Our AMA will: (a) continue to support the mission of the Department of Veterans Affairs Office of Academic Affiliations for expansion of graduate medical education (GME) residency positions; and (b) collaborate with appropriate stakeholder organizations to advocate for preservation of Veterans Health Administration funding for GME and support its efforts to expand GME residency positions in the federal budget and appropriations process.
5. Our AMA supports postgraduate medical education service obligations through programs where the expectation for service, such as military service, is reasonable and explicitly delineated in the contract with the trainee.
6. Our AMA opposes the blanket imposition of service obligations through any program where physician trainees rotate through the facility as one of many sites for their training.
Res. 1010, A-16; Appended: Res. 954, I-18; Appended: CME Rep. 6, I-19

Effectiveness of Strategies to Promote Physician Practice in Underserved Areas D-200.980
1. Our AMA, in collaboration with relevant medical specialty societies, will continue to advocate for the following: (a) Continued federal and state support for scholarship and loan repayment programs, including the National Health Service Corps, designed to encourage physician practice in underserved areas and with underserved populations. (b) Permanent reauthorization and expansion of the Conrad State 30 J-1 visa waiver program. (c) Adequate funding (up to at least FY 2005 levels) for programs under Title VII of the Health Professions Education Assistance Act that support educational experiences for medical students and resident physicians in underserved areas.

2. Our AMA encourages medical schools and their associated teaching hospitals, as well as state medical societies and other private sector groups, to develop or enhance loan repayment or scholarship programs for medical students or physicians who agree to practice in underserved areas or with underserved populations.

3. Our AMA will advocate to states in support of the introduction or expansion of tax credits and other practice-related financial incentive programs aimed at encouraging physician practice in underserved areas.

4. Our AMA will advocate for the creation of a national repository of innovations and experiments, both successful and unsuccessful, in improving access to and distribution of physician services to government-insured patients (National Access Toolbox).

5. Our AMA supports elimination of the tax liability when employers provide the funds to repay student loans for physicians who agree to work in an underserved area.

CME Rep. 1, I-08; Modified: CME Rep. 4, A-10; Reaffirmation I-11; Appended: Res. 110, A-12; Reaffirmation A-13; Reaffirmation A-14; Appended: Res. 312, I-16; Appended: Res 312, I-16

Educational Strategies for Meeting Rural Health Physician Shortage H-465.988
1. In light of the data available from the current literature as well as ongoing studies being conducted by staff, the AMA recommends that:
A. Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents.
B. Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians.
C. Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians.
D. Our AMA encourage state and county medical societies and local medical schools to develop outreach and recruitment programs in rural counties to attract promising high school and college students to medicine and the other health professions.
E. Our AMA urge continued federal and state legislative support for funding of Area Health Education Centers (AHECs) for rural and other underserved areas.
F. Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships.
G. Our AMA support full funding of the new federal National Health Service Corps loan repayment program.
H. Our AMA encourage continued legislative support of the research studies being conducted by the Rural Health Research Centers funded by the National Office of Rural Health in the Department of Health and Human Services.
I. Our AMA continue its research investigation into the impact of educational programs on the supply of rural physicians.
J. Our AMA continue to conduct research and monitor other progress in development of educational strategies for alleviating rural physician shortages.
K. Our AMA reaffirm its support for legislation making interest payments on student debt tax deductible.
L. Our AMA encourage state and county medical societies to develop programs to enhance work opportunities and social support systems for spouses of rural practitioners.
2. Our AMA will work with state and specialty societies, medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education (ACGME), the Centers for Medicare and Medicaid Services (CMS) and other interested stakeholders to identify,

encourage and incentivize qualified rural physicians to serve as preceptors and volunteer faculty for rural rotations in residency.
3. Our AMA will: (a) work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates; and (b) work with interested stakeholders to formulate an actionable plan of advocacy with the goal of increasing residency training in rural areas.
4. Our AMA will undertake a study of issues regarding rural physician workforce shortages, including federal payment policy issues, and other causes and potential remedies (such as telehealth) to alleviate rural physician workforce shortages.
CME Rep. C, I-90; Reaffirmation A-00; Reaffirmation A-01; Reaffirmation I-01; Reaffirmed: CME Rep. 1, I-08; Reaffirmed: CEJA Rep. 06, A-18; Appended: Res. 956, I-18; Appended: Res. 318, A-19

Principles of and Actions to Address Primary Care Workforce H-200.949
1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation's current and projected demand for health care services.
2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).
3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.
4. Admissions and recruitment: The medical school admissions process should reflect the specific institution's mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.
5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.
6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.

7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.
8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.
9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.
10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.
11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.
12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.
13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).
14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.
15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.
16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further

encourage practice in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.
17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.
18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.
19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.
20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.
21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.
22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.
23. Practicing physicians in other specialties--particularly those practicing in underserved urban or rural areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.
24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.
25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.
CME Rep. 04, I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 305
(N-21)

Introduced by: Medical Student Section

Subject: Increase Awareness Among Residency, Fellowship, and Academic Programs on the United States-Puerto Rico Relationship Status

Referred to: Reference Committee C

Whereas, There are four allopathic medical schools in Puerto Rico accredited by the Liaison Committee on Medical Education (LCME) and the Middle States Commission on Higher Education (MSCHE) and members of the Association of American Medical Colleges (AAMC); and

Whereas, Most medical students from Puerto Rican schools are United States citizens and are evaluated by the same standards and examinations administered by the United States Medical Licensing Examination (USMLE) and National Board of Medical Examiners (NBME) as other medical students in the United States[1]; and

Whereas, Based on total medical school enrollment during the 2019-2020 academic year, Puerto Rico ranked 22nd out of 46 states with medical schools with 1,494 enrolled medical students[2,3]; and

Whereas, Just like all other U.S. medical graduates, students from Puerto Rican schools utilize the Visiting Student Learning Opportunities (VSLO/VSAS) portal, the Electronic Residency Application Service (ERAS), and the National Resident Matching Program (NRMP) to apply for clinical rotations and residency programs in the continental U.S.; and

Whereas, Medical students attending Puerto Rican medical schools have historically faced many hurdles in their away rotations and residency application process as they are commonly misperceived as International Medical Graduate (IMG) students by other medical students, physicians, and healthcare professionals from the continental US[4] ; and

Whereas, A study in progress shows that recently graduated physicians from Puerto Rican medical schools have reported that during the process of away rotations and residency interviews, they had to explain their citizenship, the accreditation status of Puerto Rican medical schools, the board exams taken, clarify about not being an IMG and their application being denied due to misinformation regarding these topics[5]; and

Whereas, The AMA has strong policy supporting parity in access to away rotations for D.O. students, (D-295.309) and policy supporting access to IMGs by abolishing discrimination in licensure (H-255.966**)**, protecting IMGs from unfair discrimination (H-255.978), and opposing discrimination in residency selection based on IMG status (D-255.982), but notably no policy in support of Puerto Rican medical school students who face similar barriers to IMGs despite being classified as U.S. graduates; and

Whereas, The AMA is interested in evaluating students based on merit (H-255.988, H-255.983) and eliminating discrimination (H-310.919), but lacks policy addressing the importance in merit-based evaluation of medical students from Puerto Rican medical schools; therefore be it

RESOLVED, That our American Medical Association issue an official public statement regarding the academic status of Puerto Rican medical students and schools to inform residency, fellowship, and academic programs in the continental United States that all medical schools from Puerto Rico are Liaison Committee on Medical Education (LCME), Association of American Medical Colleges (AAMC), and Middle States Commission on Higher Education (MSCHE) accredited, and their medical students are not considered international medical graduates (Directive to Take Action); and be it further

RESOLVED, That our AMA support policies that ensure equity and parity in the undergraduate and graduate educational and professional opportunities available to medical students and graduates from Puerto Rican medical schools. (New HOD Policy)

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

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Medical students attending Puerto Rican medical schools have historically faced many hurdles in their away rotations and residency application process as they are commonly misperceived as International Medical Graduate (IMG) students by other medical students, physicians, and healthcare professionals from the continental U.S. Residents and young physicians who have recently graduated from Puerto Rican medical schools report often having to explain their citizenship, the accreditation status of Puerto Rican medical schools, the board exams taken, clarify about not being an IMG and their application being denied due to misinformation regarding these topics. These issues represent significant barriers to trainees at the very beginning of their career as physicians. Given the physician shortage the U.S. Is already facing, and given the natural disasters that have so severely impacted Puerto Rico in recent years, and given the AMA's stated commitments to equity in health and healthcare, it should be an urgent AMA priority to ensure that Puerto Rican students and physicians have equal rights and equal opportunity to their counterparts from elsewhere throughout the U.S.

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3. Total Enrollment By U.S. Medical School And Sex, 2015-2016 Through 2019-2020. AAMC. https://www.aamc.org/system/files/2019-11/2019_FACTS_Table_B-1.2.pdf. Accessed March 15, 2020.
4. Dropp K, Nyhan B. Nearly Half of Americans Don't Know Puerto Ricans Are Fellow Citizens. The New York Times. https://www.nytimes.com/2017/09/26/upshot/nearly-half-of-americans-dont-know-people-in-puerto-ricoans-are-fellow-citizens.html. Published 2017. Accessed August 26, 2020.
5. Caldas P, Colon G, Irizarry J. Cross-sectional study of the experiences graduates from Puerto Rican Medical Schools had during their away elective rotations and residency application process in mainland US programs as fourth year students. In preparation 2020. https://drive.google.com/file/d/1ePiacvS-8jwMvukDCI-3uRKA0xYZRFOb/view?usp=sharing

RELEVANT AMA POLICY

Abolish Discrimination in Licensure of IMGs H-255.966
1. Our AMA supports the following principles related to medical licensure of international medical graduates (IMGs):
A. State medical boards should ensure uniformity of licensure requirements for IMGs and graduates of U.S. and Canadian medical schools, including eliminating any disparity in the years of graduate medical education (GME) required for licensure and a uniform standard for the allowed number of administrations of licensure examinations.
B. All physicians seeking licensure should be evaluated on the basis of their individual education, training, qualifications, skills, character, ethics, experience and past practice.
C. Discrimination against physicians solely on the basis of national origin and/or the country in which they completed their medical education is inappropriate.
D. U.S. states and territories retain the right and responsibility to determine the qualifications of individuals applying for licensure to practice medicine within their respective jurisdictions.
E. State medical boards should be discouraged from a) using arbitrary and non-criteria-based lists of approved or unapproved foreign medical schools for licensure decisions and b) requiring an interview or oral examination prior to licensure endorsement. More effective methods for evaluating the quality of IMGs' undergraduate medical education should be pursued with the Federation of State Medical Boards and other relevant organizations. When available, the results should be a part of the determination of eligibility for licensure.
2. Our AMA will continue to work with the Federation of State Medical Boards to encourage parity in licensure requirements for all physicians, whether U.S. medical school graduates or international medical graduates.
3. Our AMA will continue to work with the Educational Commission for Foreign Medical Graduates and other appropriate organizations in developing effective methods to evaluate the clinical skills of IMGs.
4. Our AMA will work with state medical societies in states with discriminatory licensure requirements between IMGs and graduates of U.S. and Canadian medical schools to advocate for parity in licensure requirements, using the AMA International Medical Graduate Section licensure parity model resolution as a resource.
5. Our AMA will: (a) encourage states to study existing strategies to improve policies and processes to assist IMGs with credentialing and licensure to enable them to care for patients in underserved areas; and (b) encourage the FSMB and state medical boards to evaluate the progress of programs aimed at reducing barriers to licensure--including successes, failures, and barriers to implementation.
BOT Rep. 25, A-15; Appended: CME Rep. 4, A-21

Unfair Discrimination Against International Medical Graduates H-255.978
It is the policy of the AMA to take appropriate action, legal or legislative, against implementation of Section 4752(d) of the OBRA of 1990 that requires international medical graduates, in order to obtain a Medicaid UPIN number, to have held a license in one or more states continuously since 1958, or pass the Foreign Medical Graduate Examination in Medical Sciences (FMGEMS), or pass the Educational Commission for Foreign Medical Graduates (ECFMG) Examination, or be certified by ECFMG.
Res. 123, I-90; Reaffirmation: A-00; Reaffirmed: CME Rep. 2, A-10; Reaffirmed: CME Rep. 01, A-20
Graduates of Non-United States Medical Schools H-255.983
The AMA continues to support the policy that all physicians and medical students should be evaluated for purposes of entry into graduate medical education programs, licensure, and hospital medical staff privileges on the basis of their individual qualifications, skills, and character. Sub. Res. A-88; Reaffirmed: Res. 311, A-96; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CME Rep.

1, I-03; Reaffirmed: CME Rep. 7, A-04; Reaffirmed: Sub. Res. 314, A-04; Reaffirmed: CME Rep. 11, A-10; Reaffirmed: BOT Rep. 25, A-15

AMA Principles on International Medical Graduates H-255.988
Our AMA supports:
1. Current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.
2. Current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.
3. The AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.
4. Cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
5. Continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.
6. Working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.
7. In cooperation with the ACGME and the FSMB, supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
8. The AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.
9. That special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.
10. That accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.
11. That AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.
12. The requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement: (a) completion of medical school and residency training outside the U.S.; (b) extensive U.S. medical practice; and (c) evidence of good standing within the local medical community.
13. Publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.
14. The participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. The AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.

15. Support studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.
16. AMA membership outreach to IMGs, to include a) using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians; b) publicizing its many relevant resources to all physicians, especially to nonmember IMGs; c) identifying and publicizing AMA resources to respond to inquiries from IMGs; and d) expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.
17. Recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.
18. Its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.
19. Institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.
20. Informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.
21. U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.
22. The Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.
BOT Rep. Z, A-86; Reaffirmed: Res. 312, I-93; Modified: CME Rep. 2, A-03; Reaffirmation; I-11; Reaffirmed: CME Rep. 1, I-13; Modified: BOT Rep. 25, A15; Modified: CME Rep. 01, A-16; Appended: Res. 304, A-17; Modified: CME Rep. 01, I-17; Reaffirmation: A-19; Modified: CME Rep. 2, A-21

Promoting and Reaffirming Domestic Medical School Clerkship Education D-295.309
1. Our American Medical Association:
A. Will work with the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, and other interested stakeholders to encourage local and state governments and the federal government, as well as private sector philanthropies, to provide additional funding to support: (1) infrastructure and faculty development and capacity for medical school expansion; and (2) delivery of clinical clerkships and other educational experiences.
B. Encourages clinical clerkship sites for medical education (to include medical schools and teaching hospitals) to collaborate with local, state, and regional partners to create additional clinical education sites and resources for students.
C. Advocates for federal and state legislation/regulations to: (1) Oppose any extraordinary compensation granted to clinical clerkship sites that would displace or otherwise limit the education/training opportunities for medical students in clinical rotations enrolled in medical school programs accredited by the Liaison Committee on Medical Education (LCME) or Commission on Osteopathic College Accreditation (COCA); (2) Ensure that priority for clinical clerkship slots be given first to students of LCME- or COCA-accredited medical school programs;

and (3) Require that any institution that accepts students for clinical placements ensure that all such students are trained in programs that meet requirements for educational quality, curriculum, clinical experiences and attending supervision that are equivalent to those of programs accredited by the LCME and COCA.
D. Encourages relevant stakeholders to study whether the "public service community benefit" commitment and corporate purposes of not for profit, tax exempt hospitals impose any legal and/or ethical obligations for granting priority access for teaching purposes to medical students from medical schools in their service area communities and, if so, advocate for the development of appropriate regulations at the state level.
E. Will work with interested state and specialty medical associations to pursue legislation that ensures the quality and availability of medical student clerkship positions for U.S. medical students.
2. Our AMA supports the practice of U.S. teaching hospitals and foreign medical schools entering into appropriate relationships directed toward providing clinical educational experiences for advanced medical students who have completed the equivalent of U.S. core clinical clerkships. Policies governing the accreditation of U.S. medical education programs specify that core clinical training be provided by the parent medical school; consequently, the AMA strongly objects to the practice of substituting clinical experiences provided by U.S. institutions for core clinical curriculum of foreign medical schools. Moreover, it strongly disapproves of the placement of medical students in teaching hospitals and other clinical sites that lack appropriate educational resources and experience for supervised teaching of clinical medicine, especially when the presence of visiting students would disadvantage the institution's own students educationally and/or financially and negatively affect the quality of the educational program and/or safety of patients receiving care at these sites.
3. Our AMA supports agreements for clerkship rotations, where permissible, for U.S. citizen international medical students between foreign medical schools and teaching hospitals in regions that are medically underserved and/or that lack medical schools and clinical sites for training medical students, to maximize the cumulative clerkship experience for all students and to expose these students to the possibility of medical practice in these areas.
4. AMA policy is that U.S. citizens should have access to factual information on the requirements for licensure and for reciprocity in the various U.S. medical licensing jurisdictions, prerequisites for entry into graduate medical education programs, and other relevant factors that should be considered before deciding to undertake the study of medicine in schools not accredited by the LCME or COCA.
5. AMA policy is that existing requirements for foreign medical schools seeking Title IV Funding should be applied to those schools that are currently exempt from these requirements, thus creating equal standards for all foreign medical schools seeking Title IV Funding.
CME Rep. 01, I-17

Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process H-310.919
Our AMA:
1. Opposes questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion;
2. 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 marital and dependent status, future plans for marriage or children, sexual orientation, age, race, national origin, and religion during the residency and fellowship application process;

3. Will continue to support efforts to enhance racial and ethnic diversity in medicine. Information regarding race and ethnicity may be voluntarily provided by residency and fellowship applicants;
4. Encourages the Association of American Medical Colleges (AAMC) and its Electronic Residency Application Service (ERAS) Advisory Committee to develop steps to minimize bias in the ERAS and the residency training selection process; and
5. Will advocate that modifications in the ERAS Residency Application to minimize bias consider the effects these changes may have on efforts to increase diversity in residency programs.
Res. 307, A-09; Appended: Res. 955, I-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 306
(N-21)

Introduced by: Medical Student Section

Subject: Support for Standardized Interpreter Training

Referred to: Reference Committee C

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1 Whereas, There are more than 6,900 known living languages spoken in the world[1]; and
2
3 Whereas, More than 66 million Americans speak at least one of over 350 languages other than
4 English at home and more than 25 million Americans speak English "less than very well"[2-4]; and
5
6 Whereas, Language barriers can have major adverse effects on health such as suboptimal
7 health status; lower likelihood of having regular care providers; lower rates of mammograms,
8 pap smears, and other preventative services; greater likelihood of diagnosis of more severe
9 psychopathology; leaving the hospital against medical advice; and increased risk of drug
10 complications[1,3,5]; and
11
12 Whereas, Ad hoc interpreters have been shown to engage in "false fluency", where substandard
13 interpretation skills leads to inadequate translation, thereby compromising the integrity of the
14 patient-provider interaction[6-8]; and
15
16 Whereas, Errors in medical interpretation are not uncommon, and translation errors made by ad
17 hoc interpreters are more likely to result in clinical consequences than errors made by
18 professionally trained medical interpreters[9]; and
19
20 Whereas, Underuse of a valuable health care resource, professional medical interpretation, can
21 result in these adverse effects and inappropriate care[4]; and
22
23 Whereas, Professional medical interpreter services can facilitate effective communication
24 across language differences and increase the delivery of health care to Limited English
25 Proficiency (LEP) patients, yet remain underutilized in health care[3,10]; and
26
27 Whereas, Language assistance is a legal right of patients under Title VI of the 1964 Civil Rights
28 Act, therefore hospitals have policies and processes in place, but how they are communicated
29 to front-line staff is variable[5,11]; and
30
31 Whereas, One potential contributor is the lack of a designated place within medical training
32 curricula to address language barriers, which calls for a more recognizable and accessible
33 resource for training[5,11]; and
34
35 Whereas, In recent studies, only 19% of emergency department (ED) staff had reported prior
36 training on working with interpreters, regardless of the source of training[7], and most ED
37 providers and staff who have little training in the use of language assistance were unaware of
38 hospital policy in this area[11,12]; and

Whereas, Only 28% of medical schools offer students on clerkships training involving a language interpreter[13]; and

Whereas, Dissemination of best practices for the provision of language assistance and the clinical use of non-English language skills has the potential to improve communication with LEP patients[11]; and

Whereas, Healthcare organizations should ensure that medical professionals across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery or have access to training[14]; and

Whereas, Providing training to physicians and medical students about the proper use of medical interpreter services increases the correct use of those services[15-18]; and

Whereas, Teaching medical professionals to emphasize the appropriate use of an interpreter is warranted to improve cross-language clinical encounters, and could be executed through a Continuing Medical Education (CME) module[12]; and

Whereas, It has been recommended that healthcare organizations should either verify that staff at all levels and in all disciplines participate in ongoing CME-accredited education or other training in Culturally and Linguistically Appropriate Services delivery, or arrange for such education and training to be made available to staff[14]; and

Whereas, CME is a cornerstone of improving competencies and ensuring high-quality patient care by nurses and physicians[19]; and

Whereas, Although the AMA Education Hub (EdHub) has produced a series of modules related to Health Disparities and the Health Care Workforce, such as Disparities in Research and Health Equity to Bias in Artificial Intelligence, it does not currently have any modules covering the correct use of interpreter services; and

Whereas, The American Association of Medical Colleges (AAMC) has published “Guidelines on the Use of Medical Interpreter Services,” which describe best practices for assessing English proficiency, use of an interpreter, additional considerations for ad hoc interpreters, conflicts of interest and privacy, and considerations for telephonic interpreter services[20]; and

Whereas, Though AMA policy reimbursement for and calls for further research regarding interpreter services (D-385.957, H-160.924, H-385.928, H-382.929, D-385.978), it does not recognize the importance of interpreter services for providing appropriate care or call upon physicians to use them with patients with LEP, and the AMA Ed Hub does not currently provide any resources addressing how to correctly use interpreter services; therefore be it

RESOLVED, That our American Medical Association recognize the importance of using medical interpreters as a means of improving quality of care provided to patients with Limited English Proficiency (LEP) including patients with sensory impairments (New HOD Policy); and

RESOLVED, That our AMA encourage physicians and physicians in training to improve interpreter-use skills and increase education through publicly available resources such as the American Association of Medical College’s “Guidelines for Use of Medical Interpreter Services” (New HOD Policy); and be it further

1 RESOLVED, That our AMA work with the Commission for Medical Interpreter Education,
2 National Hispanic Medical Association, National Council of Asian Pacific Islander Physicians,
3 National Medical Association, Association of American Indian Physicians, and other relevant
4 stakeholders to develop a cohesive Continuing Medical Education module offered through the
5 AMA Ed Hub for physicians to effectively and appropriately use interpreter services to ensure
6 optimal patient care. (Directive to Take Action)

Fiscal Note: Moderate - between $5,000 - $10,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

The COVID-19 pandemic revealed the particular vulnerability of individuals with limited English proficiency (LEP). People with LEP have struggled to receive adequate and proper care, and the outcomes for this population have been drastically worse than those who are proficient in English. Disparities in outcomes for people with LEP have been a known problem in healthcare, but the pandemic has made this an even more urgent problem. Lack of adequate training for using interpreter services has immense impacts on health outcomes. Our AMA recognizes the urgent priority of health equity, and should make the protection of vulnerable communities with LEP a priority. This resolution addresses that priority by recognizing the importance of and providing solutions to the problem of lacking interpreter training, which so often leads to preventable poor health and healthcare outcomes.

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RELEVANT AMA POLICY

Certified Translation and Interpreter Services D-385.957
Our AMA will: (1) work to relieve the burden of the costs associated with translation services implemented under Section 1557 of the Affordable Care Act; and (2) advocate for legislative and/or regulatory changes to require that payers including Medicaid programs and Medicaid managed care plans cover interpreter services and directly pay interpreters for such services, with a progress report at the 2017 Interim Meeting of the AMA House of Delegates.
Res. 703, A-17; Reaffirmed: CMS Rep. 7, A-21

Use of Language Interpreters in the Context of the Patient-Physician Relationship H-160.924
AMA policy is that: (1) further research is necessary on how the use of interpreters--both those who are trained and those who are not--impacts patient care; (2) treating physicians shall respect and assist the patients' choices whether to involve capable family members or friends to provide language assistance that is culturally sensitive and competent, with or without an interpreter who is competent and culturally sensitive; (3) physicians continue to be resourceful in their use of other appropriate means that can help facilitate communication--including print materials, digital and other electronic or telecommunication services with the understanding, however, of these tools' limitations--to aid LEP patients' involvement in meaningful decisions about their care; and (4) physicians cannot be expected to provide and fund these translation services for their patients, as the Department of Health and Human Services' policy guidance currently requires; when trained medical interpreters are needed, the costs of their services shall be paid directly to the interpreters by patients and/or third party payers and physicians shall not be required to participate in payment arrangements.
BOT Rep. 8, I-02; Reaffirmation: I-03; Reaffirmed in lieu of Res. 722, A-07; Reaffirmation: A-09; Reaffirmed: CMS Rep. 5, A-11; Reaffirmed in lieu of Res. 110, A-13; Reaffirmation: A-17

Patient Interpreters H-385.928
Our AMA supports sufficient federal appropriations for patient interpreter services and will take other necessary steps to assure physicians are not directly or indirectly required to pay for interpreter services mandated by the federal government.
Res. 219, I-01; Reaffirmed: BOT Rep. 8, I-02; Reaffirmation: I-03; Reaffirmed in lieu of Res .722, A-07; Reaffirmation: A-09; Reaffirmation: A-10; Reaffirmation A-14

Availability and Payment for Medical Interpreters Services in Medical Practices H-385.929
It is the policy of our AMA to: (1) the fullest extent appropriate, to actively oppose the inappropriate extension of the OCR LEP guidelines to physicians in private practice; and (2) continue our proactive, ongoing efforts to correct the problems imposed on physicians in private practice by the OCR language interpretation requirements.
BOT Rep. 25, I-01; Reaffirmation: I-03; Reaffirmed: Res. 907, I-03; Reaffirmation: A-09; Reaffirmation: A-17

Language Interpreters D-385.978
Our AMA will: (1) continue to work to obtain federal funding for medical interpretive services;(2) redouble its efforts to remove the financial burden of medical interpretive services from physicians;(3) urge the Administration to reconsider its interpretation of Title VI of the Civil Rights Act of 1964 as requiring medical interpretive services without reimbursement;(4) consider the feasibility of a legal solution to the problem of funding medical interpretive services; and(5)

work with governmental officials and other organizations to make language interpretive services a covered benefit for all health plans inasmuch as health plans are in a superior position to pass on the cost of these federally mandated services as a business expense.
Res. 907, I-03; Reaffirmed in lieu of Res. 722, A-07; Reaffirmation: A-09; Reaffirmation: A-10; Reaffirmed: CMS Rep. 5, A-11; Reaffirmed in lieu of Res. 110, A-13; Reaffirmation: A-17

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 307
(N-21)

Introduced by: Medical Student Section

Subject: Support for Institutional Policies for Personal Days for Undergraduate Medical Students

Referred to: Reference Committee C

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1 Whereas, Burnout is a multifactorial occupational syndrome characterized by emotional
2 exhaustion, depersonalization, and cynicism or professional dissatisfaction as a result of
3 prolonged stress[1,2]; and
4
5 Whereas, Burnout can not only undermine professional development, but also contribute to
6 mental health disorders including suicidal ideal and substance use[2]; and
7
8 Whereas, Over half of U.S. medical students report experiencing burnout at some point in their
9 medical education, along with greater prevalence of depressive symptoms (27.2%) and suicidal
10 ideation (11.1%) compared to the general population (7.1% and 4%, respectively)[2-4]; and
11
12 Whereas, A lack of protected time remains the prominent barrier preventing medical students
13 from accessing mental health treatment[5]; and
14
15 Whereas, Institutional policies and initiatives to address burnout and improve mental wellness
16 vary widely, including the implementation of “sick days” which may require proof of illness or be
17 restricted in how they can be utilized[6,7]; and
18
19 Whereas, Students may not feel comfortable sharing mental health concerns due to
20 professional stigma, shame, or fear or repercussions on professional development[8]; and
21
22 Whereas, Personal days are defined as excused absences that may require advance notice but
23 without an explanation for the absence, and may be also be utilized for mental wellness,
24 physical wellness, and self-care[9]; and
25
26 Whereas, Personal days have been increasingly prevalent in workplace or corporate policies,
27 and are now offered in over one third of workplaces and in companies such as Netflix, Best Buy,
28 and Virgin America[10,11]; and
29
30 Whereas, The implementation of personal days in medical schools would allow students to
31 address their health needs—including mental health and routine appointments—without
32 compromising their privacy to clerkship directors or administrators; and
33
34 Whereas, A number of medical schools have started providing personal days, though policies
35 continue to vary widely due to lack of standardization[12-31]; and

Whereas, Our AMA has policy supporting existing programs in identification and management of stress (H-405.957), prioritizing self-care among medical students and the maintenance of a healthy lifestyle (H-405.957), and promoting the recognition of burnout in students by institutional officials, program directors, resident physicians, and attending faculty (H-295.858); therefore be it

RESOLVED, That our American Medical Association encourage medical schools to accept flexible uses for excused absences from clinical clerkships (New HOD Policy); and be it further

RESOLVED, That our AMA support a clearly defined number of easily accessible personal days for medical students per academic year, which should be explained to students at the beginning of each academic year and a subset of which should be granted without requiring an explanation on the part of the students. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

The impact of the pandemic on the mental health of healthcare workers cannot be overstated. This devastating impact, however, helped illuminate some of the ways in which the field of medicine and medical training are set up to cause emotional trauma and damage mental health. One particularly harmful practice is the way personal days off of training are handled for medical students. Sick days for medical students may require extensive and invasive documentation, and personal days off may require notice weeks to months in advance. The days off system is often rigid, and the institution's policies may be opaque, and the burden is placed on the student to prove why they should not be harshly penalized for missing a day of schooling they are paying for. All of this contributes to burnout, and all of it has been significantly worsened during the pandemic, as students continue to feel pressure to show up even when potentially ill and face confusing systems when they need time off to mourn friends and family lost to COVID.

Even before the pandemic, over half of medical students reported experiencing burnout, which will doubtless be exacerbated by pandemic conditions. This is an urgent problem that is already at crisis magnitude, and it is imperative that the AMA begin taking large, bold steps if it wants to protect the healthcare workforce of the future.

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RELEVANT AMA POLICY

Access to Confidential Health Services for Medical Students and Physicians H-295.858

1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to:

A. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling

services, that: (1) include appropriate follow-up; (2) are outside the trainees' grading and evaluation pathways; and (3) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;
B. Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees;
C. Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and
D. Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle.

2. Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.
3. Our AMA encourages medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would:
A. be available to all medical students on an opt-out basis;
B. ensure anonymity, confidentiality, and protection from administrative action;
C. provide proactive intervention for identified at-risk students by mental health and addiction professionals; and
D. inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation.
4. Our AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and (c) encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior.
5. Our AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education.
6. Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty. Our AMA supports making these alternatives available to students at the earliest possible point in their medical education.

7. Our AMA will engage with the appropriate organizations to facilitate the development of educational resources and training related to suicide risk of patients, medical students, residents/fellows, practicing physicians, and other health care professionals, using an evidence-based multidisciplinary approach.
CME Rep. 01, I-16Appended: Res. 301, A-17Appended: Res. 303, A-17Modified: CME Rep. 01, A-18Appended: Res. 312, A-18Reaffirmed: BOT Rep. 15, A-19

Programs on Managing Physician Stress and Burnout H-405.957
1. Our American Medical Association supports existing programs to assist physicians in early identification and management of stress and the programs supported by the AMA to assist physicians in early identification and management of stress will concentrate on the physical, emotional and psychological aspects of responding to and handling stress in physicians' professional and personal lives, and when to seek professional assistance for stress-related difficulties.
2. Our AMA will review relevant modules of the STEPs Forward Program and also identify validated student-focused, high quality resources for professional well-being, and will encourage the Medical Student Section and Academic Physicians Section to promote these resources to medical students.
Res. 15, A-15; Appended: Res. 608, A-16; Reaffirmed: BOT Rep. 15, A-19

Study of Medical Student, Resident, and Physician Suicide D-345.983
Our AMA will: (1) explore the viability and cost-effectiveness of regularly collecting National Death Index (NDI) data and confidentially maintaining manner of death information for physicians, residents, and medical students listed as deceased in the AMA Physician Masterfile for long-term studies; (2) monitor progress by the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education (ACGME) to collect data on medical student and resident/fellow suicides to identify patterns that could predict such events; (3) support the education of faculty members, residents and medical students in the recognition of the signs and symptoms of burnout and depression and supports access to free, confidential, and immediately available stigma-free mental health and substance use disorder services; and (4) collaborate with other stakeholders to study the incidence of and risk factors for depression, substance misuse and addiction, and suicide among physicians, residents, and medical students.
CME Rep. 06, A-19

Physician and Medical Student Burnout D-310.968
1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, fellows, and medical students.
2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.
3. Our AMA will encourage partnerships and collaborations with accrediting bodies (e.g., the Accreditation Council for Graduate Medical Education and the Liaison Committee on Medical Education) and other major medical organizations to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students and faculty.
4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.
5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.

6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.
7. Our AMA will encourage medical staffs and/or organizational leadership to anonymously survey physicians to identify local factors that may lead to physician demoralization.
8. Our AMA will continue to offer burnout assessment resources and develop guidance to help organizations and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being.
9. Our AMA will continue to: (a) address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient work flows and regulatory oversight; and (b) develop and promote mechanisms by which physicians in all practices settings can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being.
CME Rep. 8, A-07; Modified: Res. 919, I-11; Modified: BOT Rep. 15, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 308
(N-21)

Introduced by: Medical Student Section

Subject: Modifying Eligibility Criteria for the Association of American Medical Colleges' Financial Assistance Program

Referred to: Reference Committee C

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1 Whereas, The American College Application Service (AMCAS) is the American Association of
2 Medical College's (AAMC) centralized medical school application processing service and is
3 used by most US medical schools as the primary application method for their entering class[1];
4 and
5
6 Whereas, The 2019 medical school application fee through AMCAS is $170 for the first
7 application and an additional $40 for each application after[2]; and
8
9 Whereas, It is estimated that the average cost of secondary applications is $80 per application,
10 and pre-medical applicants apply to an average of 16 medical schools per cycle[3,4]; and
11
12 Whereas, Pre-medical students without AAMC Fee Assistance Program (FAP) benefits spend
13 at least $2,800 on application fees alone, not including travel costs for interviews[5]; and
14
15 Whereas, Spending $2,800 on application fees alone would be four times greater than the
16 amount the median US household saves for miscellaneous fees in their budget[6]; and
17
18 Whereas, The Medical College Admission Test (MCAT), developed and administered by the
19 AAMC, is a standardized, multiple-choice examination created to help medical school
20 admissions offices assess students[7]; and
21
22 Whereas, The cost of MCAT registration is $315, with additional fees for late registration and
23 changing test dates, not including test-prep materials recommended to most students which are
24 offered by the AAMC and other test-prep companies[9]; and
25
26 Whereas, The University of California Berkeley Career Center estimates a total cost of
27 approximately $7,520 total for the medical school application process as of 2014, and notes that
28 the cost is higher for those applying to both allopathic and osteopathic programs[10]; and
29
30 Whereas, The AAMC generated over $70 million dollars in revenue by administering the MCAT
31 and AMCAS alone in 2016[8]; and
32
33 Whereas, The Fee Assistance Program (FAP), offered by AAMC, exists to assist those who,
34 without financial assistance, would not be able to apply to medical schools who use the AMCAS
35 application and would not be able to afford the MCAT registration fee[9]; and
36
37 Whereas, In order to qualify for the 2019 FAP, the applicants' total family income in 2018 must
38 be 300% or less than the 2018 national poverty level for that family size[11]; and

Whereas, In contrast to other federally funded programs, the FAP does not distinguish between independent or dependent tax statuses, and therefore, parental financial information and tax documents are required and must also fall within eligibility guidelines; This requirement is not waived based on marital status, age or tax filing status[11]; and

Whereas, An applicant having an income that meets the eligibility requirements for fee assistance themselves, are denied based on parental income[11]; and

Whereas, The Free Application for Federal Student Aid (FAFSA) provided for by the U.S. Department of Education does not require an applicant to report parental income if they file taxes as an independent[12]; and

Whereas, The Expected Family Contribution (EFC) is an index number used by the FAFSA based on family's taxed and untaxed income, assets, and benefits to generate a sliding-scale model in which a lower EFC indicates eligibility for more financial aid[13]; and

Whereas, Offering additional need-based aid to students increases the odds of obtaining their degree, thus helping to reduce inequality in higher education[14]; and

Whereas, In 2017, less than 5% of entering medical students came from the lowest quintile of family income while 51% came from the highest quintile[15]; and

Whereas, Despite several efforts to make medical education attainable to low-income students, the cost of attending medical school continues to rise, making it even more difficult for low-income students and families to afford in the future[16]; and

Whereas, Our AMA has pledged to take action on the rising cost of medical education and its contribution to student debt (H-305.925); and

Whereas, Our AMA has established support for increasing the representation of minority and economically disadvantaged populations in the medical profession (H-350.979) and has committed to working with the AAMC to achieve this goal (D-200.985); therefore be it

RESOLVED, That our American Medical Association encourage the Association of American Medical Colleges to conduct a study of the financial impact of the current Fee Assistance Program policy to medical school applicants. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

The COVID-19 pandemic has been a massive crisis for healthcare workers, resulting in losses of our physician workforce through early retirements, hour reduction due to burnout, and deaths. The U.S. faced a physician shortage before the pandemic, and the pandemic will only serve to greatly exacerbate that pre-existing crisis. A large pre-existing factor for the crisis of a physician shortage is the incomprehensible debt with which young doctors start and, increasingly commonly, spend much of their careers. The U.S. particularly faces a shortage of physicians from traditionally marginalized backgrounds: Black, Latinx, Indigenous, some Asian groups, LGBTQ+, low-SES, and disabled people remain underrepresented in medicine.

This resolution aims to address this combined crisis--physician shortage, increasing burnout, and unequal representation in medicine--by addressing a barrier at the initiation of a medical career. Medical school applicants who do not have AAMC Fee Assistance Program benefits spend an average of $2,800 on application fees alone, not including travel costs for interviews. This huge burden, especially for applicants from underprivileged backgrounds, starts all applicants into the path of medicine by experiencing one of the strongest contributors to burnout. Our resolution asks the AMA to take a stand for medical students and future physician colleagues by encouraging the AAMC to investigate the impact of fee assistance. We hope the AMA joins us in considering as priority the reduction of burnout starting before medical school, to begin to address the physician workforce crisis that has been so worsened by the pandemic.

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RELEVANT AMA POLICY

Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession H-350.979

Our AMA supports increasing the representation of minorities in the physician population by:
(1) Supporting efforts to increase the applicant pool of qualified minority students by:
(a) Encouraging state and local governments to make quality elementary and secondary education opportunities available to all; (b) Urging medical schools to strengthen or initiate programs that offer special premedical and precollegiate experiences to underrepresented minority students; (c) urging medical schools and other health training institutions to develop new and innovative measures to recruit underrepresented minority students, and (d) Supporting legislation that provides targeted financial aid to financially disadvantaged students at both the collegiate and medical school levels.
(2). Encouraging all medical schools to reaffirm the goal of increasing representation of underrepresented minorities in their student bodies and faculties.
(3) Urging medical school admission committees to consider minority representation as one factor in reaching their decisions.
(4) Increasing the supply of minority health professionals.
(5) Continuing its efforts to increase the proportion of minorities in medical schools and medical school faculty.
(6) Facilitating communication between medical school admission committees and premedical counselors concerning the relative importance of requirements, including grade point average and Medical College Aptitude Test scores.
(7) Continuing to urge for state legislation that will provide funds for medical education both directly to medical schools and indirectly through financial support to students.
(8) Continuing to provide strong support for federal legislation that provides financial assistance for able students whose financial need is such that otherwise they would be unable to attend medical school.
CLRPD Rep. 3, I-98, Reaffirmed: CLRPD Rep. 1, A-08, Reaffirmed: CME Rep. 1, A-18

Strategies for Enhancing Diversity in the Physician Workforce D-200.985

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.

4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.
10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.
13. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.
CME Rep, 1, I-06, Reaffirmation: I-10, Reaffirmation: A-13, Modified: CCB/CLRPD Rep. 2, A-14, Reaffirmation: A-16, Appended: Res. 313, A-17, Appended: Res. 314, A-17, Modified: CME Rep. 1, A-18, Appended: Res. 207, I-18, Appended: Res. 304, A-19, Appended: Res. 319, A-19; Modified: CME Rep. 5, A-21

Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925
The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:
1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.

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

"lock in" a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.
15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.
16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.
17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.
19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.
20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer; (f) Advocate that the profit status of a physicians training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.
21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.
22. Formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new polices and novel approaches to prevent debt from influencing specialty and subspecialty choice.

23. Strongly advocate for the passage of legislation to allow medical students, residents and fellows who have education loans to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education.
CME Rep. 5, I-18, Appended: Res. 953, I-18, Reaffirmation: A-19, Appended: Res. 316, A-19

Cost and Financing of Medical Education and Availability of First Year Residency Positions H-305.988
Our AMA:
1. believes that medical schools should further develop an information system based on common definitions to display the costs associated with undergraduate medical education;
2. in studying the financing of medical schools, supports identification of those elements that have implications for the supply of physicians in the future;
3. believes that the primary goal of medical school is to educate students to become physicians and that despite the economies necessary to survive in an era of decreased funding, teaching functions must be maintained even if other commitments need to be reduced;
4. believes that a decrease in student enrollment in medical schools may not result in proportionate reduction of expenditures by the school if quality of education is to be maintained;
5. supports continued improvement of the AMA information system on expenditures of medical students to determine which items are included, and what the ranges of costs are;
6. supports continued study of the relationship between medical student indebtedness and career choice;
7. believes medical schools should avoid counterbalancing reductions in revenues from other sources through tuition and student fee increases that compromise their ability to attract students from diverse backgrounds;
8. supports expansion of the number of affiliations with appropriate hospitals by institutions with accredited residency programs;
9. encourages for profit-hospitals to participate in medical education and training;
10. supports AMA monitoring of trends that may lead to a reduction in compensation and benefits provided to resident physicians;
11. encourages all sponsoring institutions to make financial information available to help residents manage their educational indebtedness; and
12. will advocate that resident and fellow trainees should not be financially responsible for their training.
CME Rep. A, I-83, Reaffirmed: CLRPD Rep. 1, I-93, Res. 313, I-95, Reaffirmed: CME Rep. 13, A-97, Modified: CME Rep. 7, A-05, Modified: CME Rep. 13, A-06, Appended: Res. 321, A-15, Reaffirmed: CME Rep. 5, A-16, Modified: CME Rep. 4, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 309
(N-21)

Introduced by: Medical Student Section

Subject: Protecting Medical Student Access to Abortion Education and Training

Referred to: Reference Committee C

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1 Whereas, Abortion is a legal medical procedure in the United States as a result of the 1973 U.S.
2 Supreme Court decision in *Roe v. Wade* recognizing a woman's constitutional right to an
3 abortion[1]; and
4
5 Whereas, The U.S. Supreme Court has reaffirmed the right to an abortion in subsequent
6 decisions holding that a state cannot ban abortion before viability, the point at which a fetus can
7 survive outside the uterus, and that any restriction on abortion after viability must contain
8 exceptions to protect the life and health of the woman[2]; and
9
10 Whereas, Following the national legalization of abortion with *Roe v. Wade* and the resultant
11 increase in physician education and skill regarding pregnancy termination procedures, deaths
12 from legal abortions declined fivefold[3]; and
13
14 Whereas, Nearly half (45%) of all pregnancies among U.S. women are unintended, and about 4
15 in 10 of these unintended pregnancies were terminated by abortion[4]; and
16
17 Whereas, Sixteen percent of all pregnancies (excluding miscarriages) in 2015 ended in
18 abortion[5]; and
19
20 Whereas, Approximately 638,169 abortions were reported to the CDC in 2015[5]; and
21
22 Whereas, The abortion rate in 2015 was 11.8 abortions per 1,000 women aged 15–44[5]; and
23
24 Whereas, It is estimated one in 20 U.S. women (5%) will have an abortion by age 20, about one
25 in five women (19%) will have an abortion by age 30, and about one in four women (24%) will
26 have an abortion by age 45[6]; and
27
28 Whereas, These numbers may be even higher given that underreporting of abortions is
29 common in nationally representative surveys[7]; and
30
31 Whereas, Pregnancy options counseling, which is defined as providing non-directive, evidence-
32 based information to newly diagnosed pregnant women about their options for continuing or
33 terminating a pregnancy and referrals as necessary, is an integral part of the public health
34 prevention framework for addressing unintended pregnancy and is considered a clinical best
35 practice in the United States[8,9]; and

Whereas, A study analyzing data from the Medical Expenditure Panel Survey from 2002-2011 found that among reproductive-age women, 42.6% were found to receive care including, but not limited to, pregnancy care from solely a family physician, an additional 21.5% received care from a family physician or general internist in addition to receiving care from an OB/GYN, and 28.6% received their care from solely an OB/GYN[10]; and

Whereas, A 2018 study analyzing data from the Nationwide Emergency Department Sample Survey from 2009-2013 found that among all Emergency Department (ED) visits by women aged 15–49 (189,480,685), 0.01% (27,941) were abortion-related[11]; and

Whereas, The large number of abortion-related ED visits demonstrates that many different types of physicians, not just abortion providers, may have to counsel patients on abortion options and/or care for patients whose health has been affected by an abortion[11]; and

Whereas, Recent studies have found U.S. medical students may be under-prepared to address essential sexual health issues in future clinical practice and have recommended increased integration of sexual health curricula into medical schools' curriculum specifically in the area of family planning[12-14]; and

Whereas, A 2009 study found that only 60% of U.S. medical schools surveyed reported any type of preclinical abortion-related education[15]; and

Whereas, A 2005 study found that 17% of clerkship directors surveyed reported no formal education regarding abortion either in the preclinical or clinical years and 23% reported no formal abortion education provided during third-year OB-GYN rotations[16]; and

Whereas, A 2011 survey of 131 third-year medical students at the University of Colorado found that while 80% wanted didactic training on abortion, 57% reported no formal didactic training on abortion, only 24% had rotated through a clinic that provided abortion, and 45% reported unsatisfactory clinical opportunities with regards to abortion training[17]; and

Whereas, A 2015 study of 4th year medical students taking a family planning elective found that 72% of the students reported taking the elective due to a need for greater exposure to family planning care, 48% indicated the elective was necessary to obtain knowledge not available to them during their third-year clerkships, and 21% reported taking the elective in order to learn about abortions and how to perform them as they were not previously given this education[18]; and

Whereas, A 2014 study found that among 362 OB-GYN residents, representing 161 of the 240 OBGYN residency programs within the U.S., 54% reported routine training on abortion, 30% reported opt-in training, and 16% reported that no abortion training was available[19]; and

Whereas, A 2018 study surveying 190 OBGYN residency program directors representing 79% of all OBGYN residency directors found that 64% reported routine abortion training with dedicated time was offered within their residency program, 31% reported only optional abortion training being offered, and 5% reported abortion training was not available[20]; and

Whereas, The American College of Obstetricians and Gynecologists formally recommends integrated medical education on abortion and universal opt-out training policies for medical students and residents[21]; and

Whereas, The ACGME Review Committee for Obstetrics and Gynecology has stated "All programs must have an established curriculum for family planning, including for complications of abortions and provisions for the opportunity for direct procedural training in terminations of pregnancy for those residents who desire it"[22]; and

Whereas, The ACGME Review Committee for Obstetrics and Gynecology stated in a 2017 report that programs must allow residents to "opt out" rather than "opt in" to family planning curriculum, education, and training which includes abortions and that the Committee would consider a program with an "opt out" curriculum to be in substantial compliance with the requirements whereas a program with an "opt in" curriculum would be non-compliant with the requirements[22]; and

Whereas, The Association of American Medical Colleges (AAMC) which sponsors, in partnership with the AMA, the Liaison Committee on Medical Education (LCME) has affirmed its support for comprehensive options counseling in regard to reproductive care and its support of the ACGME's guidelines for offering opt-out abortion education[23]; and

Whereas, The AMA sued the Trump Administration over a new executive order that prevents clinics from receiving Title X funding if they provide, counsel patients regarding, or refer patients out for abortions, which demonstrates the AMA's consistent support for access to abortion and comprehensive options counseling that includes abortion[24]; therefore be it

RESOLVED, That our American Medical Association amend policy H-295.923, "Medical Training and Termination of Pregnancy," by addition and deletion to read as follows:

H-295.923 – MEDICAL TRAINING AND TERMINATION OF PREGNANCY
1. Our AMA supports the education of medical students, residents and young physicians about the need for physicians who provide termination of pregnancy services, the medical and public health importance of access to safe termination of pregnancy, and the medical, ethical, legal and psychological principles associated with termination of pregnancy.
2.~~,~~ ~~a~~ Although observation of, attendance at, or any direct or indirect participation in ~~an~~ abortion procedures should not be required~~.~~, our AMA does support opt-out curriculum on abortion education. Further, the AMA supports the opportunity for medical students and residents to learn procedures for termination of pregnancy and opposes efforts to interfere with or restrict the availability of this training.
~~2~~3. Our AMA encourages the Accreditation Council for Graduate Medical Education to better enforce compliance with the standardization of abortion training opportunities as per the requirements set forth by the Review Committee for Obstetrics and Gynecology and the American College of Obstetricians and Gynecologists' recommendations. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Recent legislative changes have made essentially all abortion illegal in Texas with bounties and imprisonment for physicians who perform this medical procedure for their patients, and several other states have plans to enact similar legislation. Not only does this legislation violate the privacy of the patient-physician relationship and take away the rights of patients and physicians to decide the best healthcare, it also prevents residents and students in those states from being able to learn this medical procedure. Medical students and residents training in women's health will be behind their peers in understanding this procedure, and Texas, and states following suit, may become an undesirable place for training for aspiring women's health physicians.

This is a pivotal moment for women's healthcare, and we need to be able to respond adequately with policy stances that encompass all of the harms of Texas' anti-abortion laws. This resolution gives our AMA policy protecting the rights of trainees who wish to do so to learn about this medical procedure. Given the current circumstances, we believe this is a high-priority resolution which should be heard at this meeting.

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RELEVANT AMA POLICY

Medical Training and Termination of Pregnancy H-295.923

1. Our AMA supports the education of medical students, residents and young physicians about the need for physicians who provide termination of pregnancy services, the medical and public health importance of access to safe termination of pregnancy, and the medical, ethical, legal and psychological principles associated with termination of pregnancy, although observation of, attendance at, or any direct or indirect participation in an abortion should not be required. Further, the AMA supports the opportunity for residents to learn procedures for termination of pregnancy and opposes efforts to interfere with or restrict the availability of this training.
2. Our AMA encourages the Accreditation Council for Graduate Medical Education to better enforce compliance with the standardization of abortion training opportunities as per the requirements set forth by the Review Committee for Obstetrics and Gynecology and the American College of Obstetricians and Gynecologists' recommendations.

Res. 315, I-94; Reaffirmed: CME Rep. 2, A-04; Modified: CME Rep. 2, A-14; Modified: CME Rep. 1, A-15; Appended: Res. 957, I-17

Abortion H-5.995

Our AMA reaffirms that: (1) abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in conformance with standards of good medical practice and the Medical Practice Act of his state; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment. Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally held moral principles. In these circumstances, good medical practice requires only that the physician or other professional withdraw from the case, so long as the withdrawal is consistent with good medical practice.

Sub. Res. 43, A-73; Reaffirmed: I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed by Sub. Res. 208, I-96; Reaffirmed by BOT Rep. 26, A-97; Reaffirmed: CMS Rep. 1, I-00; Reaffirmed: CEJA Rep. 6, A-10; Reaffirmed: CEJA Rep. 01, A-20

E-4.2.7 Abortion

The Principles of Medical Ethics of the AMA do not prohibit a physician from performing an abortion in accordance with good medical practice and under circumstances that do not violate the law.

Issued: 2016

Oppose the Criminalization of Self-Induced Abortion H-5.980

Our AMA: (1) opposes the criminalization of self-induced abortion 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 abortion.

Res. 007, A-18

Training in Reproductive Health Topics as a Requirement for Accreditation of Family Residencies D-310.954
Our AMA: (1) will work with the Accreditation Council for Graduate Medical Education to protect patient access to important reproductive health services by advocating for all family medicine residencies to provide comprehensive women's health including training in contraceptive counseling, family planning, and counseling for unintended pregnancy; and (2) encourages the ACGME to ensure greater clarity when making revisions to the educational requirements and expectations of family medicine residents in comprehensive women's health topics.
Res. 317, A-13

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 310
(N-21)

Introduced by: Resident and Fellow Section

Subject: Resident and Fellow Access to Fertility Preservation

Referred to: Reference Committee C

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1 Whereas, The average age at completion of medical training in the United States is
2 approximately 31.6 years overall[1] and 36.8 years for surgical trainees[2]; and
3
4 Whereas, Female fertility is known to decrease substantially after age 35,[3,4] with a nearly 50%
5 drop from the early 20s to late 30s[5]; and
6
7 Whereas, Female physicians have a chance of infertility that is twice that of the general
8 population (24.1% vs. 10.9%), with an average age at diagnosis of 33.7 years[1]; and
9
10 Whereas, The demands of residency increase the risk of pregnancy complications, with a higher
11 rate of gestational hypertension, placental abruption, preterm labor, and intrauterine growth
12 restriction among female residents[6–8]; and
13
14 Whereas, A majority of recent trainees perceive a stigma associated with pregnancy during
15 training[9] and have concerns about workplace support,[10] which may deter medical students from
16 choosing a career in a surgical or other field with longer and demanding training; and
17
18 Whereas, Approximately one third of program directors have reported discouraging pregnancy
19 among residents in surgical training programs[10]; and
20
21 Whereas, Oocyte cryopreservation is an established method of preserving fertility[11] that can
22 cost $10,000 per cycle, often with multiple cycles required, and $500 per year for storage,[12] in
23 addition to requiring timely injection of ovarian stimulation medications and numerous outpatient
24 visits for cycle monitoring and egg retrieval[13]; and
25
26 Whereas, Companies such as Google, Apple, and Facebook have been offering oocyte
27 cryopreservation benefits to their workforce, who are similarly largely of reproductive age, for
28 several years[14]; therefore be it
29
30 RESOLVED, That our American Medical Association support education for residents and
31 fellows regarding the natural course of female fertility in relation to the timing of medical
32 education, and the option of fertility preservation and infertility treatment (New HOD Policy); and
33 be it further
34
35 RESOLVED, That our AMA advocate inclusion of insurance coverage for fertility preservation
36 and infertility treatment within health insurance benefits for residents and fellows offered through
37 graduate medical education programs (Directive to Take Action); and be it further

1 RESOLVED, That our AMA support the accommodation of residents and fellows who elect to
2 pursue fertility preservation and infertility treatment, including the need to attend medical visits
3 to complete the oocyte preservation process and to administer medications in a time-sensitive
4 fashion. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 10/12/21

AUTHORS STATEMENT OF PRIORITY

Every extra year of training is a sacrifice when it comes to fertility. Recent news stories, including in the New York Times, have highlighted the emotional and physical difficulties affecting our colleagues. As policies are changing around the country regarding trainee benefits, bills of rights, and compensation, a discussion of this resolution by the HOD would be timely and guide the AMA with policy it does not currently have. This policy applies to most current trainees and future physicians.

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RELEVANT AMA POLICY

Disclosure of Risk to Fertility with Gonadotoxic Treatment H-425.967

Our AMA: (1) supports as best practice the disclosure to cancer and other patients of risks to fertility when gonadotoxic treatment is used; and (2) supports ongoing education for providers who counsel patients who may benefit from fertility preservation.
Citation: Res. 512, A-19

Infertility and Fertility Preservation Insurance Coverage H-185.990

1. Our AMA encourages third party payer health insurance carriers to make available insurance benefits 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.
Citation: Res. 150, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Appended: Res. 114, A-13; Modified: Res. 809, I-14

Infertility Benefits for Veterans H-510.984
1. Our AMA supports lifting the congressional ban on the Department of Veterans Affairs (VA) from covering in vitro fertilization (IVF) costs for veterans who have become infertile due to service-related injuries.
2. Our AMA encourages interested stakeholders to collaborate in lifting the congressional ban on the VA from covering IVF costs for veterans who have become infertile due to service-related injuries.
3. Our AMA encourages the Department of Defense (DOD) to offer service members fertility counseling and information on relevant health care benefits provided through TRICARE and the VA at pre-deployment and during the medical discharge process.
4. Our AMA supports efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address infertility due to service-related injuries. Citation: CMS Rep. 01, I-16Appended: Res. 513, A-19

Right for Gamete Preservation Therapies H-65.956
1. Fertility preservation services are recognized by our AMA as an option for the members of the transgender and non-binary community who wish to preserve future fertility through gamete preservation prior to undergoing gender affirming medical or surgical therapies.
2. Our AMA supports the right of transgender or non-binary individuals to seek gamete preservation therapies. Citation: Res. 005, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 311
(N-21)

Introduced by: Resident and Fellow Section

Subject: Improving Access to Physician Health Programs for Physician Trainees

Referred to: Reference Committee C

Whereas, It is now commonly accepted that burnout is a significant issue among US physicians who experience higher levels of burnout than other US workers and groups that attain a similar higher-level of education[1]; and

Whereas, A study that further looked at burnout among medical students, residents, and early career physicians suggested an even higher risk among physician trainees[2]; and

Whereas, The authors reported that medical students were most susceptible to depression and suicidal ideation while residents had the highest fatigue. Medical students and residents/fellows had higher emotional exhaustion in comparison to early career physicians, with burnout and depersonalization reaching a peak during residency and lowest in early career[3-5]; and

Whereas, Burnout has far-reaching negative effects that can eventually lead to physician impairment through its association with alcohol abuse/dependence, worsened suicidal ideation, and increased self-perception of medical errors[3-5]; and

Whereas, Maintaining mental health and wellness across the entire lifespan of a physician's career is important but can be especially critical in the stages of training from medical school to fellowship; and

Whereas, The main governing bodies of medical education have implemented measures to address the poor mental health reported among physicians-in-training; and

Whereas, There is a need to expand advocacy for physician trainee mental health by promoting and protecting resident and fellow access to physician health programs; and

Whereas, PHPs are unique and evidence-based solutions to rehabilitate and manage impairment for licensed physicians; therefore be it

RESOLVED, That our American Medical Association work with the Accreditation Council for Graduate Medical Education and other relevant stakeholders to ensure physician health programs (PHPs) are promoted by training programs and transparent information is disseminated by programs to their trainees about PHP reporting requirements, benefits of participation, and limitations of such programs (Directive to Take Action); and be it further

RESOLVED, That our AMA recognize PHPs as one of many resources available to support physician trainee mental health. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000
Received: 10/12/21

AUTHORS STATEMENT OF PRIORITY

Physician trainees, including medical students, residents and fellows, are at increased risk of burnout even compared to practicing physicians, who are at increased risk compared to the rest of the population. Residents and fellows, who are at the early stage of the career, could benefit from established physician health programs to support their mental health. AMA advocacy on this important topic will have long-standing benefits for trainees, now and in the future and expand existing policy in important ways.

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RELEVANT AMA POLICY

H-405.961 Physician Health Programs

1. Our AMA affirms the importance of physician health and the need for ongoing education of all physicians and medical students regarding physician health and wellness.
2. Our AMA encourages state medical societies to collaborate with the state medical boards to: (a) develop strategies to destigmatize physician burnout; and (b) encourage physicians to participate in the state's physician health program without fear of loss of license or employment.

Citation: CSAPH Rep. 2, A-11; Reaffirmed in lieu of Res. 412, A-12; Reaffirmed: BOT action in response to referred for decision Res. 403, A-12; Modified: BOT Rep. 15, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 312
(N-21)

Introduced by: Resident and Fellow Section

Subject: Accountable Organizations to Resident and Fellow Trainees

Referred to: Reference Committee C

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1 Whereas, The stated mission of the Accreditation Council for Graduate Medical Education
2 (ACGME) is to, "improve healthcare and population health by assessing and advancing the
3 quality of resident physicians' education through accreditation"[1]; and
4
5 Whereas, To achieve its mission the ACGME has determined that it has two main purposes:
6 "(1) to establish and maintain accreditation standards that promote the educational quality of
7 residency and subspecialty training programs; and (2) to promote conduct of the residency
8 educational mission with sensitivity to the safety of care rendered to patients and in a humane
9 environment that fosters the welfare, learning, and professionalism of residents,"[1]; and
10
11 Whereas, While the ACGME has taken steps to advocate for residents, its ability to effectively
12 and timely work on their behalf is limited by "blunt tools" related to removal of accreditation and
13 delay in providing feedback to programs[3]; and
14
15 Whereas, Our AMA Residents and Fellows' Bill of Rights (H-310.912) establishes that residents
16 and fellows have rights to: (1) have a safe workspace that enables them to fulfill their clinical
17 duties and educational obligations; (2) defend themselves against any allegations presented by
18 a patient, health professional, or training program in accordance with due process guidelines
19 established by the AMA; (3) be able to file a formal complaint with the ACGME to address
20 program violations of residency training requirements without fear of recrimination and with the
21 guarantee of due process; and (4) confidentially evaluate faculty and programs and expect that
22 the training program will address deficiencies by these evaluations in a timely fashion[4]; and
23
24 Whereas, Resident and fellow trainees still endure suboptimal training conditions, with recourse
25 to address these issues limited by multiple factors including a high debt burden and fear of their
26 program losing accreditation thus affecting future career prospects, which ultimately makes
27 reporting even gross ACGME guideline infractions difficult to encourage[5,6]; and
28
29 Whereas, During the COVID-19 pandemic, residents and fellow trainees have been particularly
30 susceptible to poor conditions including limited availability of personal protective equipment
31 (PPE), longer work hours, lack of hazard pay or similar programs, redeployment into other
32 specialties which may or may not be relevant to education in their own specialty, and difficulty in
33 securing workers' compensation in the event of severe illness, with many programs revoking
34 promised stipend increases[6]; and
35
36 Whereas, The rate of closure of family medicine residency programs is increasing, and the
37 Federation of State Medical Boards (FSMB) has records of over 50 hospitals with accredited
38 training programs that have closed, with indications that more closures can be expected across
39 the country in multiple specialties[7,8]; and

Whereas, As exemplified by the Hahnemann University Hospital closure, residents and fellow trainees are vulnerable to the negative effects of hospital closures that threaten the quality and completion of their graduate medical education, financial wellbeing, and legal status within the United States,[9,10]; and

Whereas, Numerous organizations such as the ACGME, AMA, American Osteopathic Association (AOA), American Board of Medical Specialties (ABMS), Association of American Medical Colleges (AAMC), Council of Medical Specialty Societies, National Board of Medical Examiners (NBME), Pennsylvania Medical Society (PAMED), Philadelphia County Medical Society (PCMS), and Educational Commission for Foreign Medical Graduates (ECFMG) responded to the Hahnemann closure as well as other residency closures with offers of legal assistance, grants, visa assistance, tail-insurance coverage, and other forms of support[11]; and

Whereas, The majority of funding for Graduate Medical Education (GME) is through Medicare and Medicaid, with additional funding through the U.S. Department of Veteran Affairs (VA) and Health Resources and Services Administration (HRSA), as well as private hospital funding[12]; and

Whereas, The Centers for Medicare & Medicaid Services (CMS) is tasked with distributing the majority of GME funding, but is not responsible for overseeing the quality of training programs nor the wellness or treatment of trainees[12]; and

Whereas, None of the organizations that responded to the Hahnemann residency closures were required to by law, nor was the response coordinated, regulated, or monitored by any type of oversight organization with regards to resident and fellow interests, and an ACGME investigation of the closure of the Hahnemann University Hospital found that no existing organizations represented resident and fellow interests to the exclusion of other stakeholder interests.[3,11]; therefore be it

RESOLVED, That our American Medical Association work with relevant stakeholders to: (1) determine which organizations or governmental entities are best suited for being permanently responsible for resident and fellow interests without conflicts of interests; (2) determine how organizations can be held accountable for fulfilling their duties to protect the rights and wellbeing of resident and fellow trainees as detailed in the Residents and Fellows' Bill of Rights; (3) determine methods of advocating for residents and fellows that are timely and effective without jeopardizing trainees' current and future employability; (4) study and report back by the 2022 Annual Meeting on how such an organization may be created, in the event that no organizations or entities are identified that meet the above criteria; and (5) determine transparent methods to communicate available residency positions to displaced residents. (Directive to Take Action)

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

Received: 10/12/21

AUTHORS STATEMENT OF PRIORITY

The closure of the Hahnemann University Hospital and the residencies there highlighted the vulnerability of residents and fellows, particularly given the effect on their ability to complete their training, financial wellbeing, and legal status. While many organizations, including the AMA, stepped in to support residents, there is no single permanent accountable organization to represent resident and fellow interests without additional conflicts of interest. This resolution asks the AMA to take a leadership role in supporting residents and fellows by identifying such an organization and recommend strategies that can help in these situations in the future.

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RELEVANT AMA POLICY

Residents and Fellows' Bill of Rights H-310.912

1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.
2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.
3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.
4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for

funds; b) encourages a system of expedited repayment for purchases of $200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.
5. Our AMA encourages teaching institutions to explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation.
6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or “protected time” for resident and fellow education by “core faculty,” program directors, and assistant/associate program directors.
7. Our AMA adopts the following ‘Residents and Fellows’ Bill of Rights’ as applicable to all resident and fellow physicians in ACGME-accredited training programs:
RESIDENT/FELLOW PHYSICIANS’ BILL OF RIGHTS
Residents and fellows have a right to:
A. An education that fosters professional development, takes priority over service, and leads to independent practice.
With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.
B. Appropriate supervision by qualified faculty with progressive resident responsibility toward independent practice.
With regard to supervision, residents and fellows should expect supervision by physicians and non-physicians who are adequately qualified and which allows them to assume progressive responsibility appropriate to their level of education, competence, and experience. It is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents.
C. Regular and timely feedback and evaluation based on valid assessments of resident performance.
With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested

by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.
D. A safe and supportive workplace with appropriate facilities.
With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.
E. Adequate compensation and benefits that provide for resident well-being and health.
(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.
(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.
(3) With Regard to Benefits, Residents and Fellows Must Be Fully Informed of and Should Receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.
F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.
With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, “Resident/Fellow Clinical and Educational Work Hours,” for more information.
G. Due process in cases of allegations of misconduct or poor performance.
With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.
H. Access to and protection by institutional and accreditation authorities when reporting violations.
With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the

guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.
Citation: CME Rep. 8, A-11Appended: Res. 303, A-14Reaffirmed: Res. 915, I-15Appended: CME Rep. 04, A-16Modified: CME Rep. 06, I-18Appended: Res. 324, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 313
(N-21)

Introduced by: Resident and Fellow Section

Subject: Establishing Minimum Standards for Parental Leave During Graduate Medical Education Training

Referred to: Reference Committee C

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1 Whereas, A substantial number of trainees become parents during their training as a resident or
2 fellow; and
3
4 Whereas, PGY-1 trainees will not meet eligibility for the Family Medical Leave Act, which has a
5 12-month employment eligibility threshold; and
6
7 Whereas, Unlike other industries, such as technology and law, "there is no standardized
8 approach to parental leave across GME programs" [1]; and
9
10 Whereas, The Accreditation Council for Graduate Medical Education (ACGME) does not
11 establish minimum standards for duration of parental leave for trainees; and
12
13 Whereas, A lack of minimum national standards may result in some trainees receiving
14 substandard resources and benefits[2]; and
15
16 Whereas, Current AMA policy (H-405.960) encourages residency programs, among other
17 stakeholders, to incorporate a "six-week minimum leave allowance;" therefore be it
18
19 RESOLVED, That our American Medical Association support current efforts by the Accreditation
20 Council for Graduate Medical Education (ACGME), the American Board of Medical Specialties
21 (ABMS), and other relevant stakeholders to develop and align minimum requirements for
22 parental leave during residency and fellowship training and urge these bodies to adopt minimum
23 requirements in accordance with policy H-405.960 (New HOD Policy); and be it further
24
25 RESOLVED, That our AMA petition the ACGME to recommend strategies to prevent undue
26 burden on trainees related to parental leave; (Directive to Take Action)
27
28 RESOLVED, That our AMA petition the ACGME, ABMS, and other relevant stakeholders to
29 develop specialty specific pathways for residents and fellows in good standing, who take
30 maximum allowable parental leave, to complete their training within the original time frame.
31 (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 10/12/21

AUTHORS STATEMENT OF PRIORITY

As conversations are actively occurring around the country regarding trainee compensation, bills of rights, and benefits, discussion of this resolution by the HOD would be timely and guide the AMA with policy it does not currently have. Specifically, the ACGME is actively working on this and not having AMA policy on an issue that affects a significant number of trainees while discussions are actively being had by decision makers makes this policy particularly relevant and timely. This policy applies to current and all future physician trainees.

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RELEVANT AMA POLICY:

Principles for Graduate Medical Education H-310.929

Our AMA urges the Accreditation Council for Graduate Medical Education (ACGME) to incorporate these principles in its Institutional Requirements, if they are not already present.
(1) PURPOSE OF GRADUATE MEDICAL EDUCATION AND ITS RELATIONSHIP TO PATIENT CARE. There must be objectives for residency education in each specialty that promote the development of the knowledge, skills, attitudes, and behavior necessary to become a competent practitioner in a recognized medical specialty.
Exemplary patient care is a vital component for any residency/fellowship program. Graduate medical education enhances the quality of patient care in the institution sponsoring an accredited program. Graduate medical education must never compromise the quality of patient care. Institutions sponsoring residency programs and the director of each program must assure the highest quality of care for patients and the attainment of the program's educational objectives for the residents.
(2) RELATION OF ACCREDITATION TO THE PURPOSE OF RESIDENCY TRAINING. Accreditation requirements should relate to the stated purpose of a residency program and to the knowledge, skills, attitudes, and behaviors that a resident physician should have on completing residency education.
(3) EDUCATION IN THE BROAD FIELD OF MEDICINE. GME should provide a resident physician with broad clinical experiences that address the general competencies and professionalism expected of all physicians, adding depth as well as breadth to the competencies introduced in medical school.
(4) SCHOLARLY ACTIVITIES FOR RESIDENTS. Graduate medical education should always occur in a milieu that includes scholarship. Resident physicians should learn to appreciate the importance of scholarly activities and should be knowledgeable about scientific method. However, the accreditation requirements, the structure, and the content of graduate medical education should be directed toward preparing physicians to practice in a medical specialty. Individual educational opportunities beyond the residency program should be provided for resident physicians who have an interest in, and show an aptitude for, academic and research pursuits. The continued development of evidence-based medicine in the graduate medical education curriculum reinforces the integrity of the scientific method in the everyday practice of clinical medicine.
(5) FACULTY SCHOLARSHIP. All residency faculty members must engage in scholarly activities and/or scientific inquiry. Suitable examples of this work must not be limited to basic biomedical research. Faculty can comply with this principle through participation in scholarly meetings, journal club, lectures, and similar academic pursuits.
(6) INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS. Specialty-specific GME must operate under a system of institutional governance responsible for the development and

implementation of policies regarding the following; the initial authorization of programs, the appointment of program directors, compliance with the accreditation requirements of the ACGME, the advancement of resident physicians, the disciplining of resident physicians when this is appropriate, the maintenance of permanent records, and the credentialing of resident physicians who successfully complete the program. If an institution closes or has to reduce the size of a residency program, the institution must inform the residents as soon as possible. Institutions must make every effort to allow residents already in the program to complete their education in the affected program. When this is not possible, institutions must assist residents to enroll in another program in which they can continue their education. Programs must also make arrangements, when necessary, for the disposition of program files so that future confirmation of the completion of residency education is possible. Institutions should allow residents to form housestaff organizations, or similar organizations, to address patient care and resident work environment concerns. Institutional committees should include resident members.
(7) COMPENSATION OF RESIDENT PHYSICIANS. All residents should be compensated. Residents should receive fringe benefits, including, but not limited to, health, disability, and professional liability insurance and parental leave and should have access to other benefits offered by the institution. Residents must be informed of employment policies and fringe benefits, and their access to them. Restrictive covenants must not be required of residents or applicants for residency education.
(8) LENGTH OF TRAINING. The usual duration of an accredited residency in a specialty should be defined in the “Program Requirements.” The required minimum duration should be the same for all programs in a specialty and should be sufficient to meet the stated objectives of residency education for the specialty and to cover the course content specified in the Program Requirements. The time required for an individual resident physician’s education might be modified depending on the aptitude of the resident physician and the availability of required clinical experiences.
(9) PROVISION OF FORMAL EDUCATIONAL EXPERIENCES. Graduate medical education must include a formal educational component in addition to supervised clinical experience. This component should assist resident physicians in acquiring the knowledge and skill base required for practice in the specialty. The assignment of clinical responsibility to resident physicians must permit time for study of the basic sciences and clinical pathophysiology related to the specialty.
(10) INNOVATION OF GRADUATE MEDICAL EDUCATION. The requirements for accreditation of residency training should encourage educational innovation and continual improvement. New topic areas such as continuous quality improvement (CQI), outcome management, informatics and information systems, and population-based medicine should be included as appropriate to the specialty.
(11) THE ENVIRONMENT OF GRADUATE MEDICAL EDUCATION. Sponsoring organizations and other GME programs must create an environment that is conducive to learning. There must be an appropriate balance between education and service. Resident physicians must be treated as colleagues.
(12) SUPERVISION OF RESIDENT PHYSICIANS. Program directors must supervise and evaluate the clinical performance of resident physicians. The policies of the sponsoring institution, as enforced by the program director, and specified in the ACGME Institutional Requirements and related accreditation documents, must ensure that the clinical activities of each resident physician are supervised to a degree that reflects the ability of the resident physician and the level of responsibility for the care of patients that may be safely delegated to the resident. The sponsoring institution’s GME Committee must monitor programs’ supervision of residents and ensure that supervision is consistent with: (A) Provision of safe and effective patient care; (B) Educational needs of residents; (C) Progressive responsibility appropriate to residents’ level of education, competence, and experience; and (D) Other applicable Common and specialty/subspecialty specific Program Requirements. The program director, in cooperation with the institution, is responsible for maintaining work schedules for each resident

based on the intensity and variability of assignments in conformity with ACGME Review Committee recommendations, and in compliance with the ACGME clinical and educational work hour standards. Integral to resident supervision is the necessity for frequent evaluation of residents by faculty, with discussion between faculty and resident. It is a cardinal principle that responsibility for the treatment of each patient and the education of resident and fellow physicians lies with the physician/faculty to whom the patient is assigned and who supervises all care rendered to the patient by residents and fellows. Each patient's attending physician must decide, within guidelines established by the program director, the extent to which responsibility may be delegated to the resident, and the appropriate degree of supervision of the resident's participation in the care of the patient. The attending physician, or designate, must be available to the resident for consultation at all times.
(13) EVALUATION OF RESIDENTS AND SPECIALTY BOARD CERTIFICATION. Residency program directors and faculty are responsible for evaluating and documenting the continuing development and competency of residents, as well as the readiness of residents to enter independent clinical practice upon completion of training. Program directors should also document any deficiency or concern that could interfere with the practice of medicine and which requires remediation, treatment, or removal from training. Inherent within the concept of specialty board certification is the necessity for the residency program to attest and affirm to the competence of the residents completing their training program and being recommended to the specialty board as candidates for examination. This attestation of competency should be accepted by specialty boards as fulfilling the educational and training requirements allowing candidates to sit for the certifying examination of each member board of the ABMS.
(14) GRADUATE MEDICAL EDUCATION IN THE AMBULATORY SETTING. Graduate medical education programs must provide educational experiences to residents in the broadest possible range of educational sites, so that residents are trained in the same types of sites in which they may practice after completing GME. It should include experiences in a variety of ambulatory settings, in addition to the traditional inpatient experience. The amount and types of ambulatory training is a function of the given specialty.
(15) VERIFICATION OF RESIDENT PHYSICIAN EXPERIENCE. The program director must document a resident physician's specific experiences and demonstrated knowledge, skills, attitudes, and behavior, and a record must be maintained within the institution.
Citation: CME Rep. 9, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: CME Rep. 14, A-09; Modified: CME Rep. 06, I-18

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 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. 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. 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. Citation: CCB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14

Parental Leave H-405.954

1. Our AMA encourages the study of the health implications among patients if the United States were to modify one or more of the following aspects of the Family and Medical Leave Act (FMLA): a reduction in the number of employees from 50 employees; an increase in the number of covered weeks from 12 weeks; and creating a new benefit of paid parental leave.
2. Our AMA will study the effects of FMLA expansion on physicians in varied practice environments.
3. Our AMA: (a) encourages employers to offer and/or expand paid parental leave policies; (b) encourages state medical associations to work with their state legislatures to establish and promote paid parental leave policies; (c) advocates for improved social and economic support for paid family leave to care for newborns, infants and young children; and (d) advocates for federal tax incentives to support early child care and unpaid child care by extended family members. Citation: Res. 215, I-16; Appended: BOT Rep. 11, A-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 314
(N-21)

Introduced by: Resident and Fellow Section

Subject: Updating Current Wellness Policies and Improving Implementation

Referred to: Reference Committee C

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1 Whereas, Previous AMA-RFS policy asked our AMA to study resident burnout prevention and
2 wellness strategies (291.015R); and
3
4 Whereas, This same policy was reaffirmed at I-18 (291.036R); and
5
6 Whereas, Current Accreditation Council for Graduate Medical Education (ACGME) policy does
7 include program requirements for specific aspects, but is unclear about what satisfies those
8 requirements[1]; and
9
10 Whereas, New data exists regarding the efficacy of various specific burnout prevention
11 strategies[2-7]; and
12
13 Whereas, Some organizations such as Stanford Medicine have been leaders in the field of
14 physician wellness and burnout prevention through research, novel approaches and curriculum
15 and support such as House Staff Wellbeing Panel and it may be prudent to apply these
16 strategies into ACGME common requirements of residency programs[8]; and
17
18 Whereas, These specific strategies may be a more effective way to mitigate burnout than the
19 current ACGME policy as listed; therefore be it
20
21 RESOLVED, That our American Medical Association work with the Accreditation Council on
22 Graduate Medical Education and other appropriate stakeholders in the creation of an evidence-
23 based best practices reference to address trainee burnout prevention and mitigation. (Directive
24 to Take Action)

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

Received: 10/12/21

AUTHORS STATEMENT OF PRIORITY

This policy is lower priority. Although there is much focus on wellness in the era of COVID-19, this has been a long-standing concern for which too little has been done to affect change, and it is now taking its toll. Although this is less urgent due to the declining pandemic, medicine has struggled with how to address burnout and sustain wellness for years and there is no better place to begin to address this than at the GME level.

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RELEVANT AMA POLICY

Code of Medical Ethics
9.3.1 Physician Health & Wellness
When physician health or wellness is compromised, so may the safety and effectiveness of the medical care provided. To preserve the quality of their performance, physicians have a responsibility to maintain their health and wellness, broadly construed as preventing or treating acute or chronic diseases, including mental illness, disabilities, and occupational stress.
To fulfill this responsibility individually, physicians should:
(a) Maintain their own health and wellness by:
(i) following healthy lifestyle habits;
(ii) ensuring that they have a personal physician whose objectivity is not compromised.
(b) Take appropriate action when their health or wellness is compromised, including:
(i) engaging in honest assessment of their ability to continue practicing safely;
(ii) taking measures to mitigate the problem;
(iii) taking appropriate measures to protect patients, including measures to minimize the risk of transmitting infectious disease commensurate with the seriousness of the disease;
(iv) seeking appropriate help as needed, including help in addressing substance abuse.
Physicians should not practice if their ability to do so safely is impaired by use of a controlled substance, alcohol, other chemical agent or a health condition.
Collectively, physicians have an obligation to ensure that colleagues are able to provide safe and effective care, which includes promoting health and wellness among physicians.
Citation: Issued: 2016

Physician and Medical Student Burnout D-310.968
1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, fellows, and medical students.
2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets
3. Our AMA will encourage partnerships and collaborations with accrediting bodies (e.g., the Accreditation Council for Graduate Medical Education and the Liaison Committee on Medical Education) and other major medical organizations to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students and faculty.
4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.

5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.
6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.
7. Our AMA will encourage medical staffs and/or organizational leadership to anonymously survey physicians to identify local factors that may lead to physician demoralization.
8. Our AMA will continue to offer burnout assessment resources and develop guidance to help organizations and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being.
9. Our AMA will continue to: (a) address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient work flows and regulatory oversight; and (b) develop and promote mechanisms by which physicians in all practices settings can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being.
Citation: CME Rep. 8, A-07; Modified: Res. 919, I-11; Modified: BOT Rep. 15, A-19

Programs on Managing Physician Stress and Burnout H-405.957
1. Our American Medical Association supports existing programs to assist physicians in early identification and management of stress and the programs supported by the AMA to assist physicians in early identification and management of stress will concentrate on the physical, emotional and psychological aspects of responding to and handling stress in physicians' professional and personal lives, and when to seek professional assistance for stress-related difficulties.
2. Our AMA will review relevant modules of the STEPs Forward Program and also identify validated student-focused, high quality resources for professional well-being, and will encourage the Medical Student Section and Academic Physicians Section to promote these resources to medical students.
Citation: Res. 15, A-15; Appended: Res. 608, A-16; Reaffirmed: BOT Rep. 15, A-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 315
(N-21)

Introduced by: Resident and Fellow Section

Subject: Reducing Overall Fees and Making Costs for Licensing, Exam Fees, Application Fees, etc., Equitable for IMGS

Referred to: Reference Committee C

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1 Whereas, United States Medical Licensing Examination (USMLE) fees are steep as a US
2 medical student: Step 1 $645, Step 2 $6451,2; and
3
4 Whereas, USMLE fees are even higher for International Medical Graduates (IMGs): Step 1
5 $975, Step 2 $975[3]; and
6
7 Whereas, If a medical student takes the USMLE Step 1 or 2 exams outside the US, there is an
8 additional delivery fee of the electronic test of $180 for Step 1 and $200 for Step 2[4]; and
9
10 Whereas, In 2020, over 52,000 US MD/DO and IMG applicants applied to residencies (over
11 $38M for US MD/DO med students and over $40M for IMGs in USMLE Step 1 and 2 fees)[5]; and
12
13 Whereas, In 2018, 21,393 graduates applied for Educational Commission for Foreign Medical
14 Graduates (ECFMG) certification and only 9,431 were certified[6]; and
15
16 Whereas, ECFMG certification ($60 in 2013; $150 in 2021) is required to take USMLE Step 3
17 for IMGs: primary source of verification of credentials ($60) + passing USMLE exams[3,7]; and
18
19 Whereas, In 2019, IMGs constituted 22% of physicians in training in residency, yet their costs to
20 apply to become physicians in the US is much greater than their US counterparts[8]; and
21
22 Whereas, During the COVID-19 pandemic and suspension of USMLE Step 2 CS, ECFMG
23 required IMGs to pass an Occupational English Test (OET) ($444) (online courses available for
24 purchase from official OET sites), if students fit within 5 defined pathways ($900)[9,10]; and
25
26 Whereas, Prior to the cancellation of the USMLE Step 2 CS exam, examination fees rose year
27 after year, but even more so for IMGs (~ $1600 in 2020, up from ~$1420 in 2013) compared to
28 US counterparts (~ $1280 in 2020, up from ~$1200 in 2013)[11]; and
29
30 Whereas, ECFMG also provides an alternative way to verify credentials through Electronic
31 Portfolio of International Credentials (EPIC) that costs $130 ($125 in 2020) and $100 ($90 in
32 2020) to confirm each credential and costs $50 to deliver each subsequent EPIC report[12]; and
33
34 Whereas, The ECFMG net assets in 2018 were $151,818,498[13]; therefore be it
35
36 RESOLVED, That our American Medical Association work with all relevant stakeholders to
37 reduce application, exam, licensing fees and related financial burdens for international medical
38 graduates (IMGs) to ensure cost equity with US MD and DO trainees (Directive to Take Action);
39 and be it further

RESOLVED, That our AMA amend current policy H-255.966, "Abolish Discrimination in Licensure of IMGs," by addition to read as follows:

2. Our AMA will continue to work with the Federation of State Medical Boards to encourage parity in licensure requirements, and associated costs, for all physicians, whether U.S. medical school graduates or international medical graduates. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 10/12/21

AUTHORS STATEMENT OF PRIORITY

This policy is lower priority. Our IMG colleagues, who comprise a significant portion of the physician workforce in the US, face additional financial burdens related to extra licensing, application and exam fees on top of the required fees faced by US medical graduates. Parity in licensing and examination requirements is already part of AMA policy, but ensuring parity in the fees associated should be policy as well.

References:

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RELEVANT AMA POLICY

Retirement of the National Board of Medical Examiners Step 2 Clinical Skills Exam for US Medical Graduates: Call for Expedited Action by the American Medical Association D-275.950

Our AMA: (1) will take immediate, expedited action to encourage the National Board of Medical Examiners (NBME), Federation of State Medical Boards (FSMB), and National Board of Osteopathic Medical Examiners (NBOME) to eliminate centralized clinical skills examinations used as a part of state licensure, including the USMLE Step 2 Clinical Skills Exam and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2 - Performance Evaluation Exam; (2) in collaboration with the Educational Commission for Foreign Medical Graduates (ECFMG), will advocate for an equivalent, equitable, and timely pathway for international medical graduates to demonstrate clinical skills competency; (3) strongly encourages all state delegations in the AMA House of Delegates and other interested member organizations of the AMA to engage their respective state medical licensing boards, the Federation of State Medical Boards, their medical schools and other interested credentialling bodies to encourage the elimination of these centralized, costly and low-value exams; and (4) will advocate that any replacement examination mechanisms be instituted immediately in lieu of resuming existing USMLE Step 2-CS and COMLEX Level 2-PE examinations when the COVID-19 restrictions subside.
Citation: Res. 306, I-20

AMA Principles on International Medical Graduates H-255.988
Our AMA supports:
1. Current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.
2. Current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.
3. The AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.
4. Cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
5. Continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.
6. Working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.
7. In cooperation with the ACGME and the FSMB, supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
8. The AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.
9. That special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.
10. That accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.
11. That AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.
12. The requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure.
13. Publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.
14. The participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. The AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.
15. Support studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.
16. AMA membership outreach to IMGs, to include a) using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians; b) publicizing its many relevant resources to all physicians, especially to nonmember IMGs; c) identifying and publicizing AMA resources to respond to inquiries from IMGs; and d) expansion

of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.
17. Recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.
18. Its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.
19. Institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.
20. Informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.
21. U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.
22. The Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.
Citation: BOT Rep. Z, A-86Reaffirmed: Res. 312, I-93Modified: CME Rep. 2, A-03Reaffirmation I-11Reaffirmed: CME Rep. 1, I-13Modified: BOT Rep. 25, A-15Modified: CME Rep. 01, A-16Appended: Res. 304, A-17Modified: CME Rep. 01, I-17Reaffirmation: A-19

Abolish Discrimination in Licensure of IMGs H-255.966
Medical Licensure of International Medical Graduates
1. Our AMA supports the following principles related to medical licensure of international medical graduates (IMGs):
A. State medical boards should ensure uniformity of licensure requirements for IMGs and graduates of U.S. and Canadian medical schools, including eliminating any disparity in the years of graduate medical education (GME) required for licensure and a uniform standard for the allowed number of administrations of licensure examinations.
B. All physicians seeking licensure should be evaluated on the basis of their individual education, training, qualifications, skills, character, ethics, experience and past practice.
C. Discrimination against physicians solely on the basis of national origin and/or the country in which they completed their medical education is inappropriate.
D. U.S. states and territories retain the right and responsibility to determine the qualifications of individuals applying for licensure to practice medicine within their respective jurisdictions.
E. State medical boards should be discouraged from a) using arbitrary and non-criteria-based lists of approved or unapproved foreign medical schools for licensure decisions and b) requiring an interview or oral examination prior to licensure endorsement. More effective methods for evaluating the quality of IMGs' undergraduate medical education should be pursued with the Federation of State Medical Boards and other relevant organizations. When available, the results should be a part of the determination of eligibility for licensure.
2. Our AMA will continue to work with the Federation of State Medical Boards to encourage parity in licensure requirements for all physicians, whether U.S. medical school graduates or international medical graduates.

3. Our AMA will continue to work with the Educational Commission for Foreign Medical Graduates and other appropriate organizations in developing effective methods to evaluate the clinical skills of IMGs.
4. Our AMA will work with state medical societies in states with discriminatory licensure requirements between IMGs and graduates of U.S. and Canadian medical schools to advocate for parity in licensure requirements, using the AMA International Medical Graduate Section licensure parity model resolution as a resource.
Citation: BOT Rep. 25, A-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 316
(N-21)

Introduced by: New York

Subject: Medical Education Debt Cancellation in the Face of a Physician Shortage During the COVID-19 Pandemic

Referred to: Reference Committee C

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1 Whereas, There is a physician shortage facing our nation; and[i]
2
3 Whereas, The shortage is going to worsen since 2 of 5 current physicians will be 65 years or
4 older and in retirement age this year; and[i]
5
6 Whereas, The shortage is amplified now during the COVID-19 pandemic, demonstrating now
7 more than ever the need for a sufficient and robust physician workforce; and[i]
8
9 Whereas, An unprecedented number of physicians now plan to retire in the next year and many
10 of whom are under 45 years old and therefore would be retiring earlier than expected by
11 workforce shortage predictors due to COVID-19; and[ii]
12
13 Whereas, 8% of physicians surveyed across the United States have closed their practices
14 during the pandemic, amounting to approximately 16,000 closed practices further exacerbating
15 the shortage of healthcare providers; and[iii]
16
17 Whereas, The COVID-19 pandemic has placed immense financial strain on physicians across
18 specialties who have reported loss of staff, lack of reimbursement, and closure of independent
19 physician practices during the COVID-19 pandemic; and[iii,iv]
20
21 Whereas, Young physicians are expected to be part of the workforce for many years to come,
22 yet the majority of healthcare workers (HCW) who died during the COVID-19 pandemic were
23 under 60 years old with primary care physicians (PCPs) accounting for a disproportionate
24 number of these HCW deaths; and[v,vi]
25
26 Whereas, Before the pandemic, the physician shortage in New York State (NYS) was already
27 predicted to be between 2,500 and 17,000 by 2030; and[vii]
28
29 Whereas, During the pandemic, the shortage has been amplified in that New York City has had
30 the highest COVID-19 death rate in the country with NYS accounting for the greatest number of
31 HCW deaths in the USA; and[v,viii]
32
33 Whereas, 73% of medical students graduated with debt in 2020; and[ix]
34
35 Whereas, The cost of medical school has increased 129% in the past 20 years after adjusting
36 for inflation, affecting newer generations of students and physicians substantially more than past
37 ones; and[x]

Whereas, The average medical student debt is $207,003--an approximately 28% increase in the past 10 years--however, the average physician ultimately pays $365,000-$440,000 for an educational loan with interest; and[ix,x,xi]

Whereas, In the United States, 50% of low-income medical school graduates have educational debt that exceeds $100,000; and[x]

Whereas, The financial barrier to entry into medical school is significant in that over half of medical students belong to the top quintile of US household income, with 20-30% of students belonging to the top 5% of income; however, only less than 5% of students come from the lowest quintile of US household income; and[x]

Whereas, A recent study found that higher debt levels among medical students is more likely to motivate them to choose higher paying specialties than primary care specialties; and[xii]

Whereas, Higher burdens of educational debt has been demonstrated to cause residents to place greater emphasis on financial considerations when choosing a specialty; and[xiii]

Whereas, The COVID-19 pandemic is producing a secondary surge in primary care need that has been studied previously in natural disasters and has been shown to persist for years; and[xiv,xv]

Whereas, It is well-established that health inequities existed before the pandemic in that individuals with low socioeconomic status are more likely to also be from minority populations, and are more likely to have worse health outcomes; and[xvi]

Whereas, These inequities have now been exacerbated by the pandemic, with the heaviest burden of COVID-19 disease falling upon Black, Latinx, and immigrant communities; and[xvii]

Whereas, Over 27 million Americans have lost their employer-sponsored health insurance during the pandemic; thus, we will need more physicians now than ever before to address these disparities and rising needs in health care; and[xviii]

Whereas, 72% of physicians surveyed across specialties reported loss of income during the pandemic, with over half of these respondents reporting losses of 26% or more; and[iii]

Whereas, Policies modeled to include provisions for debt relief or increase in incomes were found by one study to be more likely to incentivize students to choose primary care physician specialties; and[xix]

Whereas, Current AMA policies support methods to alleviate debt burden but do not address debt cancellation specifically; and

Whereas, $50 billion of the initial CARES Act Provider Relief Fund were allocated to support the current healthcare system by giving hospitals and providers funding “to support health care-related expenses or lost revenue attributable to COVID-19...”; however, funding formulas based on market shares of Medicare costs and total patient revenue are most likely to bankrupt independent physicians, specifically primary care providers; and[xx,xxi]

Whereas, One study found that primary care internists whose medical education were funded through Public Service Loan Forgiveness and Federally Granted Loans were predicted to have

significantly less net present value than primary care internists who received military or private funding; and[xxii]

Whereas, Medical education debt has been shown to be a significant barrier for underrepresented minorities and low/middle income strata students to choose medicine for a career; and[xxii]

Whereas, A key strategy to address health needs of underserved communities involves recruiting students from these communities as they may be more likely to return to address local health needs; and[xxiii]

Whereas, One medical school has created a debt-free program for matriculated students and saw (1) an increase in applicants to supply the future physician workforce and (2) an increase in applicants from groups underrepresented in medicine to help address socioeconomic and racial/ethnic disparities in the medical workforce and in healthcare; and[xxiv]

Whereas, There is currently a student debt forgiveness resolution in the United States Senate to cancel $50,000 of student debt which will also apply to all medical students, training physicians, and early career physicians; and[xxv]

Whereas, Data suggests women and people of color will benefit most from such debt cancellation because they are most in need; therefore be it[xxv]

RESOLVED, That our American Medical Association study the issue of medical education debt cancellation and consider the opportunities for integration of this into a broader solution addressing debt for all medical students, physicians in training, and early career physicians. (Directive to Take Action)

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

Received: 10/13/21

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

AUTHOR'S STATEMENT OF PRIORITY

Students, training and attending docs are facing increasing amounts of administrative, regulatory and financial pressures that take a toll and cause increased rates of physician stress, demoralization, burnout and depression.
Data and experience show that physician stress and burnout result in reduced quality of care and reduced quality of patient-doc relationships and reduced patient satisfaction.
This loan forgiveness if achieved would reduce burdens on students and physicians and would contribute to reduced burnout and depression and mitigate reductions in quality of care that result from high levels of burnout.
Students and physicians need help now - this can't wait until the November AMA meetings. Physician needs will be forgotten by the end of summer when we are projected to be near herd immunity.

RELEVANT AMA POLICY

Cares Act Equity and Loan Forgiveness in the Medicare Accelerated Payment Program D-305.953
In the setting of the COVID-19 pandemic, our AMA will advocate for additional financial relief for physicians to reduce medical school educational debt.
Citation: Res. 202, I-20

Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925
The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:
1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the “20/220 pathway,” and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes,

and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.
13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the “cost of attendance”; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.
15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.
16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.
17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.
19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.
20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer; (f) Advocate that the profit status of a physicians training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i)

Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.
21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.
22. Formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new polices and novel approaches to prevent debt from influencing specialty and subspecialty choice.
Citation: CME Report 05, I-18; Appended: Res. 953, I-18; Reaffirmation: A-19; Appended: Res. 316, A-19

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 317
(N-21)

Introduced by: Illinois, American Society of Anesthesiologists

Subject: Creating a More Accurate Accounting of Medical Education Financial Costs

Referred to: Reference Committee C

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1 Whereas, The usual reference to the cost of medical education typically is the summation of
2 tuition for the period of 4 years of medical education; and
3
4 Whereas, There are 3 years of required postgraduate training prior to a medical school
5 graduate's ability to fully practice medicine, during which time school loans are typically deferred
6 and interest is compounded; and
7
8 Whereas, Matriculation into medical school typically requires completion of a four-year
9 undergraduate degree; and
10
11 Whereas, The demands of medical education typically prohibit students from undertaking
12 simultaneous endeavors that provide remuneration for their work; and
13
14 Whereas, Most postgraduate medical education is performed in large urban settings where
15 cost-of-living consumes much of the stipend paid to interns and residents leaving little for
16 repayment of school loans; and
17
18 Whereas, The frequently publicized cost of medical education underrepresents the actual
19 financial responsibility of the prospective medical student and the general public; therefore be it
20
21 RESOLVED, That our American Medical Association study the costs of medical education,
22 taking into account medical student tuition and accrued loan interest, to come up with a more
23 accurate description of medical education financial costs. (Directive to Take Action)

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

Received: 10/15/21

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

AUTHORS STATEMENT OF PRIORITY

This issue impacts all medical students and our medical education pipeline. AMA has policy related to this resolution, but underlying data to support the financial burden imposed by medical education is lacking. Taking action now to initiate the collection of data and analysis will be of tremendous benefit to future medical students and our ability to advocate on their behalf.

RELEVANT AMA POLICY

D-305.984 - Reduction in Student Loan Interest Rates

…

3. Our AMA will consider the total cost of loans including loan origination fees and benefits of federal loans such as tax deductibility or loan forgiveness when advocating for a reduction in student loan interest rates.

4. Our AMA will advocate for policies which lead to equal or less expensive loans (in terms of loan benefits, origination fees, and interest rates) for Grad-PLUS loans as this would change the status quo of high-borrowers paying higher interest rates and fees in addition to having a higher overall loan burden.

5. Our AMA will work with appropriate organizations, such as the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges, to collect data and report on student indebtedness that includes total loan costs at completion of graduate medical education training.

Res. 316, A-03 Reaffirmed: BOT Rep. 28, A-13 Appended: Res. 302, A-13 Modified and Appended: 301, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 318
(N-21)

Introduced by: North Carolina, District of Columbia, Georgia, Oklahoma, Mississippi, New Jersey, Tennessee, South Carolina, Kentucky

Subject: The Medical Student Match MisMatch

Referred to: Reference Committee C

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1 Whereas, The National Resident Matching Program (NRMP) has run a computer based, well
2 organized, evolving matching program placing medical student seniors and graduates in
3 available residency slots since 1952; and
4
5 Whereas, The number of NRMP applicants has risen significantly since 2017 to include US-MD
6 seniors, US-DO seniors, US-IMGs, IMGs and some repeat or specialty applicants (total 48,502
7 for 2021) without a matching rise in US Residency slots (only 38,106 potential residency slots
8 for matching); and
9
10 Whereas, The US National Resident Matching Program (NRMP) has a consistent mismatch of a
11 significant number of applicants, sometimes a bit less or more, each year now for about 10
12 years with dramatic increases in the last two years; and
13
14 Whereas, The average senior medical student graduates with about $250,000.00 of debt and
15 about 20% of these graduates with over $400,000.00 of medical school debt; and
16
17 Whereas, Most states require completion of a residency accredited by the Accreditations
18 Council for Graduate Medical Education (ACGME) before full state medical licensure; and
19
20 Whereas, A non-matching student may be facing significant debt with no way to repay, since no
21 job prospects as a resident physician will still leave existing educational debt; and
22
23 Whereas, A non-matching student has graduated from medical school; and
24
25 Whereas, Even without recent data we believe the potential for large debt, but no job, will
26 certainly increase health professional disparity since the potential mismatch and large debt will
27 discourage an ethnically diverse or a racially diverse medical student and thus the profession;
28 and
29
30 Whereas, AMA has both robust policy on all the above issues and a powerful FREIDA computer
31 application (see www.ama-assn.org/amgone/freida/); therefore be it
32
33 RESOLVED, That our American Medical Association hire or assign staff to staff up the FREIDA
34 system with AMA employees to: (1) work with the FREIDA system, further educate rising senior
35 students how to have a successful match; (2) give real time help to medical students to navigate
36 post no-match; (3) help no-match medical students navigate loan repayment strategies; and (4)
37 help no-match medical students find jobs in the medical or public or commercial sectors
38 (Directive to Take Action); and be it further

1 RESOLVED, That our AMA Council on Medical Education and the Medical Student and
2 Resident Fellow Sections develop a joint task force to update no-match data and reasons for
3 the phenomenon and suggestions for improvement or amelioration (Directive to Take Action);
4 and be it further
5
6 RESOLVED, That the new FREIDA staff engage with AMA legal and AMA advocacy staff to
7 redouble our AMA efforts to expand, to increase, to originate and to fund residency slots across
8 the US. (Directive to Take Action)

Fiscal Note: Estimated $175,000 annually to implement this resolution.

Received: 10/11/21

AUTHORS STATEMENT OF PRIORITY

Obviously, the Resident Match Mismatch effects students and residents, but they now are about half of AMA membership. BUT as the physician shortage grows over time, the Mismatch will begin to effect even more, in fact MOST physicians and practices. THIS is the time to ACT, because the Mismatch has greatly increased over the last two years; AND with a new Administration in DC, THIS IS the time for AMA ACTION for more Residency slots, particularly with President Biden's interest in "Human Infrastructure." To really move along the project, we need NEW POLICY as listed. WE CAN MAKE a difference in a Democrat controlled DC, particularly with our preponderance, now, at AMA, of IN TUNE AMA leadership. The AMA is best positioned to lead in this arena at this time.

AMA Policy and References
THE MATCH HISTORY AND BACKGROUND
AMA Policy
See FREIDA™ AMA Residency & Fellowship Programs Database (ama-assn.org)
Key AMA Match Policy is D-310.977 first written in 2005 and modified and amended many times since.
H-200.949 Primary Care Workforce
H-310.910 Preliminary Year Program Placement
H-200.954 US Physician Shortage
D-310.974 Policy Suggestions to Improve the National Matching Program

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Match Day Explained: How Med Students Take the Next Career Step. March 4, 2016, from the University of Michigan, Med U.
Brendan Murphy: AMA News Writer
Medical Students match in record numbers, celebrate virtually, March 20, 2020
2021 Main Residency Match Results and Data Report Now Available - The Match, National Resident Matching Program (nrmp.org)
Trends in Race/Ethnicity Among Applicants and Matriculants to US Surgical Specialties, 2010-2018 | Health Disparities | JAMA Network Open | JAMA Network

THE MISMATCH
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Why medical students aren't matching -June 7, 2015 (staff writers)
No Match for you? SOAP offers last minute option – March 8, 2021
Ten Years After, Kristi Dyer, August 15, 2009…from MOM supported by Amazon Services, LLC
Graduate Medical Education (GME) Funding News & Info | American Medical Association (ama-assn.org)

AMA Policy
H-310.910 Preliminary Year Program Placement
H-305.988 Availability of First-Year Residency Positions
H-200.954 US Physician Shortage
H-200.949 Principles to Address Primary Care Workforce
D-305.967 Full Funding of Graduate Medical Education

MEDICAL STUDENT DEBT
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How to pay off student debt. From Weatherby Healthcare, 2021 (a CHG Company) their web page

AMA Policy
H-305.925 Medical Education Costs and Medical Student Debt

POTENTIAL JOBS IF NOT MATCHED
References
Ten Years Later…see above
Physician Jobs without ABME Board Certification or Medical Licensure. 2021. From the MDJourney, by the WPFamily web page.
16 Jobs for Physicians without a Residency or Licensure. By Catherine Carroll on the Physician Tycoon web page.

AMA Policy
See above
D-200.980 Physician Practices in Underserved Areas

RELEVANT AMA POLICY

Principles of and Actions to Address Primary Care Workforce H-200.949

1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation's current and projected demand for health care services.
2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).
3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.
4. Admissions and recruitment: The medical school admissions process should reflect the specific institution's mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.
5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.
6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.
7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.
8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should

be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.
9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.
10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.
11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.
12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.
13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).
14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.
15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.
16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.
17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.

18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.
19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.
20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.
21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.
22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.
23. Practicing physicians in other specialties--particularly those practicing in underserved urban or rural areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.
24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.
25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.
Citation: CME Rep. 04, I-18

US Physician Shortage H-200.954
Our AMA:
(1) explicitly recognizes the existing shortage of physicians in many specialties and areas of the US;
(2) supports efforts to quantify the geographic maldistribution and physician shortage in many specialties;
(3) supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US;
(4) encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations;
(5) encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations;
(6) encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates' eventual practice in underserved areas and with underserved populations;

(7) will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas;
(8) will continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification;
(9) will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need;
(10) continues to work with the Association of American Medical Colleges (AAMC) and other relevant groups to monitor the outcomes of the National Resident Matching Program; and
(11) continues to work with the AAMC and other relevant groups to develop strategies to address the current and potential shortages in clinical training sites for medical students.
(12) will: (a) promote greater awareness and implementation of the Project ECHO (Extension for Community Healthcare Outcomes) and Child Psychiatry Access Project models among academic health centers and community-based primary care physicians; (b) work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States; and (c) monitor whether health care payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in programs such as Project ECHO and the Child Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians.
Citation: Res. 807, I-03; Reaffirmation I-06; Reaffirmed: CME Rep. 7, A-08; Appended: CME Rep. 4, A-10; Appended: CME Rep. 16, A-10; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 922, I-13; Modified: CME Rep. 7, A-14; Reaffirmed: CME Rep. 03, A-16; Appended: Res. 323, A-19; Reaffirmed: CME Rep. 3, A-21

Cost and Financing of Medical Education and Availability of First-Year Residency Positions H-305.988
Our AMA:
1. believes that medical schools should further develop an information system based on common definitions to display the costs associated with undergraduate medical education;
2. in studying the financing of medical schools, supports identification of those elements that have implications for the supply of physicians in the future;
3. believes that the primary goal of medical school is to educate students to become physicians and that despite the economies necessary to survive in an era of decreased funding, teaching functions must be maintained even if other commitments need to be reduced;
4. believes that a decrease in student enrollment in medical schools may not result in proportionate reduction of expenditures by the school if quality of education is to be maintained;
5. supports continued improvement of the AMA information system on expenditures of medical students to determine which items are included, and what the ranges of costs are;
6. supports continued study of the relationship between medical student indebtedness and career choice;
7. believes medical schools should avoid counterbalancing reductions in revenues from other sources through tuition and student fee increases that compromise their ability to attract students from diverse backgrounds;
8. supports expansion of the number of affiliations with appropriate hospitals by institutions with accredited residency programs;
9. encourages for profit-hospitals to participate in medical education and training;
10. supports AMA monitoring of trends that may lead to a reduction in compensation and benefits provided to resident physicians;
11. encourages all sponsoring institutions to make financial information available to help residents manage their educational indebtedness; and
12. will advocate that resident and fellow trainees should not be financially responsible for their training.

Citation: CME Rep. A, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Res. 313, I-95; Reaffirmed by CME Rep. 13, A-97; Modified: CME Rep. 7, A-05; Modified: CME Rep. 13, A-06; Appended: Res. 321, A-15; Reaffirmed: CME Rep. 05, A-16; Modified: CME Rep. 04, A-16

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

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

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the "20/220 pathway," and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-

interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.
13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the “cost of attendance”; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.
15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.
16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.
17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.
19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.

20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer; (f) Advocate that the profit status of a physicians training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.
21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.
22. Formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new polices and novel approaches to prevent debt from influencing specialty and subspecialty choice.
23. Strongly advocate for the passage of legislation to allow medical students, residents and fellows who have education loans to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education.
Citation: CME Report 05, I-18; Appended: Res. 953, I-18; Reaffirmation: A-19; Appended: Res. 316, A-19; Appended: Res. 226, A-21 Reaffirmed in lieu of: Res. 311, A-21

Preliminary Year Program Placement H-310.910
1. Our AMA encourages the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, and other involved organizations to strongly encourage residency programs that now require a preliminary year to match residents for their specialty and then arrange with another department or another medical center for the preliminary year of training unless the applicant chooses to pursue preliminary year training separately.
2. Our AMA encourages appropriate stakeholders to explore options to decrease the burden upon medical students who must apply to separate preliminary PGY-1 and categorical PGY-2 positions.
3. Our AMA will work with the Accreditation Council for Graduate Medical Education to encourage programs with PGY-2 positions in the National Resident Matching Program (NRMP) with insufficient availability of local PGY-1 positions to create local PGY-1 positions that will enable coordinated applications and interviews for medical students.
4. Our AMA encourages the NRMP, the San Francisco Match, the American Urological Association, the Electronic Residency Application Service, and other stakeholders to reduce barriers for medical students, residents, and physicians applying to match into training programs, including barriers to “couples matching,” and to ensure that all applicants have access to robust, informative statistics to assist in decision-making.
5. Our AMA encourages the NRMP, San Francisco Match, American Urological Association, Electronic Residency Application Service, and other stakeholders to collect and publish data on

a) the impact of separate matches on the personal and professional lives of medical students and b) the impact on medical students who are unable to successfully “couples match” with their significant others due to staggered entry into residency, utilization of unlinked match services, or other causes.
Citation: Res. 306, A-12; Appended: CME Rep. 03, A-19

Policy Suggestions to Improve the National Resident Matching Program D-310.974
Our AMA will: (1) request that the National Resident Matching Program review the basis for the extra charge for including over 15 programs on a primary rank order list and consider modifying the fee structure to minimize such charges; (2) work with the NRMP to increase awareness among applicants of the existing NRMP waiver and violations review policies to assure their most effective implementation; (3) request that the NRMP continue to explore measures to maximize the availability of information for unmatched applicants and unfilled programs including the feasibility of creating a dynamic list of unmatched applicants; (4) ask the National Resident Matching Program (NRMP) to publish data regarding waivers and violations with subsequent consequences for both programs and applicants while maintaining the integrity of the match and protecting the identities of both programs and participants; (5) advocate that the words "residency training" in section 8.2.10 of the NRMP Match agreement be added to the second sentence so that it reads, "The applicant also may be barred from accepting or starting a position in any residency training program sponsored by a match-participating institution that would commence training within one year from the date of issuance of the Final Report" and specifically state that NRMP cannot prevent an applicant from maintaining his or her education through rotating, researching, teaching, or otherwise working in positions other than resident training at NRMP affiliated programs; and (6) work with the Educational Commission for Foreign Medical Graduates, Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, and other graduate medical education stakeholders to encourage the NRMP to make the conditions of the Match agreement more transparent while assuring the confidentiality of the match and to use a thorough process in declaring that a violation has occurred.
Citation: (CME Rep. 15, A-06; Appended: Res. 918, I-11; Appended: CME Rep. 12, A-12)

The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967
1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).

7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College

of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.
20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.
21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.
22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.
23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.
24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.
25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.
26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.
27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.
28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.
29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.
30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.
31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of “Cap-Flexibility” and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.
32. Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the

Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates' rates of placement into GME as well as GME completion.
33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation's health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.
Citation: Sub. Res. 314, A-07; Reaffirmation I-07; Reaffirmed: CME Rep. 4, I-08; Reaffirmed: Sub. Res. 314, A-09; Reaffirmed: CME Rep. 3, I-09; Reaffirmation A-11; Appended: Res. 910, I-11; Reaffirmed in lieu of Res. 303, A-12; Reaffirmed in lieu of Res. 324, A-12; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 320, A-13; Appended: CME Rep. 5, A-13; Appended: CME Rep. 7, A-14; Appended: Res. 304, A-14; Modified: CME Rep. 9, A-15; Appended: CME Rep, 1, I-15; Appended: Res. 902, I-15; Reaffirmed: CME Rep. 3, A-16; Appended: Res. 320, A-16; Appended: CME Rep. 04, A-16; Appended: CME Rep. 05, A-16; Reaffirmation A-16; Appended: Res. 323, A-17; Appended: CME Rep. 03, A-18; Appended: Res. 319, A-18; Reaffirmed in lieu of: Res. 960, I-18; Modified: Res. 233, A-19; Modified: BOT Rep. 25, A-19; Reaffirmed: CME Rep. 3, A-21

Effectiveness of Strategies to Promote Physician Practice in Underserved Areas D-200.980
1. Our AMA, in collaboration with relevant medical specialty societies, will continue to advocate for the following: (a) Continued federal and state support for scholarship and loan repayment programs, including the National Health Service Corps, designed to encourage physician practice in underserved areas and with underserved populations. (b) Permanent reauthorization and expansion of the Conrad State 30 J-1 visa waiver program. (c) Adequate funding (up to at least FY 2005 levels) for programs under Title VII of the Health Professions Education Assistance Act that support educational experiences for medical students and resident physicians in underserved areas.
2. Our AMA encourages medical schools and their associated teaching hospitals, as well as state medical societies and other private sector groups, to develop or enhance loan repayment or scholarship programs for medical students or physicians who agree to practice in underserved areas or with underserved populations.
3. Our AMA will advocate to states in support of the introduction or expansion of tax credits and other practice-related financial incentive programs aimed at encouraging physician practice in underserved areas.
4. Our AMA will advocate for the creation of a national repository of innovations and experiments, both successful and unsuccessful, in improving access to and distribution of physician services to government-insured patients (National Access Toolbox).
5. Our AMA supports elimination of the tax liability when employers provide the funds to repay student loans for physicians who agree to work in an underserved area.
Citation: CME Rep. 1, I-08; Modified: CME Rep. 4, A-10; Reaffirmation I-11; Appended: Res. 110, A-12; Reaffirmation A-13; Reaffirmation A-14; Appended: Res. 312, I-16; Appended: Res 312, I-16

Reference Committee D

BOT Report(s)

17 Distracted Driver Education and Advocacy

CSAPH Report(s)

02 Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems

03 Physician Involvement in State Regulations of Motor Vehicle Operation and/or Firearm Use by Individuals with Cognitive Deficits Due to Traumatic Brain Surgery

Resolution(s)

401 Endorsement of Public Health Measures to End the COVID-19 Pandemic and Promotion of Research and Insurance Coverage to Define and Delimit the Emerging Issue of Post-Acute Covid Syndrome

402 Expansion on Comprehensive Sexual Health Education

403 Providing Reduced Parking Fees for Patients

404 Increase Employment Services Funding for People with Disabilities

405 Formal Transitional Care Program for Children and Youth with Special Health Care Needs

406 Addressing Gaps in Patient and Provider Knowledge to Increase HPV Vaccine Uptake and Prevent HPV-Associated Oropharyngeal Cancer

407 Traumatic Brain Injury and Access to Firearms

408* Ensuring Affordability and Equity in COVID-19 Vaccine Boosters

* Contained in the Handbook Addendum

REPORT OF THE BOARD OF TRUSTEES

B of T Report 17-N-21

Subject: Distracted Driver Education and Advocacy

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee D

Board of Trustees Report 12-I-19, "Distracted Driver Education and Advocacy" was amended by the addition of the following recommendation:

> That our AMA will escalate the distracted driving campaign to a national level of awareness in coordination with the CDC and the National Education Association to educate elementary up through high school students as well as parents regarding the high-risk behavior of driving while holding cell phones and the opportunity to save lives and avoid injuries, with a review of steps taken and report back to the House at Annual 2020.

BACKGROUND

Distracted driving is any non-driving activity a person engages in while operating a motor vehicle.[1] Non-driving activities have the potential to distract the person from the primary task of driving and increase the risk of crashing.[1] There are three main types of distraction: visual – taking your eyes off the road, manual – taking your hands off the wheel, and cognitive – taking your mind off what you are doing.[1] Data shows that, in 2017, crashes involving a distraction led to 3,166 deaths.[1] However, identifying distracted drivers can be challenging so the actual numbers are likely much higher.

Policy H-15952 asks the AMA to: (a) make it a priority to create a national education and advocacy campaign on distracted driving in collaboration with the Centers for Disease Control and Prevention and other interested stakeholders; and (b) explore developing an advertising campaign on distracted driving with report back to the House of Delegates at the 2019 Interim Meeting.

In working towards implementing the A-19 policy, the AMA had conversations with staff at the Centers for Disease Control and Prevention (CDC). We were informed that their transportation safety work is focused on impaired driving, not distracted driving, since that is where they see the greatest number of injuries and fatalities. While there are evidence-based solutions to address the problem of impaired driving, the evidence is mixed on current strategies to address distracted driving.

Twenty states and the District of Columbia have passed laws to prohibit hand-held cell phone use by drivers to limit distracted driving and save lives.[2] Legislatures in other states have specifically prohibited texting while driving or cell phone use by younger drivers or school bus drivers.[2] Research on the effects of driver cellphone and texting bans has found mixed results.[3,4] While some jurisdictions have seen promising results, overall there is considerable unsettled evidence regarding the effects of these laws on crash risk.[3,4]

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As a result, the CDC directed us to other partners who were working to address this issue. These organizations included the National Highway Traffic Safety Administration (NHTSA), the lead federal agency on the issue of distracted driving, and the Safe States Alliance, a non-profit professional association whose mission is to strengthen the practice of injury and violence prevention. During our own research, we also came across the resources developed by the National Safety Council (NSC), a non-profit public service association that is focused on eliminating preventable deaths at work, in homes and communities, and on the road through leadership, research, education and advocacy.

EXISITING NATIONAL CAMPAIGNS ON DISTRACTED DRIVING

National Highway Traffic Safety Association (NHTSA)

NHTSA's distracted driver campaign is called "U Drive. U Text. U Pay."[5] The campaign is focused on educating Americans about the dangers of distracted driving and partnering with the state and local police to enforce laws against distracted driving that help keep us safe. The campaign involves public service announcements as well as a social media campaign sharing stories and tips to help save lives. While states determine laws affecting distracted driving, NHTSA provides federal investments that address the states' specific needs.

National Safety Council (NSC)

The NSC also has a national campaign that is focused on National Distracted Driving Awareness Month, which was designated by Congress in 2010 as the month of April, making this year the 10-year anniversary of the campaign's launch.[6] The slogan for the NSC campaign is "Just Drive." The campaign encourages drivers to keep their attention where it belongs, on the road. As a part of this campaign, the NSC develops free tools, which include a social media tool kit, fact sheets, a pledge, survivor stories, and posters. These tools can be used to learn more about distraction risks and create awareness of them in your community.

AT&T

AT&T also has a national campaign on distracted driving called "It Can Wait."[7] This campaign, which includes advertising spanning print, radio, TV and online advertising, also began in 2010. The tools developed as part of this campaign include a pledge to always drive distraction free, advocacy tools – talking points, fact sheets, posters, presentations (school and corporate), media talking points, shareable videos, and a virtual reality experience.

AMA ACTIVITIES

On January 7, 2020, the AMA news team published a story titled, "Distracted driving: Most states aren't cracking down on deadly practice," which highlighted the importance of this issue as well as the AMA's model state distracted driving bill.[8] The AMA has also used its social media platforms (LinkedIn, Twitter, Facebook and the RFS and MSS Facebook pages) to highlight the issue of distracted driving with 5 posts on this issue so far in 2020 (See Images 1 and 2). Engagements (defined as the total amount of likes, shares, retweets, comments and video views) were 171 with the total impressions (defined as the total number of times social media browsers showed the content) being 18,186.

This story led to the AMA receiving an interview request by CBS News on the issue of distracted driving. The AMA referred the reporter to the Medical Association of Georgia, given its success in

addressing distracted driving. The interview was held on January 21, 2020. The AMA's position of calling for states to ban the use of handheld cellphones while driving was highlighted in the segment (See Images 3 and 4).[9]

The AMA's Advocacy Resource Center did a survey of state medical societies' legislative priorities for 2020. In looking at the public health priorities, only three states indicated that distracted driving is a priority for them this year, with most states prioritizing public health work on tobacco and e-cigarettes (32 states) and vaccines (30 states). (See Figure 1) The AMA has a model state bill, the "Distracted Driving Reduction Act" and is willing to assist medical societies in addressing this issue.

CONCLUSION

The Board of Trustees recognizes the importance of preventing distracted driving to lower crash rates and improve public safety. As the AMA was working to implement the directive from A-19, which contained a broad resolve to address distracted driving in collaboration with CDC and other stakeholders, the House of Delegates adopted a second directive at I-19 calling for the AMA to focus on educating elementary up through high school students as well as parents regarding the high-risk behavior of driving while holding cell phones.

Through the process of reviewing the literature on effective strategies to reduce distracted driving and discussing efforts underway with relevant stakeholders, the Board of Trustees proposes that AMA policy be updated to reflect the fact that hands-free laws may be a step towards reducing distracted driving in some communities, but overall the evidence of their effectiveness in reducing crash rates is mixed. Therefore, AMA policy should be modified to note the three types of distractions (visual, manual and cognitive) and to call for more research to determine the most effective strategies to reduce distracted driving and related crash risks.

The Board of Trustees further recommends that the directives adopted by House of Delegates be modified and streamlined to delete specific stakeholders that the AMA must work with on a campaign to address distracted driving and to eliminate the focus on "holding cell phones" as it is clear that manual distraction is not the only risky behavior. Furthermore, the Board believes that the directive should remain broadly focused on preventing distracted driving in order to give the AMA the flexibility to address this important issue as appropriate. While plans are underway with stakeholders to develop a national campaign to address distracted driving, at the time of the writing of this report it was too soon to announce them.

RECOMMENDATION

The Board of Trustees recommends that Policy H-15.952 be amended by addition and deletion to read as follows and the remainder of the report be filed.

H-15.952, "The Dangers of Distraction While Operating Hand-Held Devices"

1. Our AMA encourages physicians to educate their patients regarding the public health risks of ~~text messaging while operating motor vehicles or machinery~~ distracted driving, which includes the risks of visual distraction – taking one's eyes off the road, manual distraction – taking one's hands off the wheel, and cognitive distraction – taking one's mind off what he or she doing. ~~and will advocate for state legislation prohibiting the use of handheld communication devices to text message while operating motor vehicles or machinery~~.

2. Our AMA will: (a) ~~endorse~~ support legislation that would ban the use of hand-held devices while driving, as a step in the right direction towards preventing distracted driving and (b) encourage additional research to identify the most effective strategies to reduce distracted driving-related crash risks.

3. Our AMA: (a) recognizes distracted walking as a preventable hazard and encourages awareness of the hazard by physicians and the public; and (b) encourages research into the severity of distracted walking as a public health hazard as well as ways in which to prevent it.

4. Our AMA supports public education efforts regarding the dangers of distracted driving, particularly activities that take drivers' eyes off the road, and that the use of earbuds or headphones while driving is dangerous and illegal in some states.

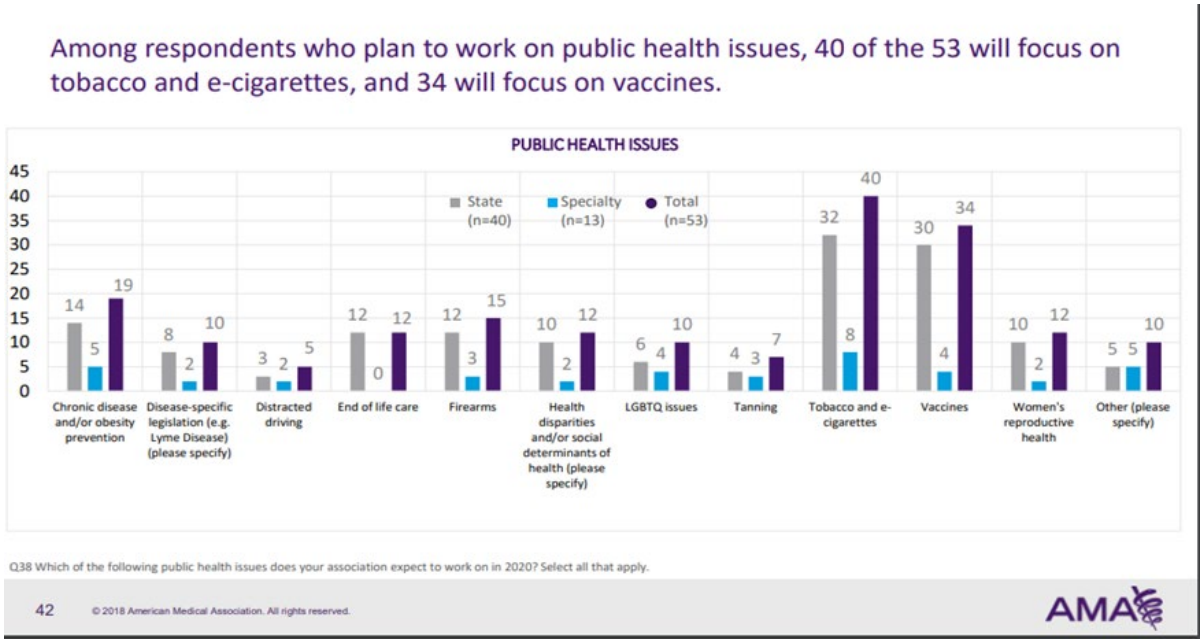
5. Our AMA: (a) supports education on the use of earbuds or headphones in both ears during outdoor activities requiring auditory attention, including but not limited to biking, jogging, rollerblading, skateboarding and walking; and (b) supports the use of warning labels on the packaging of hand-held devices utilized with earbuds or headphones, indicating the dangers of using earbuds or headphones in both ears during outdoor activities requiring auditory attention, including but not limited to biking, jogging, rollerblading, skateboarding and walking.

6. Our AMA will: (a) make it a priority to create a national education and advocacy campaign on distracted driving in collaboration with ~~the Centers for Disease Control and Prevention and other~~ interested stakeholders~~; and (b) explore developing an advertising campaign on distracted driving with report back to the House of Delegates at the 2019 Interim Meeting~~.

~~7. Our AMA will escalate the distracted driving campaign to a national level of awareness in coordination with the CDC and the National Education Association to educate elementary up through high school students as well as parents regarding the high-risk behavior of driving while holding cell phones and the opportunity to save lives and avoid injuries, with a review of steps taken and report back to the House of Delegates at the 2020 Annual Meeting.~~

Fiscal Note: less than $500

FIGURE 1



IMAGES 1 and 2

IMAGE 3

IMAGE 4

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REPORT 2 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (N-21)
Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems
(Resolution 401-JUN-21)
(Reference Committee D)

EXECUTIVE SUMMARY

BACKGROUND: Policy D-440.922 adopted at the November 2020 Special Meeting of the House of Delegates asked that our American Medical Association (AMA) study the most efficacious manner by which we can continue to achieve our mission of the betterment of public health by recommending ways in which to strengthen the health and public health system infrastructure.

Resolution 401-JUN-21, introduced by the Washington Delegation and referred by the House of Delegates asked that our AMA establish a list of all essential public health services that should be provided in every jurisdiction of the United States; a nationwide system of information sharing and intervention coordination in order to effectively manage nationwide public health issues; a federal data system that can capture the amount of federal, state, and local public health capabilities and spending that occurs in every jurisdiction to assure that their populations have universal access to all essential public health services; and a federal data system that can capture actionable evidence-based outcomes data from public health activities in every jurisdiction.

METHODS: This was a qualitative study in which semi-structured, in-depth interviews lasting 45 minutes were conducted with public health and physician experts (n=17) and members of the AMA Board of Trustees (n=11). Public health experts had federal, state, and local public health experience and were affiliated with governmental public health organizations, national public health organizations, schools of public health, public health foundations, and national medical specialty societies. Stakeholder organizations were identified by the members of the Council on Science and Public Health (CSAPH). Members of the AMA Board of Trustees were asked to participate in interviews at the discretion of the Board Chair.

RESULTS: The public health infrastructure interviews identified eight major gaps or challenges in the U.S. public health infrastructure. These include: (1) the lack of understanding and appreciation for public health; (2) the lack of consistent, sustainable public health funding; (3) legal authority and politicization of public health; (4) the governmental public health workforce; (5) the lack of data and surveillance and interoperability between health care and public health; (6) insufficient laboratory capacity; (7) the lack of collaboration between medicine and public health; and (8) the gaps in the public health infrastructure which contribute to the increasing inequities we see in health outcomes.

CONCLUSION: The Council on Science and Public Health recommends that the AMA outline an organization-wide public health strategy, aligned with the findings of this report, to develop a roadmap of the work being done by the AMA in public health and to share accomplishments as the strategy is implemented. The Council also recommends new policy urging the AMA to actively oppose the limits being placed on the authority of health officials, recognizing the authority to implement evidence-based measures may be necessary to protect the health of the public. We also propose a new policy calling for public health agencies to communicate directly with the health professionals licensed within their jurisdiction. Minor amendments are also suggested to further strengthen our existing public health policies based on the findings of this research.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 2-N-21

Subject: Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems (Resolution 401-JUN-21)

Presented by: Alexander Ding, MD, MS, MBA, Chair

Referred to: Reference Committee D

Policy D-440.922 adopted by the House of Delegates in November 2020 asked that:

> Our AMA study the most efficacious manner by which our AMA can continue to achieve its mission of the betterment of public health by recommending ways in which to strengthen the health and public health system infrastructure.

Resolution 401-JUN-21, introduced by the Washington Delegation and referred by the House of Delegates asked that:

> Our American Medical Association study the options and/or make recommendations regarding the establishment of:
> 1.a list of all essential public health services that should be provided in every jurisdiction of the United States;
> 2. a nationwide system of information sharing and intervention coordination in order to effectively manage nationwide public health issues;
> 3. a federal data system that can capture the amount of federal, state, and local public health capabilities and spending that occurs in every jurisdiction to assure that their populations have universal access to all essential public health services; and
> 4. a federal data system that can capture actionable evidence-based outcomes data from public health activities in every jurisdiction (Directive to Take Action); and be it further
>
> Our AMA prepare and publicize annual reports on current efforts and progress to achieve universal access to all essential public health services. (Directive to Take Action)

METHODS

This was a qualitative study in which semi-structured, in-depth interviews lasting 45 minutes were conducted with public health and physician experts (n=17) and members of the AMA Board of Trustees (n=11). Public health experts had federal, state, and local public health experience and were affiliated with governmental public health organizations, national public health organizations, schools of public health, public health foundations, and national medical specialty societies. Stakeholder organizations were identified by the members of the Council on Science and Public Health (CSAPH) and organizations were asked to identify a primary and alternate representative to participate in the stakeholder interview. Alternates were interviewed when there were difficulties scheduling with the primary representatives. Due to timing constraints and scheduling conflicts, some organizations were unable to participate. Members of the AMA Board of Trustees were asked

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to participate at the discretion of the Board Chair. The individuals who were interviewed provided verbal informed consent and received no financial compensation.

DATA COLLECTION AND ANALYSIS

The Council identified five objectives to guide the public health infrastructure research. The objectives were as follows:

- Understand the current challenges faced by public health professionals and health departments in preventing, detecting, and responding to emerging infectious disease threats and other public health crises.
- Understand physician and public health professionals' perspectives on what solutions need to be implemented to strengthen public health infrastructure to carry out the 10 essential public health services to improve disease and injury prevention and the health of the public
- Identify barriers and opportunities for improved and increased linkages between the public health and health care systems.
- Understand opportunities for the public health system to protect and promote the health of all people in all communities by removing systemic and structural barriers that have resulted in inequities.
- Identify opportunities for the AMA in supporting, developing, and implementing solutions.

The semi-structured interview guide (Appendix A) was developed with input from the members of CSAPH as well as AMA staff, including representatives from the Health, Science, and Ethics and the Center for Health Equity teams. The interview guide began by asking participants to define public health infrastructure, their experience, and the role of their organization in public health. The guide also asked individuals to identify challenges facing our nation's public health system, noting that these challenges could focus on the COVID-19 pandemic or challenges beyond the pandemic. The guide then aimed to give participants the opportunity to ideate possible solutions. Participants were then asked to identify how the AMA can best support solutions to strengthen public health infrastructure. A separate discussion guide was developed for the interviews with AMA trustees (Appendix B), which asked their reaction to the challenges and solutions identified by the external stakeholders and their perspective on the AMA's role in these efforts. The semi-structured interviews were conducted by C + R Research, an independent research firm. All interviews were recorded and transcribed. Transcripts were analyzed by the independent research firm for major themes. All personally identifiable information was removed from the transcripts prior to analysis. The findings of this research were presented to CSAPH and were shared to the Board of Trustees in July and serve as the basis for this report.

BACKGROUND

Public health has been defined as "what we do together as a society to ensure the conditions in which everyone can be healthy."[1(p0)] CSAPH believes that public health belongs to everyone and is everyone's responsibility. The public health system is broad and has been defined as "all public, private, and voluntary entities that contribute to the delivery of essential public health services within a jurisdiction"[2] This system includes public health professionals, health care professionals, employers, schools, parks and recreation, community-based organizations, non-governmental organizations, faith-based institutions and more (see Figure 1). However, for purposes of this report, when we talk specifically about strengthening our nation's public health infrastructure, we are talking about the work of governmental public health entities at the federal, state, territorial, local, and tribal levels.[1] The Council acknowledges that additional reports exploring the broader public health system are warranted in the near future.

10 Essential Public Health Services

The 10 Essential Public Health Services (EPHS), originally published in 1994, provide a framework by which the work of public health is to be accomplished in all communities. The 10 EPHS, which were revised in 2020, with input from the AMA, are as follows:

- Assess and monitor population health status, factors that influence health, and community needs and assets.
- Investigate, diagnose, and address health problems and hazards affecting the population.
- Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it.
- Strengthen, support, and mobilize communities and partnerships to improve health.
- Create, champion, and implement policies, plans, and laws that impact health.
- Utilize legal and regulatory actions designed to improve and protect the public's health.
- Assure an effective system that enables equitable access to the individual services and care needed to be healthy.
- Build and support a diverse and skilled public health workforce.
- Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement.
- Build and maintain a strong organizational infrastructure for public health.

Existing AMA Policy D-440.924, "Universal Access for Essential Public Health Services," called for updating the 10 EPHS to bring them in line with current and future public health practice and encourages state, local, tribal, and territorial public health departments to pursue accreditation through the Public Health Accreditation Board (PHAB). The revised EPHS are central to the PHAB framework and inform PHAB standards, which provides a framework for health departments to evaluate their policies, procedures, and programs and to make meaningful improvements.

The Roles of Health Care and Public Health in Prevention

The Council also recognizes that the roles of health care and public health can seem indistinct. The role of health care in prevention is often described as increasing the use of evidence-based preventive services for individual patients and the role of public health is often described as focused on implementing interventions that reach the whole population or a population within a jurisdiction. There is also a shared responsibility for innovative clinical prevention provided outside of the clinical setting (see Figure 2). However, we recognize that there are public health agencies that provide clinical preventive services, particularly in rural communities where there may be a shortage of primary care physicians. There are also health care professionals involved in community-wide prevention efforts.

The COVID-19 Pandemic

Organizations representing U.S. governmental public health agencies have been cautioning for years that their ability to keep the population safe from disease and public health emergencies is constrained by the lack of dedicated and sustained funding.[3] In addition to funding, our public health infrastructure has been threatened by high rates of staff turnover and obsolete data collection and reporting methods, which lead to delayed detection and response to public health threats of all types.[4,5] The COVID-19 pandemic did not create these problems, but it inarguably exposed the cracks that had long existed in our public health infrastructure. For decades, public health professionals have been advocating for greater resources to plan and prepare for just such a crisis.

The challenges of the COVID-19 pandemic response have been well documented.[6,7] While it is true that there certainly have been errors and omissions in the COVID-19 response, public health leaders should also be recognized for their successes and the tireless work that they have done under incredibly challenging circumstances.[8] The development, authorization, distribution, and administration of over 300,000,000 doses of safe and effective vaccines in the United States in 20 months since the identification of the SARS-CoV-2 novel pathogen has been nothing short of remarkable.

RESULTS

The public health infrastructure interviews identified eight major gaps or challenges in the U.S. public health infrastructure. These include:

(1) the lack of understanding and appreciation for public health;
(2) the lack of consistent, sustainable public health funding;
(3) legal authority and politicization of public health;
(4) the governmental public health workforce;
(5) the lack of data and surveillance and interoperability between health care and public health;
(6) insufficient laboratory capacity;
(7) the lack of collaboration between medicine and public health; and
(8) the gaps in the public health infrastructure which contribute to the increasing inequities we see in health outcomes.

Lack of Understanding and Appreciation for Public Health

Challenge: When public health is working, it is invisible. Because of this, individuals outside of public health too often take it for granted and do not realize the way it impacts health and well-being on a daily basis. The public assumes the air is clean and their food and water is safe without giving the work of public health recognition for these accomplishments. As a result of this invisibility, public health is not prioritized or adequately funded.

There is broad consensus that the gaps we see in the public health infrastructure stem from a broad misunderstanding of what public health is and what it does. Some stakeholders indicated that public health is misunderstood by the public as "health care for poor people" and it is disregarded or devalued given this misjudgment. Others believe governmental and some health care organizations do not fully understand the role of public health professionals. Alternatively, health care is highly visible and well-regarded and is better understood by the public as it has a clear outcome (i.e., treating people when they are sick). Although health care's mission is an important one, it does little to prevent people from becoming sick in the first place and health care is only one of several determinants of health.[9]

Solution: Prioritize public health by communicating about the work that public health agencies and practitioners do and their vital role in the health of our nation. Medical societies, at the county, state and national levels, can share their power with public health and raise its visibility in their communities. At the individual level, physicians can become advocates for public health programs, activities, policies, and campaigns. Physician groups can encourage more physicians to go into public service roles and provide support for more physicians to specialize in preventive medicine and related disciplines.

> *"That white coat carries a lot of power with county commissioners and mayors, you know. I've worked in state legislatures, and I remember doctor days and you would just be like, oh man,*

> *you know, you've got 40 people walking around in white coats. People respect that, right? Physicians do have an exalted place in our society…so that's a huge thing. We've just never been able to kind of crack that group…as a real advocate."* – Public Health Stakeholder

Existing AMA Policy: Our AMA should collaborate with national public health organizations to explore ways in which public health and clinical medicine can become better integrated; such efforts may include the development of a common core of knowledge for public health and medical professionals, as well as educational vehicles to disseminate this information (Policy H-440.912, "Federal Block Grants and Public Health").

Lack of Consistent, Sustainable Funding

Challenge: Funding for public health is not consistent or sustainable. Stakeholders, in discussing public health funding referred to it as "anemic" and "emergency of the day" funding. In the past 20 years, the nation has responded to every public health crisis with temporary funding measures that have not provided state and local public health agencies with the people and the tools needed to build enduring programs and infrastructure which address the populations health and adequately prepare for or prevent future emergencies. Shoring up the system will take years of consistent effort by public health officials and policymakers. While billions are now coming from the Biden Administration in short-term funding to address the COVID-19 pandemic, the current infrastructure is ill equipped to handle the large influx of funds. Systems and administrative capabilities to distribute, manage and oversee spending quickly, adequately and equitably are lacking.

> *"The system has been so underfunded for so long that it's sort of playing a constant catchup. And now that we have money coming into the system, you have to figure out how to absorb it."* – Public Health Stakeholder

Solution: Strong and consistent funding levels are necessary for our public health system to respond to everyday health needs, sustain hard-fought health gains, and prepare for and prevent unexpected public health emergencies. Consistent and sustainable funding is needed not just for public health programs, but also for foundational capabilities (i.e., communication and information technology). Similar to the way that the Federal Emergency Management Agency (FEMA) is consistently funded to prepare for and respond to the "unexpected crises" regardless of whether they occur, public health needs a strategy to fund for the long-term future of our population rather than focusing on the emergency of the day and after-the-fact. A shared common goal between health care and public health would drive more collaboration and shared funding between medicine and public health.

Existing AMA Policy: Our AMA urges Congress and responsible federal agencies to establish set-asides or stable funding to states and localities for essential public health programs and services, provide for flexibility in funding but ensure that states and localities are held accountable for the appropriate use of the funds; and involve national medical and public health organizations in deliberations on proposed changes in funding of public health programs. The AMA also supports the continuation of the Preventive Health and Health Services Block Grant, or the securing of adequate alternative funding, in order to assure preservation of many critical public health programs for chronic disease prevention and health promotion and will communicate support of the continuation of the Preventive Health and Health Services Block Grant, or the securing of adequate alternative funding, to the US Congress (Policy H-440.912 "Federal Block Grants and Public Health"). The AMA recognizes the importance of flexible funding in public health for unexpected infectious diseases to improve timely response to emerging outbreaks and build public health infrastructure at the local level with attention to medically underserved areas (Policy H-440.892, "Bolstering Public Health Preparedness").

Legal Authority and Politicization of Public Health

Challenge: The COVID-19 pandemic raised concerns about the structure of our public health system due to the politicization of specific public health measures to mitigate the spread or impact of the pandemic. Concerns were raised about the interference with the scientific guidance put out by the CDC and the impact that had on both public trust and the willingness to follow evidence-based recommendations. Concerns were also raised about collaboration and the lack of consistent messaging across the federal, state, territorial, local, and tribal levels. It was noted that at the state level, in some jurisdictions, public health leaders may have believed that requiring certain public health measures was the right thing to do (e.g., requiring masks or vaccines for returning college students), but they would not say it because the governor was not in favor of it.

> *"You must remember that public health is a confederated system. Based on the Tenth Amendment to the U.S. Constitution, the responsibility for public health falls to the states. Federal government can pump as much money as they'd like into it, but that money goes through governors' offices. So, you have any number of governors…who have, throughout the pandemic, taken policy positions that were 180 degrees opposite public health practice recommendations."* – Public Health Stakeholder

Concerns were also raised that state legislatures have passed laws to severely limit the legal authority of public health agencies, necessary to protect the population from serious illness, injury, and death, which will lead to preventable tragedies.[10] Public health is not in a position, on its own, to be able defend against the curtailing of public health authorities.

Solution: There was agreement among the stakeholders that public health agencies need to be able to communicate openly and make recommendations to protect and promote the health of the public based on the science. It was noted that some federal agencies seem to be able to navigate this better than others, including during the pandemic. How to best achieve this for the CDC and state health agencies in particular was not agreed upon. However, there was broad support for advocating for public health officials to have the authority they need to lead and make evidence-based decisions including emergency declarations. This includes defending against efforts by legislatures to strip that power away or efforts by governors to countermand evidence-based recommendations.

> *"I think the AMA and the state medical societies really need to take a strong stance on that. This is a health and medical issue. I mean, if you can't act quickly to curtail…infectious disease outbreaks, or maybe environmental disasters…and, do that in an evidence-based way…we could find ourselves in serious trouble."* – Public Health Stakeholder

Existing AMA Policy: Our AMA: (1) recognizes the Office of the United States Surgeon General as the esteemed position of the "nation's doctor;" and (2) calls for the Office of the United States Surgeon General to be free from the undue influence of politics, and be guided by science and the integrity of his/her role as a physician in fulfilling the highest calling to promote the health and welfare of all people (Policy H-440.863, "Restoring the Independence of the Office of the US Surgeon General").

Workforce Shortages

Challenge: There is a growing public health workforce shortage at the local, state, and federal levels. Within the next few years, state and federal public health agencies could lose up to half of their workforce to retirement and to the private sector. Due to local and state budget crises and federal budget cuts, the potential for a shortage of highly skilled public health professionals has become

more immediate and severe in scope. In addition, governmental public health salaries are not competitive with other industries. Recent public health graduates are opting for careers in other industries. Public health agencies struggle to attract and retain top talent because they cannot afford to pay them salaries comparable to the private sector.

> *"Even though schools of public health are producing a lot of public health-trained graduates, they're not going into governmental public health where we need them at that federal, state and local level because of differences in pay parity with the private sector…it's very difficult to get highly-trained individuals because of competition with private sector in areas, for example, like informatics that IT and informatics, which is a very large and growing area of public health."* – Public Health Stakeholder

Public health workers might be at risk for negative mental health consequences because of stresses associated with the prolonged demand for responding to the pandemic and for implementing an unprecedented vaccination campaign.[11] Among a survey of 26,174 state, tribal, local, and territorial public health workers, 53.0 percent reported symptoms of at least one mental health condition in the past 2 weeks (during the pandemic).[11] Symptoms were more prevalent among those who were unable to take time off or who worked ≥41 hours per week.[11] The COVID-19 pandemic has been exceptionally challenging for the public health workforce due to the personal threats to their safety or even the safety of their family members that some public health officials have faced.

> *The turnover that we're experiencing right now is extraordinary. There are lots of things driving that, it's just been a horrific time to be in public health, in any capacity, given the attacks on individuals, the attacks on science, the undermining of authority, all of those things make these jobs incredibly challenging…and so we're now in a position where I'm seeing people leaving the field, leaving these positions and there is not a workforce at the ready to stand into those roles. So, figuring out what that pipeline of public health professionals is, is absolutely critical."* – Physician Stakeholder

<u>Solution</u>: To strengthen the workforce, the first step should be to raise the visibility of public health as a potential career choice and promote it as a valuable component to keeping populations healthy. In addition, providing competitive salaries would also help attract talent, as would student debt reduction or elimination programs and loan repayment programs. The public health workforce is aging and efforts to recruit young talent are direly needed. Supporting strengthening of the Commissioned Corps of the US Public Health Service, the Epidemic Intelligence Service Program and the expansion of preventive medicine residency programs and occupation and environmental health residency programs are also important solutions. There is also an important role for health care in standing up for science, against misinformation, and supporting health officials who are facing threats.

<u>Existing AMA Policy</u>: Our AMA will work to support increased federal funding for training of public health physicians through the Epidemic Intelligence Service program and work to support increased federal funding for preventive medicine residency training programs (Policy D-305.964 "Support for the Epidemic Intelligence Service (EIS) Program and Preventive Medicine Residency Expansion"). Our AMA strongly supports the continuation of the Commissioned Corps of the US Public Health Service (Policy H-440.989 "Continuation of the Commissioned Corps".) Our AMA supports investments that strengthen our nation's public health infrastructure and the public health workforce (Policy H-440.820, "Vector-Borne Diseases").

Our AMA: (1) acknowledges and will act to reduce the incidence of antagonistic actions against physicians as well as other health care workers including first responders and public health

officials, outside as well as within the workplace, including physical violence, intimidating actions of word or deed, and cyber-attacks (Policy H-515.950, "Protecting Physicians and Other Healthcare Workers in Society").

Antiquated Data Systems

Challenge: Public health data systems are outdated and in dire need of modernization. This issue was brought to light during the COVID-19 crisis. Many public health agencies did not have access to real-time data around testing results and incidence of infections and illness to efficiently respond to the emerging crisis. Health departments are often unable to access accurate, complete, and timely data to effectively surveil disease outbreaks and promote healthy communities. Many state and local public health departments rely on paper documents, phone calls, and faxes to communicate. Many also require manual input of data into systems with limited functionality. Consistency of demographic data collection has been particularly poor. Race and ethnicity data for infections, hospitalizations, and deaths have been missing, or slow to be published, in many states.

Financial investments were made to modernize the health care data infrastructure, but the same has not happened on the public health side. In health care, data is collected in the electronic health record (EHR) and despite there being requirements for data to be reported to public health, it can be days and weeks before public health is alerted. When public health receives case reports, they are often missing key information, including race and ethnicity data. Reports are also missing data elements like a patient's address, so public health cannot geo-locate or map the cases to determine if there's an outbreak occurring in a particular area. Case reports are also often missing a patient's phone number, which is needed to conduct interviews for contact tracing. Furthermore, clinical medicine is not getting what it needs from public health. Clinicians should be able to work very closely with state and local health departments to get population-based data about their practice community.

Public health department data and systems are siloed. They work independently of each other and do not have an easy way to share information across state lines or even, at times, between agencies within a given state, preventing them from efficiently supporting each other. It is important to note that even with public health data modernization, data shared with public health agencies for review and action, will only be shared in accordance with applicable health care privacy and public health reporting laws. Improving antiquated data systems will overall improve data governance and security as well as improving access to vital surveillance data.

Solution: Data are the foundation to both population medicine and public health and rapid access to timely and accurate data are essential to drive decision-making. Priorities for public health data modernization should include automating the reporting of clinical and laboratory data from clinical health area data systems to public health. Clinicians should be incentivized to upgrade their EHR systems to support electronic case reporting and be incentivized to submit complete case reports and timely case reports. For example, if the case report is complete, including the race and ethnicity information, then clinicians should receive a bonus.

The U.S. also need to ensure interoperability among health care and public health as well as among core public health surveillance systems. There are core pieces of the public health data infrastructure that need to be modernized, such as the National Notifiable Diseases Surveillance System and the vital records systems which capture data from births and deaths annually and which can signal changes in trends, monitor urgent events and provide faster notification of cause of death. It is also important to support modernization of our syndromic surveillance system, so public health receives

data in real-time from hospital emergency departments and urgent care centers to maintain a pulse on emergency-type visits and how the health care system is being impacted by emerging syndromes.

Existing AMA Policy: Our AMA recognizes public health surveillance as a core public health function that is essential to inform decision making, identify underlying causes and etiologies, and respond to acute, chronic, and emerging health threats and recognizes the important role that physicians play in public health surveillance through reporting diseases and conditions to public health authorities. The AMA supports increased federal, state, and local funding to modernize our nation's public health data systems to improve the quality and timeliness of data and supports electronic case reporting, which alleviates the burden of case reporting on physicians through the automatic generation and transmission of case reports from electronic health records to public health agencies for review and action in accordance with applicable health care privacy and public health reporting laws. The AMA will advocate for increased federal coordination and funding to support the modernization and standardization of public health surveillance systems data collection by the Centers for Disease Control and Prevention and state and local health departments and supports data standardization that provides for minimum national standards, while preserving the ability of states and other entities to exceed national standards based on local needs and/or the presence of unexpected urgent situations (Policy H-440.813, "Public Health Surveillance"). Our AMA encourages hospitals and other entities that collect patient encounter data to report syndromic (i.e., symptoms that appear together and characterize a disease or medical condition) data to public health departments in order to facilitate syndromic surveillance, assess risks of local populations for disease, and develop comprehensive plans with stakeholders to enact actions for mitigation, preparedness, response, and recovery (Policy H-440.892, "Bolstering Public Health Preparedness").

Insufficient Laboratory Capacity

Challenge: Our nation lacks the capacity to conduct adequate testing and surveillance of infectious diseases and other pathogens, including a lack of whole genome sequencing during the pandemic needed to identify SARS-CoV-2 variants. Public health labs have the technology to identify a wider range of diseases and are therefore expected to support clinical labs. However, public health labs often lack the resources needed to keep up with the workload, that has been especially true during the pandemic. Throughout the pandemic, all laboratories have faced challenges obtaining the necessary testing supplies. While public, commercial and hospital labs have shared resources throughout the pandemic, this has varied by jurisdiction and has occurred informally based on relationships among lab directors rather than systematically or consistently

Solution: Our public health labs at the state and local level need to be better resourced and would benefit from more formal relationships between them and commercial labs, hospital and academic labs, and the CDC. The components of the laboratory community, though they may have different missions, need to see themselves as partners within a very interconnected system. As a nation, we need to do more whole genome sequencing, working with urgent care clinics, emergency departments, and hospitals, so that trends in virus variants can be identified and tracked. We also need to strengthen and broaden supplies within the Strategic National Stockpile and the capacity to ramp up production of supplies domestically; overreliance on international sources of supplies can be a national security issue.

Existing AMA Policy: Our AMA supports the Centers for Disease Control and Prevention's national Laboratory Response Network for communicating, coordinating, and collaborating with physicians and laboratory professionals on public health concerns (Policy H-440.891, "Support of the National Laboratory Response Network"). Our AMA: (1) encourages payers, regulators and providers to make clinical variant data and their interpretation publicly available through a system

that assures patient and provider privacy protection; and (2) encourages laboratories to place all clinical variants and the clinical data that was used to assess the clinical significance of these results, into the public domain which would allow appropriate interpretation and surveillance for these variations that can impact the public's health (Policy D-460.971, "Genome Analysis and Variant Identification"). Our AMA urges Congress and the Administration to work to ensure adequate funding and other resources for the CDC, the National Institutes of Health (NIH), the Strategic National Stockpile and other appropriate federal agencies, to support the maintenance of and the implementation of an expanded capacity to produce the necessary vaccines, anti-microbial drugs, medical supplies, and personal protective equipment, and to continue development of the nation's capacity to rapidly manufacture the necessary supplies needed to protect, treat, test and vaccinate the entire population and care for large numbers of seriously ill people, without overreliance on unreliable international sources of production (Policy H-440.847, "Pandemic Preparedness").

Lack of Collaboration between Health Care and Public Health

Challenge: While the work of health care and public health are interconnected, the work is done in silos. Both physicians and public health practitioners that were interviewed expressed a strong desire for more collaboration. Some of the challenges in collaborating were mentioned previously around data modernization and the need to share information between health care and public health. Physicians also expressed frustration that they do not hear directly from their state and local health departments. During the pandemic, most physicians received updates on what is happening in their community through the news media. There is a desire for health departments to provide updates to clinicians in their jurisdictions directly. Beyond collaboration between health agencies and the physicians in their jurisdiction, there is also the desire for more collaboration between medicine and public health at the local, state and national levels among their professional organizations.

Solution: A critical component to improving public health infrastructure is to promote more collaboration and communication pathways between medicine and public health. There is a need to jointly arrive as the point of consensus that prevention is a shared goal which, if emphasized, will advance both fields. To that end, we need a "health" system--not divided between public health and health care, which unites in its shared goal of prevention. Greater collaboration also means that health-related jobs become easier, with fewer high-risk patients needing clinical care and more prevention activities to reduce demand on the health care system. The AMA should use some of its political capital, in collaboration with national public health organizations, to rebuild our public health infrastructure.

It is worth noting that in 1994, the AMA and the American Public Health Association (APHA) co-convened the Medicine and Public Health Initiative (MPHI).[12] In 1996, MPHI hosted a Congress inviting 400 representatives from Medicine & Public Health and provided grants at the state/local level to build sustainable, collaborative partnerships. By the year 2000, changes in leadership at the state and national level resulted in difficulty sustaining momentum. In 2002, following the September 11th attacks, the presidents of the AMA and APHA reiterated their dedication to MPHI. In 2004, the AMA and the CDC hosted the First National Preparedness Congress. This collaboration was not sustained due to shifting priorities. The Council urges consideration of the best way for clinical medicine and for our AMA and member organizations of the Federation of Medicine to collaborate with public health in a meaningful and sustainable way going forward.

Existing AMA Policy: Our AMA (1) encourages medical societies to establish liaison committees through which physicians in private practice and officials in public health can explore issues and mutual concerns involving public health activities and private practice; (2) seeks increased dialogue, interchange, and cooperation among national organizations representing public health professionals

and those representing physicians in private practice or academic medicine; (3) actively supports promoting and contributing to increased attention to public health issues in its programs in medical science and education; (4) continues to support the providing of medical care to poor and indigent persons through the private sector and the financing of this care through an improved Medicaid program; (5) encourages public health agencies to focus on assessment of problems, assurance of healthy living conditions, policy development, and other related activities; and (6) encourages physicians in private practice and those in public health to work cooperatively, striving to ensure better health for each person and an improved community as enjoined in the Principles of Medical Ethics (Policy H-440.960, "Organized Medicine and Public Health Collaboration").

Ensuring Equity

Challenge: The gaps in the public health infrastructure mentioned previously all contribute to health inequities. The COVID-19 pandemic highlighted the equity gap in health outcomes for marginalized communities, as shown by the substantially higher rates of infection, hospitalization, and death in marginalized communities compared with White people. Incomplete data and fragmented access to data prevents public health from accurately identifying populations at greatest risk and prioritizing efforts and funding. Inadequate and inequitable funding means increased disparities in health outcomes because resources will not reach those in most need. The workforce needs to change so it has more people who are known and trusted in their communities, working on many of the issues that we face. These efforts require resources, and there are currently insufficient resources to support those kinds of meaningful efforts.

> *"Public health is for everybody. It's just not for the poor. It's not just for the rich. Public health is something that everyone should have access to. But some people need more help than others to get that access. And that's got to be solved."* – Physician Stakeholder

Many practicing physicians lack the training to consider and address the social determinants of health with their patients. Limited time for patient visits contributes to doctors not having time to address social determinants during a regular visit even if they are trained in understanding and incorporating the social determinants of health. Physicians do not have to do this work alone; public health is here to address the social determinants of health in communities collaboratively, but we need a common language and a common understanding.

> *"I think as physicians, we increasingly realize that our patients' diseases that we're treating them for, diabetes, whatever, are being driven by risk behaviors that they're taking that we don't always feel like our counseling … is effective … without other interventions at the community level. Living conditions, social environment, institutional things, inequities that are happening, that are affecting their freedom, and housing, and transportation, … are affecting the disease that shows up in our office."* – Physician Stakeholder

Solution: All of these gaps in the public health infrastructure contribute to the increasing inequities we see in health outcomes in the United States. Fragmented access to data prevents public health from accurately prioritizing efforts. Access to data is needed to inform equitable policy. Adequate funding is needed to decrease inequities in health outcomes and ensure resources reach those in most need. The workforce that is leading the charge against inequities needs to include more persons who look like the population it serves. Equity involves engagement with communities in an ongoing and meaningful way so those most affected by public health challenges are part of the conversations and part of the solutions.

Existing AMA Policy: Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity (Policy H-180.944, "Plan for Continued Progress Toward Health Equity").

DISCUSSION

When public health stakeholders were asked about the work the AMA does in public health, there was little recognition of current public health activities. Some stakeholders referenced the work the AMA has done to address tobacco use and more were familiar with the AMA's health equity strategy, which had been released around the time of the interviews. When asked about the AMA's role in strengthening public health infrastructure, public health stakeholders highlighted the following as the strengths of the AMA and where the organization should focus its efforts:

- Communicating - Raise the visibility of public health to ensure the work public health professionals do is not invisible; share power--ensuring public health is at the table;
- Advocating - Elevate physicians' and organized medicine's influence in policy and support initiatives that focus more on public health; help build bi-partisan support for public health; and
- Educating - Help further emphasize public health and the social determinants of health in medical education, support training opportunities for medical students in health departments (see Appendix C, which outlines relevant existing activities).

Public health stakeholders encouraged the AMA to be a champion for public health while maintaining our brand position of being in the health care sector.

The AMA trustees who were interviewed as a part of this research strongly agreed with the challenges that were identified by the public health stakeholders as impacting our nation's public health infrastructure. There was also general agreement that these efforts would fit within the AMA's current strategic arcs. Trustees recommended solutions that are on-brand, fiscally responsible, and aligned with current strategy and operating goals. Some trustees cautioned that the AMA should not try to do all of these things, but to pick a few where the organization can be the most impactful. In addition to communicating, advocating, and educating, the trustees felt the AMA was well-equipped to be a convener and should focus on this while also engaging in other opportunities.

CONCLUSION

There is widespread recognition that our nation's public health infrastructure needs to be strengthened. The AMA already has extensive policy aligned with many of the challenges and solutions outlined in this report. These policies, adopted by the House of Delegates over the past decades, serve as the basis for the AMA to act. We recognize that there are many programs and initiatives happening across the organization that are relevant to this work. Members of the AMA Board of Trustees who participated in this process indicated that this work fits into the AMA's currently articulated strategic priorities. Therefore, your Council on Science and Public Health recommends that the AMA outline an organization-wide public health strategy, aligned with the findings of this report, to develop a clear roadmap of the work being done by the AMA in public health and to share accomplishments as the strategy is implemented. The Council also recommends new policy urging the AMA to actively oppose the limits being placed on the authority of health officials, recognizing the authority to implement evidence-based measures, including mandates, may

be necessary to protect the health of the public. The Council also calls on the AMA to advocate for the solutions identified through this research, including sustainable funding to support public health infrastructure, incentives to help recruit and retain staff within the governmental public health workforce, public health data modernization and efforts to promote interoperability between health care and public health, and efforts to ensure equitable access to public health funding and programs. The Council also proposes new policy encouraging public health agencies to communicate directly with the health professionals licensed within their jurisdiction. We recognize that some jurisdictions are doing this well, but in many jurisdictions, there is little communication between health care professionals and their public health agency. Minor amendments are also suggested to further strengthen our existing public health policies based on the findings of this research.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following be adopted in lieu of Resolution 401-JUN-21 and the remainder of the report be filed.

1. That Policy D-440.922, "Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems" be amended by addition and deletion to read as follows:

   Our AMA will: (1) champion the betterment of public health by enhancing advocacy and support for programs and initiatives that strengthen public health systems, to address pandemic threats, health inequities and social determinants of health outcomes; ~~and (2) study the most efficacious manner by which our AMA can continue to achieve its mission of the betterment of public health by recommending~~ (2) develop an organization-wide strategy on public health including ways in which the AMA can ~~to~~ strengthen the health and public health system infrastructure and report back as needed on progress; (3) work with the Federation and other stakeholders to strongly support the legal authority of health officials to enact reasonable, evidence-based public health measures, including mandates, when necessary to protect the public from serious illness, injury, and death and actively oppose efforts to strip such authority from health officials; (4) advocate for (a) consistent, sustainable funding to support our public health infrastructure, (b) incentives, including loan forgiveness and debt reduction, to help strengthen the governmental public health workforce in recruiting and retaining staff, (c) public health data modernization and data governance efforts as well as efforts to promote interoperability between health care and public health; and (d) efforts to ensure equitable access to public health funding and programs. (Modify Current AMA Policy)

2. That Policy H-440.960, "Organized Medicine and Public Health Collaboration" be amended by addition and deletion to read as follows:

   Our AMA (1) encourages medical societies to establish liaison committees through which physicians in private practice and officials in public health can explore issues and mutual concerns involving public health activities and private practice; (2) seeks increased dialogue, interchange, and cooperation among national organizations representing public health professionals, including representatives from governmental public health, and those representing physicians in private practice or those employed in health systems and in academic medicine (3) actively supports promoting and contributing to increased attention to public health issues in its programs in medical science and education; ~~(4) continues to support the providing of medical care to poor and indigent persons through the private sector and the financing of this care through an improved Medicaid program;~~ (~~5~~4) encourages public health agencies to focus on assessment of problems, assurance of healthy living conditions, policy development, and other related activities; ~~and~~ (~~6~~5) encourages physicians in private practice and those in public

health to work cooperatively, striving to ensure better health for each person and an improved community as enjoined in the Principles of Medical Ethics; and (6) encourages state and local health agencies to communicate directly with physicians licensed in their jurisdiction about the status of the population's health, the health needs of the community, and opportunities to collectively strengthen and improve the health of the public. (Modify Current AMA Policy)

3. That AMA Policy H-440.912, "Federal Block Grants and Public Health" which calls on the AMA to collaborate with national public health organizations to explore ways in which public health and clinical medicine can become better integrated and urges Congress and responsible federal agencies to: (a) establish set-asides or stable funding to states and localities for essential public health programs and services, (b) provide for flexibility in funding but ensure that states and localities are held accountable for the appropriate use of the funds; be reaffirmed. (Reaffirm Current AMA Policy)

4. That AMA Policy H-440.989, "Continuation of the Commissioned Corps," be amended by addition to read as follows:

   Our AMA strongly supports the expansion and continuation of the Commissioned Corps of the US Public Health Service and recognize the need for it to be adequately funded. (Modify Current AMA Policy)

5. That our AMA reaffirm Policies D-305.964, "Support for the Epidemic Intelligence Service (EIS) Program and Preventive Medicine Residency Expansion," and D-295.327, "Integrating Content Related to Public Health and Preventive Medicine Across the Medical Education Continuum." (Reaffirm Current AMA Policy)

6. That our AMA reaffirm Policy H-440.89, "Support of the National Laboratory Response Network," and Policy D-460.971, "Genome Analysis and Variant Identification." (Reaffirm Current AMA Policy)

7. That our AMA amend Policy H-440.813, "Public Health Surveillance" by addition and deletion to read as follows:

   Our AMA: (1) recognizes public health surveillance as a core public health function that is essential to inform decision making, identify underlying causes and etiologies, and respond to acute, chronic, and emerging health threats; (2) recognizes the important role that physicians play in public health surveillance through reporting diseases and conditions to public health authorities; (3) encourages state legislatures to engage relevant state and national medical specialty societies as well as public health agencies when proposing mandatory reporting requirements to ensure they are based on scientific evidence and meet the needs of population health; (4) recognizes the need for increased federal, state, and local funding to modernize our nation's public health data systems to improve the quality and timeliness of data; (5) supports the CDC's data modernization initiative, including electronic case reporting, which alleviates the burden of case reporting on physicians through the automatic generation and transmission of case reports from electronic health records to public health agencies for review and action in accordance with applicable health care privacy and public health reporting laws; (6) will advocate for incentives for physicians to upgrade their EHR systems to support electronic case reporting as well as incentives to submit case reports that are timely and complete; (~~6~~7) will share updates with physicians and medical societies on public health surveillance and the progress made toward implementing electronic case reporting; (~~7~~8~~)~~ will advocate for increased federal coordination and funding to support the modernization and standardization of public

health surveillance systems data collection by the Centers for Disease Control and Prevention and state and local health departments; ~~and~~ (~~8~~9) supports data standardization that provides for minimum national standards, while preserving the ability of states and other entities to exceed national standards based on local needs and/or the presence of unexpected urgent situations. (Modify Current AMA Policy)

Fiscal Note: $650,000

Figure 1

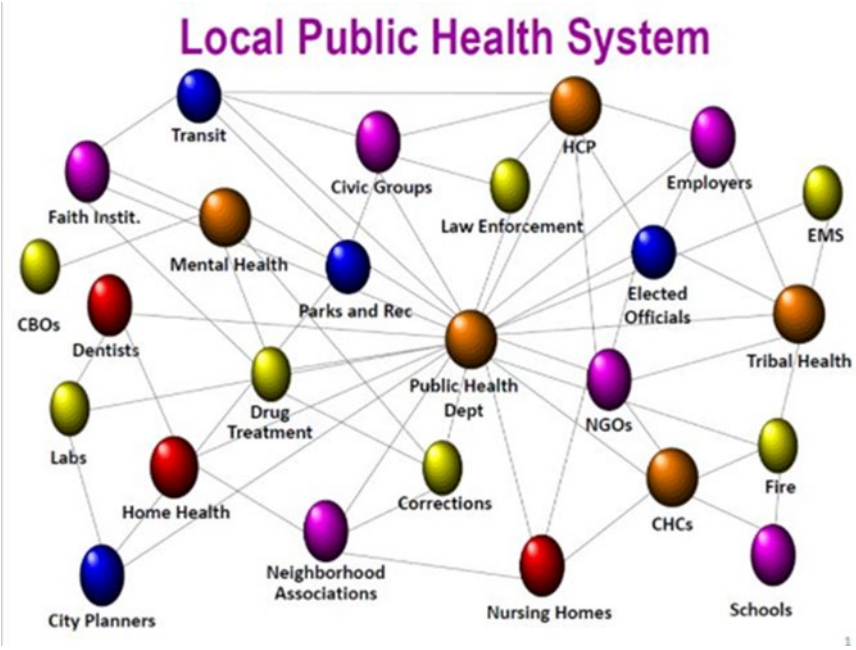
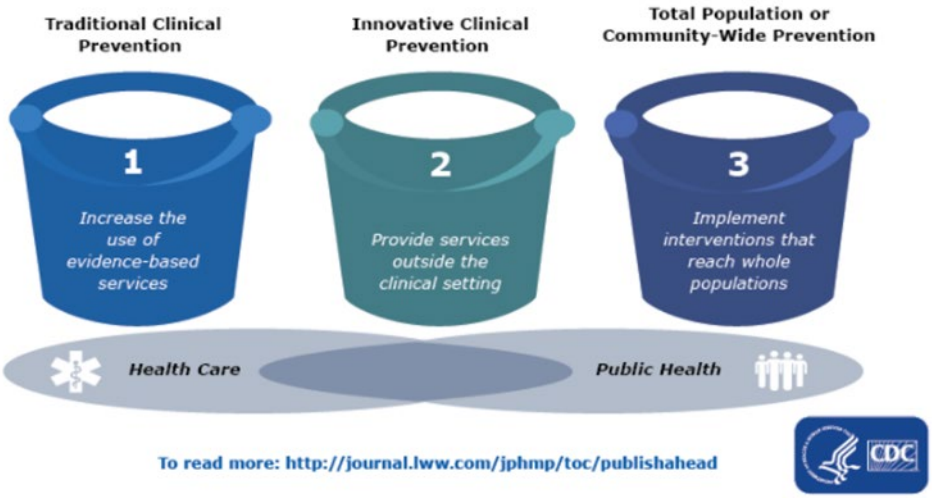


Figure 2



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APPENDIX A

#24495 Public Health Infrastructure Interviews

Background and Objectives

The American Medical Association's Council on Science and Public Health is assessing ways to strengthen our nation's public health infrastructure, and the AMA's role in supporting and improving public health systems. More specifically:

- Understand the current challenges faced by public health professionals and health departments in preventing, detecting, and responding to emerging infectious disease threats and other public health crises.
- Understand physician and public health professionals' perspectives on what solutions need to be implemented to strengthen public health infrastructure to carry out the 10 essential public health services to improve disease and injury prevention and the health of the public
- Identify barriers and opportunities for improved and increased linkages between the public health and health care systems.
- Understand opportunities for the public health system to protect and promote the health of all people in all communities by removing systemic and structural barriers that have resulted in inequities.
- Identify opportunities for the AMA in supporting, developing, and implementing solutions.

Methodology and Sample

N=30-33 External stakeholders

- Government and Public Health (n=10)
- National Public Health (n=6)
- Federation of Medicine (n=12)
- Foundations (n=2)

Note on in-depth interviews format:

Questions might not be asked in the order below and all questions will likely not be asked. Rather, they are used as a guideline for the discussion. We will aim to have a natural conversation with the interviewees and touch upon the topics as they become part of the discussion and as they are relevant to the interviewee.

Intros (2-3 minutes)

- C+R Research – independent market research firm
- Talking with Physicians and Public Health Professionals like you for research purposes but don't belong to any health organization – think of me as a neutral third-party
- No wrong answers!

- I'm a moderator, not an expert in this field, so I may ask you to clarify things along the way
- Documenting the interview with audio (for notetaking and report writing purposes only)
- Other C+R and AMA researchers may join your interview to observe your responses. They may also view session recordings or notes in the future. The AMA may publish research reports or articles that include your anonymous comments and experiences shared. C+R and the AMA will not provide any details with its use of the information resulting from the interview which would allow any third party to identify you, nor will it use this information in any way that can be damaging to you.
- Questions before we get started?

BACKGROUND AND CONTEXT 5 minutes

- First off, we mentioned that we would be talking about the public health infrastructure in our interview today. From your perspective, how do you define "public health infrastructure"?
- Can you briefly describe your organization/your position and how long you have been in that role?
- How would you describe your background in terms of your expertise or involvement in public health?
    - *Understand whether their focus is research, epidemiology, policy & management, environmental health, etc.*
    - *Understand primary issue/area of focus within the field of public health (e.g., immunizations, maternal health, gun violence, health equity, etc.)*
- What previous roles have you had related to public health (in other organizations)? *Listen for if they were previously a state/local health official*

For Governmental/National Public Health Organizations:

- What is the role of your organization and/or members in the public health system?
- Can you briefly **describe your location or jurisdiction/population of focus?**

For physicians/primary care organizations:

- How do you or your members support or interact with the public health system?
- Can you briefly **describe your location or jurisdiction/population of focus?**

CURRENT CHALLENGES 15 minutes

Now I'd like to talk more about the challenges facing our nation's public health system. You are welcome to focus this conversation on COVID-19, as we understand it's likely a main part of what your organization is currently focused on, or you can consider challenges beyond the pandemic.

Successes + What Works Well

- **National Public Health Organizations:**
    - What are some **"big picture" successes** your organization/members/our public health system have had?

  - What's an example of a **"small success"** your organization/members/our public health system have had on a given day or week?
  - Please share some **examples of how your organization/members/the public health system has successfully collaborated** with physicians or healthcare delivery systems to address a public health issue.
  - *Probe: how do we sure the **10 Essential Public Health Services** are available to all people in all communities?*
  - *Probe: is there an explicit strategy to advance equity?* Please describe any explicit **strategies to advance equity** that you/your organization/members use consistently.

- **National Physician Organizations:**
  - What are some **examples of how physicians/your members/health care systems have successfully collaborated** with public health agencies? Have these been sustained?
  - Please share an **example from your or your organization's perspective** of when the public health and healthcare sectors were in **alignment** on a significant public health issue in your local community and/or nationally.
  - *Probe: how do we sure the **10 Essential Public Health Services** are available to all people in all communities?*
  - *Probe: Do you have an explicit strategy to advance equity?* Please describe any explicit **strategies to advance equity** that your organization/members use consistently.

Previous and/or Ongoing Challenges

- What would you say are the three to five **biggest challenges facing the nation's public health infrastructure** today?
  - Why do you think each of these is an important issue?
- How would you prioritize these issues?

  - *Probes: authority, communication, collaboration across levels of government, public health workforce, data modernization, linkages between health care and public health, ensuring equity*
  - **Physician Orgs:** How do challenges in public health infrastructure impact physician practices and patients?
- *Probes: for those who are former state/local health officials to think about what they needed when they were in that job and what would have been most beneficial.*

- **[For each challenge mentioned]** Tell me about a recent challenge the public health system faced. These challenges can be specific to the COVID-19 pandemic or on issues other than the pandemic.
  - What was the issue/challenge?
  - What made it challenging or difficult?
  - What was the plan to resolve this issue?
  - How was it implemented (whether successfully or unsuccessfully)?
  - What were the outcomes?
  - What was the impact on health equity?
  - What did you or your organization learn from this? What will be done differently in the future?

Repeat as time allows to understand multiple issues and their context.

IDEATE FUTURE SOLUTIONS 10-15 minutes

Now that we've talked about these challenges, I'd like to hear more from you about your thoughts on how these can be solved.

- From your perspective, what do you think **needs to be done to improve** the public health infrastructure?

- Thinking back to each of those challenges you have faced, what would have made these issues easier to solve?

  - **National Public Health Organizations:**
    - What can help your **organization/members/the public health system** be more successful in their efforts?
    - What can help you/your members/the public health be more successful in your/their job?
    - What would improve collaboration between medicine and public health and lead to better health outcomes for patients and communities?

  - **National Physician Organizations:**
    - What would improve collaboration between medicine and public health and lead to better health outcomes for patients and communities?
    - What is the perspective of physicians/your members on linking the principles of public health (upstream approaches) into the language and practice of medicine?
      How do we move health care upstream to improve the structural and social drivers of health and equity?

- What's **one thing you'd want to change** that would make the work of the public health system easier, more effective and equitable tomorrow?
  - What about making the next few weeks/months easier more effective and equitable?
  - And the next few years?

- How would you **prioritize** these changes?
  - What should be focused on first? What is most important?
  - What are areas that could be addressed at a later time?

- What **goals** do you or your organization already have in place to address these in the future?
  - Which are more short-term, and which are longer term goals?
- Which organizations (for profit, not-for-profit, public, private) would be part of the solution to the U.S.'s public health infrastructure problems? What roles/contributions would they have in the solution?
- *If time allows.* Who would be a **reliable and trustworthy source** for you related to recommendations on how to better manage future public health issues?
  - Why are these sources more reliable than others? *Probe to get beyond simply peer reviewed research or the CDC.*

AMA POTENTIAL SOLUTIONS + WRAP UP 10 minutes

I'd like to talk more specifically about how the AMA can **support efforts to strengthen public health infrastructure.**

- Public Health Orgs: In what way(s), does/do the AMA already help support you in your role/organization improve public health?
- Physician Orgs: In what ways does the AMA already support you in addressing the upstream factors that impact health?

- Thinking back to your previous challenges, how, if at all, can the AMA help with these?
    - What can the AMA do to help you face these challenges in a better way?
    - What would the AMA need to do? What would this solution look like?
    - What should the AMA provide?

- Do you have any **final words of advice** for those designing and implementing future public health policies, recommendations, and programs?

Moderator will check with back room for additional questions, thank and close

APPENDIX B

#24495 Public Health Infrastructure Interviews
FINAL GUIDE – Internal B.O.T. Interviews
45 minutes

Background and Objectives

The American Medical Association's Council on Science and Public Health is assessing ways to strengthen our nation's public health infrastructure, and the AMA's role in supporting and improving public health systems. More specifically:

- Understand the current challenges faced by public health professionals and health departments in preventing, detecting, and responding to emerging infectious disease threats and other public health crises.
- Understand physician and public health professionals' perspectives on what solutions need to be implemented to strengthen public health infrastructure to carry out the 10 essential public health services to improve disease and injury prevention and the health of the public
- Identify barriers and opportunities for improved and increased linkages between the public health and health care systems.
- Understand opportunities for the public health system to protect and promote the health of all people in all communities by removing systemic and structural barriers that have resulted in inequities.
- Identify opportunities for the AMA in supporting, developing, and implementing solutions.

Methodology and Sample

N=11 Internal B.O.T. Members

Note on in-depth interviews format:

Questions might not be asked in the order below and all questions will likely not be asked. Rather, they are used as a guideline for the discussion. We will aim to have a natural conversation with the interviewees and touch upon the topics as they become part of the discussion and as they are relevant to the interviewee.

Intros (2-3 minutes)

- C+R Research – independent market research firm
- Working with the AMA and talking with internal board members like you as well as external stakeholders in public health – think of me as a neutral third-party
- No wrong answers!
- I'm a moderator, not an expert in this field, so I may ask you to clarify things along the way

- Documenting the interview with audio (for notetaking and report writing purposes only)
- Other C+R and AMA researchers may join your interview to observe your responses. Just a reminder that this is all for research purposes and your responses will be reported back in the aggregate along with other board members like you.
- Questions before we get started?

BACKGROUND AND CONTEXT 2-3 minutes

- Can you briefly describe **your role** as it relates to the AMA and how long you have been in that role?

- Today, we are going to be talking about the public health infrastructure as well as ways AMA can help. When I say **public health infrastructure**, I am talking about the governmental public health system at the federal, state, local, territorial and tribal levels.
  Can you describe **your background** along with any previous involvement in efforts **related to public health** (if applicable)?

CURRENT CHALLENGES 10 minutes

As you may know, we just completed an initial round of interviews with external public health experts from a variety of organizations. They provided their perspective on what challenges are facing our nation's public health infrastructure today. But before we talk about what they told us, I'm curious what your perspective is.

Challenges (Unaided) – 3 minutes

- Just briefly, what would you say are the top three **biggest challenges facing the nation's public health infrastructure** today?
  - *Listen for and probe around any mentions of misperceptions of public health, funding, workforce, data modernization, collaboration between healthcare and public health, equity issues, etc.*

- How do these challenges **impact your practice or your patients**? *(do not ask if respondent is not a clinician)*

Challenges (Aided) – 7 minutes

- When we spoke with the external public health stakeholders, here are some of the **biggest challenges they mentioned**. I am curious to get your perspective on these and hear how you would prioritize them.
  HAVE RESPONDENT RANK ORDER CHALLENGES FROM HIGHEST TO LOWEST PRIORITY
  - Perception problems/lack of understanding of public health (i.e., public health is invisible)
  - Lack of consistent, sustainable funding
  - Workforce/staffing issues

- Data modernization and lack of interoperability with health care
- Lack of collaboration between healthcare and public health
- Equity issues

IDEATE FUTURE SOLUTIONS 15 minutes

Now that we've talked about these challenges, I'd like to hear more from you about your thoughts on **how the AMA could help address each of these areas.**

- **[For each challenge mentioned, ask in order of priority] What could the AMA do** to help solve this challenge?
  - What would the potential solution(s) look like?
  - Who would need to be involved?
  - What would it take to accomplish this? (what would have to happen?)

- In addition to the solutions we just discussed, here are some other ideas the external stakeholders mentioned as **possible solutions, which include the AMA's role in strengthening the public health system.** I'd like to get your perspective on which of these the AMA feels best suited to support and why.

  - **Collaboration Between Medicine and Public Health**
    For example, sharing of data across public health and healthcare, more communication between public health and health care, sharing the common goal of prevention, etc.

  - **Prioritizing Public Health**
    For example, raising the visibility of our public health system to help ensure the work they do is not invisible and share power ensuring their voice is at the table.

  - **Advocating for Sustainable Public Health Funding**
    For example, advocating at the federal level for sustainable funding for the public health infrastructure (communications, IT, workforce) and services (immunizations, chronic disease, injury prevention to ensure that public health isn't only funded well in a crisis.

    Working with state/county medical societies to advocate for evidence-based public health polices as well as support for public health authority during emergencies.

  - **Data Modernization**
    For example, supporting interoperability between health care and public health as well as incentives for health care professionals who report timely, accurate and complete data on notifiable conditions to public health agencies.

    Supporting incentives for clinicians to upgrade the EHR systems to support electronic case reporting.

- **Strengthening the Public Health Workforce**
  For example, supporting incentives for those who work in governmental public health so public health can attract the talent it needs to be successful.
  Prioritizing physician and medical student education in public health as well as education focusing on, equity and the social determinants of health.

  Supporting residency programs for preventive medicine specialists.

- How would you **prioritize** these changes?
  - What should be focused on first? What is most important?
  - What are areas that could be addressed at a later time?

AMA POTENTIAL SOLUTIONS + WRAP UP 15 minutes

I'd like to talk more specifically about what else the AMA can do to **support efforts to strengthen public health infrastructure.**

- How does strengthening the public health system **fit into the AMA's current strategic plan and operating goals?** *Moderator may reference slide for strategic plan and operating goals*

- What do you think the AMA **should do** to further strengthen the public health infrastructure beyond what it is already doing?

  - What should the AMA do to strengthen collaboration between medicine and public health?

- What, if anything, would you **caution the AMA <u>not</u> to do or not to get involved in?**

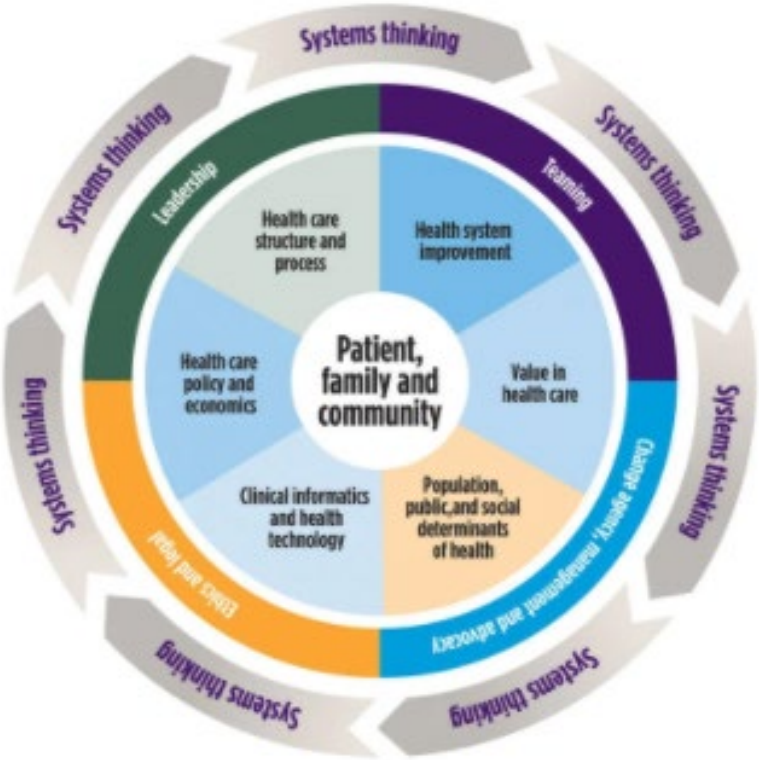
- Do you have any **final words of advice** for those considering the AMA's role in strengthening public health infrastructure?

Moderator will check with back room for additional questions, thank and close

APPENDIX C

Health System Science
Health systems science (HSS) is the third pillar of medical science, along with the basic and clinical sciences. It involves understanding how care is delivered, how health care professionals work together to deliver that care and how the health system can improve patient care and health care delivery. It is critical for the successful functioning of a health system. Physicians need to know the domains of health systems science, understand how it intersects with the basic and clinical sciences and explore how it can maximize health for patients and society.

The HSS cirriculum includes issues related to how social determinants of health effect the entire population and the improvement strategies at the population health level to address gaps in care such as the organized assessment, monitoring or measurement of key health metrics necessary to improve health outcomes for a group of individuals.



Core functional, foundational, and linking domains of health systems science

AMA ACE Consortium

Relevant exemplar medical school efforts in the consortium, funded by AMA grants:

- Brown Warren Alpert School of Medicine established the Primary Care-Population Medicine in which students receive a Masters of Science in Population Medicine in addition to their MD https://pcpm.med.brown.edu/curriculum/scm-curriculum
- AT Still School of Osteopathic Medicine in Arizona embeds 2nd-4th year medical students in underserved communities where they perform needs assessments and work with

community health center leadership and community stakeholders to perform community-based research, quality improvement or service projects that recognize the local, social and economic determinants of health.

- Florida International University Herbert Wertheim College of Medicine (FIU HWCOM) NeighborhoodHELP program places medical students on inter-professional teams that perform home visits that have resulted in increased use of preventive health services and a trend toward decreasing the use of the emergency department as a regular place of care. The program also allows for collaboration with local hospitals to improve population health outcomes.
- Similarly, University of Texas Rio Grande Valley School of Medicine (UTRGV) places medical students on inter-professional teams that serve colonias, impoverished rural settlements in unincorporated areas along the U.S./Mexico border, providing integrated care and connecting patients and families with public health services
- The University of California, Davis, School of Medicine (UC Davis) established a model three-year education track, the "Davis Accelerated Competency-based Education in Primary Care" (ACE-PC) that addresses pressing societal needs by including work with medically underserved populations and enhanced training in population management, chronic disease management, and preventive health skills

AMA Reimagining Residency initiative

The goal of the Reimagining Residency grant program is to transform residency training to best address the workplace needs of our current and future health care system. It supports bold and innovative projects that provide a meaningful and safe transition from undergraduate medical education to graduate medical education, establish new curricular content and experiences to enhance readiness for practice and promote well-being in training.

Examples of relevant projects:

- Montefiore is developing a curriculum in social determinants of health in four primary care residency programs.
- COMPADRE is a collaboration between OHSU and UC-Davis to address workforce in the predominantly rural and indigenous communities in the corridor between their institutions. They are providing training in those communities, so trainees understand the social context for care and the community resources available to support their work.
- The FIRST program at UNC expanding its 3+3+3 model (3 years of medical school, 3 years of residency, 3 years of early career mentorship) to 4 regions in the state (3 of them AHECs) and across disciplines. This is also an effort to link training and early career experience to community resources.
- Penn State is collaborating with Geisinger, Allegheny, and Kaiser Permanente to define the personal and learning environment characteristics that contribute the creation of "systems citizens" – those physicians who effectively navigate health systems and appropriately apply system and community resources to the care of their patients.

REPORT 3 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (N-21)
Physician Involvement in State Regulations of Motor Vehicle Operation and/or Firearm Use by Individuals with Cognitive Deficits Due to Traumatic Brain Injury
(Resolution 424-A-19)
(Reference Committee D)

EXECUTIVE SUMMARY

Objective. This report summarizes the evidence around cognitive deficits, including traumatic brain injury (TBI), the legal landscape of cognitive impairment as it relates to firearm ownership and driving, and the role of the physician in adjudicating fitness. While the resolution specifically cites TBI, there is currently limited research available on TBI and driving or firearm ownership. As such, more well-studied cognitive deficits (such as dementias) are examined to provide context.

Methods. English language reports were selected from searches of the PubMed and Google Scholar databases from January 2011 to July 2021 using the search terms "medical advisory board" and "gun" or "firearm" or "driver license" or "motor vehicle;" "cognitive impairment" or "dementia" or "traumatic brain injury" and "gun" or "firearm" or "driver license" or "motor vehicle." Additional articles were identified by manual review of the reference lists of pertinent publications. Websites managed by federal and state agencies and applicable regulatory and advocacy organizations were also reviewed for relevant information

Results. The role of the physician in adjudicating fitness for driver licensing and firearm ownership are primarily dictated by individual state policies. Differences in state policies, such as the duration of revocation, severity of symptoms and appeals process were noted. Generally, a medical advisory board is utilized for driver licensing adjudication and appeals. For firearm ownership, cognitive impairment-based removals are more uncommon and extreme risk protection orders have only recently become established in a smaller number of states, with varying roles of physician involvement.

Conclusion. Given the unpredictable nature of symptom progression in an individual living with TBI, it is difficult to compare to the current regulatory framework with other cognitive impairments, such as dementias. Your Council recommends that additional research is needed to understand TBI as a risk factor for harming oneself or others in order to inform the development of policies and protocols for the revocation or reinstatement for the purposes of driver licenses and firearm ownership
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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 3-N-21

Subject: Physician Involvement in State Regulations of Motor Vehicle Operation and/or Firearm Use by Individuals with Cognitive Deficits Due to Traumatic Brain Injury

Presented by: Alexander Ding, MD, MS, MBA, Chair

Referred to: Reference Committee D

INTRODUCTION

Resolution 424-A-19, "Physician Involvement in State Regulations of Motor Vehicle Operation and/or Firearm Use by Individuals with Cognitive Deficits Due to Traumatic Brain Injury," introduced by the American Academy of Physical Medicine and Rehabilitation and referred by the American Medical Association (AMA) House of Delegates (HOD) asked:

> That our AMA reaffirm current AMA Policy H-145.999, stating it supports stricter enforcement of current federal and state gun legislation and that our AMA advocate for physician-led committees in each state to give further recommendations to the state regarding driving and/or gun use by individuals who are cognitively impaired and/or a danger to themselves or others.

This report summarizes the evidence around cognitive deficits, including traumatic brain injury (TBI), the legal landscape of cognitive impairment as it relates to firearm ownership and driving, and the role of the physician in adjudicating fitness. While the resolution specifically cites TBI, there is currently limited research available on TBI and driving or firearm ownership. As such, more well-studied cognitive deficits (such as dementias) are examined to provide context.

METHODS

English language reports were selected from searches of the PubMed and Google Scholar databases from January 2011 to July 2021 using the search terms "medical advisory board" and "gun" or "firearm" or "driver license" or "motor vehicle;" "cognitive impairment" or "dementia" or "traumatic brain injury" and "gun" or "firearm" or "driver license" or "motor vehicle." Additional articles were identified by manual review of the reference lists of pertinent publications. Websites managed by federal and state agencies and applicable regulatory and advocacy organizations were also reviewed for relevant information.

OVERVIEW OF COGNITIVE IMPAIRMENT

Cognitive impairment describes a durable characteristic in which an individual has difficulty concentrating, learning, remembering, or exercising sound judgment during everyday tasks due to illness or injury. Cognitive impairment is not limited to a specific condition or disease, but severe cases are typically associated with degenerative brain diseases, such as Alzheimer's, Parkinson's or Lewy Body disease. In these cases, cognitive impairment can be measured using the Global Deterioration Scale, which ranges from 1 (no cognitive impairment) to 7 (severe dementia).[1] Age is

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the primary risk factor for cognitive impairment. Current estimates suggest that there are approximately 44 million individuals worldwide living with dementia, nearly double the number of cases from 1990.[2] While a portion of this increase can be attributed to improved screening and awareness of dementia, it also is a key indicator of the impending "silver tsunami" as the baby boomer generation (birth years 1946-1964) ages.[3,4]

It is generally accepted that individuals experiencing dementia, or other forms of cognitive impairment, may be at increased risk for harming themselves or others. To reduce injuries and deaths, while respecting their autonomy and rights, it is recognized that some activities, such as driving or firearm access, may need to be restricted in this population.

Traumatic Brain Injury

TBI is an emerging area of scrutiny, not only in the medical profession, but in the public sphere, raising questions as to whether individuals with TBI may be at higher risk of harming themselves or others. TBI occurs when an individual receives a blow to the head. It can be categorized broadly in two ways: mode of injury (closed/non-penetrative or open/penetrative) and severity (mild, moderate or severe).[5] Secondary injuries from the initial impact may include increased intracranial pressure, decreased cerebral perfusion and intracranial hemorrhage. Persons with TBI commonly experience loss of consciousness, headache, nausea, fatigue, depression, mood swings and difficulty concentrating.[6] In the most severe cases, persons with TBI may be left with persistent and severe cognitive impairment or they may remain in a comatose state long after their initial injury. While symptoms typically abate after approximately six months, many patients report lifelong complications from even a single, mild incident of TBI.[7] Common causes of TBI include falls, motor vehicle crashes, sports injuries and gunshot wounds. Unlike other forms of cognitive impairment, persons living with TBI may recover and regain some or all cognitive function and motor skills, this is especially true in cases where rehabilitation is sought. This makes understanding symptom progression particularly difficult.[8]

It is estimated that approximately 1.1 percent of the U.S. population experiences life-long effects from TBI.[9] Of particular interest to this report is the connection between TBI and later-in-life development of neurodegenerative disease such as dementias, including Alzheimer's and Parkinson's.[10] Studies have suggested that patients who have experienced at least one incident of TBI in their life are up to 4 times more likely to develop Alzheimer's in their lifetime, with more severe incidents (such as those resulting in loss of consciousness) resulting in the highest risk.[11-13] One of the historic difficulties of diagnosing and treating TBI has been managing the sequalae that may not manifest until much later in life. For example, studies have shown that cognitive function post-TBI can steadily improve for up to 10 years only to be followed by a sharp decline.[14]

With regard to whether individuals with TBI may be at higher risk of harming themselves or others, data suggest TBI may be a risk factor for violent behavior and suicide. One study found that approximately 40 percent of patients monitored at 3, 6 and 12 months post-TBI presented signs of aggression.[15] Similarly, several studies have shown TBI is a risk factor for intimate partner violence and violent criminal behavior,[16-21] and a study of Vietnam war veterans with TBI found a correlation between lesions of the prefrontal cortex and a positive implicit attitude towards violence.[22] Additionally, violent behavior may present as self-harm, as a 35-year retrospective study in Denmark found the absolute suicide rate was over double (41 vs 20 per 100,000 person-years) for patients with diagnosed TBI at any severity,[23] and this risk increases with subsequent head traumas.[24]

DRIVER LICENSING

There is no constitutionally protected right to maintain a driver license, and there are clear guidelines for the role of the physician in protecting their patients from unsafe driving. In collaboration with the U.S. Department of Transportation and the National Highway Traffic Safety Administration, the AMA previously developed and published guidance for physicians. While this guidance is presented in the context of an aging driver, potential cognitive and noncognitive impairment from a previous TBI can occur at any age.[25]

In brief, the guidance suggests that physicians perform a battery of tests to assess driving skills (visual acuity, spatial awareness, dexterity, memory). If a physician believes that their patient is unfit to drive, they are advised to counsel the patient and their family or caregivers to voluntarily retire from driving and surrender their driver license, or they may refer the patient for occupational therapy. In the case of TBI, this is especially critical as surveys have shown that half of drivers recovering from mild TBI have no intention of self-moderating driving behavior.[26]

Depending on the state, the physician may also have legal responsibilities as dictated by their medical licensing board. Some states, such as California, mandate that all physicians report to the Department of Motor Vehicles (DMV) any instances of patients with disorders resulting in loss of consciousness or severe impairment of motor vehicle operation. Other instances where a physician has a good faith belief that a driver is a risk to public safety are encouraged to be reported, but not required to do so. Some states, such as Kansas, explicitly do not require a physician to report this information and further require the physician to obtain written consent from the patient before releasing any information to the DMV. Additional state-level differences to be aware of include the legal protection (or liability) that a physician may be entitled to in the event of an accident from a known unsafe driver, and whether the physician may submit a DMV referral anonymously.

FIREARM OWNERSHIP

Firearm ownership in the United States is largely controlled by the Second Amendment to the Constitution, which indicates that "the right of the people to keep and bear Arms, shall not be infringed." However, Supreme Court decisions in *District of Columbia v. Heller* (2008) and *McDonald v. City of Chicago* (2010) found that this right is not absolute and may be limited appropriately by federal, state and local governments.[27,28] Limits to firearm ownership relevant to this report fall into two categories: cognitive impairment restrictions and risk-based removals.

It should be noted that instances of interpersonal firearm violence committed by people with mental illness often attract media and public scrutiny. However, only 4 percent of all interpersonal firearm violence in the United States can be attributed to individuals with mental illness.[29] By comparison, up to 74 percent of deaths by suicide are related to a diagnosed mental illness.[30]

Firearm Ownership and Possession Restrictions

Federal law 18 U.S.C. § 922(d) prevents the sale of a firearm or ammunition to any person that "has been adjudicated as a mental defective or has been committed to any mental institution," although all but 4 states (Colorado, Indiana, Kentucky and New Hampshire) have additional restrictions related to mental health and firearm ownership.[31] The resulting patchwork of restrictions and regulatory authorities has been criticized for ineffectiveness. For example, the gunman responsible for the deaths of 32 people at Virginia Tech in 2007 had been found to be mentally unfit by a court in 2005 after accusations of stalking. The shooter was required by the court to attend treatment, but due to his treatment being on an outpatient basis, he was not

prevented from purchasing the firearms used in the mass shooting, as federal law requires involuntary commitment.[32]

All states but one (Hawaii) do not allow restrictions on firearm purchases on the basis of diagnosis alone. This practice of requiring an individual risk assessment is consistent with the recommendations of the American Psychiatric Association (APA).[33] While a practitioner may report the status of an individual's diagnosis or treatment to a third party, that is not sufficient to bar the purchasing of a firearm (outside of Hawaii).

At the federal level, individuals adjudicated to be mentally unfit to own a firearm are reported to the National Instant Criminal Background Check System (NICS). Firearm dealers who hold a federal firearms license must process all potential buyers through NICS prior to selling them a firearm. Since 1998, firearm sales have been denied 1,970,264 times due to failing a NICS background check, but only 3 percent of them have been due to mental health concerns.[34] Several factors may have contributed to this relatively low rate of rejection, such as a lack of mandatory reporting of mental health data by states, the inability for states to report violations of their stricter purchasing restrictions, and a lack of clarity around NICS reporting and the Health Insurance Portability and Protection Act (which was clarified in 2016).[35,36]

Firearm Removals

Once an individual has legally purchased a firearm, the primary means for removal are through extreme risk protection orders (ERPOs), although they may go by other names depending on the state, such as gun violence restraining orders (California), or risk warrants (Connecticut). Currently, 19 states (and the District of Columbia) have some version of ERPO law that allows for the petitioning of a court to remove firearms from the possession of someone deemed high risk.[37] ERPO laws have recently gained momentum, with 8 of the 20 states having passed legislation during the 2018 session immediately following the school shooting in Parkland, Florida. In June 2021, under the direction of President Biden, the Department of Justice released model legislation for states to follow if they wished to enact ERPO laws.[38] A 2018 report from this Council further discusses the role of the physician in firearm safety and ERPOs.[39] ERPO laws are still new, but research suggests that while public awareness remains low, California's approach has shown signs of success in removing firearms from individuals threatening mass shooting events.[40,41]

By contrast, Oklahoma passed an anti-ERPO law in May 2020 which prohibits any county or local government from enacting ERPO laws. Texas, Alaska, Georgia, Minnesota and Kansas legislatures have all introduced anti-ERPO laws which have not passed at the time of writing. State legislators in these jurisdictions have argued that ERPO laws may infringe upon the First, Second, Fourth and Fifth Amendment, but in limited court proceedings, these arguments have been rejected.[37,42-44]

The exact implementation of ERPO laws varies from state to state, but broadly they allow for a process in which a court can hear a petition to remove firearms and ammunition from the possession of an individual.[45] The laws largely differ in three major areas: who may petition the court, the burden of evidence required to approve the removal, and the duration of the removal and the overturning of the individual's rights to otherwise possess a firearm. The most narrowly drafted state legislation allows law enforcement officers or their agencies to petition a court to remove firearms, where other states allow some combination of household members, intimate partners, employers, coworkers, or school officials to additionally file an ERPO. Most relevant to this report, Maryland and the District of Columbia allow healthcare providers to file ERPO petitions as well, although professional groups have varying ways of defining and measuring risky behavior.[46] An individual may or may not be notified that a petition for an ERPO against them has been made, and

law enforcement may be empowered to seize an individual's weapons within 24 hours and then to prevent the individual from regaining possession of their firearms until a hearing has been held, which, per some state statutes, can extend for up to a year.

Firearm Ownership and Cognitive Impairment

Studies have indicated that up to 60 percent of outpatients living with dementia are in households containing firearms, placing them at higher risk for death by suicide.[47,48] Older adults die by suicide at rates disproportionate with the general population and firearms are the most common means.[49] Caregivers for those with dementia have been surveyed and over 70 percent feel that the caregiver plays a key role in firearm safety, but only 5 percent of caregivers had training or guidance.[50] The Veteran's Health Administration has developed guidance for counseling family or caregivers on creating a safe environment if firearms are accessible to a person living with dementia.[51]

As described above, the progression of TBI is unpredictable. Some report no behavioral or physical effects for many years only to be followed by a steep decline, while others report a full recovery of function. Currently, conditions such as chronic traumatic encephalopathy (CTE) from sports injuries can only be diagnosed posthumously which would make any blanket policy around TBI and firearm ownership difficult to craft and implement. However, TBI does increase the risk of developing other neurological conditions, such as dementias which have more established protocols for evaluating cognitive fitness.[10,52-54] Depending on the progression of TBI, a similar approach to that used for dementia may be appropriate.

Medical Advisory Boards

Legal requirements and medical thresholds for firearm ownership and driver licensing in the event of cognitive impairment vary from state to state. To ensure that the physician's voice is heard in the process, states can implement a medical advisory board (MAB) at several different points: to create best practices guidelines, to perform the medical assessment, or to evaluate appeals for reinstatement.

MABs are much more commonly utilized in the case of driver licensing. A summary of MAB roles from state to state can be found in a 2017 NHTSA publication.[55] In brief, the MAB may be involved in all steps of the process. In New York, input from the MAB is given to the DMV for developing the regulations dictating a driver's fitness. Other states use their MABs on a case-by-case basis. Louisiana's MAB is forwarded complaints from the DMV for evaluation, whereas Maine's MAB is engaged only on driver appeal. Some states, like Montana, do not retain a MAB at all. It should also be noted that the function of state MABs are dependent not only on statutory authority but also on funding, which has historically not been consistent.

For firearm ownership, there are no known MABs in the country. In Texas, a MAB has been used to review cognitive fitness for concealed handgun licenses, but the MAB is not used for purchasing firearms or reviewing ERPOs. In 2020, a bill was introduced in the New York state legislature (S7065) to require anyone seeking to purchase a firearm to submit to a mental health screening, but it did not receive a vote in the committee that first had hearings on the bill. Countries as diverse as Argentina, Turkey, Ukraine, Croatia, France, Spain, Japan and Israel require either a mental health evaluation or access to medical records prior to purchasing any firearm.[56]

Given the unpredictable nature of symptom progression in an individual living with TBI, including the potential for recovery, the role of a MAB in both driver licensing and firearm ownership becomes more critical. For example, many states utilize their MAB to develop a protocol for

reinstating the driver's license of an individual living with epilepsy, a disease which can be managed with medication or other interventions. A typical procedure involves the revocation of the driver's license, followed by an appeals process in which the individual must go a set amount of time without a seizure event (3-18 months depending on the state) followed by an individual risk assessment performed by the MAB.[57] More research is needed to understand TBI as a risk factor for harming oneself or others in order to inform the development of policies and protocols for the revocation or reinstatement for the purposes of driver licenses and firearm ownership.

CURRENT AMA POLICY

The AMA has a multitude of policies regarding firearm violence, mental health and/or driver licensing as listed in the appendix of this report. AMA policy clearly defines firearm violence as a public health threat and aims to limit high-risk individuals from possessing firearms in order to protect themselves and others from morbidity and mortality. Most relevant to this report include AMA policies on "Medical Advisory Boards in Driver Licensing" (H-15.995), "Firearms and High-Risk Individuals" (H-145.972) and "Violence Prevention" (H-145.970).

DISCUSSION

When creating and implementing policy related to TBI, one must acknowledge the non-linear progression of even mild TBI. Many people who suffer a concussion will go on to live complication-free lives after their initial recovery, whereas others may be at risk of cognitive decline decades later. The potential for increased risk, even after long symptom-free periods, need to be balanced with individual dignity, constitutional rights, and physician liability.

With respect to driver licensing, AMA policy is clear, guidance has been published in collaboration with the U.S. Department of Transportation, and physicians are being utilized on MABs in 32 states as of 2015.[55] With respect to firearm ownership, the AMA supports the establishment of laws, such as ERPOs allowing family members, intimate partners, household members, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence.

In CSAPH Report 4-A-18, "The Physician's Role in Firearm Safety," the Council identified those individuals considered to be high-risk of firearm violence to themselves or others and the report supported common-sense laws allowing for the removal of firearms in certain circumstances. In the case of TBI, where there can be a large range of severity, non-linear progression and a lack of conclusive diagnostic testing, a diagnosis alone may not be sufficient to quantify risk of harm to oneself or others.

With the Biden administration signaling an interest in passing a federal ERPO law and increasing pressure on states to pass standardized ERPO laws, opportunities may exist to develop guidance for physicians and courts, similar to the work previously done around driver licensing. The AMA has developed a CME module to prepare physicians to counsel their patients on firearm safety.[58] The module is designed to assist physicians in recognizing risk factors that increase the potential for firearm injury and death, identifying barriers to communicating with patients about firearm safety, and effectively communicating with patients to reduce the risk of firearm injury and death.

RECOMMENDATIONS

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

1. Our AMA encourages research on cognitive impairment, including traumatic brain injury (TBI), as a risk factor for driving and/or firearm ownership, and the role of the physician in preventing morbidity and mortality (New HOD Policy).

2. That Policy H-15.995, "Medical Advisory Boards in Driver Licensing," advocating for state governments to create and maintain medical advisory boards to oversee driver licensing, be reaffirmed. (Reaffirm Current HOD Policy)

3. That Policy H-145.972, "Firearms and High-Risk Individuals," which advocates for ERPO laws and protocols for removing firearms from those deemed to be high-risk in the wake of a petition from concerned parties, be reaffirmed. (Reaffirm Current HOD Policy)

4. That Policy H-145.970, "Violence Prevention," calling upon state and federal government entities to strengthen and promote the use of the NICS background check system, be reaffirmed. (Reaffirm Current HOD Policy)

5. That Policy H-145.976, "Firearm Safety Counseling in Physician-Led Health Care Teams," which protects the right of a physician to counsel a patient and/or their family about the risks of gun ownership and appropriate safety measures, be reaffirmed. (Reaffirm Current HOD Policy)

Fiscal Note: Less than $1000

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RELEVANT AMA POLICY

H-470.954, "Reduction of Sports-Related Injury and Concussion"
1. Our AMA will: (a) work with appropriate agencies and organizations to promote awareness of programs to reduce concussion and other sports-related injuries across the lifespan; and (b) promote awareness that even mild cases of traumatic brain injury may have serious and prolonged consequences.
2. Our AMA supports the adoption of evidence-based, age-specific guidelines on the evaluation and management of concussion in all athletes for use by physicians, other health professionals, and athletic organizations.
3. Our AMA will work with appropriate state and specialty medical societies to enhance opportunities for continuing education regarding professional guidelines and other clinical resources to enhance the ability of physicians to prevent, diagnose, and manage concussions and other sports-related injuries.
4. Our AMA urges appropriate agencies and organizations to support research to: (a) assess the short- and long-term cognitive, emotional, behavioral, neurobiological, and neuropathological consequences of concussions and repetitive head impacts over the life span; (b) identify determinants of concussion and other sports-related injuries in pediatric and adult athletes, including how injury thresholds are modified by the number of and time interval between head impacts and concussions; (c) develop and evaluate effective risk reduction measures to prevent or reduce sports-related injuries and concussions and their sequelae across the lifespan; and (d) develop objective biomarkers to improve the identification, management, and prognosis of athletes suffering from concussion to reduce the dependence on self-reporting and inform evidence-based, age-specific guidelines for these patients.
5. Our AMA supports research into the detection, causes, and prevention of injuries along the continuum from subconcussive head impacts to conditions such as chronic traumatic encephalopathy (CTE).
CSAPH Rep. 3, A-15; Appended: Res. 905, I-16.

H-25.991, "Alzheimer's Disease"
Our AMA: (1) encourages physicians to make appropriate use of guidelines for clinical decision making in the diagnosis and treatment of Alzheimer's disease and other dementias;
(2) encourages physicians to make available information about community resources to facilitate appropriate and timely referral to supportive caregiver services;
(3) encourages studies to determine the comparative cost-effectiveness/cost-benefit of assisted in-home care versus nursing home care for patients with Alzheimer's disease and related disorders;
(4) encourages studies to determine how best to provide stable funding for the long-term care of patients with Alzheimer's disease and other dementing disorders;
(5) supports the use of evidence-based cost-effective technologies with prior consent of patients or designated healthcare power of attorney, as a solution to prevent, identify, and rescue missing patients with Alzheimer's disease and other related dementias with the help of appropriate allied specialty organizations;
(6) supports increased awareness of the sex and gender differences in incidence and etiology of Alzheimer's disease and related dementias; and
(7) encourages increased enrollment in clinical trials of appropriate patients with Alzheimer's disease and related dementias, and their families, to better identify sex-differences in incidence and progression and to advance a treatment and cure of Alzheimer's disease and related dementias.
CSA Rep. 6, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Appended: Res. 503, A-16; Appended: Res. 915, I-16.

H-15.954, "Older Driver Safety"
(1) Our AMA recognizes that the safety of older drivers is a growing public health concern that is best addressed through multi-sector efforts to optimize vehicle design, the driving environment, and the individual's driving capabilities, and:
(a) believes that because physicians play an essential role in helping patients slow their rate of functional decline, physicians should increase their awareness of the medical conditions, medications, and functional deficits that may impair an individual's driving performance, and counsel and manage their patients accordingly;
(b) encourages physicians to familiarize themselves with driver assessment and rehabilitation options, refer their patients to such programs whenever appropriate, and defer recommendations on permanent driving cessation until establishing that a patient's driving safety cannot be maintained through medical interventions or driver rehabilitation;
(c) urges physicians to know and adhere to their state's reporting statutes for medically at-risk drivers; and
(d) encourages continued scientific investigation into strategies for the assessment and management of driving safety in the clinical setting.
(2) Our AMA encourages physicians to use the Physician's Guide to Assessing and Counseling Older Drivers as an educational tool to assist them in helping their patients.
CSA Rep. 6, A-03; Reaffirmed: CSAPH Rep. 1, A-13.

Ethics Opinion 8.2, "Impaired Drivers & Their Physicians"
A variety of medical conditions can impair an individual's ability to operate a motor vehicle safely, whether a personal car or boat or a commercial vehicle, such as a bus, train, plane, or commercial vessel. Those who operate a vehicle when impaired by a medical condition pose threats to both public safety and their own well-being. Physicians have unique

opportunities to assess the impact of physical and mental conditions on patients' ability to drive safely and have a responsibility to do so in light of their professional obligation to protect public health and safety. In deciding whether or how to intervene when a patient's medical condition may impair driving, physicians must balance dual responsibilities to promote the welfare and confidentiality of the individual patient, and to protect public safety.
Not all physicians are in a position to evaluate the extent or effect of a medical condition on a patient's ability to drive, particularly physicians who treat patients only on a short-term basis. Nor do all physicians necessarily have appropriate training to identify and evaluate physical or mental conditions in relation to the ability to drive. In such situations, it may be advisable to refer a potentially at-risk patient for assessment.
To serve the interests of their patients and the public, within their areas of expertise physicians should:
(a) Assess at-risk patients individually for medical conditions that might adversely affect driving ability, using best professional judgment and keeping in mind that not all physical or mental impairments create an obligation to intervene.
(b) Tactfully but candidly discuss driving risks with the patient and, when appropriate, the family when a medical condition may adversely affect the patient's ability to drive safely. Help the patient (and family) formulate a plan to reduce risks, including options for treatment or therapy if available, changes in driving behavior, or other adjustments.
(c) Recognize that safety standards for those who operate commercial transportation are subject to governmental medical standards and may differ from standards for private licenses.
(d) Be aware of applicable state requirements for reporting to the licensing authority those patients whose impairments may compromise their ability to operate a motor vehicle safely.
(e) Prior to reporting, explain to the patient (and family, as appropriate) that the physician may have an obligation to report a medically at-risk driver:
(i) when the physician identifies a medical condition clearly related to the ability to drive;
(ii) when continuing to drive poses a clear risk to public safety or the patient's own well-being and the patient ignores the physician's advice to discontinue driving; or
(iii) when required by law.
(f) Inform the patient that the determination of inability to drive safely will be made by other authorities, not the physician.
(g) Disclose only the minimum necessary information when reporting a medically at-risk driver, in keeping with ethics guidance on respect for patient privacy and confidentiality.
Issued: 2016

H-15.995, "Medical Advisory Boards in Driver Licensing"
Our AMA (1) endorses the establishment of state motor vehicle department medical advisory boards to improve licensure of vehicle operators and to reduce incidence of injury and death and (2) urges state medical associations to encourage establishment of such boards and to work actively with them.
Res. 2, A-72; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20.

H-160.972, "Physician Representation on State and National Health Care Advisory Bodies"
The AMA urges Congress, and others who select members of state and national health advisory bodies, to increase the proportion of physicians in active clinical practice serving on these bodies, with selected members being recommended by state or national medical associations.
Sub. Res. 110, A-88; Reaffirmed: Sunset Report, I-98. Reaffirmed: BOT Rep. 23, A-09; Reaffirmed: BOT Rep. 09, A-19

H-145.975, "Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care"
1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.
2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.
3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.

Sub. Res. 221, A-13; Appended: Res. 416, A-14; Reaffirmed: Res. 426, A-16; Reaffirmed: BOT Rep. 28, A-18; Reaffirmation: A-18; Modified: CSAPH Rep. 04, A-18; Reaffirmation: I-18

D-145.995, "Gun Violence as a Public Health Crisis"
Our AMA: (1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and
(2) will actively lobby Congress to lift the gun violence research ban.
Res. 1011, A-16; Reaffirmation: A-18; Reaffirmation: I-18.

H-145.996, "Firearm Availability"
1. Our AMA: (a) advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.
2. Our AMA supports requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms.
3. Our AMA supports "gun violence restraining orders" for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as "red-flag" laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and "red-flag" laws, we also support the importance of due process so that individuals can petition for their rights to be restored.
Res. 140, I-87; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: BOT Rep. 12, A-16; Appended: Res. 433, A-18; Reaffirmation: I-18; Modified: BOT Rep. 11, I-18

H-145.999, "Gun Regulation"
Our AMA supports stricter enforcement of present federal and state gun legislation and the imposition of mandated penalties by the judiciary for crimes committed with the use of a firearm, including the illegal possession of a firearm.
Sub. Res. 31, I-81; Reaffirmed: CLRPD Rep. F, I-91; Amended: BOT Rep. I-93-50; Reaffirmed: Res. 409, A-00; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Modified: Res. 401, A-17; Reaffirmation: I-18.

H-145.972, "Firearms and High-Risk Individuals"
Our AMA supports: (1) the establishment of laws allowing family members, intimate partners, household members, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms; (3) expanding domestic violence restraining orders to include dating partners; (4) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons; (5) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and (6) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals.
CSAPH Rep. 04, A-18; Reaffirmed: BOT Rep. 11, I-18.

H-145.991, "Waiting Periods for Firearm Purchases"
The AMA supports using its influence in matters of health to effect passage of legislation in the Congress of the U.S. mandating a national waiting period that allows for a police background and positive identification check for anyone who wants to purchase a handgun from a gun dealer anywhere in our country.
Sub. Res. 34, I-89; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Modified: Res. 401, A-17; Reaffirmation: A-18; Reaffirmation: I-18

H-145.970, "Violence Prevention"
Our AMA: (1) encourages the enactment of state laws requiring the reporting of all classes of prohibited individuals, as defined by state and federal law, to the National Instant Criminal Background Check System (NICS); (2) supports federal funding to provide grants to states to improve NICS reporting; and (3) encourages states to automate the reporting of relevant information to NICS to improve the quality and timeliness of the data.

H-145.976, "Firearm Safety Counseling in Physician-Led Health Care Teams"
1. Our AMA: (a) will oppose any restrictions on physicians' and other members of the physician-led health care team's ability to inquire and talk about firearm safety issues and risks with their patients; (b) will oppose any law restricting physicians' and other members of the physician-led health care team's discussions with patients and their families about firearms as an intrusion into medical privacy; and (c) encourages dissemination of educational materials related to firearm safety to be used in undergraduate medical education.

2. Our AMA will work with appropriate stakeholders to develop state-specific guidance for physicians on how to counsel patients to reduce their risk for firearm-related injury or death, including guidance on when and how to ask sensitive questions about firearm ownership, access, and use, and clarification on the circumstances under which physicians are permitted or may be required to disclose the content of such conversations to family members, law enforcement, or other third parties.
Res. 219, I-11; Reaffirmation A-13; Modified: Res. 903, I-13; Appended: Res. 419, A-17; Reaffirmed: CSAPH Rep. 04, A-18.

H-145.971, "Development and Implementation of Recommendations for Responsible Media Coverage of Mass Shootings"
Our AMA encourages the Centers for Disease Control and Prevention, in collaboration with other public and private organizations, to develop recommendations and/or best practices for media coverage of mass shootings, including informed discussion of the limited data on the relationship between mental illness and gun violence, recognizing the potential for exacerbating stigma against individuals with mental illness.
Res. 212, I-18; Modified: Res. 934, I-19.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 401
(N-21)

Introduced by: Senior Physicians Section

Subject: Endorsement of Public Health Measures to End the COVID-19 Pandemic and Promotion of Research and Insurance Coverage to Define and Delimit the Emerging Issue of Post Acute Covid Syndrome

Referred to: Reference Committee D

Whereas, The COVID-19 pandemic has recently surpassed 40 million cases in the US and 650,000 deaths, with more than 10% of new cases reported in the past 30 days[1], and

Whereas, The COVID-19 pandemic has exacerbated health inequities in any number of ways, including disproportionately negatively affecting seniors and other marginalized and minoritized populations; and

Whereas, On September 9, 2021, President Joe Biden announced a sweeping set of new policies, recommendations, executive orders and specific mandates designed to control the resurgence of COVID-19, particularly in light of dangerous emerging variants with increasing contagious and pathological properties; and

Whereas, In the "Path out of Pandemic" Plan, https://www.whitehouse.gov/covidplan/, the White House has proposed a sweeping set of public health and other measures designed to thwart the escalating "Pandemic of the Unvaccinated"; and

Whereas, The American Medical Association Senior Physicians Section, many of whose members may be especially vulnerable to COVID-19, strongly endorses in principle President Biden's sweeping and timely public health measures aimed at ending the pandemic; and

Whereas, AMA has through public statements endorsed many of the principles embedded in the "Path out of the Pandemic" plans, including notably the concepts of mandatory vaccination in general, and mandatory vaccination of health care workers in particular as effective means aimed at ending the pandemic[1]which are consistent with recent HOD policy[2,3], and

Whereas, Ending the pandemic will allow our AMA to better address health inequities and other efforts to enhance its mission to better the health of the American public and to address the emerging issue of Post Acute Covid Syndrome[4]; therefore be it

RESOLVED, That our American Medical Association through its advocacy and public relations divisions promote and support all public health recommendations relating to the Covid-19 emergency that are consistent with sound scientific principles and law, and not inconsistent with evolving AMA policy (Directive to Take Action); and be it further

RESOLVED, That our AMA promote and encourage through all available means the further investigation of PACS, and third-party support for evaluation and care of COVID-19 long-hauler patients. (Directive to Take Action)

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

Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

We wrote the initial draft within minutes of President Biden's public address dealing with the urgency of taking bolder action to end the "Pandemic of the Unvaccinated" that has seen the emergence of one of the most communicable and deadly Covid 19 variants sweep across the country. Although our AMA President Gerald Harmon, MD issued a public statement supporting the Biden initiative within a few hours, we feel it needs support of strong new and specific policy enacted by the AMA HOD. Yes, there is prior AMA policy, but it is generic and does not address this new threat that is aggravated by extensive anti scientific comments in the public media and amplified by misinformation and disinformation.

The AMA Senior Physician Section is uniquely qualified to introduce this resolution given the preponderance of our age demographics, longstanding experience in formulating public policy (thanks to the contributions of many of our members in relevant AMA Councils, Specialty Societies and Sections and leadership over many years). We crafted specific language that give lots of freedom to add details as needed and avoided unnecessary constraints affecting the BOT and current leadership.

REFERENCES

[1] Centers for Disease Control and Prevention (CDC), COVID Data Tracker
[2]AMA Press Release AMA in support of COVID-19 vaccine mandates for health care workers, July 26, 2021
[3]AMA Statement, AMA encourages COVID-19 vaccine mandates to defeat pandemic,
August 24, 2021
[4]Phillips, S & Williams, M. Confronting Our Next National Health Disaster — Long-Haul Covid
N Engl J Med 2021; 385:577-579, DOI: 10.1056/NEJMp2109285.

RELEVANT AMA POLICY

Digital Vaccine Credential Systems and Vaccine Mandates in COVID-19 H-440.808
COVID-19 and COVID-19 vaccines raise unique challenges. To meet these challenges, our AMA:
1. Encourages the development of clear, strong, universal, and enforceable federal guidelines for the design and deployment of digital vaccination credentialing services (DVCS), and that before decisions are taken to implement use of vaccine credentials:
a. vaccine is widely accessible;
b. equity-centered privacy protections are in place to safeguard data collected from individuals;
c. provisions are in place to ensure that vaccine credentials do not exacerbate inequities; and
d. credentials address the situation of individuals for whom vaccine is medically contraindicated.
2. Recommends that decisions to mandate COVID-19 vaccination be made only:
a. After a vaccine has received full approval from the U.S. Food and Drug Administration through a Biological Licenses Application;
b. In keeping with recommendations of the Advisory Committee on Immunization Practices for use in the population subject to the mandate as approved by the Director of the Centers for Disease Control and Prevention;
c. When individuals subject to the mandate have been given meaningful opportunity to voluntarily accept vaccination; and
d. Implementation of the mandate minimizes the potential to exacerbate inequities or adversely affect already marginalized or minoritized populations.
3. Encourages the use of well-designed education and outreach efforts to promote vaccination to protect both public health and public trust.
4. Recommends that vaccination credentials not be provided on the basis of natural immunity or prior SARS-CoV-2 infection.
Citation: BOT Rep. 18, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 402
(N-21)

Introduced by: Medical Student Section

Subject: Expansion on Comprehensive Sexual Health Education

Referred to: Reference Committee D

Whereas, Data from the Centers for Disease Control and Prevention's Youth Risk Behavior Surveillance System indicate that 41.2% of all high school students are sexually active, and 11.5% have had 4 or more partners;[1] and

Whereas, Of the 39 states and D.C. that mandate some form of sex education, only 12 states mandate that sex education be medically accurate, and 16 states mandate that HIV education be medically accurate;[2,3] and

Whereas, Comprehensive sex education is defined as a medically accurate, age appropriate and evidenced-based teaching approach which stresses abstinence and other methods of contraception equally in order to prevent negative health outcomes for teenagers;[4] and

Whereas, A study surveying adolescents aged 15-24 reported over half (60.4% of females and 64.6% males) engaging in fellatio within the past year, while fewer than 10% (7.6% females and 9.3% males) used a condom;[5] and

Whereas, There is a lack of knowledge among adolescents regarding the importance of condoms, dental dams and alternative barrier protection methods use during oral sex to prevent the spread of STIs;[5–7] and

Whereas, When sex education is taught, only 20 states and D.C. require provision of information on contraception;[3] and

Whereas, Several studies have shown parents tasked with teaching their children sexual education frequently needed support in information, motivation, and strategies to achieve competency[8]; and

Whereas, LGBTQ youth are at higher risk for sexual health complications due to differing sexual practices and behaviors;[9] and

Whereas, Current sex education initiatives negatively impact transgender youth and their sexual health by failing to appropriately address their behavior, leading rates of HIV more than 4 times the national average, and increased likelihood to experience coerced sexual contact;[9] and

Whereas, The GLSEN 2013 National School Climate Survey found that fewer than five percent of LGBT students had health classes that included positive representations of LGBT-related topics.2 Among Millennials surveyed in 2015, only 12% said their sex education classes covered same-sex relationships;[9,10] and

Whereas, LGBTQ youth are at a significantly higher risk of teen pregnancy involvement (between two and seven times the rate of their heterosexual peers);[11] and

Whereas, When sex education is taught, seven states prohibit sex educators from discussing LGBTQ relationships and identities or require homosexuality to be framed negatively if it is discussed;[3] and

Whereas, In 2010, the federal government redirected funds from abstinence-only programs to evidence-based teen pregnancy prevention programs;[12] and

Whereas, In 2017, 31 federal and state bills were introduced to advance comprehensive sexuality education, but only 4 were enacted or passed;[2,13] and

Whereas, The 2018 CDC School Health Profile determined that only 17.6% of middle schools across all the states taught comprehensive sex education encompassing topics including pregnancy and STIs;[14] and

Whereas, Since 2000, estimated medical costs of $6.5 billion dollars were associated with the treatment of young people with sexually transmitted infections, excluding costs of HIV/AIDS;[15] and

Whereas, Forty states and D.C. require school districts to involve parents in sex education and/or HIV education, of which nearly all states allow parents the option to remove their child from such education;[11] and

Whereas, Some high-risk populations such as teenagers in foster care may not be able to receive adequate reproductive and sexual health education in their home;[16,17] and

Whereas, Regardless of political affiliation, parents overwhelmingly report that sex education is important and should include topics such as puberty, healthy relationships, abstinence, birth control, and STIs;[18] and

Whereas, The rate of teenage pregnancy and STIs in the US has remained consistently higher than many other industrialized countries;[19–21] and

Whereas, The US teen birth rate declined by 9% between 2009 and 2010, with evidence showing that during this time, there was a significant increase in teen use of contraceptives and no significant change in teen sexual activity, highlighting the importance of education on contraception in decreasing teen births[22]; and

Whereas, Studies have found that abstinence-based sex education has insignificant effect on improving teen birth rates, abortion rates, are not effective in delaying initiation of sexual intercourse or changing other sexual risk-taking behaviors, and may actually increase STI rates in states with smaller populations;[23–25] and

Whereas, Comprehensive sex education has been shown to be effective at changing knowledge, attitudes, and behaviors related to sexual health and reproductive knowledge as well as reducing sexual activity, numbers of sexual partners, teen pregnancy, HIV, and STI rates;[23,26–28] and

Whereas, The federal government has recognized the advantages of comprehensive sex education and has dedicated funds for these programs including the Personal Responsibility Education Program (PREP), a state-grant program from the federal government that funds comprehensive sex education;[29,30] and

Whereas, As of 2017, 41 PREP programs that emphasize abstinence and contraception equally with a focus on individualized decision making have been vigorously reviewed, endorsed, and funded by the HHS;[29] and

Whereas, Federal funding has increased the amount of funding for abstinence based programs by 67% since the 2018 Consolidation of Appropriations act;[30] and

Whereas, The American College of Obstetricians and Gynecologists (ACOG), Society for Adolescent Health and Medicine's (SAHM), and the American Public Health Association have all adopted official positions of support for comprehensive sexuality education;[31–33] and

Whereas, The AMA has existing policy acknowledging the importance and public health benefit of sex education, including Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools H-170.968; Health Information and Education H-170.986; and Comprehensive Health Education H-170.977, but falls short of underscoring the importance of comprehensive sex education in schools or advocating for actual implementation; and

Whereas, Lack of funding for comprehensive sex education programs means they are less likely to be taught; therefore be it

RESOLVED, That our American Medical Association amend Policy H-170.968, "Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools," by addition and deletion to read as follows:

> Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools, H-170.968
>
> (1) ~~Recognizes that the primary responsibility for family life education is in the home, and additionally~~ ~~s~~ Supports the concept of a ~~complementary~~ family life and sexuality education program in the schools at all levels, at local option and direction;
> (2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms dental dams, and other barrier protection methods available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of LGBTQ+ ~~gay, lesbian, and bisexual~~ youth; (f) appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities;

(g) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; (h) are part of an overall health education program; and (i) include culturally competent materials that are language-appropriate for Limited English Proficiency (LEP) pupils;

(3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate;

(4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program;

(5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems;

(6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes;

(7) Supports federal funding of comprehensive sex education programs that stress the importance of ~~abstinence in~~ preventing unwanted teenage pregnancy and sexually transmitted infections via comprehensive education, ~~and also teach about~~ including contraceptive choices, abstinence, and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and

(8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy;

(9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, and conversations about consent; and

(10) Encourages physicians and all interested parties to ~~conduct research and~~ develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate.

(Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Sexual health education has been an important but often neglected topic in the United States. Research indicates that sexual health education is of paramount importance to the wellness and health of adolescents and teens. The current abstinence only until marriage (AOUM) sex education is outdated and does not provide proper support and education to our youths. Medically accurate and comprehensive sexual health education will more than likely decrease the rate of STIs transmission and accidental pregnancies, among many other benefits. The LGBTQ+ community especially could benefit tremendously from improved training on sexual health education due to increased awareness of complications of unsafe sexual practices as well as promote tolerance towards the community. This resolution lends much needed focus on utilizing the primary school setting as the principle method of providing medically accurate and comprehensive sexual health education. Given the recent increases in anti-LGBTQ+ legislation, it is vital that our AMA take action to better protect this vulnerable population, to show that their health and safety is truly a priority, and to make clear our stance that LGBTQ+ health s deserves equal attention and protection.

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RELEVANT AMA POLICY

Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools H-170.968

(1) Recognizes that the primary responsibility for family life education is in the home, and additionally supports the concept of a complementary family life and sexuality education program in the schools at all levels, at local option and direction;
(2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of gay, lesbian, and bisexual youth; (f) appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities; (g) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; (h) are part of an overall health education program; and (i) include culturally competent materials that are language-appropriate for Limited English Proficiency (LEP) pupils;
(3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate;

(4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program;
(5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems;
(6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes;
(7) Supports federal funding of comprehensive sex education programs that stress the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections, and also teach about contraceptive choices and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and
(8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy;
(9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, and conversations about consent; and
(10) Encourages physicians and all interested parties to develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate.
CSA Rep. 7 and Reaffirmation: I-99; Reaffirmed: Res. 403, A-01; Modified: Res. 441, A-03; Appended: Res. 834, I-04; Reaffirmed: CSAPH Rep. 7, A-09; Modified: Res. 405, A-16; Appended: Res. 401, A-16; Appended: Res. 414, A-18; Appended: Res. 428, A-18

Television Broadcast of Sexual Encounters and Public Health Awareness H-485.994
The AMA urges television broadcasters, producers, and sponsors to encourage education about safe sexual practices, including but not limited to condom use and abstinence, in television programming of sexual encounters, and to accurately represent the consequences of unsafe sex.
Res. 421, A-91; Reaffirmed: CSA Rep. 3, A-95; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15

Health Information and Education H-170.986
(1) Individuals should seek out and act upon information that promotes appropriate use of the health care system and that promotes a healthy lifestyle for themselves, their families and others for whom they are responsible. Individuals should seek informed opinions from health care professionals regarding health information delivered by the mass media self-help and mutual aid groups are important components of health promotion/disease and injury prevention, and their development and maintenance should be promoted.
(2) Employers should provide and employees should participate in programs on health awareness, safety and the use of health care benefit packages.
(3) Employers should provide a safe workplace and should contribute to a safe community environment. Further, they should promptly inform employees and the community when they know that hazardous substances are being used or produced at the worksite.
(4) Government, business and industry should cooperatively develop effective worksite programs for health promotion and disease and injury prevention, with special emphasis on substance abuse.

(5) Federal and state governments should provide funds and allocate resources for health promotion and disease and injury prevention activities.
(6) Public and private agencies should increase their efforts to identify and curtail false and misleading information on health and health care.
(7) Health care professionals and providers should provide information on disease processes, healthy lifestyles and the use of the health care delivery system to their patients and to the local community.
(8) Information on health and health care should be presented in an accurate and objective manner.
(9) Educational programs for health professionals at all levels should incorporate an appropriate emphasis on health promotion/disease and injury prevention and patient education in their curricula.
(10) Third party payers should provide options in benefit plans that enable employers and individuals to select plans that encourage healthy lifestyles and are most appropriate for their particular needs. They should also continue to develop and disseminate information on the appropriate utilization of health care services for the plans they market.
(11) State and local educational agencies should incorporate comprehensive health education programs into their curricula, with minimum standards for sex education, sexual responsibility, and substance abuse education. Teachers should be qualified and competent to instruct in health education programs.
(12) Private organizations should continue to support health promotion/disease and injury prevention activities by coordinating these activities, adequately funding them, and increasing public awareness of such services.
(13) Basic information is needed about those channels of communication used by the public to gather health information. Studies should be conducted on how well research news is disseminated by the media to the public. Evaluation should be undertaken to determine the effectiveness of health information and education efforts. When available, the results of evaluation studies should guide the selection of health education programs.
BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmation: A-07; Reaffirmation: A-15; Reaffirmed: BOT Rep. 15, A-19

Comprehensive Health Education H-170.977
(1) Educational testing to confirm understanding of health education information should be encouraged. (2) The AMA accepts the CDC guidelines on comprehensive health education. The CDC defines its concept of comprehensive school health education as follows: (a) a documented, planned, and sequential program of health education for students in grades pre-kindergarten through 12; (b) a curriculum that addresses and integrates education about a range of categorical health problems and issues (e.g., human immunodeficiency virus (HIV) infection, drug misuse, drinking and driving, emotional health, environmental pollution) at developmentally appropriate ages; (c) activities to help young people develop the skills they will need to avoid: (i) behaviors that result in unintentional and intentional injuries; (ii) drug and alcohol misuse; (iii) tobacco use; (iv) sexual behaviors that result in HIV infection, other sexually transmitted diseases, and unintended pregnancies; (v) imprudent dietary patterns; and (vi) inadequate physical activity; (d) instruction provided for a prescribe amount of time at each grade level; (e) management and coordination in each school by an education professional trained to implement the program; (f) instruction from teachers who have been trained to teach the subject; (g) involvement of parents, health professionals, and other concerned community members; and (h) periodic evaluations, updating, and improvement.
BOT Rep. X, A-92; Modified: CME Rep. 2, A-03; Reaffirmation: A-04; Reaffirmed: CSAPH Rep. 7, A-09; Modified: CSAPH Rep. 01, A-19

HIV/AIDS Education and Training H-20.904
(1) Public Information and Awareness Campaigns
Our AMA:
a) Supports development and implementation of HIV/AIDS health education programs in the United States by encouraging federal and state governments through policy statements and recommendations to take a stronger leadership role in ensuring interagency cooperation, private sector involvement, and the dispensing of funds based on real and measurable needs. This includes development and implementation of language- and culture-specific education programs and materials to inform minorities of risk behaviors associated with HIV infection.
b) Our AMA urges the communications industry, government officials, and the health care communities together to design and direct efforts for more effective and better targeted public awareness and information programs about HIV disease prevention through various public media, especially for those persons at increased risk of HIV infection;
c) Encourages education of patients and the public about the limited risks of iatrogenic HIV transmission. Such education should include information about the route of transmission, the effectiveness of universal precautions, and the efforts of organized medicine to ensure that patient risk remains immeasurably small. This program should include public and health care worker education as appropriate and methods to manage patient concern about HIV transmission in medical settings. Statements on HIV disease, including efficacy of experimental therapies, should be based only on current scientific and medical studies;
d) Encourages and will assist physicians in providing accurate and current information on the prevention and treatment of HIV infection for their patients and communities;
e) Encourages religious organizations and social service organizations to implement HIV/AIDS education programs for those they serve.
(2) HIV/AIDS Education in Schools
Our AMA:
a) Endorses the education of elementary, secondary, and college students regarding basic knowledge of HIV infection, modes of transmission, and recommended risk reduction strategies;
b) Supports efforts to obtain adequate funding from local, state, and national sources for the development and implementation of HIV educational programs as part of comprehensive health education in the schools.
(3) Education and Training Initiatives for Practicing Physicians and Other Health Care Workers
Our AMA supports continued efforts to work with other medical organizations, public health officials, universities, and others to foster the development and/or enhancement of programs to provide comprehensive information and training for primary care physicians, other front-line health workers (specifically including those in addiction treatment and community health centers and correctional facilities), and auxiliaries focusing on basic knowledge of HIV infection, modes of transmission, and recommended risk reduction strategies.
CSA Rep. 4, A-03; Appended: Res. 516, A-06; Modified: CSAPH 01, A-16; Reaffirmed: Res. 916, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 403
(N-21)

Introduced by: Medical Student Section

Subject: Providing Reduced Parking for Patients

Referred to: Reference Committee D

Whereas, In the United States, an estimated four million individuals fail to receive annual medical care due to transportation barriers[1]; and

Whereas, Many patients with common illnesses attend multiple outpatient appointments a year, such as one study which showed 47% of patients with hypertension had four or more visits in 2014[2]; and

Whereas, Parking prices at some of the country's largest medical centers can be as high as $20 to $43 per day[3-4]; and

Whereas, The public transportation system in the United States varies greatly within the country in terms of usage, location, and infrastructure, with most of the public transport concentrated in the Northeast[5]; and

Whereas, Approximately only a third of patients are within walking distance to their nearest public transportation in certain metropolitan medical centers[6]; and

Whereas, Public transport is not readily available in all locations, such as rural areas where the scarcity of local physicians can still require patients to drive to urban areas for care[7]; and

Whereas, Programs such as non-emergency patient/medical transportation (NEMT) are often limited to approved patients within Medicaid and can have many disadvantages, including restrictions on the type and number of rides, the necessity of a social worker to coordinate transportation, having to schedule days in advance, and carpooling with other patients leading to longer travel and wait times[8]; and

Whereas, The average cost of an NEMT in 2014 was $28, and this price rises in rural and suburban areas that are farther from medical centers[8,9]; and

Whereas, When surveying older Americans, the group that utilizes the most inpatient and outpatient healthcare, rideshare services were not seen as a practical option, with 74% of patients reporting no knowledge of these services and only 1.7% making use of them[10]; and

Whereas, In a study of patients with heart disease, individuals reported the high cost of parking at healthcare facilities as a financial barrier to attending multiple specialist appointments[11]; and

Whereas, In a study of factors influencing family burden in pediatric hematology/oncology, parking was cited as one of the most disproportionately distressing factors[12]; and

Whereas, Nonmedical costs, such as transportation, meals, and child care, have been reported to range from $50 to $165 a day, further contributing to a family's financial stress[13]; and

Whereas, The lower the financial burden a patient has, the less likely they are to miss appointments and adhere to treatment, preventing high cost emergent situations that would lead to hospitals losing money on patients who cannot pay[14]; and

Whereas, Reduced parking fees have been cited as an incentive for patients to travel to hospitals that can offer better treatment than local counterparts[15]; and

Whereas, A minority of hospitals rely on nonpatient care income to offset revenue losses, such that providing parking vouchers would only represent a minor loss in revenue while providing a major benefit to patients[16]; and

Whereas, Many hospitals have already implemented programs for patient parking such as reduced monthly rates and free validated parking[17-19]; and

Whereas, Several associations of healthcare facilities focus on developing solutions for and advocating improvements in social and economic aspects of healthcare, including the American Hospital Association, the Federation of American Hospitals, and the Children's Hospital Association[20-27]; and

Whereas, The American Hospital Association is a national organization of "5,000 hospitals, health care systems, networks, [and] other providers of care" and publishes standards and guidelines on various social and economic aspects of care[20,21]; and

Whereas, The Federation of American Hospitals is a national organization of over 1,000 hospitals that are not tax-exempt, including for-profit hospitals, and advocates their priorities[22-24]; and

Whereas, The Children's Hospital Association is a national organization of over 220 pediatric hospitals and develops and shares solutions with its members on various social and economic aspects of care[26,27]; therefore be it

RESOLVED, That our American Medical Association work with relevant stakeholders to recognize parking fees as a burden of care for patients and to implement mechanisms for reducing parking costs. (Directive to Take Action)

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

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

The COVID-19 pandemic has shown light upon the many inequities in and barriers to accessibility of care. One of these barriers is transportation and parking fees. Parking fees at large medical centers can be up to nearly $50 per day. This cost is prohibitive to low-income and low-SES patients and families. It is unconscionable that healthcare facilities should profit off their patients' need to park at a healthcare facility in order to receive needed care. Studies have documented that patients see parking costs as a significant stress and a financial barrier to attending appointments. Further, many patients have already missed important healthcare appointments due to the pandemic, and given that the long-term consequences of COVID-19 will make it necessary for many more individuals to attend multiple follow-up appointments in the coming months and years. Our AMA should act now to begin to work to reduce this barrier and burden, to ensure our patients are able to access the care they need as we learn to address the long-term effects of this ongoing pandemic.

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RELEVANT AMA POLICY

Non-Emergency Patient Transportation Systems H-130.954

Our AMA:
1. supports the education of physicians, first responders, and the public about the costs associated with inappropriate use of emergency patient transportation systems; and
2. encourages the development of non-emergency patient transportation systems that are affordable to the patient, thereby ensuring cost effective and accessible health care for all patients.

Sub. Res. 812, I-93; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed in lieu of Res. 101, A-12; Modified: CMS Rep. 02, I-18

Controlling Cost of Medical Care H-155.966

The AMA urges the American Hospital Association and all hospitals to encourage the administrators and medical directors to provide to the members of the medical staffs, housestaff and medical students the charges for tests, procedures, medications and durable medical equipment in such a fashion as to emphasize cost and quality consciousness and to maximize the education of those who order these items as to their costs to the patient, to the hospital and to society in general.

Sub. Res. 75, I-81; Reaffirmed: CLRPD Rep. F, I-91; Res. 801, A-93; CMS Rep. 12, A-95; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmation: A-08; Reaffirmed in lieu of Res. 5, A-12

Voluntary Health Care Cost Containment H-155.998

1. All physicians, including physicians in training, should become knowledgeable in all aspects of patient-related medical expenses, including hospital charges of both a service and professional nature.
2. Physicians should be cost conscious and should exercise discretion, consistent with good medical care, in determining the medical necessity for hospitalization and the specific treatment, tests and ancillary medical services to be provided a patient.

Res. 34, A-78; Reaffirmed: CLRPD Rep. C, A-89; Res. 100, I-89; Res. 822, A-93; Reaffirmed: BOT Rep. 40, I-93; CMS Rep. 12, A-95; Reaffirmed: Res. 808, I-02; Modified: CMS Rep. 4, A-12

Health Promotion and Disease Prevention H-425.993

The AMA (1) reaffirms its current policy pertaining to the health hazards of tobacco, alcohol, accidental injuries, unhealthy lifestyles, and all forms of preventable illness; (2) advocates intensified leadership to promote better health through prevention; (3) believes that preventable

illness is a major deterrent to good health and accounts for a major portion of our country's total health care expenditures; (4) actively supports appropriate scientific, educational and legislative activities that have as their goals: (a) prevention of smoking and its associated health hazards; (b) avoidance of alcohol abuse, particularly that which leads to accidental injury and death; (c) reduction of death and injury from vehicular and other accidents; and (d) encouragement of healthful lifestyles and personal living habits; (5) advocates that health be considered one of the goals in transportation planning and policy development including but not limited to the establishment, expansion, and continued maintenance of affordable, accessible, barrier-free, reliable, and preferably clean-energy public transportation; and (6) strongly emphasizes the important opportunity for savings in health care expenditures through prevention.
Presidential Address, A-82; Reaffirmed: CMRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: BOT Rep. 8, I-06; Reaffirmed: CSAPH Rep. 01, A-16; Modified: Res. 923, I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 404
(N-21)

Introduced by: Medical Student Section

Subject: Increase Employment Services Funding for People with Disabilities

Referred to: Reference Committee D

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1 Whereas, The American Disabilities Act defines “disability” as “a physical or mental impairment
2 that substantially limits one or more major life activities of such individual, a record of such an
3 impairment, or being regarded as having such an impairment”[1]; and
4
5 Whereas, Adults with disabilities experience health disparities related to social determinants of
6 health, as they are less likely to have jobs with competitive wages, more likely to live in poverty,
7 and more likely to experience mental health issues[2]; and
8
9 Whereas, People with disabilities have been disproportionately affected by the COVID-19
10 pandemic, in terms of both health outcomes and economically, with unemployment rates that
11 are nearly double the unemployment rates of nondisabled people[3-5]; and
12
13 Whereas, One in five people with disabilities, or approximately one million people in the US, lost
14 their job during the COVID-19 pandemic, compared to one in seven people in the general
15 population[6]; and
16
17 Whereas, Between 2019 and 2020, the percentage of people with disabilities who were
18 employed fell from 19.2% to 17.9%, whereas non-disabled people saw a decrease in
19 employment from 66.3% to 61.8%[7]; and
20
21 Whereas, Almost half of unemployed disabled individuals endorse barriers to employment, while
22 less than 10% of individuals with disabilities have been able to use career assistance
23 programs[8]; and
24
25 Whereas, Existing literature demonstrates that employment training programs are highly
26 beneficial for students with disabilities to gain competitive employment, and many have success
27 rates of 100% employment for their students[2,9]; and
28
29 Whereas, The Workforce Innovation and Opportunity Act of 2014 (WIOA) provides state grants
30 through the Department of Labor for employment and training services for people with
31 disabilities, serving over 46,000 adults with disabilities and 26,000 youth with disabilities in
32 2018[10,11]; and
33
34 Whereas, WIOA reserves 15% of its budget for Vocational Rehabilitation programs to assist
35 students with disabilities through a transition from school to employment[10]; and

Whereas, In order to sustain the services provided to the community, Centers for Independent Living (CIL) programs developed by the WIOA independently raised six times the federal appropriation of funds in 2019, contributing to a 27% increase in utilization of resources to assist with transition from youth to adult life[2]; and

Whereas, Lack of funding has been increasingly detrimental during the COVID-19 pandemic, with community programs through WIOA reporting over 30% of employment service programming closed due to COVID-19[12]; and

Whereas, The Arc, an organization that trains and employs thousands of individuals with disabilities nationally, reported that employment programs have struggled during the COVID-19 pandemic due to funding concerns, and 44% of agencies through The Arc had to lay-off or furlough staff[13,14]; and

Whereas, Section 188 of WIOA requires that employment services provide equal opportunities for individuals with disabilities to participate in services and receive appropriate accommodations; however, the COVID-19 pandemic has created disparities in receiving these accommodations[15]; and

Whereas, AMA Policy H-90.967 and MSS Policy 25.002 encourage government agencies and other organizations to provide psychosocial support for people with disabilities, but do not include employment benefits; and

Whereas, As employment and socioeconomic status are social determinants of health closely linked to health outcomes, increased resources for employment support programs would provide equitable solutions for the drastic disparities that the COVID-19 pandemic has created for people with disabilities[16]; therefore be it

RESOLVED, That our American Medical Association support increased resources for employment services to reduce health disparities for people with disabilities. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

People with disabilities have been disproportionately affected by the COVID-19 pandemic, with job loss rates that are nearly double the unemployment rates of nondisabled people. Employment is a social determinant of health, and disparities in employment status for people with disabilities could contribute to worse health outcomes. Existing policy H-90.967 encourages government agencies to provide psychosocial support for people with disabilities, yet social determinants of health including employment and socioeconomic status are not included. This resolution is an impactful ask requesting increased funding for employment services to provide people with disabilities with more equitable employment and socioeconomic opportunities, through existing federal and state programs which have demonstrated evidence-based success. This resolution is especially timely considering that Congress is currently considering ending a federal program that allows subminimum wages for workers with disabilities, so that AMA advocacy on this issue could provide an important voice to an issue of justice, equity, and better health outcomes for people with disabilities.. Improving employment opportunities through increased access to resources will contribute to improved social determinants of health and reduced health disparities for people with disabilities.

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RELEVANT AMA POLICY

H-90.967 Support for Persons with Intellectual Disabilities
Our AMA encourages appropriate government agencies, non-profit organizations, and specialty societies to develop and implement policy guidelines to provide adequate psychosocial resources for persons with intellectual disabilities, with the goal of independent function when possible.
Res. 01, A-16

D-90.992 Preserving Protections of the Americans with Disabilities Act of 1990
1. Our AMA supports legislative changes to the Americans with Disabilities Act of 1990, to educate state and local government officials and property owners on strategies for promoting access to persons with a disability.
2. Our AMA opposes legislation amending the Americans with Disabilities Act of 1990, that would increase barriers for disabled persons attempting to file suit to challenge a violation of their civil rights.
3. Our AMA will develop educational tools and strategies to help physicians make their offices more accessible to persons with disabilities, consistent with the Americans With Disabilities Act as well as any applicable state laws.
Res. 220, I-17

H-90.971 Enhancing Accommodations for People with Disabilities
Our AMA encourages physicians to make their offices accessible to patients with disabilities, consistent with the Americans with Disabilities Act (ADA) guidelines.
Res. 705, A-13

H-90.969 Early Intervention for Individuals with Developmental Delay
(1) Our AMA will continue to work with appropriate medical specialty societies to educate and enable physicians to identify children with developmental delay, autism and other developmental disabilities, and to urge physicians to assist parents in obtaining access to appropriate individualized early intervention services. (2) Our AMA supports a simplified process across appropriate government agencies to designate individuals with intellectual disabilities as a medically underserved population.
CCB/CLRPD Rep. 3, A-14; Reaffirmed: Res. 315, A-17

H-90.986 SSI Benefits for Children with Disabilities
The AMA will use all appropriate means to inform members about national outreach efforts to find and refer children who may qualify for Supplemental Security Income benefits to the Social Security Administration and promote and publicize the new rules for determining disability.
Res. 420, A-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CMS Rep. 4, A-13

H-160.890 Support for Housing Modification Policies
Our AMA supports improved access to housing modification benefits for populations that require modifications in order to mitigate preventable health conditions, including but not limited to the elderly, the disabled and other persons with physical and/or mental disabilities.
Res. 806, I-19

H-290.970 Federal Legislation on Access to Community-Based Services for People with Disabilities
Our AMA strongly supports reform of the Medicaid program established under title XIX of the Social Security Act (42 U.S.C. 1396) to provide services in the most appropriate settings based upon the individual's needs, and to provide equal access to community-based attendant services and supports.
Res. 917, I-07; Reaffirmed: BOT Rep. 22, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 405
(N-21)

Introduced by: Medical Student Section

Subject: Formal Transitional Care Program for Children and Youth with Special Health Care Needs

Referred to: Reference Committee D

Whereas, Children and youth with special health care needs (CYSHCN) are those whose health care needs are more complex and require specialized care for their physical, behavioral, or emotional development beyond that required by children generally[1]; and

Whereas, "Special health care needs" include any chronic conditions, such as cystic fibrosis, cerebral palsy, congenital defects/conditions, type 1 diabetes and other similar health conditions[1,2]; and

Whereas, Almost 20% of children between 12 and 18 years of age have a special health care need[3]; and

Whereas, People with disabilities are described as having an activity limitation or who use assistance or perceive themselves as having a disability[4]; and

Whereas, Most of CYSHCN do not fall under the formal definition of "disabled" and are under their own category given that[4]; and

Whereas, Ninety percent of CYSHCN, who previously faced high rates of childhood mortality, now increasingly survive to adulthood due to advances in medicine and therefore need the appropriate care they received as children and young adults[5]; and

Whereas, Pediatric practices do not routinely start planning for transition to adult care until around the patient is 18 years of age, and many pediatric practices do not have the available policies, plans, or educational materials for a proper transition[6]; and

Whereas, Adult clinicians often do not have the specific infrastructure, education, and training to care for young adults with pediatric-onset conditions[7]; and

Whereas, Research demonstrates that CYSHCN currently are inadequately supported during the transition from pediatric to adult health care[6-9]; and

Whereas, Transitioning from pediatric to adult services, particularly for CYSHCN, is associated with decreased medication adherence, decreased patient engagement, increased avoidable hospitalization, and other health risks like permanent end-organ damage and even an early death[8, 10]; and

Whereas, The transition to adult services occurs during a developmental period marked by increased risky behavior[11], indicating the need for stability and clear planning to promote good outcomes and continued treatment adherence; and

Whereas, The ability of pediatricians and adult clinicians to communicate effectively during the transition to adult care results in better health outcomes for the individual[12]; and

Whereas, The American Academy of Pediatrics, the American Academy of Family Physicians, and the American College of Physicians have released and reaffirmed a consensus statement supporting high-quality, planned transitions of care for all youth, especially CYSHCN[13]; and

Whereas, Transitional Clinical Report and Algorithm was published as basic guidelines to set up potential transition systems[13]; and

Whereas, After nearly 10 years of effort and research since the Transitional Clinical Report and Algorithm was published, some effective models of transition systems were made by reputable organizations, like National Standards for CYSHCN, but none have been nationally established[13,14]; and

Whereas, Current AMA policy encourages physicians to establish transitional care programs for children with disabilities (H-60.974), but existing language is not inclusive of all children with special health care needs[16]; therefore be it

RESOLVED, That our American Medical Association amend Policy H-60.974, “Children and Youth with Disabilities,” by addition and deletion to read as follows, to strengthen our AMA policy and to include a population of patients that do not fall under “disability” but also need extra care, especially when transitioning to adult health care, that they are currently not receiving due to a gap:

H-60.974: CHILDREN AND YOUTH WITH DISABILITIES AND WITH SPECIAL HEALTH CARE NEEDS
It is the policy of the AMA: (1) to inform physicians of the special health care needs of children and youth with disabilities and children and youth with special health care needs (CYSHCN);
(2) to encourage physicians to pay special attention during the preschool physical examination to identify physical, emotional, or developmental disabilities that have not been previously noted;
(3) to encourage physicians to provide services to children and youth with disabilities and CYSHCN that are family-centered, community-based, and coordinated among the various individual providers and programs serving the child;
(4) to encourage physicians to provide schools with medical information to ensure that children and youth with disabilities and CYSHCN receive appropriate school health services;
(5) to encourage physicians to establish formal transition programs or activities that help adolescents with disabilities, ~~and~~ CYSHCN, and their families to plan and make the transition to the adult medical care system;
(6) to inform physicians of available educational and other local resources, as well as various manuals that would help prepare them to provide family-centered health care; and
(7) to encourage physicians to make their offices accessible to patients with disabilities and CYSHCN, especially when doing office construction and renovations. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

This resolution aims to resolve gaps in existing AMA policy to address the critical healthcare needs of children and youth with special healthcare needs (CYSHCN), a vulnerable population, as they transition from pediatric to adult medical care. CYSHCN often requires long-term health services from multiple sectors of the healthcare field. The children and their families tend to face many barriers to care especially if they belong to a minority population. The medical literature clearly illustrates how imperative it is to support patients, particularly CYSHCN, during this transition period to optimize medication adherence, patient engagement, and end-organ function. The American Academy of Pediatrics, the American Academy of Family Physicians, and the American College of Physicians have already released a consensus statement supporting high-quality, planned transitions of care for all youth, especially CYSHCN. However, existing AMA policy, most notably policy H-60.974, currently addresses only youth with disabilities. While some CYSHCN may have an activity limitation or perceive themselves as having a disability, many CYSHCN do not fall under the formal definition of "disabled" and are thus forgotten under current AMA policy. Therefore, while current policy affirms the complex nature of care for this population and encourages transition programs for children with disabilities, as the policy is written currently it ignores a large swath of vulnerable patients. For these reasons, the AMA should prioritize this critical and timely issue to protect a vulnerable population that is falling through the gaps in current policy.

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RELEVANT AMA POLICY

H-60.974: Children and Youth with Disabilities

It is the policy of the AMA: (1) to inform physicians of the special health care needs of children and youth with disabilities;
(2) to encourage physicians to pay special attention during the preschool physical examination to identify physical, emotional, or developmental disabilities that have not been previously noted;
(3) to encourage physicians to provide services to children and youth with disabilities that are family-centered, community-based, and coordinated among the various individual providers and programs serving the child;
(4) to encourage physicians to provide schools with medical information to ensure that children and youth with disabilities receive appropriate school health services;
(5) to encourage physicians to establish formal transition programs or activities that help adolescents with disabilities and their families to plan and make the transition to the adult medical care system;
(6) to inform physicians of available educational and other local resources, as well as various manuals that would help prepare them to provide family-centered health care; and
(7) to encourage physicians to make their offices accessible to patients with disabilities, especially when doing office construction and renovations.
CSA Reo. J, 1-91 Modified: Sunset Report, I-01; CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 1, A-21

H-160.942: Evidence-Based Principles of Discharge and Discharge Criteria

(1) The AMA defines discharge criteria as organized, evidence-based guidelines that protect patients' interests in the discharge process by following the principle that the needs of patients must be matched to settings with the ability to meet those needs.
(2) The AMA calls on physicians, specialty societies, insurers, and other involved parties to join in developing, promoting, and using evidence-based discharge criteria that are sensitive to the physiological, psychological, social, and functional needs of patients and that are flexible to meet advances in medical and surgical therapies and adapt to local and regional variations in health care settings and services.
(3) The AMA encourages incorporation of discharge criteria into practice parameters, clinical guidelines, and critical pathways that involve hospitalization.
(4) The AMA promotes the local development, adaption and implementation of discharge criteria.
(5) The AMA promotes training in the use of discharge criteria to assist in planning for patient care at all levels of medical education. Use of discharge criteria will improve understanding of

the pathophysiology of disease processes, the continuum of care and therapeutic interventions, the use of health care resources and alternative sites of care, the importance of patient education, safety, outcomes measurements, and collaboration with allied health professionals.
(6) The AMA encourages research in the following areas: clinical outcomes after care in different health care settings; the utilization of resources in different care settings; the actual costs of care from onset of illness to recovery; and reliable and valid ways of assessing the discharge needs of patients.
(7) The AMA endorses the following principles in the development of evidence-based discharge criteria and an organized discharge process:
(a) As tools for planning patients' transition from one care setting to another and for determining whether patients are ready for the transition, discharge criteria are intended to match patients' care needs to the setting in which their needs can best be met.
(b) Discharge criteria consist of, but are not limited to: (i) Objective and subjective assessments of physiologic and symptomatic stability that are matched to the ability of the discharge setting to monitor and provide care. (ii) The patient's care needs that are matched with the patient's, family's, or caregiving staff's independent understanding, willingness, and demonstrated performance prior to discharge of processes and procedures of self care, patient care, or care of dependents. (iii) The patient's functional status and impairments that are matched with the ability of the care givers and setting to adequately supplement the patients' function. (iv) The needs for medical follow-up that are matched with the likelihood that the patient will participate in the follow-up. Follow-up is time-, setting-, and service-dependent. Special considerations must be taken to ensure follow-up in vulnerable populations whose access to health care is limited.
(c) The discharge process includes, but is not limited to: (i) Planning: Planning for transition/discharge must be based on a comprehensive assessment of the patient's physiological, psychological, social, and functional needs. The discharge planning process should begin early in the course of treatment for illness or injury (prehospitalization for elective cases) with involvement of patient, family and physician from the beginning. (ii) Teamwork: Discharge planning can best be done with a team consisting of the patient, the family, the physician with primary responsibility for continuing care of the patient, and other appropriate health care professionals as needed. (iii) Contingency Plans/Access to Medical Care: Contingency plans for unexpected adverse events must be in place before transition to settings with more limited resources. Patients and caregivers must be aware of signs and symptoms to report and have a clearly defined pathway to get information directly to the physician, and to receive instructions from the physician in a timely fashion. (iv) Responsibility/Accountability: Responsibility/accountability for an appropriate transition from one setting to another rests with the attending physician. If that physician will not be following the patient in the new setting, he or she is responsible for contacting the physician who will be accepting the care of the patient before transfer and ensuring that the new physician is fully informed about the patient's illness, course, prognosis, and needs for continuing care. If there is no physician able and willing to care for the patient in the new setting, the patient should not be discharged. Notwithstanding the attending physician's responsibility for continuity of patient care, the health care setting in which the patient is receiving care is also responsible for evaluating the patient's needs and assuring that those needs can be met in the setting to which the patient is to be transferred. (v) Communication: Transfer of all pertinent information about the patient (such as the history and physical, record of course of treatment in hospital, laboratory tests, medication lists, advanced directives, functional, psychological, social, and other assessments), and the discharge summary should be completed before or at the time of transfer of the patient to another setting. Patients should not be accepted by the new setting without a copy of this patient information and complete instructions for continued care. (8) The AMA supports the position that the care of

the patient treated and discharged from a treating facility is done through mutual consent of the patient and the physician; and (9) Policy programs by Congress regarding patient discharge timing for specific types of treatment or procedures be discouraged.
CSA Rep. 4, A-96, Reaffirmation I-96; Modified by Res. 216, A-97; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: BOT Rep. 1, A-08; Reaffirmed: CMS Rep. 07, I-16; Reaffirmed: BOT Rep. 16, A-19

H-165.877: Increasing Coverage for Children
Our AMA: (1) supports appropriate legislation that will provide health coverage for the greatest number of children, adolescents, and pregnant women; (2) recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary interim step toward universal access; (3) places particular emphasis on advocating policies and proposals designed to expand the extent of health expense coverage protection for presently uninsured children and recommends that the funding for this coverage should preferably be used to allow these children, by their parents or legal guardians, to select private insurance rather than being placed in Medicaid programs; (4) supports, and encourages state medical associations to support, a requirement by all states that all insurers in that jurisdiction make available for purchase individual and group health expense coverage solely for children up to age 18; (5) encourages state medical associations to support study by their states of the need to extend coverage under such children's policies to the age of 23; (6) seeks to have introduced or support federal legislation prohibiting employers from conditioning their provision of group coverage including children on the availability of individual coverage for this age group for direct purchase by families; (7) advocates that, in order to be eligible for any federal or state premium subsidies or assistance, the private children's coverage offered in each state should be no less than the benefits provided under Medicaid in that state and allow states flexibility in the basic benefits package; (8) advocates that state and/or federal legislative proposals to provide premium assistance for private children's coverage provide for an appropriately graduated subsidy of premium costs for insurance benefits; (9) supports an increase in the federal and/or state sales tax on tobacco products, with the increased revenue earmarked for an income-related premium subsidy for purchase of private children's coverage; (10) advocates consideration by Congress, and encourage consideration by states, of other sources of financing premium subsidies for children's private coverage; (11) supports and encourages state medical associations and local medical societies to support, the use of school districts as one possible risk pooling mechanism for purchase of children's health insurance coverage, with inclusion of children from birth through school age in the insured group; (12) supports and encourages state medical associations to support, study by states of the actuarial feasibility of requiring pure community rating in the geographic areas or insurance markets in which policies are made available for children; and (13) encourages state medical associations, county medical societies, hospitals, emergency departments, clinics and individual physicians to assist in identifying and encouraging enrollment in Medicaid of the estimated three million children currently eligible for but not covered under this program.
Sub. Res. 208, A-97, CMS Rep.7, A-97; Reaffirmation A-99, Reaffirmed: CMS Rep. 5, I-99; Reaffirmed: Res. 238 and Reaffirmation A-00; Reaffirmation A-02, Reaffirmation A-05; Consolidated: CMS Rep.7, I-05, Reaffirmation A-07; Reaffirmation A-08, Modified: Speakers Rep.2, I-14; Reaffirmed: CMS Rep. 01, A-18

H-290.982: Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured

AMA policy is that our AMA: (1) urges that Medicaid reform not be undertaken in isolation, but rather in conjunction with broader health insurance reform, in order to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients;
(2) encourages physicians to participate in efforts to enroll children in adequately funded Medicaid and State Children's Health Insurance Programs using the mechanism of "presumptive eligibility," whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be, in fact, eligible.
(3) encourages states to ensure that within their Medicaid programs there is a pluralistic approach to health care financing delivery including a choice of primary care case management, partial capitation models, fee-for-service, medical savings accounts, benefit payment schedules and other approaches;
(4) calls for states to create mechanisms for traditional Medicaid providers to continue to participate in Medicaid managed care and in State Children's Health Insurance Programs;
(5) calls for states to streamline the enrollment process within their Medicaid programs and State Children's Health Insurance Programs by, for example, allowing mail-in applications, developing shorter application forms, coordinating their Medicaid and welfare (TANF) application processes, and placing eligibility workers in locations where potential beneficiaries work, go to school, attend day care, play, pray, and receive medical care;
(6) urges states to administer their Medicaid and SCHIP programs through a single state agency;
(7) strongly urges states to undertake, and encourages state medical associations, county medical societies, specialty societies, and individual physicians to take part in, educational and outreach activities aimed at Medicaid-eligible and SCHIP-eligible children. Such efforts should be designed to ensure that children do not go without needed and available services for which they are eligible due to administrative barriers or lack of understanding of the programs;
(8) supports requiring states to reinvest savings achieved in Medicaid programs into expanding coverage for uninsured individuals, particularly children. Mechanisms for expanding coverage may include additional funding for the SCHIP earmarked to enroll children to higher percentages of the poverty level; Medicaid expansions; providing premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level; providing some form of refundable, advanceable tax credits inversely related to income; providing vouchers for recipients to use to choose their own health plans; using Medicaid funds to purchase private health insurance coverage; or expansion of Maternal and Child Health Programs. Such expansions must be implemented to coordinate with the Medicaid and SCHIP programs in order to achieve a seamless health care delivery system, and be sufficiently funded to provide incentive for families to obtain adequate insurance coverage for their children;
(9) advocates consideration of various funding options for expanding coverage including, but not limited to: increases in sales tax on tobacco products; funds made available through for-profit conversions of health plans and/or facilities; and the application of prospective payment or other cost or utilization management techniques to hospital outpatient services, nursing home services, and home health care services;
(10) supports modest co-pays or income-adjusted premium shares for non-emergent, non-preventive services as a means of expanding access to coverage for currently uninsured individuals;
(11) calls for CMS to develop better measurement, monitoring, and accountability systems and indices within the Medicaid program in order to assess the effectiveness of the program, particularly under managed care, in meeting the needs of patients. Such standards and measures should be linked to health outcomes and access to care;

(12) supports innovative methods of increasing physician participation in the Medicaid program and thereby increasing access, such as plans of deferred compensation for Medicaid providers. Such plans allow individual physicians (with an individual Medicaid number) to tax defer a specified percentage of their Medicaid income;
(13) supports increasing public and private investments in home and community-based care, such as adult day care, assisted living facilities, congregate living facilities, social health maintenance organizations, and respite care;
(14) supports allowing states to use long-term care eligibility criteria which distinguish between persons who can be served in a home or community-based setting and those who can only be served safely and cost-effectively in a nursing facility. Such criteria should include measures of functional impairment which take into account impairments caused by cognitive and mental disorders and measures of medically related long-term care needs;
(15) supports buy-ins for home and community-based care for persons with incomes and assets above Medicaid eligibility limits; and providing grants to states to develop new long-term care infrastructures and to encourage expansion of long-term care financing to middle-income families who need assistance;
(16) supports efforts to assess the needs of individuals with intellectual disabilities and, as appropriate, shift them from institutional care in the direction of community living;
(17) supports case management and disease management approaches to the coordination of care, in the managed care and the fee-for-service environments;
(18) urges CMS to require states to use its simplified four-page combination Medicaid / Children's Health Insurance Program (CHIP) application form for enrollment in these programs, unless states can indicate they have a comparable or simpler form; and
(19) urges CMS to ensure that Medicaid and CHIP outreach efforts are appropriately sensitive to cultural and language diversities in state or localities with large uninsured ethnic populations.
BOT Rep. 31, I-97, Reaffirmed by CMS Rep. 2, A-98; Reaffirmation A-99 and Reaffirmed: Res. 104, A-99; Appended: CMS Rep 2, A-99, Reaffirmation A-00; Appended: CMS Rep. 6, A-01, Reaffirmation A-02; Modified: CMS Rep. 8, A-03; Reaffirmed: CMS Rep. 1, A-05, Reaffirmation A-05; Reaffirmation A-07, Modified: CMS Rep. 8, A-08; Reaffirmation A-11, Modified: CMS Rep. 3, I-11; Reaffirmed: CMS Rep. 02, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 406
(N-21)

Introduced by: Resident and Fellow Section

Subject: Addressing Gaps in Patient and Provider Knowledge to Increase HPV Vaccine Uptake and Prevent HPV-Associated Oropharyngeal Cancer

Referred to: Reference Committee D

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1 Whereas, The annual incidence of human papilloma virus (HPV)-associated oropharyngeal
2 squamous cell carcinoma (OPSCC) in the United States has risen steadily over the past several
3 decades[1]; and
4
5 Whereas, The majority of new OPSCC diagnoses are associated with underlying oropharyngeal
6 HPV infection[1]; and
7
8 Whereas, OPSCC now accounts for the largest burden of HPV-associated cancer diagnoses in
9 the United States, with over 80% of cases occurring in men[2]; and
10
11 Whereas, HPV-16 accounts for 90 to 95% of HPV-associated OPSCC[3]; and
12
13 Whereas, All Food and Drug Administration-approved HPV vaccines demonstrate efficacy
14 against HPV-16[3]; and
15
16 Whereas, While HPV vaccination rates are overall improving, only 54.2% of adolescents aged
17 13-17 years had completed the HPV vaccine series in 2019[4]; and
18
19 Whereas, Despite equivalent vaccine schedule recommendations from the Centers for Disease
20 Control and Prevention, vaccine uptake among males remains lower than females[5]; and
21
22 Whereas, Awareness regarding the association between HPV infection and OPSCC remains
23 low among pediatricians, and public awareness is minimal, with only 0.8% of respondents in an
24 online survey of 2,126 adults identifying HPV as a risk factor for mouth and throat cancer[6,7]; and
25
26 Whereas, The strength and comprehensiveness of the healthcare provider's recommendation
27 are frequently cited as key factors influencing both parents and adult patients to pursue HPV
28 vaccination[8-11]; and
29
30 Whereas, There is no evidence-based screening test available for OPSCC; and
31
32 Whereas, Our AMA supports increased physician and public awareness about HPV-associated
33 diseases, as well as the availability of the HPV vaccine (policy H-440.872); therefore be it

RESOLVED, That our American Medical Association amend current policy H-440.872 "HPV Vaccine and Cervical Cancer Prevention Worldwide," by addition and deletion to read as follows:

1. Our AMA (a) urges physicians to educate themselves and their patients about all HPV-mediated ~~and associated~~ diseases, HPV vaccination, as well as routine cervical cancer screening; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and cervical cancer screening in countries without organized cervical cancer screening programs.

2. Our AMA will intensify efforts to improve awareness and understanding about all HPV-mediated ~~and associated~~ diseases, the availability and efficacy of HPV vaccinations, and the need for routine cervical cancer screening in the general public.

3. Our AMA (a) encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits for adolescents and young adults, (b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations, and (c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination.

4. Our AMA supports efforts (a) to enhance awareness in the general public regarding the association between HPV infection and oropharyngeal squamous cell carcinoma, and (b) to further develop oropharyngeal squamous cell carcinoma screening tools. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA amend current policy H-440.872 "HPV Vaccine and Cervical Cancer Prevention Worldwide" by title change to "HPV Vaccine and ~~Cervical~~ HPV-mediated Cancer Prevention Worldwide"; (Modify Current HOD Policy) and be it further

RESOLVED, That our AMA reaffirm Policies D-170.995 "Human Papillomavirus (HPV) Inclusion in our School Education Curricula," and D-440.955 "Insurance Coverage for HPV Vaccine." (Reaffirm HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 10/12/21

AUTHORS STATEMENT OF PRIORITY

The AMA has policy regarding HPV-associated diseases including cervical cancer, but with the increase in HPV-associated oropharyngeal cancer amongst our patients, having increased awareness amongst physicians and patients will help to address this incidence and allow the AMA to continue its work in advocating for evidence-based medicine.

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RELEVANT AMA POLICY

HPV Vaccine and Cervical Cancer Prevention Worldwide H-440.872

1. Our AMA (a) urges physicians to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine cervical cancer screening; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and cervical cancer screening in countries without organized cervical cancer screening programs.
2. Our AMA will intensify efforts to improve awareness and understanding about HPV and associated diseases, the availability and efficacy of HPV vaccinations, and the need for routine cervical cancer screening in the general public.
3. Our AMA (a) encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits for adolescents and young adults, (b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations, and (c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination.

Citation: Res. 503, A-07Appended: Res. 6, A-12

Human Papillomavirus (HPV) Inclusion in our School Education Curricula D-170.995

Our AMA will: (1) strongly urge existing school health education programs to emphasize the high prevalence of human papillomavirus in all genders, the causal relationship of HPV to cancer and genital lesions, and the importance of routine pap tests in the early detection of cancer; (2) urge that students and parents be educated about HPV and the availability of the HPV vaccine; and (3) support appropriate stakeholders to increase public awareness of HPV vaccine effectiveness for all genders against HPV-related cancers.

Citation: Res. 418, A-06Reaffirmed: CSAPH Rep. 01, A-16Modified: Res. 404, A-18

Insurance Coverage for HPV Vaccine D-440.955

Our AMA: (1) supports the use and administration of Human Papillomavirus vaccine as recommended by the Advisory Committee on Immunization Practices; (2) encourages insurance carriers and other payers to appropriately cover and adequately reimburse the HPV vaccine as a standard policy benefit for medically eligible patients; and (3) will advocate for the development of vaccine assistance programs to meet HPV vaccination needs of uninsured and underinsured populations.

Citation: Res. 818, I-06Reaffirmed: CMS Rep. 01, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 407
(N-21)

Introduced by: Resident and Fellow Section

Subject: Traumatic Brain Injury and Access to Firearms

Referred to: Reference Committee D

Whereas, Traumatic brain injury (TBI) is a prevalent issue in society with approximately 1.7 million incidents annually, a third of which contribute to injury-related deaths in the US; and

Whereas, Although extensive research is conducted in the field to better assess interventions in limiting consecutive brain damage after the initial head trauma, the actual mechanisms of neural recovery are poorly understood; and

Whereas, An increased focus is placed on therapies to treat individuals who have sustained brain injury and to improve their long-term recovery as many of these individuals suffer from significant cognitive, behavioral, and communicative disabilities which interfere with their daily activities and lives; and

Whereas, Approximately 20% of patients develop long-term medical complications such as epilepsy, Alzheimer's disease, Parkinson's syndrome, and depression in addition to their initial medical treatments after sustaining injury which costs the nation's healthcare more than $56 billion each year; and

Whereas, There are some very important policies that the AMA has supported that relate to gun violence and injury prevention. In H-145-997, the AMA acknowledges that firearms are a public health problem, encourages research into innovative manufacturing techniques, advocates for additional funding toward developing new safer weapon designs, and promotes education programs for firearm safety and prevention; and

Whereas, Our AMA has since developed several other corollary policies surrounding firearm violence prevention and intervention. Some of these policies asked for the establishment of preventative measureswhich would target the sale and manufacture of guns, specifically to decrease the availability. AMA policies calling for a waiting period preceding any firearm purchase include H-145.991, H-145.992, and H-145.996. Policies calling for the imposition of background checks for handgun purchases include H-145.991, H-145.996, H-145.970, and H-145.972; and

Whereas, TBI is a wide-ranging diagnosis that encompasses a variety of phenotypes and amending current policy would be more effective if intentionally defines TBI and high-risk individuals; and

Whereas, Our AMA has policy supporting screening by physicians for a number of public health and health concerns, including, not limited to: intimate partner and family violence (D-515.980, H- 515.981), potential violent behavior within mental health assessments (H-145.975), alcohol and drug use (H-30.942, H-95.922), pediatric mental health screening (H-

345.977), social and economic risk factors (H-160.896), maternal depression (D-420.991), and adverse childhood events (H-515.952); and

Whereas, While our AMA has policy regarding sports-related injuries and concussions, which includes TBI, there is not any policy that involves the importance of screening for active symptoms or history of TBI in settings such as primary care, pediatrics, psychiatry, neurology, schools, homeless shelters, within the criminal justice system, and athletic communities; and

Whereas, Failing to identify TBI may have severe consequences. Screening tools like the Ohio State University TBI-ID Method (OSU-TBI-ID), Brain Injury Screening Questionnaire (BISQ), HELPS Brain Injury Screening Tool, and Brain Check Survey may aid in the identification of those at risk for more severe consequences, and allow for supportive measures such as vocational rehabilitation or cognitive rehabilitation; therefore be it

RESOLVED, That our American Medical Association reaffirm Policy H-145.972 “Firearms and High-Risk Individuals” (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA amend Policy H-145.975 “Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care,” by addition and deletion to read as follows:

> …2. Our AMA supports initiatives designed to enhance access to the comprehensive assessment and treatment of mental ~~illness~~ health and ~~concurrent~~ substance use disorders~~,~~ in patients with traumatic brain injuries, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.
>
> 3. Our AMA work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to evaluate the risk of potential violent behavior in patients with traumatic brain injuries.
>
> ~~3.~~ 4. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 10/12/21

AUTHORS STATEMENT OF PRIORITY
This policy is lower priority. It will update current AMA policies to better address the burden traumatic brain injuries place on patients and ensure appropriate access to dangerous weapons.

RELEVANT AMA POLICY

Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975
1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.
2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.
3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.
Citation: Sub. Res. 221, A-13; Appended: Res. 416, A-14; Reaffirmed: Res. 426, A-16; Reaffirmed: BOT Rep. 28, A-18; Reaffirmation: A-18; Modified: CSAPH Rep. 04, A-18; Reaffirmation: I-18

Screening and Brief Interventions For Alcohol Problems H-30.942
Our AMA in conjunction with medical schools and appropriate specialty societies advocates curricula, actions and policies that will result in the following steps to assure the health of patients who use alcohol: (a) Primary care physicians should establish routine alcohol screening procedures (e.g., CAGE) for all patients, including children and adolescents as appropriate, and medical and surgical subspecialists should be encouraged to screen patients where undetected alcohol use could affect care. (b) Primary care physicians should learn how to conduct brief intervention counseling and motivational interviewing. Such training should be incorporated into medical school curricula and be subject to academic evaluation. Physicians are also encouraged to receive additional education on the pharmacological treatment of alcohol use disorders and co-morbid problems such as depression, anxiety, and post-traumatic stress disorder. (c) Primary care clinics should establish close working relationships with alcohol treatment specialists, counselors, and self-help groups in their communities, and, whenever feasible, specialized alcohol and drug treatment programs should be integrated into the routine clinical practice of medicine.
Citation: CSA Rep. 14, I-99; Reaffirmation I-01; Modified: CSAPH Rep. 1, A-11; Reaffirmation: A-18

Substance Use and Substance Use Disorders H-95.922
Our AMA:
(1) will continue to seek and participate in partnerships designed to foster awareness and to promote screening, diagnosis, and appropriate treatment of substance misuse and substance use disorders;
(2) will renew efforts to: (a) have substance use disorders addressed across the continuum of medical education; (b) provide tools to assist physicians in screening, diagnosing, intervening, and/or referring patients with substance use disorders so that they have access to treatment; (c) develop partnerships with other organizations to promote national policies to prevent and treat these illnesses, particularly in adolescents and young adults; and (d) assist physicians in becoming valuable resources for the general public, in order to reduce the stigma and enhance knowledge about substance use disorders and to communicate the fact that substance use disorder is a treatable disease; and
(3) will support appropriate federal and state legislation that would enhance the prevention, diagnosis, and treatment of substance use disorders.
Citation: CSAPH Rep. 01, A-18; Reaffirmed: BOT Rep. 14, I-20

Violence Prevention H-145.970
Our AMA: (1) encourages the enactment of state laws requiring the reporting of all classes of prohibited individuals, as defined by state and federal law, to the National Instant Criminal Background Check System (NICS); (2) supports federal funding to provide grants to states to improve NICS reporting; and (3) encourages states to automate the reporting of relevant information to NICS to improve the quality and timeliness of the data.
Citation: BOT Rep. 11, I-18

Firearms and High-Risk Individuals H-145.972
Our AMA supports: (1) the establishment of laws allowing family members, intimate partners, household members, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms; (3) expanding domestic violence restraining orders to include dating partners; (4) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons; (5) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and (6) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals.
Citation: CSAPH Rep. 04, A-18; Reaffirmed: BOT Rep. 11, I-18

Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975
1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.
2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.
3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.
Citation: Sub. Res. 221, A-13; Appended: Res. 416, A-14; Reaffirmed: Res. 426, A-16; Reaffirmed: BOT Rep. 28, A-18; Reaffirmation: A-18; Modified: CSAPH Rep. 04, A-18; Reaffirmation: I-18

Improving Pediatric Mental Health Screening H-345.977
Our AMA: (1) recognizes the importance of, and supports the inclusion of, mental health (including substance use, abuse, and addiction) screening in routine pediatric physicals; (2) will work with mental health organizations and relevant primary care organizations to disseminate recommended and validated tools for eliciting and addressing mental health (including substance use, abuse, and addiction) concerns in primary care settings; and (3) recognizes the importance of developing and implementing school-based mental health programs that ensure at-risk children/adolescents access to appropriate mental health screening and treatment services and supports efforts to accomplish these objectives.
Citation: Res. 414, A-11; Appended: BOT Rep. 12, A-14; Reaffirmed: Res. 403, A-18

Expanding Access to Screening Tools for Social Determinants of Health/Social Determinants of Health in Payment Models H-160.896
Our AMA supports payment reform policy proposals that incentivize screening for social determinants of health and referral to community support systems.
Citation: BOT Rep. 39, A-18; Reaffirmed: CMS Rep. 10, A-19

Adverse Childhood Experiences and Trauma-Informed Care H-515.952
1. Our AMA recognizes trauma-informed care as a practice that recognizes the widespread impact of trauma on patients, identifies the signs and symptoms of trauma, and treats patients by fully integrating knowledge about trauma into policies, procedures, and practices and seeking to avoid re-traumatization.
2. Our AMA supports:
a. evidence-based primary prevention strategies for Adverse Childhood Experiences (ACEs);
b. evidence-based trauma-informed care in all medical settings that focuses on the prevention of poor health and life outcomes after ACEs or other trauma at any time in life occurs;
c. efforts for data collection, research and evaluation of cost-effective ACEs screening tools without additional burden for physicians;
d. efforts to educate physicians about the facilitators, barriers and best practices for providers implementing ACEs screening and trauma-informed care approaches into a clinical setting; and
e. funding for schools, behavioral and mental health services, professional groups, community and government agencies to support patients with ACEs or trauma at any time in life.
Citation: Res. 504, A-19

Improving Screening and Treatment Guidelines for Intimate Partner Violence (IPV) Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals (LGBTQ) D-515.980
Our AMA will: (1) promote crisis resources for LGBTQ patients that cater to the specific needs of LGBTQ survivors of IPV; (2) encourage physicians to familiarize themselves with resources available in their communities for LGBTQ survivors of IPV; (3) advocate for federal funding to support programs and services for survivors of IPV that do not discriminate against underserved communities, including on the basis of sexual orientation and gender identity; (4) encourage research on intimate partner violence in the LGBTQ community to include studies on the prevalence, the accuracy of screening tools, effectiveness of early detection and interventions, as well as the benefits and harms of screening; and (5) encourage the dissemination of research to educate physicians and the community regarding the prevalence of IPV in the LGBTQ population, the accuracy of screening tools, effectiveness of early detection and interventions, as well as the benefits and harms of screening.
Citation: Res. 903, I-17; Modified: CSAPH Rep. 01, I-18

Family Violence-Adolescents as Victims and Perpetrators H-515.981
The AMA (1) (a) encourages physicians to screen adolescents about a current or prior history of maltreatment. Special attention should be paid to screening adolescents with a history of alcohol and drug misuse, irresponsible sexual behavior, eating disorders, running away, suicidal behaviors, conduct disorders, or psychiatric disorders for prior occurrences of maltreatment; and (b) urges physicians to consider issues unique to adolescents when screening youths for abuse or neglect. (2) encourages state medical society violence prevention committees to work with child protective service agencies to develop specialized services for maltreated adolescents, including better access to health services, improved foster care, expanded shelter and independent living facilities, and treatment programs. (3) will investigate research and resources on effective parenting of adolescents to identify ways in which physicians can promote parenting styles that reduce stress and promote optimal development. (4) will alert the national school organizations to the increasing incidence of adolescent maltreatment and the need for training of school staff to identify and refer victims of maltreatment. (5) urges youth correctional facilities to screen incarcerated youth for a current or prior history of abuse or neglect and to refer maltreated youth to appropriate medical or mental health treatment programs. (6) encourages the National Institutes of Health and other organizations to expand continued research on adolescent initiation of violence and abuse to promote understanding of how to prevent future maltreatment and family violence.
Citation: CSA Rep. I, A-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13

Improving Treatment and Diagnosis of Maternal Depression Through Screening and State-Based Care Coordination D-420.991
Our AMA: (1) will work with stakeholders to encourage the implementation of a routine protocol for depression screening in pregnant and postpartum women presenting alone or with their child during prenatal, postnatal, pediatric, or emergency room visits; (2) encourages the development of training materials related to maternal depression to advise providers on appropriate treatment and referral pathways; and (3) encourages the development of state-based care coordination programs (e.g., staffing a psychiatrist and care coordinator) to assure appropriate referral, treatment and access to follow-up maternal mental health care.
Citation: Res. 910, I-17

Waiting Periods for Firearm Purchases H-145.991
The AMA supports using its influence in matters of health to effect passage of legislation in the Congress of the U.S. mandating a national waiting period that allows for a police background and positive identification check for anyone who wants to purchase a handgun from a gun dealer anywhere in our country.
Citation: Sub. Res. 34, I-89; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Modified: Res. 401, A-17; Reaffirmation: A-18; Reaffirmation: I-18

Waiting Period Before Gun Purchase H-145.992
The AMA supports legislation calling for a waiting period of at least one week before purchasing any form of firearm in the U.S.
Citation: Res. 171, A-89Reaffirmed: BOT Rep.50, I-93Reaffirmed: CSA Rep. 8, A-05Reaffirmation A-07Reaffirmed: BOT Rep. 22, A-17Reaffirmation: A-18

Firearm Availability H-145.996
1. Our AMA: (a) advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.
2. Our AMA supports requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms.
3. Our AMA supports “gun violence restraining orders” for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as “red-flag” laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and “red-flag” laws, we also support the importance of due process so that individuals can petition for their rights to be restored.
Citation: Res. 140, I-87; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: BOT Rep. 12, A-16; Appended: Res. 433, A-18; Reaffirmation: I-18; Modified: BOT Rep. 11, I-18

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997
1. Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths.
Therefore, the AMA:
(A) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;
(B) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;
(C) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;
(D) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;

(E) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;
(F) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and
(G) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.
2. Our AMA will advocate for firearm safety features, including but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or misappropriation of the weapon by a non-registered user; and support legislation and regulation to standardize the use of these firearm safety features on weapons sold for non-military and non-peace officer use within the U.S.; with the aim of establishing manufacturer liability for the absence of safety features on newly manufactured firearms.
Citation: CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appended: Res. 403, I-99; Reaffirmation A-07; Reaffirmation A-13; Appended: Res. 921, I-13; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmation: A-18; Reaffirmation: I-18; Appended: Res. 405, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 408
(N-21)

Introduced by: New York

Subject: Ensuring Affordability and Equity in COVID-19 Vaccine Boosters

Referred to: Reference Committee D

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1 Whereas, Development of COVID-19 vaccine was developed in record time in response to a
2 worldwide pandemic emergency; and
3
4 Whereas, The federal government funded development and purchase of COVID-19 vaccine for
5 no cost distribution to the states, allowing the possibility of equity in the administration of this
6 precious commodity; and
7
8 Whereas, Booster doses are likely to be needed to maintain the health and economy of our
9 country; and
10
11 Whereas, Such boosters must be equitably available to all willing recipients in the states around
12 our country to maintain herd immunity; therefore be it
13
14 RESOLVED, That our American Medical Association support the public purchase and cost-free
15 distribution of COVID-19 booster vaccine doses. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 10/11/21

AUTHORS STATEMENT OF PRIORITY

This resolution is critically important to ensure the health of America. The COVID-19 booster has been debated and has been authorized by the CDC and FDA for those with compromised immune systems and those age 65 and older. Indications are that immune response from previous vaccinations does not last well in all patients and booster shots will be required. Many patients have already begun to receive their Covid booster shots. Physicians and the organizations which represent us have a responsibility to ensure that booster shots are available to those needing it, and indeed with time to all Americans. The AMA must take a position supporting the availability of booster shots without cost to those needing and/or wanting them.

RELEVANT AMA POLICY

COVID-19 Vaccination Rollout to Emergency Departments and Urgent Care Facilities D-440.918
Our AMA will work with other relevant organizations and stakeholders to lobby the current Administration for the distribution of COVID-19 vaccinations to our nation's emergency departments and urgent care facilities during the COVID-19 public health emergency.
Citation: Res. 228, A-21

Financing of Adult Vaccines: Recommendations for Action H-440.860
1. Our AMA supports the concepts to improve adult immunization as advanced in the Infectious Diseases Society of America's 2007 document "Actions to Strengthen Adult and Adolescent Immunization Coverage in the United States," and support the recommendations as advanced by the National Vaccine Advisory Committee's 2008 white paper on pediatric vaccine financing.
2. Our AMA will advocate for the following actions to address the inadequate financing of adult vaccination in the United States:
Provider-related
a. Develop a data-driven rationale for improved vaccine administration fees.
b. Identify and explore new methods of providing financial relief for adult immunization providers through, for example, vaccine company replacement systems/deferred payment/funding for physician inventories, buyback for unused inventory, and patient assistance programs.
c, Encourage and facilitate adult immunization at all appropriate points of patient contact; e.g., hospitals, visitors to long-term care facilities, etc.
d. Encourage counseling of adults on the importance of immunization by creating a mechanism through which immunization counseling alone can be reimbursed, even when a vaccine is not given.
Federal-related
a. Increase federal resources for adult immunization to: (i) Improve Section 317 funding so that the program can meet its purpose of improving adult immunizations; (ii) Provide universal coverage for adult vaccines and minimally, uninsured adults should be covered; (iii) Fund an adequate universal reimbursement rate for all federal and state immunization programs.
b. Optimize use of existing federal resources by, for example: (i) Vaccinating eligible adolescents before they turn 19 years of age to capitalize on VFC funding; (ii) Capitalizing on public health preparedness funding.
c. Ease federally imposed immunization burdens by, for example: (i) Providing coverage for Medicare-eligible individuals for all vaccines, including new vaccines, under Medicare Part B; (ii) Creating web-based billing mechanisms for physicians to assess coverage of the patient in real time and handle the claim, eliminating out-of-pocket expenses for the patient; (iii) Simplifying the reimbursement process to eliminate payment-related barriers to immunization.
d. The Centers for Medicare & Medicaid Services should raise vaccine administration fees annually, synchronous with the increasing cost of providing vaccinations.
State-related
a. State Medicaid programs should increase state resources for funding vaccines by, for example: (i) Raising and funding the maximum Medicaid reimbursement rate for vaccine administration fees; (ii) Establishing and requiring payment of a minimum reimbursement rate for administration fees; (iii) Increasing state contributions to vaccination costs; and (iv) Exploring the possibility of mandating immunization coverage by third party payers.
b. Strengthen support for adult vaccination and appropriate budgets accordingly.
Insurance-related
1. Provide assistance to providers in creating efficiencies in vaccine management by: (i) Providing model vaccine coverage contracts for purchasers of health insurance; (ii) Creating simplified rules for eligibility verification, billing, and reimbursement; (iii) Providing vouchers to

patients to clarify eligibility and coverage for patients and providers; and (iv) Eliminating provider/public confusion over insurance payment of vaccines by universally covering all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines.
b. Increase resources for funding vaccines by providing first-dollar coverage for immunizations.
c. Improve accountability by adopting performance measurements.
d. Work with businesses that purchase private insurance to include all ACIP-recommended immunizations as part of the health plan.
e. Provide incentives to encourage providers to begin immunizing by, for example: (i) Including start up costs (freezer, back up alarms/power supply, reminder-recall systems, etc.) in the formula for reimbursing the provision of immunizations; (ii) Simplifying payment to and encouraging immunization by nontraditional providers; (iii) Facilitating coverage of vaccines administered in complementary locations (e.g., relatives visiting a resident of a long-term care facility).
Manufacturer-related
Market stability for adult vaccines is essential. Thus: (i) Solutions to the adult vaccine financing problem should not deter research and development of new vaccines; (ii) Solutions should consider the maintenance of vibrant public and private sector adult vaccine markets; (iii) Liability protection for manufacturers should be assured by including Vaccine Injury Compensation Program coverage for all ACIP-recommended adult vaccines; (iv) Educational outreach to both providers and the public is needed to improve acceptance of adult immunization.
3. Our AMA will conduct a survey of small- and middle-sized medical practices, hospitals, and other medical facilities to identify the impact on the adult vaccine supply (including influenza vaccine) that results from the large contracts between vaccine manufacturers/distributors and large non-government purchasers, such as national retail health clinics, other medical practices, and group purchasing programs, with particular attention to patient outcomes for clinical preventive services and chronic disease management.
Citation: CSAPH Rep. 4, I-08; Reaffirmation I-10; Reaffirmation: I-12; Reaffirmation I-14; Reaffirmed: CMS Rep. 3, I-20

An Urgent Initiative to Support COVID-19 Vaccination and Information Programs D-440.921
Our AMA will institute a program to promote the integrity of a COVID-19 vaccination information program by: (1) educating physicians on speaking with patients about COVID-19 infection and vaccination, bearing in mind the historical context of “experimentation” with vaccines and other medication in communities of color, and providing physicians with culturally appropriate patient education materials; (2) educating the public about up-to-date, evidence-based information regarding COVID-19 and associated infections as well as the safety and efficacy of COVID-19 vaccines, by countering misinformation and building public confidence; (3) forming a coalition of health care and public health organizations inclusive of those respected in communities of color committed to developing and implementing a joint public education program promoting the facts about, promoting the need for, and encouraging the acceptance of COVID-19 vaccination; (4) supporting ongoing monitoring of COVID-19 vaccines to ensure that the evidence continues to support safe and effective use of vaccines among recommended populations; and (5) educating physicians and other healthcare professionals on means to disseminate accurate information and methods to combat medical misinformation online.
Citation: Res. 408, I-20; Reaffirmed: Res. 228, A-21 Reaffirmed: Res. 421, A-21

Reference Committee E

CSAPH Report(s)

04 Pharmacovigilance

Resolution(s)

501 Ensuring Continued Access to Equitable Take-Home Methadone Treatment
502 Advocating for Heat Exposure Protections for Outdoor Workers
503 Marketing Guardrails for the "Over-Medicalization" of Cannabis Use
504 Air Pollution and COVID: A Call to Tighten Regulatory Standards
505 Representation of Dermatological Pathologies in Varying Skin Tones
506 Enhancing Harm Reduction for People Who Use Drugs

REPORT 4 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (November 2021)
Pharmacovigilance
(Res 518-A-19, Chemical Variability in Pharmaceutical Products)
(Reference Committee E)

EXECUTIVE SUMMARY

Objective. In past AMA House of Delegates meeting, confusion about several concepts detailed in the multiple resolutions related to the quality of pharmaceutical products and concepts related to pharmacovigilance (PV) in general was recognized. Your Council on Science and Public Health (CSAPH) noted that there are several issues related to PV, track and trace, and testing and verification of pharmaceuticals that could benefit from further study, in addition to addressing referred Resolution 518-A-19, Chemical Variability in Pharmaceutical Products.

Methods. English-language articles were selected from a search of the PubMed database through August 2021 using the search terms "pharmacovigilance," "pharmaceutical/drug quality," and "pharmaceutical/drug impurities." Additional articles were identified from a review of the references cited in retrieved publications. Searches of selected medical specialty society and international, national, and local government agency websites were conducted to identify clinical guidelines, position statements, and reports.

Results. The originally referred resolution that initiated this report was in response to the recalls of multiple drug products because of impurities present in the medications. These impurities were identified by the FDA and partner testing. The FDA subsequently informed the public about the problem, continues to investigate the issue, and continues to take corrective action. The source of detected impurities is linked to manufacturing issues and subsequent inspections revealed systemic problems of supervision that could have created the conditions for quality issues to arise; corrective action is underway. Importantly, FDA procedures identified the issue.

Conclusion. PV is a continuous process requiring active participation and combined efforts from physicians, other authorized prescribers, the pharmaceutical industry, government regulators, public health officials, clinicians, and health care organizations. Informed participation by all in PV processes is necessary to continually improve drug product safety, drug supply chain integrity and to identify safety signals. The AMA already has significant, relevant, and well-written policy related to PV and drug quality. Therefore, your Council recommends updating two outdated policies and reaffirmation of several existing polices.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 4-N-21

Subject: Pharmacovigilance
(Res 518-A-19, Chemical Variability in Pharmaceutical Products)

Presented by: Alexander Ding, MD, MS, MBA, Chair

Referred to: Reference Committee E

INTRODUCTION

Resolution 518-A-19, "Chemical Variability in Pharmaceutical Products," introduced by the American College of Cardiology and referred by the House of Delegates (HOD) asked:

> That our American Medical Association (AMA) do a study and report back by the 2019 Interim Meeting regarding the pharmaceutical variability, both in active pharmaceutical ingredient and dissolution, the impact on patient care and make recommendations for action from their report findings; that our AMA advocate for legislation requiring independent testing and verification of the chemical content of batches of pharmaceuticals; and that our AMA advocate for the logging of batches at the patient level, so the batches can be traced and connected to patient outcomes or adverse events.

In addition, two resolutions were introduced and debated at I-19 on the topic of pharmaceutical production and quality. At both A-19 and I-19, there was confusion about several concepts detailed in the resolutions and the concept of pharmacovigilance (PV) in general. Your Council on Science and Public Health (CSAPH) noted that there are several issues related to PV, track and trace, and testing and verification of pharmaceuticals that could benefit from further study. This report summarizes and explains the current state of PV for medications taken by patients in the United States; describes the role of the U.S. Food and Drug Administration (FDA) in PV; explains Drug Supply Chain and Security Act (DSCSA, also called "track and trace") and its implementation; clarifies testing and verification procedures for medications; comments on issues associated with the pharmaceutical supply chain related to medication safety and quality; and provides recommendations related to PV policy. Additionally, CSAPH acknowledges the delay in this report due to the COVID-19 public health emergency and shifting of priorities for Council staff. This report from the Council also includes new developments related to pharmaceutical quality that have arisen during the COVID-19 public health emergency.

METHODS

English-language articles were selected from a search of the PubMed database through August 2021 using the search terms "pharmacovigilance," "pharmaceutical/drug quality," and "pharmaceutical/drug impurities." Additional articles were identified from a review of the references cited in retrieved publications. Searches of selected medical specialty society and international, national, and local government agency websites were conducted to identify clinical guidelines, position statements, and reports.

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BACKGROUND

PV is defined by the World Health Organization (WHO) as comprising the science and activities relating to the detection, assessment, understanding, and prevention of adverse effects and other drug-related problems.[1] PV is described as a systematic process involving the collection of information about the nature, severity, clinical characteristics, and outcomes of adverse effects of medicinal products; documentation and analysis of the collected adverse-effects data to detect a causal link between the medicinal product and adverse effect; remedial actions to eliminate (or minimize) hazards posed by adverse effects of medicinal products, and continued monitoring of the impact of any such remedial actions.[2] The field of PV has undergone rapid growth over the last two decades.[3]

Various medicinal product-related safety issues not attributable to the pharmacologic properties of the product are also a part of PV. Safety issues include dosage form problems such as contamination, physical defects, abnormal odor or taste; product packaging issues such as broken seals, leaking bottles, and incorrect fill amount; labeling problems such as missing labels, missing lot numbers, and missing expiration dates; and counterfeit medicines. Upon learning about issues, regulatory authorities ask manufacturers to take remedial actions, for example, product recalls. This report addresses many aspects of adverse events and the tracking of those, but also drug product supply chains and recent and ongoing efforts to improve the tracking of medicinal product production, distribution, shipping, and location.

Terminology

PV is a growing field and mounting concern in healthcare, which aims to enhance patient care and patient safety in relation to the use of medicines. However, often in healthcare, the terms including adverse event, adverse drug reaction, and side effect are used interchangeably. Experts note that standardization of medication-safety-related terminology is an important goal of PV. With that in mind, the following terms are provided for clarity:[4,5]

<u>Adverse event (AE)</u>. All undesirable events occurring after the use of a medicinal product that may not necessarily be ascribed to the product are AEs.

<u>Adverse drug reaction (ADR)</u>. A response to a drug which is noxious and unintended, and which occurs at doses normally used for the prophylaxis, diagnosis, or therapy of disease, or used for modifications of physiological function, is an ADR.

AEs or ADRs are considered unexpected if it is not consistent with applicable product information or characteristics of the drug. Serious AEs or ADRs are untoward medical occurrences that at any dose results in death, are life-threatening, requires inpatient hospitalization or prolongation of existing hospitalization, and/or results in persistent of significant disability or incapacity.

<u>Side effect</u>. An unintended effect, regardless of dosage, that occurs related to the pharmacological properties of a medication, is considered a side effect; side effects are not necessarily adverse and are often foreseen.

PHARMACOVIGILANCE AT THE U.S. FOOD AND DRUG ADMINISTRATION (FDA)

The FDA has several offices dedicated to drug quality, surveillance, and epidemiology. The aim of FDA PV processes is to collect information about various broad aspects of medicinal product safety. These aspects are listed in the FDA's guidance document on good PV practices.[6]

Specifically, the document provides guidance on safety signal identification, pharmacoepidemiologic assessment and safety signal interpretation, and PV plan development. The FDA also hosts an informational website that provides and outlines resources related to pharmaceutical quality.[7]

FDA Office of Surveillance and Epidemiology (OSE)

The FDA's Office of Surveillance and Epidemiology (OSE) monitors and evaluates the safety profiles of drugs using a variety of tools and disciplines throughout the life cycle of the drugs.[8] OSE has four core functions: pharmacovigilance; pharmacoepidemiology; medication error prevention and analysis; and risk management. The Office operates across multiple disciplines to review and assess the safety of medicines and maintains a system of postmarketing surveillance and risk assessment programs to identify adverse events that did not appear during the drug development process. OSE evaluates more than 1.5 million adverse event reports (AERs) submitted every year to the FDA's MedWatch program,[9] part of the FDA Adverse Event Reporting System (FAERS)[10,11] or Safety Reporting Portal (SRP).[12]

OSE is part of the Center for Drug Evaluation and Research (CDER) and houses the Office of Pharmacovigilance and Epidemiology (OPE) as well as the Office of Medication Error Prevention and Risk Management. OPE's Division of PV (DPV) evaluates the safety of drug and therapeutic biologic products, engages in monitoring/surveillance, analyzes safety signals, recommends regulatory actions, and communicates relevant safety information. OPE and DPV recognize that pre-approval clinical trials of drugs have limitations and that the pharmaceutical industry and the FDA must rely on postmarket surveillance and AE reports to monitor medications and monitor for safety signals. OSE and its office and divisions are responsible for:

- Postmarketing safety surveillance for all marketed drug and therapeutic biologic products;
- Conducting active drug safety surveillance;
- Reviewing drug safety-related epidemiologic study protocols and study reports;
- Ensuring that the postmarketing requirements conducted by sponsors meet the best practices in epidemiology and can provide robust and actionable evidence to inform regulatory decision making following initial approval;
- Procuring, managing, and analyzing pharmaceutical sales and health care data to describe and characterize drug utilization levels and treatment patterns in the United States;
- Working with drug companies to reduce medication errors related to confusing labels, labeling, drug packaging, and drug names that look alike or sound alike; and
- Providing risk management expertise on development and implementation of programs and initiatives to support policies related to Risk Evaluation and Mitigation Strategies (REMS).

In May 2021, OSE issued its first annual report highlighting the key OSE initiatives to detect, assess, prevent, and monitor the risks of medicines, with a special focus on its efforts to respond to the COVID-19 pandemic.[13]

FDA Office of Pharmaceutical Quality (OPQ)

FDA's CDER also houses the Office of Pharmaceutical Quality (OPQ) which works to assure that quality medicines are available for the American public.[14] OPQ integrates assessment, inspection, surveillance, policy, and research activities to strengthen pharmaceutical quality on a global scale. OPQ oversees the quality of marketed drugs over the entire drug lifecycle and monitors the state of quality for all regulated manufacturing sites and drug products by establishing quality standards, including current good manufacturing practices (cGMP); identifying quality problems which

require corrective action; and encouraging the adoption of emerging technologies to enhance pharmaceutical quality. OPQ works closely with other FDA offices if enforcement decisions need to be made and strives to balance potential quality risks with the risk of a patient not getting a needed medication. It also attempts to anticipate quality problems before they develop so as to help prevent drug shortages.

The OPQ 2019 annual report described activities in 2019 and over the office's five-year life, including efforts in drug assessment, inspection, surveillance, policy, and research. The report also detailed the number of additional FDA staff hired to work on pharmaceutical quality.[15] The 2020 annual report on the state of pharmaceutical quality contains select quality indicators and trends that provide insight into the quality of the U.S. drug supply chain and includes an analysis of the impact of the COVID-19 public health emergency on the pharmaceutical supply chain and on the quality of drugs.[16]

Facility Inspections

A U.S. Government Accountability Office (GAO) report from December 2019, *Preliminary Findings Indicate Persistent Challenges with FDA Foreign Inspections,* noted that more than 60 percent of drug manufacturers for the United States market are located overseas. The FDA inspects foreign and domestic drug manufacturers to ensure drug safety and effectiveness; however, the number of inspections of foreign drug manufacturers has declined since FY 2016 and most foreign inspections are preannounced. The report notes concerns about FDA's ability to oversee the global supply chain.[17]

In March 2020, at the beginning of the COVID-19 public health emergency, the FDA made the decision to pause most foreign and domestic facility inspections, with the exception of mission-critical inspection work. This decision was made in response to federal guidelines to mitigate the spread of the COVID-19 virus. The Agency relied on alternative tools such as inspection reports from foreign regulators, records requests, and product sampling to complement its oversight activities.

The FDA acknowledges that the pandemic had an impact on inspection work in a report titled "Resiliency Roadmap for FDA Inspectional Oversight," which outlines the effect of the public health emergency on inspection activities and the detailed plan for inspections and operations moving forward. The report notes that a significant backlog of both domestic and international inspections that are likely to persist through much of the next calendar year.[18]

FDA Drug Quality Sampling and Testing Programs

FDA Drug Quality Sampling and Testing Programs help assure that only safe and effective drugs are sold.[19] The FDA tests drugs in FDA laboratories and through research contracts and grants. This includes active pharmaceutical ingredients (API) used to make the product and the finished drug product sold to consumers. FDA tests drugs using the same standards that are part of the drug approval process for identity, strength, purity, and bioavailability, which is also used to establish bioequivalence. Although some research has indicated batch-to-batch variability,[20] FDA offices and labs evaluate these issues and take corrective action as necessary, including recalls.[21]

DRUG SUPPLY CHAIN

Of note when discussing the topic of PV is overall pharmaceutical supply chain issues. Because of the way API are distributed in the supply chain, one source of contaminated API can impact

multiple products from multiple manufacturers. At times, because of a lack of transparency in the supply chain, it is difficult and time-consuming to determine all links in the supply chain.

Recently, considerable attention has been focused on supply chain resilience. In 2021, the FDA published several guidance documents related to supply chain security,[22] the White House released a report on policies to support the creation of resilient supply chains,[23,24] and The Duke-Margolis Center for Health Policy and the COVID Collaborative released a new white paper on challenges and potential solutions for resilient drug supply chains that complements the White House report.[25] All of these publications include aspects of AMA policy regarding drug shortage including calls for increased transparency, global cooperation, resiliency and redundancy in manufacturing capability, and the creation of a quality rating system. While advanced manufacturing, including continuous manufacturing,[26] is an important component to drug quality, the specifics regarding implications and implementation of advanced manufacturing are outside of the scope of this report.

Additionally, a recent report from the National Academies of Sciences, Engineering, and Medicine, *Stronger Food and Drug Regulatory Systems Abroad,* recommends strategies and a framework that regulatory agencies worldwide can adopt to support the availability of good quality, safe food and medicines globally and to identify areas of greatest risk. The report also recommends ways that U.S. government agencies, international development donors, and the WHO can strengthen the capacity of food and drug regulators, particularly those in low- and middle-income countries. Such investments should prioritize the expansion of WHO's approval and quality control processes for priority medicines and vaccines; the development of tools for rapidly screening food and drug quality; and improving the evaluation of how well regulatory agencies are performing.[27]

PHARMACEUTICAL IMPURITIES

The FDA, the International Conference on Harmonization (ICH), and the United States Pharmacopeia (USP) define an impurity as "any component of a drug substance that is not the chemical entity defined as the drug substance and in addition, for a drug product, any component that is not a formulation ingredient."[28-30] Impurities in a drug substance (i.e., an API) or a drug product that can arise due to synthetic/manufacturing processes (process-related impurities [PRIs]) and degradation (degradation-related impurities [DRIs]), or due to factors such as storage conditions, containers, excipients, or contamination. In addition, impurities can be categorized as identified or unidentified, volatile or nonvolatile, or organic or inorganic species. Figure 1 provides a flowchart that details the categories of impurities.[31]

Nitrosamine Impurities

Unacceptable levels of nitrosamine impurities in some batches of the angiotensin II receptor blocker (ARB) valsartan were first detected in 2018. Subsequently, impurities were found in other ARBs, as well as unrelated drugs, including ranitidine, nizatidine, metformin, varenicline, rifampin and rifapentine.[32-34]

Nitrosamines are a group of chemical compounds, some of which can pose a risk to patients and public health due to their mutagenic properties. They are well known to be present in foods, such as smoked or grilled meats and fish, and they are also present in mainstream and sidestream air from combusted tobacco in cigarettes, cigars and pipes. Nitrosamines or their precursors can also be present in a wide variety of manufactured and natural products. Nitrosamines generally are not intentionally added to foods or consumer products but are formed from constituents of the foods or products that are either naturally present or added during production. When they are metabolized, nitrosamines are converted to alkylating agents. Some of these are known to damage DNA and

have been linked to an increased risk of cancer if a patient is exposed to unacceptable levels of the impurity for an extended period of time.[35]

FDA testing found the levels of the nitrosamine N-nitrosodimethylamine (NDMA) increased under normal storage conditions and increase in samples stored at higher temperatures. FDA testing also determined that levels of NDMA present in drugs is similar to levels a person is exposed to through consuming grilled meats. The Agency has established "interim limits" for three nitrosamine compounds: NDMA, NDEA and NMBA.[36] The FDA also noted that the identification of nitrosamine impurities in tested drug samples may not reflect an emerging regulatory problem, but is an evolution of scientific methods that are capable of detecting the impurities at significantly lower levels than in the past.[37]

In numerous updates, the FDA notes that they continue to work with manufacturers to investigate the source of nitrosamines in drug products and whether they are at a level that may pose risks to human health. The FDA and manufacturers are testing samples of certain medications that may contain nitrosamines and will continue to take rapid and appropriate action when needed.[36,38-40] Additionally, the FDA held a public workshop on nitrosamine impurities to educate about nitrosamine chemistry and toxicology, on the finding of nitrosamines as impurities in drugs, data gaps and research needs to address uncertainties in nitrosamine safety assessment, and about how to prevent or minimize their presence in drugs, as well as to provide a forum for an open discussion of questions.[41]

Manufacturers are held responsible for understanding their manufacturing processes and following cGMP, which includes identifying and preventing the presence of unacceptable impurities. This involves developing new predictive approaches, along with using suitable methods to detect and control these impurities as well as others that may arise when making changes to manufacturing processes. The FDA issued and then revised an immediately-in-effect Guidance for Industry on the *Control of Nitrosamine Impurities in Human Drugs* which describes steps manufacturers of active pharmaceutical ingredients and drug products should take to detect and prevent objectionable levels of nitrosamine impurities in pharmaceutical products. The Guidance also describes conditions that may introduce nitrosamine impurities. Material in the Guidance is consistent with recommendations from the ICH on the assessment and control of mutagenic impurities.[42] USP has also provided information on the topic and has developed a new general chapter to provide information useful for ensuring the appropriate control of nitrosamine impurities in drug substances which becomes official on Dec 1, 2021.[43-45]

POSTMARKET SURVEILLANCE

The FDA outlines risk-based best practices for conducting ongoing postmarket safety surveillance activities for drugs and biological products in the document, "Best Practices in Drug and Biological Product Postmarket Safety Surveillance for FDA Staff," which was required under a provision of the 21st Century Cures Act.[46] The document includes considerations that inform the frequency and extent of systematic drug and biologic safety monitoring; considerations based on specific product types and patient populations; safety signal identification based on screening and data mining of the FDA's AE reporting system and other data sources, including general practices for the frequency and extent of screening these data sources, as well as prioritizing identified signals; a multidisciplinary, comprehensive evaluation of the identified safety signal that integrates the cumulative data gathered from all available sources; an assessment of the causal association between the identified AE and the product; and an overview of regulatory and other actions that can be taken in response to identified safety signals.

Adverse Event Reporting

Regulatory authorities are interested in receiving reports of serious and unexpected AEs and ADRs on an urgent and priority basis.[47] All reporting by physicians is voluntary and also strongly recommended; the FDA gives extra credence to physician reports. The Safety Reporting Portal (SRP)[12] streamlines the process of reporting product safety issues to the FDA and the NIH, formerly done through FAERS[10,11] and MedWatch[9] Online Voluntary Reporting Form. The SRP can be used by manufacturers, health care professionals, researchers, public health officials, and patients.[48]

DRUG SUPPLY CHAIN AND SECURITY ACT

The Drug Supply Chain and Security Act (DSCSA) also called "track and trace," enacted as part of the Drug Quality and Security Act of 2013, includes extensive requirements related to supply chain participants and regulated products. The law outlines the steps manufacturers, repackagers, wholesale distributors, dispensers (i.e., pharmacies), and third-party logistics providers need to take to develop an electronic, interoperable system that tracks a drug at the unit-level throughout the drug supply chain.[49-51] For the tracking component, each supply chain entity should be able to see a valid chain of custody for any product. The tracking component will allow FDA the ability to follow the chain of custody of a product back to its point of origin.

DSCSA includes provisions on product identification and verification, data sharing, detection and response to suspect any illegitimate products, recordkeeping, and unified licensure standards for wholesale distributors and third-party logistics providers. The schedule of milestones has been broken down into three phases:

- Phase 1: Lot-level traceability and verification of products and transactions (2015)
- Phase 2: Drug product serialization and enhanced verification of serialized products (2017-2020)
- Phase 3: Unit-level traceability (2023)

Requirements for Phase 1 are thus already in effect. In January 2015, the FDA expected dispensers to have established a system for verification and handling of suspect or illegitimate products, and to confirm that trading partners (i.e., manufacturers, wholesale distributors) are appropriately registered or licensed with the FDA or the appropriate state authority. As of March 2016, the FDA began enforcing the requirement. In addition, dispensers must maintain such information for no less than 6 years after the date of the transaction. Currently with a product transaction, the ability to track and trace the product down to the lot level is possible.

By 2023, electronic package-level tracing information using a product identifier will be required. A recent presentation from FDA's CDER provided updates on implementation of these security requirements for enhanced drug distribution security.[52] The stated goals are to implement interoperable, electronic tracing of products at the package level by 2023 that will enable secure tracing of products at the package level; use product identifiers to verify products at the package level; enable prompt response to suspect and illegitimate products when found; and improve efficiency of recalls. National standards for licensure for wholesale distributers and third-party logistics providers will be established by 2023 as well.

Additionally, four guidance documents describing key details of how the FDA plans to secure the pharmaceutical supply chain were recently released. The documents relate to various aspects of the "track and trace" system.[53] *Enhanced Drug Distribution Security at the Package Level Under the*

Drug Supply Chain Security Act provides recommendations on the system attributes necessary for enabling the secure tracing of drug product at the package level, defined as the smallest individual salable unit of drug product for distribution by a manufacturer or repackager.[54] *Definitions of Suspect Product and Illegitimate Product for Verification Obligations Under the Drug Supply Chain Security Act Guidance for Industry* lays out the FDA's current understanding of terms used to define "suspect" and "illegitimate" products.[55] *Product Identifiers under the Drug Supply Chain Security Act - Questions and Answers* clarifies information for industry.[56] *Drug Supply Chain Security Act Implementation: Identification of Suspect Product and Notification Guidance for Industry* is intended to aid certain trading partners in identifying a suspect product and specific scenarios that could significantly increase the risk of a suspect product entering the pharmaceutical distribution supply chain.[57]

CURRENT AMA POLICY

AMA has several polices on the topic of PV (see appendix for full text). AMA Policy H-100.946, "Source and Quality of Medications Critical to National Health and Security," supports studies of United States dependency on foreign components, legislative and regulatory initiatives to ensure proper domestic capacity, production, and quality of pharmaceuticals, and encourages the development and enforcement of standards that make the sources of pharmaceuticals and their chemical substrates used in the United States transparent to prescribers and the general public. Policy H-100.969, "Assuring the Safety and Quality of Foreign-Produced Pharmaceuticals," addresses the safety and quality of foreign manufactured pharmaceuticals and supports inspection of all products entering the United States and surveillance inspections of foreign manufacturers. Policy D-100.977, "Pharmaceutical Quality Control for Foreign Medications," advocates that the Congress and the FDA use their authorities to ensure safe imported drugs. Policy H-100.995, "Support of American Drug Industry," supports pharmaceutical manufacturing industry efforts to develop and market pharmaceutical products meeting proper standards of safety and efficacy. Policy D-125.987, "Biosimilar Product Naming and Labeling," supports appropriate PV for biosimilar products.

Policies D-100.988, "Tracking and Punishing Distributors of Counterfeit Pharmaceuticals," H-100.966, "Tracking and Punishing Distributors of Counterfeit Pharmaceuticals," and D-100.985, "Federal Regulation and Computerized Tracking of Pharmaceuticals During Shipping and Handling from Manufacture Until Ultimately Received by Patient," support pharmaceutical tracking systems, identification and eradication of illegal activities in the pharmaceutical industry and punishment of pharmaceutical counterfeiters. Policy H-120.958, "Supporting Safe Medical Products as a Priority Public Health Initiative," supports reporting of adverse events; a coding system for prescription medicine packaging to improve patient safety; and the need for public health infrastructure and local consortiums to work on problems related to medical product safety.

Policy H-100.956, "National Drug Shortages," notes several relevant themes including: supporting the improvement of manufacturing quality systems; requiring drug manufacturers to establish a plan for continuity of supply of vital and life-sustaining medications and vaccines to avoid production shortages whenever possible; urging the development of a comprehensive independent report on the root causes of drug shortages, which includes the number of manufacturers, economic factors and contracting practices; and urging the FDA to require manufacturers to provide greater transparency regarding production locations of drugs and to provide more detailed information regarding the causes and anticipated duration of drug shortages.

CONCLUSION

The originally referred resolution that initiated this report was in response to the recalls of multiple drug products because of impurities present in the medications. These impurities were identified by the FDA and partner testing. The FDA subsequently informed the public about the problem, continues to investigate the issue, and continues to take corrective action. The source of detected impurities is linked to manufacturing issues and subsequent inspections revealed systemic problems of supervision that could have created the conditions for quality issues to arise; corrective action is underway. Importantly, FDA procedures identified the issue.

PV is a continuous process requiring active participation and combined efforts from physicians, other authorized prescribers, the pharmaceutical industry, government regulators, public health officials, clinicians, and health care organizations. Informed participation by all in PV processes is necessary to continually improve drug product safety, maintain drug supply chain integrity, and to identify safety signals. The AMA already has significant, relevant, and well-written policy related to PV and drug quality. Therefore, your Council recommends updating two outdated policies and reaffirmation of several existing polices.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following be adopted in lieu of Resolution 518-A-19 and the remainder of the report be filed:

1. That Policy D-100.988, "Tracking and Punishing Distributors of Counterfeit Pharmaceuticals" be amended by addition and deletion to read as follows:

   Our AMA will support the Food and Drug Administration's efforts to evaluate and facilitate implementation of effective tracking systems for pharmaceuticals~~.~~, including all outlined implementation phases of the Drug Supply Chain and Security Act (DSCSA, Public Law 113-54) also called "track and trace," which contains extensive requirements and provisions related to supply chain participants and regulated products. (Modify Current HOD Policy)

2. That Policy H-120.958, "Supporting Safe Medical Products as a Priority Public Health Initiative" be amended by addition and deletion to read as follows:

   Our AMA will: (1) work through the United States Adopted Names (USAN) Council to adopt methodology to help prevent "look alike-sound alike" errors in giving new drugs generic names;
   (2) continue participation in ~~the National Patient Safety Foundation's~~ efforts to advance the science of safety in the medication use process, including ~~and likewise~~ work with the National Coordinating Council for Medication Error Reporting and Prevention;
   (3) support the FDA's Medwatch program by working to improve physicians' knowledge and awareness of the program and encouraging proper reporting of adverse events;
   (4) vigorously work to support the Drug Supply Chain and Security Act (DSCSA, Public Law 113-54), including provisions on product identification and verification, data sharing, detection and response, ~~and encourage efforts to create and expeditiously implement a national machine-readable coding system for prescription medicine packaging~~ in an effort to improve patient safety;
   (5) participate in and report on the work of the Healthy People ~~2010~~ 2030 initiative in the area of safe medical products especially as it relates to existing AMA policy; and

(6) seek opportunities to work collaboratively within the Medicine-Public Health initiative (H-440.991) and with the Food and Drug Administration (FDA), National Institutes of Health (NIH), United States Pharmacopoeia (USP) and Centers for Disease Control and Prevention (CDC) the Agency for ~~Health Care Policy and Research (AHCPR)~~ Healthcare Research and Quality (AHRQ) and the Centers for Medicare & Medicaid Services (CMS) to provide information to individual physicians and state medical societies on the need for public health infrastructure and local consortiums to work on problems related to medical product safety. (Modify Current HOD Policy)

3. That Policy D-100.977, "Pharmaceutical Quality Control for Foreign Medications," that calls upon Congress to provide the FDA with the necessary authority and resources to ensure that imported drugs are safe for American consumers and patients, be reaffirmed. (Reaffirm HOD Policy)

4. That Policy D-100.985, "Federal Regulation and Computerized Tracking of Pharmaceuticals During Shipping and Handling from Manufacture Until Ultimately Received by Patient," opposing illegal drug diversion, illegal Internet sales of drugs, illegal importation of drugs, and drug counterfeiting, be reaffirmed. (Reaffirm HOD Policy)

5. That Policy D-100.988, "Tracking and Punishing Distributors of Counterfeit Pharmaceuticals," supporting the FDA's efforts to evaluate and facilitate implementation of effective tracking systems for pharmaceuticals, be reaffirmed. (Reaffirm HOD Policy)

6. That Policy H-100.946, "Source and Quality of Medications Critical to National Health and Security," supporting legislative and regulatory initiatives that help to ensure proper domestic capacity, production and quality of pharmaceutical and chemical substrates as a matter of public well-being and national security and encouraging the development and enforcement of standards that make the sources of pharmaceuticals and their chemical substrates used in the United States of America transparent to prescribers and the general public, be reaffirmed. (Reaffirm HOD Policy)

7. That Policy H-100.969, "Assuring the Safety and Quality of Foreign-Produced Pharmaceuticals," supporting the inspection of all foreign manufacturers of pharmaceutical chemicals and products which are exported to the United States to assure compliance with U.S. standards, be reaffirmed. (Reaffirm HOD Policy)

8. That Policy H-100.995, "Support of American Drug Industry," supporting the American pharmaceutical manufacturing industry in its efforts to develop and market pharmaceutical products meeting proper standards of safety and efficacy for the benefit of the American people, be reaffirmed. (Reaffirm HOD Policy)

Fiscal Note: Less than $1000

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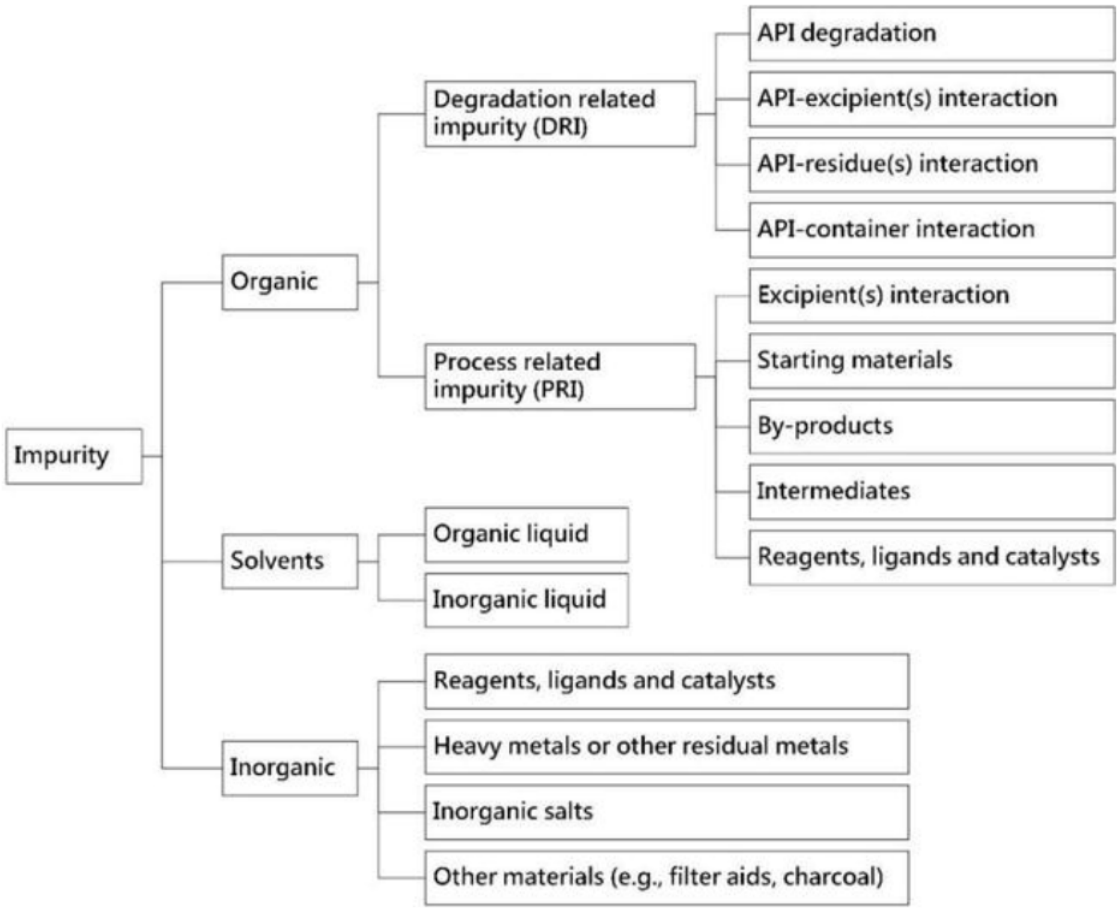
Figure 1. Categorization of impurities from FDA and USP (figure from [31]).



APPENDIX: AMA Policies Related Pharmacovigilance

D-100.977, "Pharmaceutical Quality Control for Foreign Medications"
Our AMA will call upon Congress to provide the US Food and Drug Administration with the necessary authority and resources to ensure that imported drugs are safe for American consumers and patients. Res. 508, A-08

D-100.985, "Federal Regulation and Computerized Tracking of Pharmaceuticals During Shipping and Handling from Manufacture Until Ultimately Received by Patient"
Our AMA will: (1) continue to actively oppose illegal drug diversion, illegal Internet sales of drugs, illegal importation of drugs, and drug counterfeiting; and (2) work with the Congress, the Food and Drug Administration, the Drug Enforcement Administration, and other federal agencies, the pharmaceutical industry, and other stakeholders to ensure that these illegal activities are minimized. Res. 501, A-04; Reaffirmation I-06; Reaffirmed: BOT Rep. 06, A-16; Reaffirmed: CMS Rep. 01, I-18

D-100.988, "Tracking and Punishing Distributors of Counterfeit Pharmaceuticals"
Our AMA will support the Food and Drug Administration's efforts to evaluate and facilitate implementation of effective tracking systems for pharmaceuticals. Res. 924, I-03 Reaffirmation I-06 Reaffirmed: BOT Rep. 06, A-16

D-125.987, "Biosimilar Product Naming and Labeling"
Our AMA urges the FDA to finalize Guidance on the naming and labeling conventions to be used for biosimilar products, including those that are deemed interchangeable. Any change in current nomenclature rules or standards should be informed by a better and more complete understanding of how such changes, including requiring a unique identifier for biologic USANs would impact prescriber attitudes and patient access, and affect post marketing surveillance. Actions that solely enhance product identification during surveillance but act as barriers to clinical uptake are counterproductive. However, because of unique product attributes, a relatively simple way to identify and track which biosimilar products have been dispensed to individual patients must be established. If unique identifiers for biosimilar USANs are required to support pharmacovigilance, they should be simple and the resulting names should reinforce similarities by using the same root name following standards for nonproprietary names established by the USAN Council. CSAPH Rep. 4, A-14

H-100.946, "Source and Quality of Medications Critical to National Health and Security"
Our AMA: (1) supports studies that identify the extent to which the United States is dependent on foreign supplied pharmaceuticals and chemical substrates; (2) supports legislative and regulatory initiatives that help to ensure proper domestic capacity, production and quality of pharmaceutical and chemical substrates as a matter of public well-being and national security; and (3) encourages the development and enforcement of standards that make the sources of pharmaceuticals and their chemical substrates used in the United States of America transparent to prescribers and the general public. Res. 932, I-19

H-100.956, "National Drug Shortages"
1. Our AMA considers drug shortages to be an urgent public health crisis, and recent shortages have had a dramatic and negative impact on the delivery and safety of appropriate health care to patients. 2. Our AMA supports recommendations that have been developed by multiple stakeholders to improve manufacturing quality systems, identify efficiencies in regulatory review that can mitigate drug shortages, and explore measures designed to drive greater investment in production capacity for products that are in short supply, and will work in a collaborative fashion

with these and other stakeholders to implement these recommendations in an urgent fashion. 3. Our AMA supports authorizing the Secretary of the U.S. Department of Health and Human Services (DHHS) to expedite facility inspections and the review of manufacturing changes, drug applications and supplements that would help mitigate or prevent a drug shortage. 4. Our AMA will advocate that the US Food and Drug Administration (FDA) and/or Congress require drug manufacturers to establish a plan for continuity of supply of vital and life-sustaining medications and vaccines to avoid production shortages whenever possible. This plan should include establishing the necessary resiliency and redundancy in manufacturing capability to minimize disruptions of supplies in foreseeable circumstances including the possibility of a disaster affecting a plant. 5. The Council on Science and Public Health shall continue to evaluate the drug shortage issue, including the impact of group purchasing organizations on drug shortages, and report back at least annually to the House of Delegates on progress made in addressing drug shortages. 6. Our AMA urges the development of a comprehensive independent report on the root causes of drug shortages. Such an analysis should consider federal actions, the number of manufacturers, economic factors including federal reimbursement practices, as well as contracting practices by market participants on competition, access to drugs, and pricing. In particular, further transparent analysis of economic drivers is warranted. The federal Centers for Medicare & Medicaid Services (CMS) should review and evaluate its 2003 Medicare reimbursement formula of average sales price plus 6% for unintended consequences including serving as a root cause of drug shortages. 7. Our AMA urges regulatory relief designed to improve the availability of prescription drugs by ensuring that such products are not removed from the market due to compliance issues unless such removal is clearly required for significant and obvious safety reasons. 8. Our AMA supports the view that wholesalers should routinely institute an allocation system that attempts to fairly distribute drugs in short supply based on remaining inventory and considering the customer's purchase history. 9. Our AMA will collaborate with medical specialty society partners and other stakeholders in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs. 10. Our AMA urges that during the evaluation of potential mergers and acquisitions involving pharmaceutical manufacturers, the Federal Trade Commission consult with the FDA to determine whether such an activity has the potential to worsen drug shortages. 11. Our AMA urges the FDA to require manufacturers to provide greater transparency regarding production locations of drugs and provide more detailed information regarding the causes and anticipated duration of drug shortages. 12. Our AMA encourages electronic health records (EHR) vendors to make changes to their systems to ease the burden of making drug product changes. 13. Our AMA urges the FDA to evaluate and provide current information regarding the quality of outsourcer compounding facilities. 14. Our AMA urges DHHS and the U.S. Department of Homeland Security (DHS) to examine and consider drug shortages as a national security initiative and include vital drug production sites in the critical infrastructure plan. CSAPH Rep. 2, I-11; Modified: CSAPH Rep. 7, A-12; Modified: CSAPH Rep. 2, I-12; Modified: CSAPH Rep. 8, A-13; Modified in lieu of Res. 912, I-13; Modified: CSAPH Rep. 3, A-14; Modified: CSAPH Rep. 2, I-15; Appended: CSAPH Rep. 04, I-17; Modified: CSAPH Rep. 02, A-18

H-100.966, "Tracking and Punishing Distributors of Counterfeit Pharmaceuticals"
Our AMA supports legislation making the production and distribution of counterfeit pharmaceuticals a felony. Res. 924, I-03; Reaffirmation I-06; Reaffirmed: BOT Rep. 06, A-16

H-100.969, "Assuring the Safety and Quality of Foreign-Produced Pharmaceuticals"
Our AMA supports: (1) the inspection of all foreign manufacturers of pharmaceutical chemicals and products which are exported to the United States to assure compliance with U.S. standards; and (2) periodic surveillance inspections of all foreign pharmaceutical manufacturers with timely follow-up inspection of all foreign manufacturers that have been identified as having serious

manufacturing deficiencies. Res. 512, A-99 Reaffirmation I-06 Reaffirmation A-08 Reaffirmed: Res. 508, A-08 Reaffirmation A-09

H-100.995, "Support of American Drug Industry"
Our AMA continues to support the American pharmaceutical manufacturing industry in its efforts to develop and market pharmaceutical products meeting proper standards of safety and efficacy for the benefit of the American people.
Sub. Res. 20, A-74; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10

H-120.958, "Supporting Safe Medical Products as a Priority Public Health Initiative"
Our AMA will: (1) work through the United States Adopted Names (USAN) Council to adopt methodology to help prevent "look alike-sound alike" errors in giving new drugs generic names;
(2) continue participation in the National Patient Safety Foundation's efforts to advance the science of safety in the medication use process and likewise work with the National Coordinating Council for Medication Error Reporting and Prevention;
(3) support the FDA's Medwatch program by working to improve physicians' knowledge and awareness of the program and encouraging proper reporting of adverse events;
(4) vigorously work to support and encourage efforts to create and expeditiously implement a national machine-readable coding system for prescription medicine packaging in an effort to improve patient safety;
(5) participate in and report on the work of the Healthy People 2010 initiative in the area of safe medical products especially as it relates to existing AMA policy; and
(6) seek opportunities to work collaboratively within the Medicine-Public Health initiative (H-440.991) and with the Food and Drug Administration (FDA), National Institutes of Health (NIH), United States Pharmacopoeia (USP) and Centers for Disease Control and Prevention (CDC) the Agency for Health Care Policy and Research (AHCPR) and the Centers for Medicare & Medicaid Services (CMS) to provide information to individual physicians and state medical societies on the need for public health infrastructure and local consortiums to work on problems related to medical product safety.
Res. 416, A-99; Appended: Res. 504, I-01; Reaffirmation A-10

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 501
(N-21)

Introduced by: Washington

Subject: Ensuring Continued Access to Equitable Take-Home Methadone Treatment

Referred to: Reference Committee E

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1 Whereas, The Substance Abuse and Mental Health Services Administration (SAMHSA) issued
2 an exemption for Opioid Treatment Programs (OTPs) to request 28 days of take-home doses
3 for stable patients and 14 days of take-home doses for less stable patients, to be given at
4 provider discretion[1], in response to the escalating COVID-19 pandemic; and
5
6 Whereas, Evidence from multiple studies has shown that increases in take-home doses
7 following the SAMHSA exemption do not lead to worse treatment outcomes, higher overdose
8 rates, increased healthcare utilization, lack of adherence to treatment, or to significant diversion
9 of doses among patients on methadone maintenance therapy;[2-5] and
10
11 Whereas, Engagement with opioid agonist therapy results in improved clinical and community
12 outcomes for people who use opioids, including reduced risk of overdose, drug use, and crime,
13 improvements in quality of life, and viral suppression among HIV-positive patients[6-9]; and
14
15 Whereas, Access to lower-threshold opioid substitution therapy is associated with improved
16 adherence and treatment outcomes, and decreased overdose rates when compared to usual
17 care;[10,11] and
18
19 Whereas, A limited number of federally certified OTPs exist in the United States, causing many
20 patients to travel long distances to access treatment, which negatively impacts adherence and
21 retention. Almost 3 million Americans do not have access to a federally certified opioid
22 treatment program within a 2-hour drive.[12,13] As such, reducing the frequency of which patients
23 have to make long drives to access their OTP may improve adherence and retention; and
24
25 Whereas, Clinicians have responded overwhelmingly positively to the modifications in practice
26 permitted by the SAMHSA exemption, and public health advocates have long argued for
27 loosening federal guidelines to prevent unnecessary barriers to treatment;[14,15] and
28
29 Whereas, A report from the George Washington University Regulatory Studies Center
30 concluded that SAMHSA has the legal authority to extend this flexibility granted during the
31 COVID-19 public health emergency without additional authorization from Congress;[15] therefore
32 be it
33
34 RESOLVED, That our American Medical Association support increasing the interval between
35 take-home methadone distributions for maintenance and detoxification treatment, per provider
36 discretion; this may include policy similar to the COVID-era extension policy created by the
37 Substance Abuse and Mental Health Services Administration (SAMHSA) (New HOD Policy);
38 and be it further

1 RESOLVED, That our AMA utilize the "Good Guidance" petition process to request SAMHSA
2 modify current policy to reflect the COVID-19 era policy on take-home methadone doses.
3 (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

COVID-19 has dramatically impacted our ability to provide appropriate addiction medicine services. At the start of the pandemic, patients who had been prescribed Methadone for Opioid Treatment Program faced challenges accessing their medication due to isolation requirements. As a result, SAMSHA issued exemptions that allow Opioid Treatment Programs to request 28 days of take-home doses of Methadone for stable patients and 14 days of take-home doses for less stable patients, to be prescribed at provider discretion. This change has not shown to have a negative impact on medication compliance or rates of opioid overdose. For patients who live in rural areas or have challenge accessing social support such as transportation, this policy change improves access to life saving treatment. We urge the AMA to advocate for policy that will permanent increase the interval between take-home methadone distributions for maintenance and detoxification treatment, per provider discretion.

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RELEVANT AMA POLICY

Methadone Maintenance in Private Practice H-95.957
Our AMA: (1) reaffirms its position that, "the use of properly trained practicing physicians as an extension of organized methadone maintenance programs in the management of those patients whose needs for allied services are minimal" (called "medical" maintenance) should be evaluated further;
(2) supports the position that "medical" methadone maintenance may be an effective treatment for the subset of opioid dependent patients who have attained a degree of behavioral and social stability under standard treatment and thereby an effective measure in controlling the spread of infection with HIV and other blood-borne pathogens but further research is needed;
(3) encourages additional research that includes consideration of the cost of "medical" methadone maintenance relative to the standard maintenance program (for example, the cost of additional office security and other requirements for the private office-based management of methadone patients) and relative to other methods to prevent the spread of blood-borne pathogens among intravenous drug users;
(4) supports modification of federal and state laws and regulations to make newly approved anti-addiction medications available to those office-based physicians who are appropriately trained and qualified to treat opiate withdrawal and opiate dependence in accordance with documented clinical indications and consistent with sound medical practice guidelines and protocols; and
(5) urges that guidelines and protocols for the use of newly approved anti-addiction medications be developed jointly by appropriate national medical specialty societies in association with relevant federal agencies and that continuing medical education courses on opiate addiction treatment be developed by these specialty societies to help designate those physicians who have the requisite training and qualifications to provide therapy within the broad context of comprehensive addiction treatment and management.
Citation: CSA Rep. 2 - I-94; Reaffirmed: CSA Rep. 12 and Append Res. 412, A-99; Reaffirmation I-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Enabling Methadone Treatment of Opioid Use Disorder in Primary Care Settings D-95.961
Our AMA: (1) will research current best practices and support pilot programs and other evidence-based efforts to expand and integrate primary care services for patients receiving methadone maintenance treatment; (2) supports further research to help define the population of patients who may be safely treated with methadone maintenance treatment via office-based treatment, including primary care; and (3) urges all payers, including health insurance companies, pharmacy benefit management companies, and state and federal agencies, to reduce prior authorization and other administrative burdens and to enhance the provision of primary care, counseling, and other medically necessary services for patients being treated with methadone maintenance treatment.
Citation: BOT Rep. 16, I-20

Support the Elimination of Barriers to Medication-Assisted Treatment for Substance Use Disorder D-95.968
1. Our AMA will: (a) advocate for legislation that eliminates barriers to, increases funding for, and requires access to all appropriate FDA-approved medications or therapies used by licensed drug treatment clinics or facilities; and (b) develop a public awareness campaign to increase awareness that medical treatment of substance use disorder with medication-assisted treatment is a first-line treatment for this chronic medical disease.
2. Our AMA supports further research into how primary care practices can implement medication-assisted treatment (MAT) into their practices and disseminate such research in coordination with primary care specialties.
3. The AMA Opioid Task Force will increase its evidence-based educational resources focused on methadone maintenance therapy (MMT) and publicize those resources to the Federation.
Citation: Res. 222, A-18; Appended: BOT Rep. 02, I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 502
(N-21)

Introduced by: Washington

Subject: Advocating for Heat Exposure Protections for Outdoor Workers

Referred to: Reference Committee E

Whereas, Heat-related death is one of the leading causes of death from natural weather or environmental events[1]; and

Whereas, During 2004 to 2018, an average of 702 heat-related deaths (415 with heat as the underlying cause and 287 as a contributing cause) occurred in the United States annually[2]; and

Whereas, Population exposure to extreme heat has increased over the past several years as a result of climate change leading to increased heat related morbidity and mortality across the World[3]; and

Whereas, As a result of global climate change, heat-related deaths increased by 74% from 1980 to 2016, revealing hotter regions of the world are most likely suffering from an uptick in extreme heat mortality[4]; and

Whereas, The recent Pacific Northwest Heat Wave in June 2021 led to over 200 heat-injury related deaths in Washington and Oregon states over a week-long period[5]; and

Whereas, Prolonged exposure to extreme heat can cause heat exhaustion, heat cramps, heat stroke, and death, as well as exacerbate pre-existing chronic conditions including various respiratory, cerebral, and cardiovascular diseases[6]; and

Whereas, Prompt treatment of heat-related illnesses with aggressive fluid replacement and cooling of core body temperature is critical to reducing illness and preventing death[7]; and

Whereas, According to the Center for Disease Control and Prevention (CDC), despite the fact that all heat-related deaths and illnesses are preventable, each year an average of about 658 people succumb to extreme heat[2]; and

Whereas, There are currently 2.4 million farmworkers in the U.S., including 524,000 child workers[8]; and

Whereas, Non-U.S. citizens age 18 to 24 were twenty times more likely to die from excessive heat exposure, than were U.S. citizens in the same age group[1]; and

Whereas, Since 2010, the Latinx population have accounted for 33% of all heat fatalities, yet represent only 17% of the U.S. workforce[9]; and

Whereas, For many immigrant workers, a population that makes up half of the farm worker workforce, a combination of factors can make them more vulnerable to heat-related illnesses, including seasonality, extreme work conditions, a severe lack of knowledge and safety training, poverty, cultural differences, and language barriers[10]; and

Whereas, The CDC provides several evidence based methods for reducing risk of heat related injury including: staying in an air-conditioned place as much as possible, limiting outdoor activity to when it's coolest with rest often in shady areas, reducing physical activity in the heat, staying hydrated, and ensuring that workers are well educated regarding the signs and symptoms of heat-related illnesses and how to treat them[11]; and

Whereas, The United States Military also provides guidelines on evidence-based "Fluid Replacement and Work/Rest Guide" to protect the country's military workforce against heat injury by quantifying outdoor temperature, level of activity, and humidity into designated work and break period recommendations[12]; and

Whereas, The CDC's National Institute for Occupational Safety and Health (NIOSH) has long urged better federal heat injury protections with recommendations that OSHA (Occupational Safety and Health Administration) write heat-specific protections for workers back in 1975 which were refined further in 1986 and again in 2016[13], however none of these recommendations have been formally adopted into policy; and

Whereas, OSHA has not adopted any provisions regarding heat injury protections of workers. Absent a heat standard, OSHA must rely on a 50-year-old regulation that requires companies to provide adequate water but not other heat-safety measures[14]; and

Whereas, Only 21 states have their own agencies that oversee workplace safety for the private sector, while the rest rely on the federal OSHA[13], and

Whereas, OSHA will be submitting multiple proposed rules on the topic of Heat Illness Prevention in Outdoor and Indoor Work Settings in Fall 2021[15]; and

Whereas, Current AMA policy lacks the content and specificity to adequately comment on the upcoming proposed OSHA regulations; and

Whereas, the National Institute for Occupational Safety and Health (NIOSH) recommends several basic heat injury prevention workplace recommendations to protect workers from morbidity and mortality associated with heat exposure such as establishment of education programs, implementing acclimatization procedures, ensuring evidence-based hydration methodology and providing appropriate work breaks in cool, shaded areas[16]; and

Whereas, There is currently proposed legislation that has been introduced which would direct the Occupational Safety and Health Administration (OSHA) to set a federal standard for protections against heat stress specific to the hazards of the workplace[17]; therefore be it

RESOLVED, That our American Medical Association advocate for outdoor workers to have access to preventative cool-down rest periods in shaded areas for prevention of heat exhaustion and health educational materials in their primary language (Directive to Take Action); and be it further

RESOLVED, That our AMA support legislation creating federal standards for protections against heat stress specific to the hazards of the workplace including appropriate access to emergency services at signs and symptoms of heat exposure injury (New HOD Policy); and be it further

RESOLVED, That our AMA work with the United States Department of Labor, the Occupational Safety and Health Administration, and other appropriate federal stakeholders to develop and enforce evidence-based policies, guidelines, and protections against heat injury for outdoor workers independent of legal status. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Our delegation strongly believes that this resolution meets the priority and urgency requirements set out by our Speakers. Over the past few years, there have been rising rates of severe morbidity and mortality related to heat exposure/injury. Our country has seen the devastating impact that excessive heat exposure has on our workforce, and our farmworker population in particular. This past year, heat waves in our country have led to dramatic increases in severe morbidity and mortality rates among the general population. This is an issue of equity as many of our nation's immigrant workers, a population that makes up half of the farm worker workforce, faces a combination of factors increasing vulnerability to heat-related illnesses, including extreme work conditions, safety training, and language barriers. Although it has been recommended by multiple scientific bodies to develop regulations on this issue based on NIOSH recommendations, OSHA has not had a change in policy in over 50 years. It was announced recently, for the first time in over 50 years, that the federal agency OSHA will be producing proposed regulations on labor protections for heat exposure in the fall of 2021. The AMA doesn't have enough specific or appropriate policy to meaningfully participate in conversations and advocacy on this issue. It is critical that the AMA adopt evidence-based policy on this issue to provide public health advocacy for a marginalized population without appropriate labor and public health protections.

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RELEVANT AMA POLICY

Heat-Related Illness H-130.951
The AMA recognizes the significant public health threat imposed by heat-related emergencies and provides the following policy: (1) Physicians should identify patients at risk for extreme heat-related illness such as the elderly, children, individuals with physical or mental disabilities, alcoholics, the chronically ill, and the socially isolated. Patients, family members, friends, and caretakers should be counseled about prevention strategies to avoid such illness. Physicians should provide patients at risk with information about cooling centers and encourage their use during heat emergencies. (2) The AMA encourages patients at risk for heat-related illness to consider wearing appropriate medical identification. CSA Rep. 10, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17.

Auto Heat Deaths H-15.949
Our American Medical Association supports efforts to reduce deaths of children left in unattended vehicles. Res. 417, A-15.

Global Climate Change and Human Health H-135.938
Our AMA: 1. Supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor. 2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies. 3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes. 4. Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability. 5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort. 6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment. CSAPH Rep. 3, I-08; Reaffirmation A-14; Reaffirmed: CSAPH Rep. 04, A-19; Reaffirmation: I-19.

Occupational Safety and Health Administration Regulations H-365.983
The AMA (1) will work to modify the Occupational Safety and Health Administration regulations on Occupational Exposure to Bloodborne Pathogens to address its practicality and to make physician compliance possible; and (2) in conjunction with other national health provider groups, will work with Congress and other government regulatory agencies to ensure that all decisions regarding the regulation of medical practices be based upon scientific principles and/or fact. Res. 242, I-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 28, A-13.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 503
(N-21)

Introduced by: Young Physicians Section

Subject: Marketing Guardrails for the "Over-Medicalization" of Cannabis Use

Referred to: Reference Committee E

Whereas, The cannabis-legalization movement has swept the country; and

Whereas, In many states, "medical cannabis" and "medical marijuana" laws have put physicians in the uncomfortable position of being asked to prescribe cannabis for questionable medical indications; and

Whereas, In states where medical cannabis has been legalized, marketing for cannabis for "all your ills" has become excessive; and

Whereas, Emerging research in Colorado has shown that "marijuana use during pregnancy, concerns related to marijuana in homes with children, and adolescent use should continue to guide public health education and prevention efforts:

- The percentage of women who use marijuana in pregnancy … is higher among younger women, women with less education, and women with unintended pregnancies. Marijuana exposure in pregnancy is associated with decreased cognitive function and attention problems in childhood;

- Unintentional marijuana consumption among children under age 9 continues a slow upward trend, as do emergency visits due to marijuana. Additionally, an estimated 23,000 homes with children in Colorado have marijuana stored potentially unsafely. Marijuana exposures in children can lead to significant clinical effects that require medical attention;" [1] and

Whereas, The American College of Obstetricians and Gynecologists (ACOG) warns that women who are pregnant or contemplating pregnancy should be encouraged to discontinue marijuana use, because of concerns regarding impaired neurodevelopment;" [2] and

Whereas, Infants exposed to marijuana during pregnancy had a decrease in birth weight, preterm delivery, and long-term adverse neurodevelopmental effects;[3] and

Whereas, In some states, women who are positive for cannabis are restricted from providing breastmilk to preterm babies in the neonatal intensive care unit; and

Whereas, There may be a correlation between heavy cannabis use during adolescence and neuropsychiatric diseases such as schizophrenia;[4] and

Whereas, The U.S. Surgeon General has issued a warning about “Marijuana Use and the Developing Brain;”[5,6] and

Whereas, ACOG has issued a statement discouraging obstetrician–gynecologists from prescribing or suggesting the use of marijuana for medicinal purposes during preconception, pregnancy, and lactation;[2] and

Whereas, Despite such warnings, cannabis is promoted as a treatment for hyperemesis with many pregnant women being marketed a neuroactive drug during critical developmental periods of the embryo and fetus;[7] and

Whereas, Two-thirds of Colorado’s cannabis dispensaries recommend marijuana for first trimester nausea although chronic cannabis use is actually associated with nausea and vomiting, which leads to emergency department visits;"[1] and

Whereas, Marketing cannabis to vulnerable populations like pregnant women and adolescents can have long-term effects for population health; and

Whereas, As an example, the targeted marketing of menthol cigarettes to African-Americans has led to in 85% of Black smokers using menthol cigarettes compared to 29% of White smokers and contributing to health disparities;[8] and

Whereas, A report by a committee of the Food and Drug Administration concluded that if menthol cigarettes had been removed from the marketplace in 2010, then (a) by 2020, roughly 17,000 premature deaths would have been avoided and about 2.3 million people would not have started smoking;[8] and

Whereas, Inadequate information about the potential dangers/harms of cannabis (especially among vulnerable populations) is available, especially amid the storm of pro-cannabis marketing from that industry; and

Whereas, This results in the lay public considering cannabis to be as safe as Tylenol, or carrots; and

Whereas, Regulation of supplements continues to be highly flawed; and

Whereas, There are a small number of cannabinoid products (such as marinol) which are indeed FDA-approved for specific indications; and

Whereas, There appears to be a need for “guardrails” for the marketing of cannabis, especially to protect vulnerable populations; and

Whereas, AMA has established policy to seek more data on cannabis, but in the meantime, cannabis and cannabinoid products are rapidly becoming the “snake oil” of our time; therefore be it

RESOLVED, That our American Medical Association send a formal letter to the Food and Drug Administration and Federal Trade Commission requesting more direct oversight of the marketing of cannabis for medical use. (Directive to Take Action)

Fiscal note: Minimal - less than $1,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Marketing Guardrails for the 'Over-Medicalization' of Cannabis Use is being submitted for consideration as a medium-priority resolution. The prevalence of this issue ensures that AMA action would be high impact in terms of public health. Outcomes associated with cannabis use include lower birth weight, increased number of car accidents and other adverse outcomes. Further, limited data on the efficacy of cannabis to treat various medical conditions contribute to ongoing safety concerns. However, given that the issue at hand has been developing over several years, we feel the resolution is timely but not necessarily urgent.

Fiscal note: not yet determined

Date Received: 09/30/21

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RELEVANT AMA POLICY

Cannabis Warnings for Pregnant and Breastfeeding Women H-95.936
Our AMA advocates for regulations requiring point-of-sale warnings and product labeling for cannabis and cannabis-based products regarding the potential dangers of use during pregnancy and breastfeeding wherever these products are sold or distributed.
Citation: Res. 922, I-15; Reaffirmed: CSAPH Rep. 05, I-17;

Taxes on Cannabis Products H-95.923
Our AMA encourages states and territories to allocate a substantial portion of their cannabis tax revenue for public health purposes, including: substance abuse prevention and treatment programs, cannabis-related educational campaigns, scientifically rigorous research on the health effects of cannabis, and public health surveillance efforts.
Citation: CSAPH Rep. 05, I-17;

Cannabis and Cannabinoid Research H-95.952
1. Our AMA calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease.

2. Our AMA urges that marijuana's status as a federal schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods. This should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product.
3. Our AMA urges the National Institutes of Health (NIH), the Drug Enforcement Administration (DEA), and the Food and Drug Administration (FDA) to develop a special schedule and implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research involving cannabis and its potential medical utility. This effort should include: a) disseminating specific information for researchers on the development of safeguards for cannabis clinical research protocols and the development of a model informed consent form for institutional review board evaluation; b) sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of cannabis for clinical research purposes; c) confirming that cannabis of various and consistent strengths and/or placebo will be supplied by the National Institute on Drug Abuse to investigators registered with the DEA who are conducting bona fide clinical research studies that receive FDA approval, regardless of whether or not the NIH is the primary source of grant support.
4. Our AMA supports research to determine the consequences of long-term cannabis use, especially among youth, adolescents, pregnant women, and women who are breastfeeding.
5. Our AMA urges legislatures to delay initiating the legalization of cannabis for recreational use until further research is completed on the public health, medical, economic, and social consequences of its use.
6. Our AMA will advocate for urgent regulatory and legislative changes necessary to fund and perform research related to cannabis and cannabinoids.
7. Our AMA will create a Cannabis Task Force to evaluate and disseminate relevant scientific evidence to health care providers and the public.
Citation: CSA Rep. 10, I-97; Modified: CSA Rep. 6, A-01; Modified: CSAPH Rep. 3, I-09; Modified in lieu of Res. 902, I-10; Reaffirmed in lieu of Res. 523, A-11; Reaffirmed in lieu of Res. 202, I-12; Reaffirmed: CSAPH Rep. 2, I-13; Modified: CSAPH Rep. 05, I-17; Reaffirmed in lieu of: Res. 434, A-19; Appended: Res. 913, I-19;

Cannabis Legalization for Adult Use (commonly referred to as recreational use) H-95.924
Our AMA: (1) believes that cannabis is a dangerous drug and as such is a serious public health concern; (2) believes that the sale of cannabis for adult use should not be legalized (with adult defined for these purposes as age 21 and older); (3) discourages cannabis use, especially by persons vulnerable to the drug's effects and in high-risk populations such as youth, pregnant women, and women who are breastfeeding; (4) believes states that have already legalized cannabis (for medical or adult use or both) should be required to take steps to regulate the product effectively in order to protect public health and safety including but not limited to: regulating retail sales, marketing, and promotion intended to encourage use; limiting the potency of cannabis extracts and concentrates; requiring packaging to convey meaningful and easily understood units of consumption, and requiring that for commercially available edibles, packaging must be child-resistant and come with messaging about the hazards about unintentional ingestion in children and youth; (5) laws and regulations related to legalized cannabis use should consistently be evaluated to determine their effectiveness; (6) encourages local, state, and federal public health agencies to improve surveillance efforts to ensure data is available on the short- and long-term health effects of cannabis, especially emergency department visits and hospitalizations, impaired driving, workplace impairment and worker-related injury and safety, and prevalence of psychiatric and addictive disorders, including cannabis use disorder; (7) supports public health based strategies, rather than incarceration, in the handling of individuals possessing cannabis for personal use; (8) encourages research on

the impact of legalization and decriminalization of cannabis in an effort to promote public health and public safety; (9) encourages dissemination of information on the public health impact of legalization and decriminalization of cannabis; (10) will advocate for stronger public health messaging on the health effects of cannabis and cannabinoid inhalation and ingestion, with an emphasis on reducing initiation and frequency of cannabis use among adolescents, especially high potency products; use among women who are pregnant or contemplating pregnancy; and avoiding cannabis-impaired driving; (11) supports social equity programs to address the impacts of cannabis prohibition and enforcement policies that have disproportionately impacted marginalized and minoritized communities; and (12) will coordinate with other health organizations to develop resources on the impact of cannabis on human health and on methods for counseling and educating patients on the use cannabis and cannabinoids.
Citation: CSAPH Rep. 05, I-17; Appended: Res. 913, I-19; Modified: CSAPH Rep. 4, I-20;

Cannabis Legalization for Medicinal Use D-95.969
Our AMA: (1) believes that scientifically valid and well-controlled clinical trials conducted under federal investigational new drug applications are necessary to assess the safety and effectiveness of all new drugs, including potential cannabis products for medical use; (2) believes that cannabis for medicinal use should not be legalized through the state legislative, ballot initiative, or referendum process; (3) will develop model legislation requiring the following warning on all cannabis products not approved by the U.S. Food and Drug Administration: "Marijuana has a high potential for abuse. This product has not been approved by the Food and Drug Administration for preventing or treating any disease process."; (4) supports legislation ensuring or providing immunity against federal prosecution for physicians who certify that a patient has an approved medical condition or recommend cannabis in accordance with their state's laws; (5) believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions; (6) will, when necessary and prudent, seek clarification from the United States Justice Department (DOJ) about possible federal prosecution of physicians who participate in a state operated marijuana program for medical use and based on that clarification, ask the DOJ to provide federal guidance to physicians; and (7) encourages hospitals and health systems to: (a) not recommend patient use of non-FDA approved cannabis or cannabis derived products within healthcare facilities until such time as federal laws or regulations permit its use; and (b) educate medical staffs on cannabis use, effects and cannabis withdrawal syndrome.
Citation: CSAPH Rep. 05, I-17; Appended: Res. 211, A-18; Appended: CSAPH Rep. 3, I-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 504
(N-21)

Introduced by: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Subject: Air Pollution and COVID: A Call to Tighten Regulatory Standards

Referred to: Reference Committee E

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1 Whereas, The Environmental Protection Agency (EPA) is in the process of reviewing the current
2 National Ambient Air Quality Standards (NAAQS) for fine particulate matter (particles with a
3 diameter of ≤2.5 µm [PM2.5]) -- that is, levels not exceeding an annual average of 12 µg per
4 cubic meter and a 24-hour average of 35 µg per cubic meter; and
5
6 Whereas, The current EPA guidelines are not sufficient to protect public health, since exposure to
7 ambient PM2.5 at the current accepted EPA levels is estimated to be responsible for tens of
8 thousands of premature deaths in the United States each year[1]; and
9
10 Whereas, Current AMA policy calls for more stringent standards than are currently followed by the
11 EPA as noted in the policy summary below; and
12
13 Whereas, Air pollution is known to correlate with numerous other adverse health outcomes also,
14 including heart disease, stroke, asthma, COPD, and neurodegenerative disorders; and air
15 pollution disproportionately affects vulnerable populations and communities of color[1]; and
16
17 Whereas, Results suggest that exposure to traffic-related air pollution is associated with
18 dementia, via both direct neural damage as well as indirect pathways related to diabetes and
19 metabolic dysfunction; and
20
21 Whereas, Nearly all deaths attributable to air pollution in the contiguous United States are
22 associated with ambient air pollution concentrations below the current EPA standards, a finding
23 that both reflects past success and suggests that more stringent $PM_{2.}$ air quality standards may
24 further reduce the national death toll associated with air pollution; and
25
26 Whereas, Vulnerable populations and communities of color are most at risk for negative health
27 impacts from particulate air pollution owing to their location near emission sources or to
28 demographic or clinical characteristics (e.g., age or disease status) that increase their
29 susceptibility[1]; and
30
31 Whereas, Despite many improvements since passage of the Clean Air Act in 1970, according to a
32 report from the National Bureau of Economic Research, “After declining by 24.2% from 2009 to
33 2016, annual average fine particulate matter (PM2.5) in the United States in counties with
34 monitors increased by 5.5% between 2016 and 2018;” and
35
36 Whereas, Former members of the EPA Clean Air Scientific Advisory Committee on Particulate
37 Matter (which was dissolved on October 10, 2018), who now make up the nongovernmental
38 Independent Particulate Matter Review Panel, unequivocally and unanimously concluded that the
39 current PM2.5 standards do not adequately protect public health[1]; and

Whereas, A recent health impact assessment modeling a 40% reduction in $PM_{2.5}$ exposure estimated a drop in mortality by > 100,000 among adults in the Continental United States; and

Whereas, Increased mortality due to COVID-19 has been shown in studies at Harvard and in the Netherlands to be associated with air pollution: an increase of 1ug/m3 of PM 2.5 was shown to be associated with an 8% increase in the COVID-19 death rate in the US, and a 16% increase in the death rate due to COVID-19 in the Netherlands; and

Whereas, Indoor air pollution in the COVID-19 era has demonstrated unequivocally to be a much greater source of viral transmission than outdoor pollution by CDC, EPA and other agencies, recently resulting in recommended improvements in ventilation and air filtering; and[1]

Whereas, COVID-19 has also disproportionately affected vulnerable populations and communities of color where there has been a higher burden of disease and higher mortality; therefore be it

RESOLVED, That our American Medical Association advocate for stronger federal particulate matter air quality standards and improved enforcement that will better protect the public's health. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 10/06/21

AUTHORS STATEMENT OF PRIORITY

Air pollution is ubiquitous. It affects all physicians and all patients. On June 10, 2021, EPA announced it will re-evaluate the current air quality standards for particulate matter (PM) with a proposal to follow in Spring 2022. Thus, the need for advocacy on this issue is imminent, urgent and timely. The current guidelines are not sufficient to protect public health. Nearly all deaths attributable to air pollution in the US are associated with air pollution below the current standards. Vulnerable populations and communities of color are most at risk due to their locations living close to high emission sources. Furthermore, increased mortality due to COVID-19 is associated with air pollution, both which disproportionately affect vulnerable populations. As climate change leads to increased wildfires, another major source of PM, it becomes even more imperative that we advocate for stronger federal PM air quality standards and improved enforcement to reduce the modifiable sources of air pollution.

[1] Ventilation and Coronavirus (COVID-19) | US EPA Residential (ashrae.org)

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Link that is most pertinent: https://www.epa.gov/pm-pollution/national-ambient-air-quality-standards-naaqs-pm
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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 505
(N-21)

Introduced by: Medical Student Section

Subject: Representation of Dermatological Pathologies in Varying Skin Tones

Referred to: Reference Committee E

Whereas, Worse healthcare outcomes result from the under recognition of dermatologic pathologies, such as erythema migrans and the late detection of melanoma in individuals with darker skin tones – also known as Fitzpatrick skin types III-VI[1-4]; and

Whereas, There is a higher probability that individuals with darker skin tones have late detection of disease when compared to lighter skin tones (Fitzpatrick skin types I-II)[5-8]; and

Whereas, There is a lack of targeted skin cancer awareness and prevention efforts for patients with darker skin tones[9] resulting in lower rates of skin cancer screening; and

Whereas, Research has demonstrated that patients with darker skin tones feel frustrated when dermatologists do not demonstrate competency recognizing and treating pathologies on darker skin[10]; and

Whereas, It has been shown that overrepresentation of minority group skin tones relative to their proportion in the population is required to achieve equitable diagnostic outcomes[11-13]; and

Whereas, About 75 percent of dermatological imagery in medical textbooks represent individuals with lighter skin tones while core dermatology textbooks used to educate trainees, dermatologists, and generalists have limited representations of skin of color[14]; and

Whereas, Terms such as “Classic Presentation” are usually examples of lighter skin tones[15]; and

Whereas, Although our AMA recognizes the importance of racial and ethnic disparities in healthcare (H-350.974), the terms “race” and “ethnicity” are not equivalent nor interchangeable with the genotypic and phenotypic characteristics of “skin tone”[16-18]; and

Whereas, Existing AMA policy “promote[s] education on the importance of skin cancer screening and skin cancer screening in patients of color” (H-55.972) but lacks policy to ensure medical students are adequately primed to recognize such pathologies in a variety of skin colors; and

Whereas, While current AMA policy supports ensuring diversity in United States Medical Licensing Examination exam test/oversight committees representative of the test takers (D-275.963), this policy does not cover diversity in test questions themselves, nor the importance of skin tone as a relevant pathological factor missing in dermatological exam questions; therefore be it

RESOLVED, That our American Medical Association encourage the inclusion of a diverse range of skin tones in preclinical and clinical dermatologic medical education materials and evaluation (New HOD Policy); and be it further

RESOLVED, That our AMA encourage the development of educational materials for medical students and physicians that contribute to the equitable representation of diverse skin tones (New HOD Policy); and be it further

RESOLVED, That our AMA support the overrepresentation of darker skin tones in dermatologic medical education materials. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Racism remains a strong influence woven into much of medicine. The reckoning with long-standing racism that began in summer 2020 has also touched medicine, where the urgency of this reckoning is compounded by the knowledge that medical racism and racism built into the structures and institutions of medicine causes deaths every day. One such institution is the underrepresentation of darker skin tones in dermatological teaching and references. The lack of exposure to presentations of various skin tones leads to misdiagnoses or missed diagnoses for people with darker skin, further exacerbating disparities.

Our AMA has a long and shameful history of participating in and exacerbating medical racism, but in recent times our organization has made admirable strides toward trying to repair its past damage and show itself to be a leader on the road to greater health equity. Our delegation believes the AMA's commitment to This resolution provides tangible steps forward for our AMA to demonstrate our continued commitment to reducing and combating the harms of racism in medicine, and maybe even preventing them.

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RELEVANT AMA POLICY

Early Detection and Prevention of Skin Cancer H-55.972

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 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 (3) 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.
CCB/CLRPD Rep. 3, A-14

Educating Medical Students in the Social Determinants of Health and Cultural Competence H-295.874

Our AMA: (1) Supports efforts designed to integrate training in social determinants of health, cultural competence, and meeting the needs of underserved populations across the undergraduate medical school curriculum to assure that graduating medical students are well prepared to provide their patients safe, high quality and patient-centered care. (2) Supports faculty development, particularly clinical faculty development, by medical schools to assure that faculty provide medical students' appropriate learning experiences to assure their cultural competence and knowledge of social determinants of health. (3) Supports medical schools in their efforts to evaluate the effectiveness of their social determinants of health and cultural competence teaching of medical students, for example by the AMA serving as a convener of a consortium of interested medical schools to develop Objective Standardized Clinical Exams for use in evaluating medical students' cultural competence. (4) Will conduct ongoing data gathering, including interviews with medical students, to gain their perspective on the integration of social determinants of health and cultural competence in the undergraduate medical school curriculum. (5) Recommends studying the integration of social determinants of health and cultural competence training in graduate and continuing medical education and publicizing successful models.

CME Rep. 11, A-06, Reaffirmation A-11, Modified in lieu of Res. 908, I-14, Reaffirmed in lieu of Res. 306, A-15, Reaffirmed: BOT Rep. 39, A-18, Modified: CME Rep. 01, A-20

Racial and Ethnic Disparities in Health Care H-350.974
1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.
2. The AMA emphasizes three approaches that it believes should be given high priority:
A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.
B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.
C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities
3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.
4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.
CLRPD Rep. 3, I-98, Appended and Reaffirmed: CSA Rep.1, I-02, Reaffirmed: BOT Rep. 4, A-03, Reaffirmed in lieu of Res. 106, A-12, Appended: Res. 952, I-17, Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 3, A-21

Ensuring Diversity in United States Medical Licensing Examination Exams D-275.963
Our AMA will pursue diversity on all United States Medical Licensing Examination test/oversight committees in order to include the perspectives from others, including international medical graduates, to better reflect the diversity of the test takers.
Sub. Res. 306, A-09, Reaffirmed: CME Rep. 01, A-19

Continued Support for Diversity in Medical Education D-295.963

Our AMA will: (1) publicly state and reaffirm its stance on diversity in medical education; (2) request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups; (3) work with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations; (4) advocate for funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population; and (5) work with appropriate stakeholders to study reforms to mitigate demographic and socioeconomic inequities in the residency and fellowship selection process, including but not limited to the selection and reporting of honor society membership and the use of standardized tools to rank applicants, with report back to the House of Delegates.
Res. 325, A-03, Appended: CME Rep. 6, A-11, Modified: CME Rep. 3, A-13; Appended: CME Rep. 5, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 506
(N-21)

Introduced by: Medical Student Section

Subject: Enhancing Harm Reduction for People Who Use Drugs

Referred to: Reference Committee E

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1 Whereas, Overdose is the leading cause of preventable death in the USA and has contributed
2 to an unprecedented decline in life expectancy among certain demographics; in 2018, the age-
3 adjusted death rate from drug overdose in the USA was 17.1 per 100,000, which is almost 3
4 times what it was in 2010[1-3]; and
5
6 Whereas, The majority of overdose fatalities from 2014-2017 involved opioids[1]; and
7
8 Whereas, High potency opioids such as fentanyl that have entered the drug supply have played
9 a major role in recent increases in overdose deaths[1,4-6]; and
10
11 Whereas, Across the 10 states participating in the CDC's 2016 Enhanced State Opioid
12 Overdose Surveillance (ESOOS) program, fentanyl was detected in over half of all opioid
13 overdose deaths, and, of the deaths involving fentanyl, fentanyl was determined to contribute to
14 death in 97.1% of cases[7]; and
15
16 Whereas, Most people who are using fentanyl-contaminated drugs do not know that they
17 contain fentanyl[8], nor are they seeking to use fentanyl, and a pilot drug checking program found
18 that of 907 samples expected to be heroin only 160 (17.6%) contained the expected substance,
19 and 822 (90.6%) tested positive for fentanyl[4,8]; and
20
21 Whereas, Fentanyl is not the only adulterant commonly found in the illicit drug supply, and other
22 psychoactive adulterants such as benzodiazepines, non-fentanyl synthetic opioids, stimulants,
23 and synthetic cannabinoids are also present and can contribute to health risks and overdose[10];
24 and
25
26 Whereas, Potentially harmful adulterants, including fentanyl, have been identified in multiple
27 classes of illegal drugs, including heroin, cocaine, methamphetamine, and counterfeit
28 prescription pills; people using the drugs do not know which products contain adulterants, which
29 increases risk of adverse events[9,11]; and
30
31 Whereas, The use of novel synthetic opioids that include fentanyl analogs and non-fentanyl
32 compounds have resulted in a spike in overdose deaths[12]; and
33
34 Whereas, Drug-checking technologies, such as fentanyl test strips, allow people who use drugs
35 to check what drugs and potential adulterants are contained in the substance they purchased[13];
36 and
37
38 Whereas, Fentanyl test strips are a relatively inexpensive testing modality and multiple studies
39 have demonstrated high uptake and acceptance of fentanyl test strips among people who use
40 drugs[13-17]; and

Whereas, Although concerns have arisen that drug checking technologies such as fentanyl strips will "enable fentanyl seeking behavior", it has been found that a positive test strip result was associated with a higher intention to decrease fentanyl dosage[18,19]; and

Whereas, There is an association between test strip use and overdose risk-reducing behaviors, including disposing of the drug, not using alone, and having naloxone on hand while using[12-17,19-21]; and

Whereas, Although drug-checking technologies are associated with positive health outcomes and decreased overdose rates, limitations, including their current illegality, have been identified as a major barrier to their implementation and use[22,23]; and

Whereas, Forty-four US states have laws which qualify any drug testing equipment, including fentanyl testing strips, as illegal paraphernalia[24,25]; and

Whereas, Legislation providing an exemption to existing paraphernalia laws for all drug-checking technologies has been enacted in various states including Maryland, Washington DC, and Illinois, and preliminary results have shown the use of drug-checking technology to be effective in helping people use drugs more safely [23,26]; and

Whereas, Multiple states, including California and Utah, have piloted and used State and private funds to promote the use and distribution of fentanyl testing strips with outcomes showing participants taking steps to reduce their risk of overdose[27-31]; and

Whereas, Use of federal funds for fentanyl testing strips was approved in April 2021[32]; and

Whereas, Experts believe that the decriminalization of drug checking technologies in the USA will be associated with decreases in overdose rates[19,23]; and

Whereas, People who inject drugs (PWID) are at higher risk of contracting and transmitting infectious diseases (e.g. HBV, HCV, and HIV) via blood exposure due to the practice of sharing injection supplies[33,34]; and

Whereas, Syringe exchange programs (SEPs) were developed to reduce the harms associated with injection drug use and multiple studies across the USA indicate that SEPs are associated with significant decreases in risky injection practices and bloodborne infections such as HIV[35-38]; and

Whereas, Although most discussions of risks related to injection drug use focus on syringes and needles, PWID require more than just needles and syringes: injection drug preparation equipment (IDPE) includes items such as cookers, water containers, and filters[39,40]; and

Whereas, PWID are increasingly making use of SEPs to obtain safe injecting equipment[41]; and

Whereas, The majority of SEPs explicitly state that they supply needles, syringes, and offer a place to deposit used needles[42]; and

Whereas, SEPs may, but are not required to, provide other equipment needed to prepare and consume drugs such as filters, mixing containers, and sterile water[43]; and

Whereas, HIV and HCV transmission can occur via sharing of IDPE even when needles/syringes are not shared[39,44]; and

Whereas, Not using fresh IDPE is associated with MRSA-related infectious endocarditis and other viral and bacterial infections in drug users[40,45]; and

Whereas, CDC best practices state that SEPs, as they are implemented, should be a part of a comprehensive service program that includes, as appropriate: provision of sterile needles, syringes and other drug preparation equipment (purchased with non-federal funds) and disposal services[46]; and

Whereas, Individuals are more likely to reuse injection materials if they fear arrest for possession of drug paraphernalia[47]; and

Whereas, As of 2019, 32 states allow SEPs to operate in exception to state drug paraphernalia laws[48]; and

Whereas, The majority of current state laws allowing for SEP operation only specify the distribution of needles and syringes, thus the inclusion of IDPE in these programs is not explicitly protected despite being an independent harm reduction measure[48-49]; therefore be it

RESOLVED, That our American Medical Association amend Policy D-95.987, "Prevention of Opioid Overdose," by addition and deletion as follows:

D-95.987 – PREVENTION OF ~~OPIOID~~ DRUG-RELATED OVERDOSE
1. Our AMA: (A) recognizes the great burden that ~~opioid addiction and prescription drug abuse~~ substance use disorders (SUDs) and drug-related overdoses and death places on patients and society alike and reaffirms its support for the compassionate treatment of ~~such~~ patients with a SUD and people who use drugs; (B) urges that community-based programs offering naloxone and other opioid overdose and drug safety and prevention services continue to implemented in order to further develop best practices in this area; ~~and~~ (C) encourages the education of health care workers and people who use drugs ~~opioid users~~ about the use of naloxone and other harm reduction measures in preventing opioid and other drug-related overdose fatalities; and (D) will continue to monitor the progress of such initiatives and respond as appropriate.
2. Our AMA will: (A) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of ~~opioid~~ a drug-related overdose; and (B) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for ~~opioid~~ a drug-related overdose.
3. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from ~~opioid addiction~~ a SUD and their friends/families that address harm reduction measures ~~how a return to opioid use after a period of abstinence can, due to reduced opioid tolerance, result in overdose and death~~.
4. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the use of "drug paraphernalia" designed to support safe use of drugs, including drug contamination testing and injection drug preparation, use, and disposal supplies.
(Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Though COVID-19 has taken most of the headlines, the opioid epidemic has been a persistent issue facing the nation that continues to worsen and that has been exacerbated by the pandemic. Further, chemical adulterants such as synthetic opioids are increasing in prevalence in non-opioid drugs. Over the last decade, mitigation efforts, such as syringe exchange programs (SEPs) have been established to promote safe use and recovery for people who inject drugs (PWID). However, current paraphernalia laws limit harm reduction measures that SEPs can provide as well as simple chemical tests that people who use drugs could utilize to promote safer use by detecting adulterants. One harm reduction measure would be to exempt SEP distribution of cookers and other preparation equipment which can harbor hepatitis C and HIV from paraphernalia laws. Another harm reduction measure is to exempt use of drug checking technologies as studies have shown decreased use when there is a known adulterant in the drug product. The most prescient example of this are fentanyl test strips, a cheap and effective testing modality which has recently been given federal funding and piloted by cities and counties across the country. This resolution seeks to amend D-95.987 to encompass overdose as due to more than just opioids and to support initiatives to protect individuals who are using harm reduction measures, such as providing fresh IDPE and using drug checking technologies from criminal and civil prosecution under drug paraphernalia laws, to better address the ongoing tragedy of the opioid crisis.

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RELEVANT AMA POLICY

Prevention of Opioid Overdose D-95.987

1. Our AMA: (A) recognizes the great burden that opioid addiction and prescription drug abuse places on patients and society alike and reaffirms its support for the compassionate treatment of such patients; (B) urges that community-based programs offering naloxone and other opioid overdose prevention services continue to be implemented in order to further develop best practices in this area; and (C) encourages the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities; and (D) will continue to monitor the progress of such initiatives and respond as appropriate.
2. Our AMA will: (A) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of opioid overdose; and (B) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for opioid overdose.
3. Our AMA will support the development and implementation of appropriate education programs for persons in recovery from opioid addiction and their friends/families that address how a return to opioid use after a period of abstinence can, due to reduced opioid tolerance, result in overdose and death.

Res. 526, A-06; Modified in lieu of Res. 503, A-12; Appended: Res. 909, I-12; Reaffirmed: BOT Report. 22, A-16; Modified: Res. 511, A-18; Reaffirmed: Res. 235, I-18

Drug Paraphernalia H-95.989

The AMA opposes the manufacture, sale and use of drug paraphernalia.
BOT Rep. N, A-82; Reaffirmed: Sub Res. 108, A-87; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: CSAPH Rep. 1, A-13

Syringe and Needle Exchange Programs H-95.958

Our AMA: (1) encourages all communities to
establish needle exchange programs and physicians to refer their patients to such programs; (2) will initiate and support legislation providing funding for needle exchange programs for injecting drug users; and (3) strongly encourages state medical associations to initiate state legislation modifying drug paraphernalia laws so that injection drug users can purchase and possess needles and syringes without a prescription and needle exchange program employees are protected from prosecution for disseminating syringes.
Res. 231, I-94; Reaffirmed Ref Cmt. D, I-96; Modified by CSA Rep. 8, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Modified: Res. 203, A-13; Modified: Res. 914, I-16

Dispelling Myths of Bystander Opioid Overdose D-95.965

Our AMA will work with appropriate stakeholders to: (1) develop and disseminate educational materials aimed at dispelling the fear of bystander overdose via inhalation or dermal contact with fentanyl or other synthetic derivatives; and (2) identify those professions, such as first responders, most impacted by opioid overdose deaths in order to provide targeted education to dispel the myth of bystander overdose via inhalation or dermal contact with fentanyl or other synthetic derivatives.
Res. 532, A-19

Opioid Mitigation D-95.964
Our AMA: (1) encourages relevant federal agencies to evaluate and report on outcomes and best practices related to federal grants awarded for the creation of Quick Response Teams and other innovative local strategies to address the opioid epidemic, and will share that information with the Federation; and (2) will update model state legislation regarding needle and syringe exchange to state and specialty medical societies.
BOT Rep. 09, I-19

The Reduction of Medical and Public Health Consequences of Drug Abuse H-95.954
Our AMA: (1) encourages national policy-makers to pursue an approach to the problem of drug abuse aimed at preventing the initiation of drug use, aiding those who wish to cease drug use, and diminishing the adverse consequences of drug use; (2) encourages policy-makers to recognize the importance of screening for alcohol and other drug use in a variety of settings, and to broaden their concept of addiction treatment to embrace a continuum of modalities and goals, including appropriate measures of harm reduction, which can be made available and accessible to enhance positive treatment outcomes for patients and society; (3) encourages the expansion of opioid maintenance programs so that opioid maintenance therapy can be available for any individual who applies and for whom the treatment is suitable. Training must be available so that an adequate number of physicians are prepared to provide treatment. Program regulations should be strengthened so that treatment is driven by patient needs, medical judgment, and drug rehabilitation concerns. Treatment goals should acknowledge the benefits of abstinence from drug use, or degrees of relative drug use reduction; (4) encourages the extensive application of needle and syringe exchange and distribution programs and the modification of restrictive laws and regulations concerning the sale and possession of needles and syringes to maximize the availability of sterile syringes and needles, while ensuring continued reimbursement for medically necessary needles and syringes. The need for such programs and modification of laws and regulations is urgent, considering the contribution of injection drug use to the epidemic of HIV infection; (5) encourages a comprehensive review of the risks and benefits of U.S. state-based drug legalization initiatives, and that until the findings of such reviews can be adequately assessed, the AMA reaffirm its opposition to drug legalization; (6) strongly supports the ability of physicians to prescribe syringes and needles to patients with injection drug addiction in conjunction with addiction counseling in order to help prevent the transmission of contagious diseases; and (7) encourages state medical associations to work with state regulators to remove any remaining barriers to permit physicians to prescribe needles for patients.
CSA Rep. 8, A-97; Reaffirmed: CSA Rep. 12, A-99; Appended: Res. 416, A-00; Reaffirmation: I-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: CSAPH Rep. 2, I-13

1

Reference Committee F

BOT Report(s)

18 Financial Protections for Doctors in Training
19 Advocacy for Physicians with Disabilities

CLRPD Report(s)

01 Minority Affairs Section Five-Year Review
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HOD Comm on Compensation of the Officers

01 Report of the House of Delegates Committee on the Compensation of the Officers

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601 "Virtual Water Cooler" for our AMA
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606 Increasing the Effectiveness of Online Reference Committee Testimony
607 AMA Urges Health and Life Insurers to Divest From Investments in Fossil Fuels
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610 Creation of Employed Physician Section
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617* Together We are Stronger Marketing Campaign

* Contained in the Handbook Addendum

REPORT OF THE BOARD OF TRUSTEES

B of T Report 18-N-21

Subject: Financial Protections for Doctors in Training

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee F

At the 2019 Annual Meeting, the House of Delegates referred resolution 608-A-19, "Financial Protections for Doctors in Training," to the Board of Trustees. Resolution 608, introduced by the Resident and Fellow Section, asked:

> That our American Medical Association (AMA) support retirement plans for all residents and fellows, which includes retirement plan matching in order to further secure the financial stability of physicians and increase financial literacy during training; and
>
> That our AMA support that all programs provide financial advising to residents and fellows.

The reference committee heard testimony acknowledging the significance of medical student debt and the need for robust financial counseling. It also heard limited testimony in support of retirement plans and matching, noting concern about the restricted amount of GME funding available to institutions.

BACKGROUND

Training institutions generally offer residents and fellows medical, dental, vision and disability benefits that are comparable to those offered to other employees of an institution. Some also offer retirement plan options including matching contributions, but anecdotal reports indicate that this benefit is inconsistent, which results in inequitable and unreliable financial protections for trainees. Similarly, while some training institutions provide education on financial management and planning, anecdotal reports indicate that this benefit is also inconsistent and results in large variation in trainees' proficiency in and confidence on the subject.

Medicare is the single largest funding source for graduate medical education (GME)[1] with the federal government matching a portion of what state Medicaid programs pay teaching institutions.[2,3] Funding is limited, and Congress repeatedly considers cuts to GME. As a result, training institutions that do not currently offer retirement-related benefits could be hard-pressed to begin doing so.

DISCUSSION

Retirement savings

The depth and breadth of institutional benefits afforded to physicians in training varies widely and can lead to anxiety over financial stability and preparedness for the future, especially retirement. In fact, resident and fellow respondents to a 2017 study conducted by AMA Insurance (AMAI)

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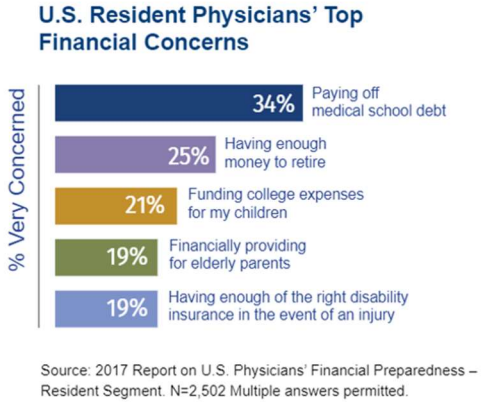
reported their two highest concerns as "having enough money to retire" and "paying off medical school debt."[4]



While financial advisors are split on how to prioritize saving money and reducing debt, it is generally agreed upon that taking advantage of retirement plan matching contributions is a must. But, as noted, not all teaching institutions offer this critical benefit to residents and fellows, even where they offer it to other employees. Arguably, as the primary providers of care in a teaching hospital, spending between 50 and 80 hours a week caring for patients, it is not only appropriate that residents and fellows be classified as employees under applicable law but that they be offered retirement plan options, including contribution matching, no less favorable than those offered to other institution employees.

Education and advising

Sound financial education and advising are critical for residents and fellows, who face a unique and challenging financial situation relative to their non-physician peers. Nevertheless, the aforementioned AMAI study indicated that 88% of residents and fellows do not use a financial advisor, with the primary reasons being (1) lack of time, (2) cost, and (3) lack of trustworthiness. These barriers are a strong indication that busy trainees need easy-to-digest, affordable information from credible sources. While our AMA offers some resources, gaps still exist. Therefore, it stands to reason that our AMA should encourage teaching institutions to offer financial education and advising to residents and fellows.

Existing AMA resources

The AMA's Career Planning Resource (https://www.ama-assn.org/amaone/career-planning-resource) helps residents and fellows plan and achieve their career goals, and includes basic guidance on topics such as loan repayment options, creating a budget and financial plan, choosing the best insurance policies, and planning for retirement. Additionally, AMAI operates the

Physicians Financial Partners program (https://www.amainsure.com/physicians-financial-partners/about-us.html), which provides medical students and physicians with a single source to find experienced and fully vetted financial professionals. Finally, the AMA offers member benefits to help medical students and physicians organize personal finances and manage debt, most notably through a partnership with Laurel Road offering discounted rates and other benefits on student loan refinancing, mortgages, and personal loans (https://www.ama-assn.org/member-benefits/personal-member-benefits-discounts/loans-financial-services).

Current AMA policy

The AMA has long-standing policy encouraging teaching institutions to offer benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation, as well as supporting quality and affordable comprehensive medical, mental health, dental, and vision care, including professional liability and disability insurance (see for example Policies H-310.912, H-295.942, H-295.873, and H-305.988, which are reproduced in full in the Appendix). Existing AMA policy does not address retirement planning or financial advising for residents and fellows.

CONCLUSION

Residents and fellows often are burdened with significant debt coming out of medical school. As they progress through training, aside from attaining clinical competency, it is of utmost importance that they become financially prepared for the future—whether that entails paying down debt, saving for retirement, or otherwise making sound financial decisions. While some teaching institutions offer benefit packages including retirement plans with matching contributions, many do not, and funds are limited. Similarly, while some institutions provide financial education and advising, many do not, and many trainees are left feeling ill-prepared and unsettled when it comes to their financial security.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 608-A-19 and the remainder of the report be filed:

1. That our American Medical Association (AMA) support the availability of retirement plans for residents and fellows at all teaching institutions that are no less favorable than those offered to other institution employees. (New HOD Policy)

2. That AMA Policy H-310.912, "Residents and Fellows' Bill of Rights," be amended by addition and deletion to read as follows:

   1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.

   2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.

   3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.

   4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes

disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of $200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.

5. Our AMA will partner with ACGME and other relevant stakeholders to encourage training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services.

6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or "protected time" for resident and fellow education by "core faculty," program directors, and assistant/associate program directors.

7. Our AMA encourages teaching institutions to offer retirement plan options, retirement plan matching, financial advising and personal finance education.

8. ~~7~~ Our AMA adopts the following "Residents and Fellows' Bill of Rights" as applicable to all resident and fellow physicians in ACGME-accredited training programs:

RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS
Residents and fellows have a right to:

[…]

E. Adequate compensation and benefits that provide for resident well-being and health.

[…]

(3) With Regard to Benefits, Residents and Fellows Must Be Fully Informed of and Should Receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as retirement plan options, professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided. (Modify Current HOD Policy)

Fiscal Note: Less than $500

REFERENCES

1. Direct Graduate Medical Education (DGME). https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/DGME
2. Indirect Graduate Medical Education (IGME). https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Indirect-Medical-Education-IME
3. Medicaid Graduate Medical Education Payments: Results From the 2018 50-State Survey. https://store.aamc.org/downloadable/download/sample/sample_id/284/
4. 2017 Report on U.S. Physicians' Financial Preparedness. American Medical Association Insurance. https://www.amainsure.com/research-reports/2017-financial-preparedness-resident-physicians/index.html?page=1

APPENDIX: RELEVANT AMA POLICY

Policy H-310.912, "Residents and Fellows' Bill of Rights"
1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines. 2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills. 3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights. 4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of $200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended. 5. Our AMA encourages teaching institutions to explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation. 6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or "protected time" for resident and fellow education by "core faculty," program directors, and assistant/associate program directors. 7. Our AMA adopts the following 'Residents and Fellows' Bill of Rights' as applicable to all resident and fellow physicians in ACGME-accredited training programs:

RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS
Residents and fellows have a right to:
A. An education that fosters professional development, takes priority over service, and leads to independent practice. With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings. B. Appropriate supervision by qualified faculty with progressive resident responsibility toward independent practice.

With regard to supervision, residents and fellows should expect supervision by physicians and non-physicians who are adequately qualified and which allows them to assume progressive responsibility appropriate to their level of education, competence, and experience. It is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents. C. Regular and timely feedback and evaluation based on valid assessments of resident performance. With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request. D. A safe and supportive workplace with appropriate facilities. With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract. E. Adequate compensation and benefits that provide for resident well-being and health. (1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal. (2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages) and include appropriate adjustments for changes in the cost of living. (3) With Regard to Benefits, Residents and Fellows Must Be Fully Informed of and Should Receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided. F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education. With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, “Resident/Fellow Clinical and Educational Work Hours,” for more information. G. Due process in cases of allegations of misconduct or poor performance. With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient,

health professional, or training program in accordance with the due process guidelines established by the AMA. H. Access to and protection by institutional and accreditation authorities when reporting violations. With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey. Citation: CME Rep. 8, A-11; Appended: Res. 303, A-14; Reaffirmed: Res. 915, I-15; Appended: CME Rep. 04, A-16; Modified: CME Rep. 06, I-18; Appended: Res. 324, A-19

Policy H-295.942 "Insurance Coverage for Medical Students and Resident Physicians"
The AMA urges (1) all medical schools to pay for or offer affordable policy options and, assuming the rates are appropriate, require enrollment in disability insurance plans by all medical students; (2) all residency programs to pay for or offer affordable policy options for disability insurance, and strongly encourage the enrollment of all residents in such plans; (3) medical schools and residency training programs to pay for or offer comprehensive and affordable health insurance coverage, including but not limited to medical, dental, and vision care, to medical students and residents which provides no less than the minimum benefits currently recommended by the AMA for employer-provided health insurance and to require enrollment in such insurance; (4) carriers offering disability insurance to: (a) offer a range of disability policies for medical students and residents that provide sufficient monthly disability benefits to defray any educational loan repayments, other living expenses, and an amount sufficient to continue payment for health insurance providing the minimum benefits recommended by the AMA for employer-provided health insurance; and (b) include in all such policies a rollover provision allowing continuation of student disability coverage into the residency period without medical underwriting. (5) Our AMA: (a) actively encourages medical schools, residency programs, and fellowship programs to provide access to portable group health and disability insurance, including human immunodeficiency virus positive indemnity insurance, for all medical students and resident and fellow physicians; (b) will work with the ACGME and the LCME, and other interested state medical societies or specialty organizations, to develop strategies and policies to ensure access to the provision of portable health and disability insurance coverage, including human immunodeficiency virus positive indemnity insurance, for all medical students, resident and fellow physicians; and (c) will prepare informational material designed to inform medical students and residents concerning the need for both disability and health insurance and describing the available coverage and characteristics of such insurance. Citation: BOT Rep. W, I-91Reaffirmed: BOT Rep. 14, I-93Appended: Res. 311, I-98 Modified: Res. 306, A-04Modified: CME Rep. 2, A-14

Policy H-295.873 "Eliminating Benefits Waiting Periods for Residents and Fellows"
Our AMA: (1) supports the elimination of benefits waiting periods imposed by employers of resident and fellow physicians-in-training; (2) will strongly encourage the Accreditation Council for Graduate Medical Education (ACGME) to require programs to make insurance for health care, dental care, vision care, life, and disability available to their resident and fellow physicians on the trainees' first date of employment and to aggressively enforce this requirement; and (3) will work with the ACGME and with the Liaison Committee on Medical Education (LCME) to develop policies that provide continuous hospital, health, and disability insurance coverage during a traditional transition from medical school into graduate medical education. (4) encourages the Accreditation Council for Graduate Medical Education to request that sponsoring institutions offer

to residents and fellows a range of comparable medical insurance plans no less favorable than those offered to other institution employees. Citation: BOT Action in response to referred for decision Res. 318, A-06 Appended: CME Rep. 5, A-10

Policy H-305.988 "Cost and Financing of Medical Education and Availability of First-Year Residency Positions"
Our AMA: 1. believes that medical schools should further develop an information system based on common definitions to display the costs associated with undergraduate medical education; 2. in studying the financing of medical schools, supports identification of those elements that have implications for the supply of physicians in the future; 3. believes that the primary goal of medical school is to educate students to become physicians and that despite the economies necessary to survive in an era of decreased funding, teaching functions must be maintained even if other commitments need to be reduced; 4. believes that a decrease in student enrollment in medical schools may not result in proportionate reduction of expenditures by the school if quality of education is to be maintained; 5. supports continued improvement of the AMA information system on expenditures of medical students to determine which items are included, and what the ranges of costs are; 6. supports continued study of the relationship between medical student indebtedness and career choice; 7. believes medical schools should avoid counterbalancing reductions in revenues from other sources through tuition and student fee increases that compromise their ability to attract students from diverse backgrounds; 8. supports expansion of the number of affiliations with appropriate hospitals by institutions with accredited residency programs; 9. encourages for profit-hospitals to participate in medical education and training; 10. supports AMA monitoring of trends that may lead to a reduction in compensation and benefits provided to resident physicians; 11. encourages all sponsoring institutions to make financial information available to help residents manage their educational indebtedness; and 12. will advocate that resident and fellow trainees should not be financially responsible for their training. Citation: CME Rep. A, I-83 Reaffirmed: CLRPD Rep. 1, I-93Res. 313, I-95 Reaffirmed by CME Rep. 13, A-97 Modified: CME Rep. 7, A-05 Modified: CME Rep. 13, A-06

REPORT OF THE BOARD OF TRUSTEES

B of T Report 19-N-21

Subject: Advocacy for Physicians with Disabilities

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee F

At the 2019 Annual Meeting, the House of Delegates (HOD) adopted Policy D-90.991, "Advocacy for Physicians with Disabilities." The policy calls upon our AMA to:

> study and report back on eliminating stigmatization and enhancing inclusion of physicians with disabilities including, but not limited to:
> 1. Enhancing representation of physicians with disabilities within the AMA.
> 2. Examining support groups, education, legal resources and any other means to increase the inclusion of physicians with disabilities in the AMA…

This report addresses and makes recommendations related to strategies to help reduce stigmatization for physicians with a disability and promote remedies that enhance supportive techniques for these physicians. For the purposes of this report, "disability" is defined as it is under the federal Americans with Disabilities Act (ADA) as "a physical or mental impairment that substantially limits one or more major life activity," though the report recognizes that this is a legal definition rather than a medical one, and that other valid definitions exist.

DISCUSSION

Eliminating stigmatization

A key component of the stigmatization recognized by Policy D-90.991 is language, including spoken and written words. How physicians refer to each other, patients, and other actors in the healthcare sector can go a long way to lessening unintended emotional or professional burdens. Careful consideration of the proper use of "person first" and "identify first" language when engaging with individuals with disabilities can lead to a greater sense of belonging in the organization and at AMA-sponsored events.

Person-first language can be thought of as language that centers the personhood of someone, while identity-first language centers the community that person feels a sense of belonging to. While person-first language is taught in academic programs and frequently required for publication in scholarly journals, its use in clinical practice can lag. Whether through habit or a return to the jargon acquired during medical training, physicians can find themselves falling back into saying "diabetic" instead of "person with diabetes," for example.

Adding to the complexity and applicability of its use is the acknowledgement that not all people prefer person-first language, opting for language that centers their identity instead. Prominent examples of this identity-first approach can include members of the deaf community who understand deafness to be a formative factor in a set of cultural beliefs, behaviors, and perspectives

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central to who they are as people. Likewise, members of the autistic community may prefer "autistic" over "person with autism" because they understand autism as a component of identity.

Additionally, not all disabilities are readily apparent to the outside observer. So-called "invisible disabilities" can be challenging to address because of their less overt nature. An invisible disability can be thought of as any invisible condition that limits a person's movement or activities and is often misunderstood by others. Examples can include mental health conditions (for example, depression, anxiety, substance use disorders, etc.), learning impairments (dyslexia, attention deficit hyperactivity disorder), or biological medical conditions that aren't externally apparent, such as diabetes or gastrointestinal diseases. While any disability if serious enough could manifest external signs, the absence of those signs should not be construed to assume a person is free from them.

Cultivating an awareness and sensitivity to how people understand their own abilities, as well as a recognition that not all people feel the same way, is critical to eliminating stigmatization. The AMA should work with its internal resource teams to develop an action plan for properly and effectively addressing language, terms, and vocabulary in use at internal and public AMA events and invest in opportunities to afford a richer understanding of how disability can manifest itself among employees and members.

Enhancing inclusion

Resources for physicians with disabilities are scarce. While professional organizations, such as the Association of Medical Professionals with Hearing Loss, the Society of Healthcare Professionals with Disabilities, exist, their reach tends to be limited and information and resources for physicians may be hard to come by, particularly in times of crisis or emergency. Greater resources exist through organizations designed to help medical students, such as the Association of American Medical Colleges or the Coalition for Disability Access in Health Science and Medical Education, however more work is needed not only to bring together resources for physicians but to create them in the first place.

In 2020, the AMA launched the Access internal employee resource group intended to support and empower individuals with disabilities at the AMA and to expand the relationship of the AMA with people with disabilities. The group seeks to better identify existing access needs within the AMA and support efforts to meet those needs. Going forward, the AMA should support and work with the resource group to promote and foster educational and training opportunities for AMA members and the larger medical community to better understand the role that disabilities can play in the healthcare work environment.

Securing legal protections

Under criteria established by the U.S. Equal Employment Opportunity Commission (EEOC), a healthcare worker must meet one of three criteria to be considered an individual with a disability: the worker has a physical or mental impairment that "substantially limits one or more major life activities;" has a record of impairment that is substantially limiting; or is treated by an employer as having substantially limited impairment. Examples of "major life activities" include things that can be done with little or no difficulty, such as sitting, walking, seeing, hearing, speaking, learning, concentrating, or any other basic task.

The EEOC also recognizes people with substance use disorders as potentially qualifying for the definition of disability. Physicians with alcohol use disorder are considered to have a qualifying disability under the ADA. Likewise, physicians who have previously had a substance use disorder

diagnosis but are not currently engaging in drug use may also be considered to have a disability under the law if that disorder is substantially limiting a major life activity.

In order for physicians with a disability to be protected under the ADA, they must be qualified to perform the essential functions of a job, with or without a reasonable accommodation. This means physicians must be able to meet an employer's requirements for the job and be able to perform the fundamental job duties on their own or with reasonable assistance. These protections extend only to applicants and employees of a business. Independent contractors of a business, notably, are not covered, meaning that medical staff with a disability, separate from the non-medical employees of a healthcare facility, can find themselves with less protection than the employees. Physicians, particularly medical staff physicians, can thusly benefit from efforts to help them maximize their rights and privileges under the law.

CONCLUSION

According to the U.S. Census Bureau, approximately 85 million people in the United States have a disability, roughly 27 percent of the total population. Studies have shown that many medical treatment facilities may lack the resources necessary to adequately treat patients with disabilities simply for want of accommodations such as a ramp, or adequately sized hallways. It should be understood that if these facilities want for the ability to treat patients, they are likely also inadequate as places of employment for physicians with disabilities. And while federal and state laws have led to improvements for people with disabilities, both as patients and providers who are employees, greater action is required to create a truly equitable work and treatment environment. The reduction of stigma and the promotion of inclusion for physicians with disabilities is a daunting task requiring a variety of approaches and measures in order to achieve success. While the AMA cannot expect to single-handedly make these achievements, it can serve in good faith as a shepherd of them with relatively little disruption or financial cost.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) establish an advisory group composed of AMA members who themselves have a disability to work toward inclusion for physicians with disabilities in all AMA activities. (Directive to Take Action)

2. That our AMA promote and foster educational and training opportunities for AMA members and the medical community at large to better understand the role disabilities can play in the healthcare work environment, including cultivating a rich understanding of so-called invisible disabilities for which accommodations may not be immediately apparent. (Directive to Take Action)

3. That our AMA develop and promote tools for physicians with disabilities to advocate for themselves in their own workplaces, including a deeper understanding of the legal options available to physicians to manage their own disability-related needs in the workplace. (Directive to Take Action)

4. That our AMA communicate to employers and medical staff leaders the importance of including within personnel policies and medical staff bylaws protections and reasonable

accommodations for physicians with visible and invisible disabilities. (Directive to Take Action)

5. That part 1 of Policy D-90.991, Advocacy for Physicians with Disabilities, be rescinded as having been accomplished by this report. (Modify Current HOD Policy)

Fiscal Note: Convene advisory group and develop resources as directed at an estimated cost of $30,500.

REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 1-N-21

Subject: Minority Affairs Section Five-Year Review

Presented by: Clarence Chou, MD, Chair

Referred to: Reference Committee F

AMA Bylaw 7.0.9 states, "A delineated section must reconfirm its qualifications for continued delineated section status and associated representation in the House of Delegates by demonstrating at least every 5 years that it continues to meet the criteria adopted by the House of Delegates." AMA Bylaw 6.6.1.5 states that one function of the Council on Long Range Planning and Development (CLRPD) is "to evaluate and make recommendations to the House of Delegates, through the Board of Trustees, with respect to the formation and/or change in status of any section. The Council will apply criteria adopted by the House of Delegates."

The Council assessed information from the letter of application submitted by the Minority Affairs Section (MAS) for renewal of delineated section status.

APPLICATION OF CRITERIA TO THE MINORITY AFFAIRS SECTION

Criterion 1: Issue of Concern – Focus will relate to concerns that are distinctive to the subset within the broader, general issues that face medicine. A demonstrated need exists to deal with these matters, as they are not currently being addressed through an existing AMA group.

The MAS provides a nationwide forum to advocate for health issues of minoritized communities and professional concerns of underrepresented and minoritized physicians, residents/fellows and medical students. African American/Black, Hispanic/Latino and American Indian/Alaska Native individuals comprise one-third of the U.S. population yet represent only 11% of the total physician workforce, according to a 2019 report by the Association of American Medical Colleges; representation among these racial and ethnic groups in the physician workforce lags significantly behind their numbers in the general population. In addition, these three populations faced historical discrimination, which prevented them from entering the profession.

During the last five years the following priority issues have been the focus of the MAS:

- Diversity in medicine and minoritized physician advocacy: The MAS Doctors Back to School™ (DBTS) program aims to encourage interest in careers in medicine among elementary, middle and high school students through visits from physicians and medical students in the hope of increasing diversity within the medical profession. Over 100,000 minoritized youth have been engaged through the program by volunteer physicians and medical students nationwide. Additionally, MAS partners with the AMA Foundation to promote scholarship programs among minoritized medical students. Each year, two scholarships are awarded and over $1,000,000 in scholarships have been awarded to hundreds of minoritized medical students. Studies have demonstrated that physicians from

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diverse backgrounds increase patient satisfaction, provide culturally competent care and decrease racial and ethnic health care disparities.

- Enhancing AMA policy and advocacy on behalf of minoritized patients and physicians: The MAS has sponsored or cosponsored more than 30 resolutions that have modified AMA policy since 2015 on topics relevant to minoritized patients and physicians. These topics have included racial essentialism in medicine, primary care physicians in underserved areas, language proficiency data of physicians in the AMA Masterfile, terms and language in policies adopted to protect populations from discrimination and harassment, preventing anti-transgender violence and strategies for enhancing diversity in the physician workforce.

- Enhancing AMA partnerships with external stakeholders to improve and strengthen AMA's impact on health education for minoritized communities, programmatic initiatives, and awareness of AMA's ongoing work to achieve health equity and eliminate health disparities: The MAS has long-standing relationships with the Association of American Indian Physicians (AAIP), National Hispanic Medical Association (NHMA), National Medical Association (NMA), National Minority Quality Forum and the Medical Organization for Latino Advancement. Strategic partnerships with these organizations include collaborative efforts through representation, policy, programs, and education. Key outcomes have included remarks and presentations at annual conferences by AMA presidents and MAS leaders, designated seats on the MAS governing council (GC), and AMA sponsorships and cross-promotional activities (e.g., CME sessions, speaking engagements, exhibit booths, AMA member engagement initiatives, participation in AMA marketing campaigns, research, physician advocacy and AMA policy development.)

CLRPD assessment: The MAS focuses on the concerns of underrepresented and minoritized physicians and medical students and issues related to the health of minoritized communities. As the only formalized structure to facilitate and encourage the participation of minoritized physicians in the deliberations of the AMA HOD and other AMA activities, the MAS fills a demonstrated need, as within the physician community and organized medicine, African American/Black, Hispanic/Latino, and American Indian/Alaska Native physicians and medical students face both current and historical underrepresentation.

Criterion 2: Consistency – Objectives and activities of the group are consistent with those of the AMA. Activities make good use of available resources and are not duplicative.

In August 2020, MAS collaborated with AMA staff to identify section-specific objectives to build upon the established foundational objectives that guide all AMA sections. Those MAS-specific objectives are to improve communications with strategic partners, improve representation in medicine among minoritized populations and enhance health policy related to minoritized communities. To accomplish these objectives, the MAS developed specific key goals related to each objective using the S.M.A.R.T tool, which is used to set goals that are specific, measurable, achievable, relevant and time-bound:

- Improve communication with strategic partners: 1) fully inform GC members, MAS members and external partners of MAS activities, policy efforts and other issues of importance to the health of minoritized communities; and 2) increase engagement of MAS members.

- Improve diversity in medicine among minoritized populations: 1) increase representation of minoritized physicians and medical students in ambassador and other AMA leadership roles such as HOD delegates by 2025; and 2) contribute expertise annually to improve two pathway programs.

- Improve health policy related to minoritized populations at the AMA: contribute annually to the development and/or initiation of at least three policies.

To achieve these goals, MAS has employed the following tactics:

- Launching a member engagement survey
- Developing a leadership academy for MAS members interested in AMA leadership roles
- Collaborating with pathway programs for minoritized populations
- Continuing the DBTS program
- Strategically partnering with AMA business units including the AMA Foundation, other AMA sections, Advocacy, the Center for Health Equity, and the Board of Trustees as well as other HOD delegations
- Holding a MAS Caucus at each HOD meeting
- Developing educational programming

CLRPD Assessment: The activities of the MAS focus on bringing forward issues that are important and unique to its constituents. The section has worked to develop appropriate and measurable objectives in alignment with the AMA and has implemented tactics to achieve those goals within specified time periods. Its strategic foci on improving communications with strategic partners, improving representation in medicine among underrepresented and minoritized physicians and medical students, and improving health policy related to minoritized communities at the AMA are appropriate, and the methodologies employed toward achieving those goals demonstrate a commitment to doing so effectively and efficiently.

Criterion 3: Appropriateness - The structure of the group will be consistent with its objectives and activities.

Individual physicians or medical students initiate membership in the MAS upon request. Membership is open to any AMA member physician or medical student who expresses an interest in issues related to racially and ethnically minoritized physicians or health issues related to minoritized populations. Eligible voters with full rights and privileges are referred to as MAS members. To facilitate section business and policy development, the section's ten GC members meet in-person three times each year and hold monthly virtual meetings. Current MAS members with an active AMA membership are eligible to be nominated to the designated positions on the GC. Three physician organizations (NMA, AAIP, and NHMA) and the three AMA fixed sections nominate representatives to be elected to their designated positions on the MAS GC.

The MAS holds business meetings in conjunction with AMA HOD meetings. MAS represents the interests of its members in the HOD through the actions of its elected delegate, and the Chair of the MAS GC serves as the alternate delegate to the HOD. As part of the section business meetings, informational panels are convened to inform section members about wide-ranging critical issues that align with the section's priorities. Topics have included pathway programs for minoritized populations, gun violence, priorities of medical societies representing minoritized physicians and health equity in medicine. The MAS also conducts a DBTS program with local schools in conjunction with HOD meetings.

CLRPD Assessment: MAS membership is open to any AMA member with an interest in racially and ethnically minoritized physicians or health issues of minoritized populations. The section's business meetings provide opportunities for its members to participate in the deliberations of the section, as well as providing educational opportunities to increase members' knowledge of issues related to the priorities of the section.

Criterion 4: Representation Threshold - Members of the formal group would be based on identifiable segments of the physician population and AMA membership. The formal group would be a clearly identifiable segment of AMA membership and the general physician population. A substantial number of members would be represented by this formal group. At minimum, this group would be able to represent 1,000 AMA members.

The AMA has nearly 31,000 members self-identified as African American/Black, Hispanic/Latino and American Indian/Alaska Native (an increase of approximately 7,000 since the previous review of the MAS delineated section status in 2016), and all these physicians and medical students are eligible members of the MAS. In addition, membership to the MAS is available to any AMA member physician or medical student who expresses an interest in issues related to racially and ethnically minoritized physicians or health issues related to minoritized communities. Recent actions by the AMA and the HOD have demonstrated a recognized urgency for the Association to address current and historical inequities in medicine.

CLRPD Assessment: The MAS is comprised of members from an identifiable segment of AMA membership and the general physician population. This group represents more than 1,000 AMA members.

Criterion 5: Stability - The group has a demonstrated history of continuity. This segment can demonstrate an ongoing and viable group of physicians, who will be represented by this section. Both the segment and the AMA will benefit from an increased voice within the policymaking body.

The AMA Minority Affairs Consortium became the MAS in 2011. Approximately 100 members attend each of the two MAS business meetings held in conjunction with HOD meetings. To determine policy priorities on issues of concern, MAS members submit draft resolutions to the MAS GC for its consideration in advance of each meeting of the HOD. The GC determines priority status and approves resolutions that will advance to the HOD for further consideration. To develop a consensus opinion on MAS resolutions, MAS members participate in an online member forum and vote to support or oppose draft resolutions. In addition, MAS solicits input from all AMA meeting attendees during MAS business meetings. As noted previously, since 2015, the MAS has sponsored or cosponsored more than 30 resolutions that have been adopted, reaffirmed or amended AMA policy by the HOD on a variety of topics relevant to minoritized patients and physicians. More than 2,800 AMA members have opted in to subscribe to the MAS listserv.

CLRPD Assessment: The MAS has an established history at the AMA and actively participates in the policymaking process of the HOD, which benefits from the distinct voice of the MAS in its deliberations. Since its inception, the MAS has taken numerous steps to align its structure with the policymaking activities of the AMA.

Criterion 6: Accessibility - Provides opportunity for members of the constituency who are otherwise underrepresented to introduce issues of concern and to be able to participate in the policymaking process within the AMA HOD.

During MAS business meetings, leadership requests policy ideas from section members to submit at future HOD meetings and works to identify gaps in current policy. Attendance at in-person meetings averages approximately 100 attendees. The GC approves resolutions for adoption and works with the author(s) to refine wording and research citations. To develop a consensus opinion on draft resolutions, MAS members meet via an online forum prior to the HOD handbook deadlines and vote in support or opposition of a resolution. Members also may submit comments or testimony that offer revisions to the original resolution. Approximately 100 MAS members provide votes and testimony prior to each policymaking meeting. Over 1,500 MAS members receive the resolution information electronically. The MAS GC, in cooperation with the Committee on Advocacy, considers comments, votes and testimony before editing resolutions for a final ratification vote. A majority vote of those present directs the action of the MAS GC and MAS Delegate to submit or not submit MAS resolutions to the HOD.

CLRPD Assessment: The MAS provides opportunities for members of its constituency who are otherwise underrepresented to introduce issues of concern and participate in the HOD policymaking process. Through a variety of forums and outreach efforts, MAS members are afforded the opportunity to comment on draft resolutions, and MAS leadership considers the feedback of its members before finalizing those resolutions.

CONCLUSION

The CLRPD has determined that the MAS meets all criteria; therefore, it is appropriate to renew the delineated section status of the section.

RECOMMENDATION

The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Minority Affairs Section through 2026 with the next review no later than the 2026 Interim Meeting and that the remainder of this report be filed. (Directive to Take Action)

Fiscal Note: Less than $500 to update policy database.

REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 2-N-21

Subject: Integrated Physician Practice Section Five-Year Review

Presented by: Clarence Chou, MD, Chair

Referred to: Reference Committee F

AMA Bylaw 7.0.9 states, "A delineated section must reconfirm its qualifications for continued delineated section status and associated representation in the House of Delegates by demonstrating at least every 5 years that it continues to meet the criteria adopted by the House of Delegates." AMA Bylaw 6.6.1.5 states that one function of the Council on Long Range Planning and Development (CLRPD) is "to evaluate and make recommendations to the House of Delegates, through the Board of Trustees, with respect to the formation and/or change in status of any section. The Council will apply criteria adopted by the House of Delegates."

The Council accessed information from a letter of application submitted by the Integrated Physician Practice Section (IPPS) for renewal of delineated section status.

APPLICATION OF CRITERIA TO THE INTEGRATED PHYSICIAN PRACTICE SECTION

Criterion 1: Issue of Concern - Focus will relate to concerns that are distinctive to the subset within the broader, general issues that face medicine. A demonstrated need exists to deal with these matters, as they are not currently being addressed through an existing AMA group.

The House of Delegates (HOD) adopted the Integrated Physician Practice Section (IPPS) as a delineated section in 2011. The precursor to the IPPS was the Advisory Committee on Group Practice Physicians, a Board-appointed committee founded in the early 1990s. The characteristic that distinguishes IPPS from other AMA component groups is that the section focuses on the continuum of care through an integrated delivery system. The IPPS works to advance the interests of multi-specialty, physician-led, integrated health care delivery systems, and medical groups actively working toward systems of coordinated care. The IPPS provides a nationwide forum to give voice to and advocate for issues that impact physicians in practice settings who advance physician-led integrated care.

In 2019, AMA sections implemented a strategic planning framework that is uniform across the sections. All sections have the three common foundational objectives as follows: develop and activate impactful policy on issues of relevance to section constituencies; cultivate the next generation of physician leaders and hone the leadership skills of established leaders; and equip section leaders with resources and opportunities to tell the section story and recruit peers to AMA sections. In support of these foundational objectives, IPPS adopted the following objectives that are unique to the section: 1) strengthen awareness of the IPPS (to constituents both internal and external to the AMA) as the expert on physician-led integrated care; and 2) advance collective expertise to promote physician-led coordinated care and how it is operationalized.

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In order to maintain its role as the voice for physician-led integrated health care whose members have experience leading such health care systems, the section seeks to constitute the IPPS Governing Council (GC) mostly with executive-level physicians and also sustain diversity among its leadership including gender, ethnic, geographic and practice setting diversity. The IPPS aspires to continue growing its membership and sustain a majority of new members who are executive-level or high-ranking physicians in their organizations; works to continually advance the effectiveness of its members within the AMA's policymaking process; seeks to advance the delivery model of physician-led integrated care by showcasing IPPS members at AMA live or virtual programs, and other AMA media; proactively seeks ways to advance IPPS members for placement in advisory roles or committees; and promotes the delivery model of physician-led integrated care.

Priority issues/concerns currently being addressed by IPPS include employer-driven innovations in health care; new payment models around value-based care, risk contracts, and Medicare payment policies; health system consolidation and the impact on physician-led integrated systems; and social determinants of health and quality measurement.

CLRPD Assessment: The IPPS is the sole component group that focuses on issues concerning integrated physician practices and physician-led coordinated health care. The section provides a direct and ongoing relationship between the AMA and this cohort of physicians.

Criterion 2: Consistency - Objectives and activities of the group are consistent with those of the AMA. Activities make good use of available resources and are not duplicative.

The IPPS works closely with the AMA membership team to feature the section as an important part of the benefits package for large health systems and to help achieve the AMA's strategic membership objectives. An example of this approach is the leadership of IPPS in the development of the AMA's Integrated Care Consortium (ICC), which allows participation of physician executives from AMA member groups and focuses on recruiting large health systems into the AMA Health System Program that offers partners unique resources to improve outcomes, elevate recognition and drive value. The IPPS GC meets in conjunction with the ICC during the Annual Meeting of the HOD to help ICC members understand the opportunities for amplifying their voice and advancing their interests through the IPPS and HOD. In 2019, 100% of ICC attendees attended the IPPS meeting.

The IPPS works closely with the AMA's Professional Satisfaction and Practice Sustainability (PS2) unit. Some of those efforts include frequent partnering in the development of IPPS educational programs and featuring PS2 staff as speakers or leaders of IPPS roundtable discussions. The efforts have proved symbiotic in helping PS2 gain important insights from the IPPS as well as helping the IPPS understand and offer input into the AMA's work in the quality arena. Additionally, the IPPS has assisted the AMA's Improving Health Outcomes (IHO) efforts by inviting staff from that area to meet with IPPS GC members to obtain updates on IHO initiatives. As a result, several IPPS member organizations have rolled out IHO programs on hypertension and diabetes within their systems.

The IPPS has worked to develop policy in the HOD including advancing resolutions and offering input on council and board reports while they are still in development. At the November 2020 Special Meeting, the HOD adopted recommendations in BOT Report 6, "Covenants Not to Compete," which relates to restrictive covenants that the IPPS has particular interest in. The IPPS GC had reviewed the draft report, shared its position on the issue and found the report to be fair

and balanced. The IPPS has reached out to staff and members of councils on other occasions to discuss upcoming various issues.

CLRPD Assessment: The IPPS works with a variety of groups to help support the work of the AMA related to health system reform and physician-led integrated care. Participation in the IPPS serves as a key member benefit for physician groups considering AMA group membership. Additionally, the section has selected areas of focus that align closely with the AMA's strategic direction and has sought opportunities for collaboration on cross-cutting issues and programs. IPPS has been doubling its efforts to ensure that the section's activities and foci aptly address the criteria.

Criterion 3: Appropriateness - The structure of the group will be consistent with its objectives and activities.

The IPPS includes two levels of membership as defined in the AMA Bylaws: Associate with full privileges, and Affiliate with limited privileges. The IPPS Credentials Committee reviews all applications for Associate and Affiliate membership and makes a recommendation as to whether an applicant's organization meets the criteria established by the section for Associate or Affiliate membership.

The IPPS GC found that some existing members of the section whose systems had merged or been acquired no longer met the IPPS criteria, even though their organizations remained committed to physician leadership, and had physicians in high executive positions. Therefore, in 2018, the IPPS GC sought to strike a balance between establishing a high threshold for physician leadership while at the same time not excluding organizations that were committed to physician leadership.

The new membership criteria ultimately approved by the AMA Board of Trustees are as follows:

Associate Members. Associate Members are members of the AMA who are in physician-led, integrated health care organizations, which coordinate patient care across specialties and among physicians who share common records and clinical care processes. An organization must meet 7 characteristics of physician-led, integrated health care organizations in order to qualify its physician members as Associate Members. Associate Members must demonstrate that their organizations have physicians in defined leadership roles at high levels in the organization, with meaningful decision authority and/or input regarding strategic, quality and operational issues, as well as a defined communication channel to the organization's governing body.

Affiliate Members. Affiliate Members are members of the AMA who practice in organizations moving toward physician-led integrated health care that do not yet satisfy the characteristics of organizations eligible to qualify their physicians as Associate Members, but that meet at least one of the required characteristics for Associate Members. Affiliate Members shall be non-voting members of the Section.

The new criteria around physician leadership have made it possible for more health systems to qualify for membership and contribute to IPPS. Section members can serve on the IPPS GC; attend and be a featured speaker at Assembly Meetings; lead a roundtable discussion at live meetings; share their expertise and network with peers during IPPS meetings; submit a resolution to the section and participate in select advocacy efforts; and serve on a variety of IPPS committees including Policy Development Committee, Tellers Committee, and Credentials Committee.

CLRPD Assessment: The structure of the IPPS allows members to participate in the deliberations and pursue the objectives of the section, including opportunities for between-meeting engagement.

The IPPS GC developed a strategic framework to enhance the section's focus and impact of future efforts. In its 2020 letter of application, the IPPS noted that the section will endeavor to increase efforts of diversity among its leadership. CLRPD members will evaluate any progress on this goal with its next evaluation in five years.

Criterion 4: Representation Threshold - Members of the formal group would be based on identifiable segments of the physician population and AMA membership. A substantial number of members would be represented by this formal group. At minimum, this group would be able to represent 1,000 AMA members. It is important to note this threshold will not be used to determine representation, as each new section will be allocated only one delegate and one alternate delegate in the AMA HOD.

The IPPS has approximately 40 active health care systems whose representatives reliably attend the IPPS meetings. There are physicians of 20 additional health care systems who have completed certification forms and attended an IPPS meeting but are not active members of the section.

The IPPS has current data on the number of physicians in the organizations that partner with the AMA Health System Program. Those health systems alone represent 21,263 physician members. Outside of the Health System Partners, it has not been feasible to track data on the number of physicians in health systems in IPPS. The biggest barrier to that data collection has been the steady pace of health system mergers/acquisitions. Regarding potential IPPS membership among the general population, it is challenging to identify the universe of physician-led integrated systems. In the absence of hard data that identify how many organizations are physician-led and how many physicians are in those organizations, the number of AMA members eligible for representation in IPPS is unknown; however, that number exceeds 1,000 physician members.

During the November 2020 Special Meeting of the HOD, IPPS welcomed new members from: multiple Permanente systems across the country; Atlantic Health, New Jersey; Hattiesburg Clinic, Mississippi; Ochsner Health, Louisiana; University of Iowa Hospitals and Clinics, Iowa; and Henry Ford Health System, Michigan.

CLRPD Assessment: The IPPS estimates that 21,263 physician members are represented through their health systems, which exceeds the minimum threshold of 1,000 AMA members. Further, the total potential representation in the IPPS encompasses a significant number of AMA members.

Criterion 5: Stability - The group has a demonstrated history of continuity. This segment can demonstrate an ongoing and viable group of physicians, who will be represented by this section. Both the segment and the AMA will benefit from an increased voice within the policymaking body.

Attendance at IPPS meetings is typically higher at the Annual Meetings, which holds true across the sections. At the IPPS Annual Meetings, 50-75 people attend and 40-50 physicians attend the Interim Meetings. The primary section communication vehicle is a monthly newsletter that keeps members updated on all IPPS activities. That communication is sent primarily to IPPS members and boasts an open rate of 30% (AMA email benchmark is approximately 20%).

Outreach to potential members who have not signed up to receive the newsletter has been more challenging. To build membership, the IPPS seeks to reach out to physician executives in physician-led integrated systems. However, a list of those physicians and their contact information does not exist. In the absence of a targeted email list, the two most effective methods of growing the section have been peer-to-peer outreach and recruitment of members of the ICC. Since its

formation in 2018, the ICC has been the most successful method of attracting physician executives to IPPS meetings and activities. At the last meeting of the ICC in 2019, all ICC attendees attended the IPPS meeting on the following day.

CLRPD Assessment: Since its inception, the IPPS has taken numerous steps to align its structure with the policymaking activities of the AMA and increase its membership. The AMA and physicians from physician-led integrated practices benefit from having a distinct voice of the IPPS in the HOD.

Criterion 6: Accessibility - Provides opportunity for members of the constituency, who are otherwise underrepresented, to introduce issues of concern and to be able to participate in the policymaking process within the HOD.

The IPPS Policy Development Committee meets periodically to discuss issues relevant to the section and consider drafting specific resolutions. Any interested member can serve on the committee. Any items of interest are included in an IPPS GC Report, which is considered by the Assembly at the meeting.

Prior to every IPPS meeting, the IPPS newsletter includes a link to the IPPS website that hosts a policy primer video and information on how to submit a resolution. Once resolutions are submitted, the IPPS online forum is open for section members and nonmembers to comment on IPPS resolutions and to highlight issues of interest included in the HOD handbook.

The IPPS GC takes an active role in the process of reviewing HOD business. With each passing meeting, the IPPS GC and Assembly become more skilled in their understanding of the HOD and how to advance policies of interest.

At section meetings, attendees are invited to comment on any of the items in the IPPS GC Report, as well as raise items of interest from the HOD not included in the report. During the discussion, if it is unclear where the attendees stand on an issue, the Chair calls for a vote. The IPPS develops consensus on HOD business through the IPPS online forum, the IPPS GC's initial review of the HOD handbook, development of an IPPS Report, and discussions and voting at IPPS meetings.

CLRPD Assessment: The IPPS provides numerous opportunities for members of the constituency who are otherwise underrepresented to introduce issues of concern and to be able to participate in the HOD policymaking process.

CONCLUSION

The CLRPD has determined that the IPPS meets all required criteria; therefore, it is appropriate to renew the delineated section status of the IPPS.

RECOMMENDATION

The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Integrated Physician Practice Section through 2026 with the next review no later than the 2026 Interim Meeting and that the remainder of this report be filed. (Directive to Take Action)

Fiscal Note: Less than $500 to update policy database.

REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON THE COMPENSATION OF THE OFFICERS

Compensation Committee Report, N-21

Subject: Report of the House of Delegates Committee on the Compensation of the Officers

Presented by: Steven Tolber, MD, Chair

Referred to: Reference Committee F

This report by the committee at the November 2021 Special Meeting of the House of Delegates presents two recommendations. It also documents the compensation paid to Officers for the period July 1, 2020 thru June 30, 2021 and includes the 2020 calendar year IRS reported taxable value of benefits, perquisites, services, and in-kind payments for all Officers.

BACKGROUND

At the 1998 Interim Meeting, the House of Delegates (HOD) established a House Committee on Trustee Compensation, currently named the Committee on Compensation of the Officers, (the "Committee"). The Officers are defined in the American Medical Association's (AMA) Constitution and Bylaws. (Note: under changes to the Constitution previously approved by the HOD, Article V refers simply to "Officer," which includes all 21 members of the Board among whom are the President, President-Elect, Immediate Past President, Secretary, Speaker of the HOD and Vice Speaker of the HOD, collectively referred to in this report as Officers.) The composition, appointment, tenure, vacancy process and reporting requirements for the Committee are covered under the AMA Bylaws. Bylaws 2.13.4.5 provides:

> The Committee shall present an annual report to the House of Delegates recommending the level of total compensation for the Officers for the following year. The recommendations of the report may be adopted, not adopted, or referred back to the Committee, and may be amended for clarification only with the concurrence of the Committee.

At A-00, the Committee and the Board jointly adopted the American Compensation Association's definition of total compensation which was added to the Glossary of the AMA Constitution and Bylaws. Total compensation is defined as the complete reward/recognition package awarded to an individual for work performance, including: (a) all forms of money or cash compensation; (b) benefits; (c) perquisites; (d) services; and (e) in-kind payments.

Since the inception of this Committee, its reports document the process the Committee follows to ensure that current or recommended Officer compensation is based on sound, fair, cost-effective compensation practices as derived from research and use of independent external consultants, expert in Board compensation. Reports beginning in December 2002 documented the principles the Committee followed in creating its recommendations for Officer compensation.

At A-08, the HOD approved changes that simplified compensation practices with increased transparency and consistency. At A-10, Reference Committee F requested that this Committee recommend that the HOD affirm a codification of the current compensation principle, which

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occurred at I-10. At that time, the HOD affirmed that this Committee has and will continue to base its recommendations for Officer compensation on the principle of the value of work performed, consistent with IRS guidelines and best practices recommended by the Committee's external independent consultant, who is expert in Board compensation.

At A-11, the HOD approved the alignment of Medical Student and Resident Officer compensation with that of all other Officers (excluding Presidents and Chair) because these positions perform comparable work.

Immediately following A-11, the Committee retained Mr. Don Delves, founder of the Delves Group, to update his 2007 research by providing the Committee with comprehensive advice and counsel on Officer compensation. The updated compensation structure was presented and approved by the HOD at I-11 with an effective date of July 1, 2012.

The Committee's I-13 report recommended and the HOD approved the Committee's recommendation to provide a travel allowance for each President to be used for upgrades because of the significant volume of travel representing our AMA.

At I-16, based on results of a comprehensive compensation review conducted by Ms. Becky Glantz Huddleston, an expert in Board Compensation with Willis Towers Watson, the HOD approved the Committee's recommendation of modest increases to the Governance Honorarium and Per Diems for Officer Compensation, excluding the Presidents and Chair, effective July 1, 2017. At A-17 the HOD approved modifying the Governance Honorarium and Per Diem definition so that Internal Representation, greater than eleven days, receives a per diem.

At A-18, based on comprehensive review of Board leadership compensation, the HOD approved the Committee's recommendation to increase the President, President-elect, Immediate Past-President, Chair, and Chair-elect honoraria by 4% effective July 1, 2018.

At A-18 and A-19, the House approved the Committee's recommendation to provide a Health Insurance Stipend to President(s) who are under Medicare eligible age when the President(s) and his/her covered dependents, not Medicare eligible, lose the President's employer provided health insurance during his/her term as President. Should the President(s) become Medicare eligible while in office, he/she received an adjusted Stipend to provide insurance coverage to his/her dependents not Medicare eligible.

The Committee's I-19 report recommended and the HOD approved the Committee's recommendation to increase the Governance Honorarium and Per Diem for Officers, excluding Presidents and Chair, by approximately 3% each effective July 1, 2020.

CASH COMPENSATION SUMMARY

The cash compensation of the Officers shown in the following table will not be the same as compensation reported annually on the AMA's IRS Form 990s because Form 990s are based on a calendar year. The total cash compensation in the summary is compensation for the days these officers spent away from home on AMA business approved by the Board Chair. The total cash compensation in the summary includes work as defined by the Governance Honorarium, Per Diem for Representation and Telephone Per Diem for External Representation. Detailed definitions are in the Appendix.

1 The summary covers July 1, 2020 to June 30, 2021.

AMA Officers	Position	Total Compensation	Total Days
David H Aizuss, MD	Officer	$ 67,700	39
Grayson W Armstrong, MD, MPH	Resident/Fellow Physician Officer	$ 67,000	36.5
Susan R Bailey, MD	President	$ 290,160	72
Madelyn E. Butler, MD	Officer	-	2
Willarda V Edwards, MD, MBA	Officer	$ 71,200	38
Lisa Bohman Egbert, MD	Vice Speaker, House of Delegates	$ 142,600	97.5
Jesse M Ehrenfeld, MD, MPH	Immediate Past Chair	$ 101,300	67
Scott Ferguson, MD	Officer	$ 71,200	43.5
Sandra Adamson Fryhofer, MD	Secretary	$ 112,500	72
Gerald E Harmon, MD	President-Elect	$ 284,960	54
Patrice A Harris, MD, MA	Immediate Past President	$ 284,960	74
Drayton Charles Harvey	Officer	-	2
Pratistha Koirala, MD	Officer	-	2
Russ Kridel, MD	Chair	$ 280,280	44.5
Ilse R Levin, DO, MPH & TM	Officer	$ 67,000	36
Thomas J Madejski, MD	Officer	$ 74,000	42
Mario E Motta, MD	Officer	$ 74,000	35.5
Bobby Mukkamala, MD	Chair-Elect	$ 207,480	42
Blake Elizabeth Murphy	Medical Student Officer	$ 67,000	37.5
Harris Pastides, PhD, MPH	Public Member Officer	$ 67,000	36
Jack Resneck, Jr, MD	Officer	$ 77,500	49.5
Bruce A Scott, MD	Speaker, House of Delegates	$ 126,450	91.5
Michael Suk, MD, JD, MPH, MBA	Officer	$ 78,200	42.5
Willie Underwood, III, MD, MSc, MPH	Officer	$ 71,200	37.5

2 President, President-Elect, Immediate Past President, and Chair
3 In 2020 – 2021, each of these positions received an annual Governance Honorarium which was
4 paid in monthly increments. These four positions spent a total of 244.5 days on approved
5 Assignment and Travel, or 61.1days each on average.
6
7 Chair-Elect
8 This position received a Governance Honorarium of approximately 75% of the Governance
9 Honorarium provided to the Chair.
10
11 All other Officers
12 All other Officers received cash compensation, which included a Governance Honorarium of
13 $67,000 paid in monthly installments. The remaining cash compensation is for Assignment and
14 Travel Days that are approved by the Board Chair to externally represent the AMA and for Internal
15 Representation days above 11. These days were compensated at a per diem rate of $1,400. *Note:*
16 The Speaker and Vice Speaker had higher compensation than normal given how much extra time
17 they devoted to planning the virtual special meetings of the House.

Assignment and Travel Days
The total Assignment and Travel Days for all Officers (excluding the President, President-Elect, Immediate Past President and Chair) were 849.5.

EXPENSES

Total expenses paid for period, July 1, 2020 – June 30, 2021, $45,390, without use of upgrades for Presidents' travel per the approved Presidential Upgrade Allowance of $2,500 per position per term.

BENEFITS, PERQUISITES, SERVICES, AND IN-KIND PAYMENTS

Officers are able to request benefits, perquisites, services, and in-kind payments, as defined in the "AMA Board of Trustees Standing Rules on Travel Expenses." These non-taxable business expense items are provided to assist the Officers in performing their duties.

- AMA standard laptop computer or iPad
- iPhone
- American Express card (for AMA business use)
- Combination fax/printer/scanner
- An annual membership to the airline club of choice offered each year during the Board member's tenure
- Personalized AMA stationary, business cards, and biographical data for official use

Additionally, all Officers are eligible for $305,000 term life insurance and are covered under the AMA's $500,000 travel accident policy and $10,000 individual policy for medical costs arising out of any accident while traveling on official business for the AMA. Life insurance premiums paid by the AMA are reported as taxable income. Also, travel assistance is available to all Officers when traveling more than 100 miles from home or internationally.

Secretarial support, other than that provided by the AMA's Board office, is available up to defined annual limits as follows: President, during the Presidential year, $15,000, and $5,000 each for the President-Elect, Chair, Chair-Elect, and Immediate Past President per year. Secretarial expenses incurred by other Officers in conjunction with their official duties are paid up to $750 per year per Officer. This is reported as taxable income.

As our Officers begin to travel more on behalf of our AMA, back-up care for child(ren) or adult family member(s) could be a concern. To alleviate that concern, Officers will be eligible to participate in a service provided to AMA employees by Care@Work through Care.com. This service offers referral services at no cost and back-up care for children and adults up to 10 days a calendar year at a subsidized rate. If a Board member uses back-up care, it will be reported to the IRS as taxable income.

Calendar year taxable life insurance and taxable secretarial fee reported to the IRS totaled $43,068 and $38,500 respectively for 2020. An additional $15,125 was paid to third parties for secretarial services during 2020.

FINDINGS

The Cash Compensation Summary, travel expenses, and the suspension of tracking telephonic representation since all meetings were conducted virtually reflect the impact of the Coronavirus on the Officers in representing our AMA. Effective March 17, 2020 all travel ceased, and all in-person meetings were canceled or moved to a virtual format. Our AMA leadership quickly pivoted to continue representing the AMA, both internally and externally, in a completely virtual environment. This pivot, while appearing seamless, required significant flexibility and behind-the-scenes planning of our Officers. As you know, both our Annual and Interim Meetings were suspended.

The President, President-Elect, and Immediate Past President, along with all other Officers, have traveled to represent the AMA while continuing to represent the AMA in podcasts, on Facebook, Zoom, Microsoft Teams and other media to advocate on behalf of physicians and patients. Travel is not without risks and to minimize the risk during this health emergency, this Committee recommends an increase from $2500 to $5000 to the travel upgrade allowance for President, President-Elect, and Immediate Past-President. The Committee also recommends that to minimize the risk to all other Officers, an upgrade allowance of $1250 be piloted between November 17, 2021 thru April 17, 2022. Use of the upgrade allowance for Officers will comport with the current definition in the travel policy and the Board travel and expense standing rules. At A-22 the Committee will report on the use of the upgrade allowance during the pilot.

This Committee commends and thanks our Officers for their representation of the AMA.

RECOMMENDATIONS

1. That there be no changes to the Officers' compensation for the period beginning July 1, 2021 through June 30, 2022. (Directive to Take Action)

2. That the travel policy and the Board travel and expense standing rules be amended by addition, shown with underscores as follows:

<u>Transportation</u>

a. <u>Air</u>: AMA policy on reimbursement for domestic air travel for members of the Board is that the AMA will reimburse for coach fare only. The Presidents (President, Immediate Past President and President Elect) will each have access to an individual <u>$5,000</u> term allowance (July 1 to June 30) <u>and during the pilot, all other Officers will each have access to $1,250 (pilot extends from November 15, 2021 to April 15, 2022)</u> to use for upgrades as each deems appropriate, typically when traveling on an airline with non-preferred status. The unused portion of the allowance is not subject to carry forward or use by any other Officer and remains the property of the AMA. In rare instances it is recognized that short notice assignments may require up to first class travel because of the lack of availability of coach seating, and this will be authorized when necessary by the Board Chair, prior to travel. Business Class airfare is authorized for foreign travel on AMA business. (Also see Rule IV--Invitations, B—Foreign, for policy on foreign travel). (Directive to Take Action)

3. That the remainder of the report be filed.

Fiscal Note: Estimated cost for July 1, 2021 – June 30, is a maximum of $37,500 if all Presidents and Officers use the allowance.

APPENDIX

POSITION	**GOVERNANCE HONORARIUM**
President	$290,160
Immediate Past President	$284,960
President-Elect	$284,960
Chair	$280,280
Chair-Elect	$207,480
Officers	$67,000

Definition of Governance Honorarium Effective July 1, 2017:

The purpose of this payment is to compensate Officers for all Chair-assigned internal AMA work and related travel. This payment is intended to cover all currently scheduled Board meetings, special Board or Board Committee meetings, task forces, subcommittees, Board orientation, development and media training, Board calls, sections, councils, or other internal representation meetings or calls, and any associated review or preparatory work, and all travel days related to all meetings as noted up to eleven (11) Internal Representation days.

Definition of Per Diem for Representation effective July 1, 2017:

The purpose of this payment is to compensate for Board Chair-assigned representation day(s) and related travel. Representation is either external to the AMA, or for participation in a group or organization with which the AMA has a key role in creating/partnering/facilitating, achievement of the respective organization goals such as the AMA Foundation, PCPI, etc. or for Internal Representation days above eleven (11). The Board Chair may also approve a per diem for special circumstances that cannot be anticipated such as weather-related travel delays. Per Diem for Chair-assigned representation and related travel is $1,400 per day.

Definition of Telephone Per Diem for External Representation effective July 1, 2017:

Officers, excluding the Board Chair and the President(s) who are assigned as the AMA representative to outside groups as one of their specific Board assignments or assigned Internal Representation days above eleven (11), receive a per diem for teleconference meetings when the total of all teleconference meetings of 30 minutes or longer during a calendar day equal 2 or more hours. Payment for those meetings would require approval of the Chair of the Board. The amount of the Telephonic Per Diem will be ½ of the full Per Diem which is $700.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 601
(N-21)

Introduced by: Senior Physicians Section

Subject: "Virtual Water Cooler" for our AMA

Referred to: Reference Committee F

Whereas, 42% of physicians in all specialties report experiencing burnout, and 71% of physicians experiencing burnout report that it is having a strong or moderately negative impact on their lives. (Medscape 2021 survey of 12K physicians); and

Whereas, All physicians have experienced increasing isolation during the Covid-19 pandemic, and professional isolation is associated with increased levels of burnout; and

Whereas, Professional burnout is often associated with thoughts of leaving the profession, and when unmitigated can predispose to errors, anxiety, and other negative consequences; and

Whereas, Most physicians do not readily share feelings or professional concerns with others; nonetheless, women physicians prefer to share such sensitive issues with colleagues, and younger male physicians may likewise be willing to do so; and

Whereas, The majority of women physicians report having no mentor, and the same is likely true for young men, and possibly especially for physicians and trainees who are members of minoritized or marginalized groups; and

Whereas, Social supports are critically important to increasing survival from many serious illnesses, and to developing a more objective outlook on most aspects of life for many people; and

Whereas, Collegial advice and mentoring are associated with enhanced productivity, career satisfaction, longevity and success in every field in which it has been studied; and

Whereas, An invaluable benefit to members in a professional association is the potential ability to contact other members for advice upon occasion; and

Whereas, There is no ready mechanism for AMA members who are not active at a leadership level to identify or contact electronically or even to know which members might be willing to provide collegial advice or support from time to time; and

Whereas, Telephonic and (especially) asynchronous electronic communications have removed barriers to communication across geographic regions; and

Whereas, The AMA-SPS has over 60,000 members, all of whom have lived professional and lifetime experience, and some percentage of whom might be willing to mentor other members if asked, and if a mutually convenient mechanism exists, and

1 Whereas, Many sections and ambassadors have already voiced an interest in pursuing some
2 type of mentoring program for our AMA; therefore be it
3
4 RESOLVED, That our American Medical Association explore options facilitating the ability of
5 members to identify and directly contact other members who are interested in participating in
6 informal inter-member mentoring, in order that self-selected members may readily enter into
7 collegial communications with one another; and shall report back such options to the House of
8 Delegates within 12 months. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

The lack of mentoring affects many physicians, and has a disproportionate impact on younger physicians who are most likely to be suffering as a result of interference by Covid-19 with acquisition of training, or assimilation of acquired skills into practice. Physicians and trainees from underrepresented and disadvantaged backgrounds are even more impacted, and therefore most likely to need/benefit from mentoring. Losses in physician satisfaction, workforce productivity or continuing participation in the profession has a major adverse effect upon all physicians, and ultimately, all patients.

AMA and especially SPS has a wealth of members who are willing and able to provide mentoring or advice to younger members if approached, and many senior members have expressed dismay at not being able to more directly assist younger members to navigate their healthful and joyous pursuit of our calling. There may be mentoring proposals in the pipeline. Prior proposals may have been too complex to be successful. AMA has as yet no mechanism whereby members can identify and informally contact other members who are available and willing to advise, or self-identify their availability and interest in helping other members to deal with common concerns. The proposed action is likely to have meaningful impact, but may require new policy or modification of existing policy to implement. An AMA resolution is an appropriate avenue to address this issue.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 602
(N-21)

Introduced by: Medical Student Section

Subject: Mitigating Environmental Contributors to Disease and Sustainability of AMA National Meetings

Referred to: Reference Committee F

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1 Whereas, Environmental health is defined as the science and practice of preventing the direct
2 and indirect adverse effects of hazardous agents on health and wellbeing[1,2]; and
3
4 Whereas, A 2018 report by the World Health Organization (WHO) on the burden of disease
5 from environmental risks estimated that approximately thirteen million deaths worldwide could
6 be attributed to preventable environmental factors and 24% of global deaths were due to
7 modifiable environmental factors[3]; and
8
9 Whereas, Environmental justice is defined as the principle that all people and communities
10 regardless of race, color, national origin, or income, are entitled to equal protection by
11 environmental and public health laws and regulations, while environmental injustice describes
12 environmental laws, regulations and policies that overly affect a group of people resulting in
13 greater exposure to environmental hazards[4]; and
14
15 Whereas, Environmental racism refers to a type of environmental injustice in which the racial
16 and ethnic contexts of environmental regulations and policies, exposures, support structures,
17 and health outcomes cause inequitable environmental hazards for some racial groups[5,6]; and
18
19 Whereas, Low-income and minoritized communities are burdened by environmental injustice in
20 that they reside in areas with higher environmental exposures, reduced preventive measures,
21 and limited medical intervention, further exacerbating health outcome disparities[7-11]; and
22
23 Whereas, The enactment of exclusionary housing policies, including zoning ordinances,
24 restrictive covenants, blockbusting, steering, and redlining, purposefully created racial
25 segregation, exposed Black communities to environmental pollutants and targeting for
26 construction of toxin-releasing facilities, isolated them from essential health resources such as
27 healthy food options, hospitals, and green spaces, and permitted health inequities to
28 concentrate in disadvantaged low-income neighborhoods[12-16]; and
29
30 Whereas, The environmental justice and fair housing collaboration between the Environmental
31 Protection Agency (EPA) and U.S. Department of Housing and Urban Development (HUD)
32 remains inadequate due to insufficient action to provide non-discriminatory and affordable
33 housing units in locations without risk of environmental health exposures[17]; and
34
35 Whereas, A combination of inequitable land-use policies, lack of environmental regulation and
36 enforcement, and market forces in petrochemical and heavy metal industries have contributed
37 to the perpetuation of poverty and worse health outcomes in minoritized populations[18]; and

Whereas, Proximity to and exposure to hazards from the oil and gas, plastics, animal production, chemical manufacturing, endocrine-disrupting chemicals, and metal industries have been strongly linked to at least one of the following: neural tube defects, preterm birth, low-birth weight, diffuse interstitial lung fibrosis, chronic bronchitis, asthma exacerbation, diabetes, hypertension secondary to chronic inflammation, pneumonia, reduced child cognition from heavy metal exposure, neurologic diseases, cancers, hyperlipidemia, and thyroid disease[19-28]; and

Whereas, Closures of industrial sites and reductions in pollution have been linked to improved fertility and reduced preterm births and respiratory hospitalizations[29-31]; and

Whereas, Recent natural disasters such as hurricanes, the over 1,500 oil spills from the Dakota Access Pipeline and the Keystone Pipeline in the last decade alone, the Texas freeze, and states' responses to these natural disasters perpetuate environmental injustice by disproportionately affecting predominantly minoritized and low-income communities[32-37]; and

Whereas, The health of American Indian tribes depends on essential natural resources that have either been depleted and/or contaminated by mining and oil corporations, leading to adverse health outcomes[38-41]; and

Whereas, Government agencies have failed to act on current policy and integrate current environmental science research or expertise into ongoing environmental regulations and public health initiatives, resulting in continued and amplified environmental hazards and failing to protect people, especially in Black and American Indian communities, from known and predictable environmental health dangers[42-49]; and

Whereas, Climate change represents an important tenet of environmental health that can significantly impact public and community health[50]; and

Whereas, The United States healthcare system alone is responsible for 10% of national greenhouse gas emissions and, if it were its own country, it would be the 13th largest producer of greenhouse gas emissions in the world[50,51]; and

Whereas, Extreme weather and climate events have significantly increased healthcare spending in the United States, with $14 billion in additional spending through 760,000 additional patient encounters and 1,689 premature deaths between 2000 and 2009[52-53]; and

Whereas, The Intergovernmental Panel on Climate Change (IPCC) has determined it is possible to avoid warming past 1.5°C above pre-industrial levels by 2100 if extreme measures are taken to curtail anthropogenic emissions[54]; and

Whereas, If global warming exceeds 1.5°C, the estimated global effects include 92,207 additional heat-related deaths per year by 2030, 350 million more humans exposed to severe heat by 2050, and 31 to 69 million humans exposed to flooding from sea level rise by 2100[54]; and

Whereas, Compared to no action, limiting global warming to less than 1.5°C would result in ~50% lower annual health-related costs and prevention of ~50% of infectious disease cases in the United States by 2100[52,53]; and

Whereas, The IPCC has estimated that limiting global warming to 1.5°C would require "global net human-caused emissions of carbon dioxide to fall by about 45 percent from 2010 levels by 2030, and reach net zero by approximately 2050"[54]; and

Whereas, IPCC defines net zero emissions as a state where anthropogenic emissions of greenhouse gasses (GHG) are balanced by anthropogenic removals of GHG over a specific time period[52]; and

Whereas, Setting emissions targets is an essential part of carbon abatement, and many non-profit organizations, large corporations, and countries have committed to carbon neutrality for their business operations by a date certain in order to improve their business efficiencies and to foster the development of carbon neutral practices[55-57;] and

Whereas, Multiple organizations in the healthcare industry have committed to becoming carbon neutral on or before 2030, including Harvard Medical School and its affiliated hospitals, all University of California campus and medical centers, the Cleveland Clinic, and Kaiser-Permanante[58-61]; and

Whereas, Other professional organizations, including the Association of Energy Services Professionals, and International Federation of Medical Students' Associations have committed to making their conferences carbon neutral[62,63]; and

Whereas, Our AMA has set discrete benchmark dates for achieving goals in other settings, including child blood lead levels (H-60.924), accreditation of health care service providers in jails (D-430.997), and disaggregation of demographic data (H-350.954); and

Whereas, Our AMA recognizes that racism, in all its forms, is an urgent public health threat, and has pledged to work to combat the adverse health effects of racism (H-65.952); and

Whereas, Our AMA has substantial policy recognizing the impacts of climate change, committing to sustainable business operations, emphasizing the importance of physician leadership regarding climate change, encouraging the study of environmental causes of disease, and encouraging other stakeholders in healthcare to practice environmental responsibility, but has no explicit emissions goal and no way to account for progress towards environmental sustainability (H-135.938, H-135.923, G-630.100, D-135.997, H-135.973); therefore be it

RESOLVED, That our American Medical Association amend Policy D-135.997, "Research into the Environmental Contributors to Disease," by addition and deletion to read as follows:

> ~~Research into the~~ Environmental Contributors to Disease and Advocating for Environmental Justice D-135.997
> Our AMA will (1) advocate for greater public and private funding for research into the environmental causes of disease, and urge the National Academy of Sciences to undertake an authoritative analysis of environmental causes of disease; (2) ask the steering committee of the Medicine and Public Health Initiative Coalition to consider environmental contributors to disease and environmental racism as ~~a~~ priority public health issues; (3) encourage federal, state, and local agencies to address and remediate environmental injustice, environmental racism, and all other environmental conditions that are adversely impacting health, especially in marginalized communities; and (4) lobby Congress to support ongoing initiatives that include reproductive health outcomes and development particularly in minority populations in Environmental Protection Agency Environmental Justice policies (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA commit to reaching net zero emissions for its business operations by 2030, and remain net zero or net negative, as defined by a carbon neutral certifying organization (Directive to Take Action); and be it further

RESOLVED, That our AMA create educational programs for and encourage the United States healthcare system, including but not limited to hospitals, clinics, ambulatory care centers, and healthcare professionals, to decrease emissions to half of 2010 levels by 2030 and become net zero by 2050, and remain net zero or negative, as defined by a carbon neutral certifying organization (Directive to Take Action); and be it further

RESOLVED, That our AMA report the progress on implementing this resolution at each annual meeting hereafter. (Directive to Take Action)

Fiscal Note: Implementation of this resolution would be a multi-million dollar undertaking.

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

The damaging effects of climate change are clear and urgent. Life-threatening natural disasters continue to displace people, limit access to resources, and cause devastating loss of life are increasing in frequency. Further, these effects are felt most profoundly by marginalized communities, especially communities of color. These populations are much more likely to live near power plants, uranium mines, concrete plants, and many other dangerous industrial sources of emissions, which lead to high rates of exposures to heavy metals, particulate matter, endocrine-disrupting chemicals, and radiation, which have all been strongly linked to lung diseases, neurological disorders, cancers, and numerous other pathologies. This is not by choice, but due to environmental racism, as companies and governments have deliberately targeted marginalized communities for construction of these industrial sites, knowing these communities do not have the resources or political power to fight back. Our AMA has an obligation to take a strong stance against this discrimination and to protect these vulnerable communities. Further, we as an organization have a strong obligation to halt our own contributions to the harms of environmental injustice. The AMA should join other large professional and healthcare institutions in committing to reducing the emissions of its business meetings to net zero by 2030, so that our meetings are no longer contributing to environmental harm to vulnerable communities and to all. This resolution is vital and time-sensitive, and it gives the AMA concrete actions to take to address the urgent crisis of climate change and environmental racism.

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RELEVANT AMA POLICY

Global Climate Change and Human Health H-135.938

Our AMA:
(1) Supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor.
(2) Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.
(3) (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.
(4) Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.
(5) Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort.
(6) Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.
CSAPH Rep. 3, I-08; Reaffirmation A-14; Reaffirmed: CSAPH Rep. 04, A-19; Reaffirmation: I-19

Global Climate Change - The “Greenhouse Effect” H-135.977

Our AMA
(1) Endorses the need for additional research on atmospheric monitoring and climate simulation models as a means of reducing some of the present uncertainties in climate forecasting;

(2) Urges Congress to adopt a comprehensive, integrated natural resource and energy utilization policy that will promote more efficient fuel use and energy production;
(3) Endorses increased recognition of the importance of nuclear energy's role in the production of electricity;
(4) Encourages research and development programs for improving the utilization efficiency and reducing the pollution of fossil fuels; and
(5) Encourages humanitarian measures to limit the burgeoning increase in world population.
CSA Rep. E, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmation A-12; Reaffirmed in lieu of Res. 408, A-14

AMA Advocacy for Environmental Sustainability and Climate H-135.923
Our AMA:
(1) Supports initiatives to promote environmental sustainability and other efforts to halt global climate change;
(2) Will incorporate principles of environmental sustainability within its business operations; and
(3) Supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities.
Res. 924, I-16; Reaffirmation: I-19

Stewardship of the Environment H-135.973
The AMA:
(1) Encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients;
(2) Encourages the medical community to cooperate in reducing or recycling waste;
(3) Encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner;
(4) Supports enhancing the role of physicians and other scientists in environmental education;
(5) Endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention;
(6) Encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes;
(7) Encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation;
(8) Encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment;
(9) Encourages educational programs for worldwide family planning and control of population growth;
(10) Encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy;
(11) Encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation.
(12) Encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment;
(13) Encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives;
(14) Encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues;
(15) Will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS);
(16) Encourages expanded funding for environmental research by the federal government; and
(17) Encourages family planning through national and international support.

CSA Rep. G, I-89; Amended: CLRPD Rep. D, I-92; Amended: CSA Rep. 8, A-03; Reaffirmed in lieu of Res. 417, A-04; Reaffirmed in lieu of Res. 402, A-10; Reaffirmation I-16

AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies H-135.921
(1) Our AMA will choose for its commercial relationships, when fiscally responsible, vendors, suppliers, and corporations that have demonstrated environmental sustainability practices that seek to minimize their fossil fuels consumption.
(2) Our AMA will support efforts of physicians and other health professional associations to proceed with divestment, including to create policy analyses, support continuing medical education, and to inform our patients, the public, legislators, and government policy makers.
BOT Rep. 34, A-18

Support of Clean Air and Reduction in Power Plant Emissions H-135.949
Our AMA supports:
(1) Federal legislation and regulations that meaningfully reduce the following four major power plant emissions: mercury, carbon dioxide, sulfur dioxide and nitrogen oxide; and
(2) Efforts to limit carbon dioxide emissions through the reduction of the burning of coal in the nation's power generating plants, efforts to improve the efficiency of power plants and continued development, promotion, and widespread implementation of alternative renewable energy sources in lieu of carbon-based fossil fuels
Res. 429, A-03; Reaffirmation I-07; Reaffirmed in lieu of Res. 526, A-12; Reaffirmed: Res. 421, A-14; Modified: Res. 506, A-15; Modified: Res. 908, I-17

EPA and Greenhouse Gas Regulation H-135.934
(1) Our AMA supports the Environmental Protection Agency's authority to promulgate rules to regulate and control greenhouse gas emissions in the United States.
(2) Our AMA: (a) strongly supports evidence-based environmental statutes and regulations intended to regulate air and water pollution and to reduce greenhouse gas emissions; and (b) will advocate that environmental health regulations should only be modified or rescinded with scientific justification.
Res. 925, I-10; Reaffirmed in lieu of Res. 526, A-12; Reaffirmed: Res. 421, A-14; Appended: Res. 523, A-17

Conservation, Recycling, and Other “Green” Initiatives G-630.100
AMA policy on conservation and recycling include the following:
(1) Our AMA directs its offices to implement conservation-minded practices whenever feasible and to continue to participate in "green" initiatives.
(2) It is the policy of our AMA to use recycled paper whenever reasonable for its in-house printed matter and publications, including JAMA, and materials used by the House of Delegates, and that AMA printed material using recycled paper should be labeled as such.
(3) During meetings of the American Medical Association House of Delegates, our AMA Sections, and all other AMA meetings, recycling bins, where and when feasible, for white (and where possible colored) paper will be made prominently available to participants.
CCB/CLRPD Rep. 3, A-12; Modified: Speakers Rep., A-15

Disaggregation of Demographic Data Within Ethnic Groups H-350.954
(1) Our AMA supports the disaggregation of demographic data regarding: (a) Asian-Americans and Pacific Islanders in order to reveal the within-group disparities that exist in health outcomes and representation in medicine; and (b) ethnic groups in order to reveal the within-group disparities that exist in health outcomes and representation in medicine.

(2) Our AMA: (a) will advocate for restoration of webpages on the Asian American and Pacific Islander (AAPI) initiative (similar to those from prior administrations) that specifically address disaggregation of health outcomes related to AAPI data; (b) supports the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in health outcomes; (c) supports the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in representation in medicine, including but not limited to leadership positions in academic medicine; and (d) will report back at the 2020 Annual Meeting on the issue of disaggregation of data regarding AAPIs (and other ethnic subgroups) with regards to the ethnic subgroup disparities that exist in health outcomes and representation in medicine, including leadership positions in academic medicine.
Res. 001, I-17; Appended: Res. 403, A-19

Reducing Lead Poisoning H-60.924
(1) Our AMA: (a) supports regulations and policies designed to protect young children from exposure to lead; (b) urges the Centers for Disease Control and Prevention to give priority to examining the current weight of scientific evidence regarding the range of adverse health effects associated with blood lead concentrations below the current "level of concern" in order to provide appropriate guidance for physicians and public health policy, and encourage the identification of exposure pathways for children who have low blood lead concentrations, as well as effective and innovative strategies to reduce overall childhood lead exposure; (c) encourages physicians and public health departments to screen children based on current recommendations and guidelines and to report all children with elevated blood levels to the appropriate health department in their state or community in order to fully assess the burden of lead exposure in children. In some cases this will be done by the physician, and in other communities by the laboratories; (d) promotes community awareness of the hazard of lead-based paints; and (e) urges paint removal product manufacturers to print precautions about the removal of lead paint to be included with their products where and when sold.
(2) Our AMA will call on the United States government to establish national goals to: (a) ensure that no child has a blood lead level >5 µg/dL (>50 ppb) by 2021, and (b) eliminate lead exposures to pregnant women and children, so that by 2030, no child would have a blood lead level >1 µg/dL (10 ppb).
(3) Our AMA will call on the United States government in all its agencies to pursue the following strategies to achieve these goals: (a) adopt health-based standards and action levels for lead that rely on the most up-to-date scientific knowledge to prevent and reduce human exposure to lead, and assure prompt implementation of the strongest available measures to protect pregnant women and children from lead toxicity and neurodevelopmental impairment; (b) identify and remediate current and potential new sources of lead exposure (in dust, air, soil, water and consumer products) to protect children before they are exposed; (c) continue targeted screening of children to identify those who already have elevated blood lead levels for case management, as well as educational and other services; (d) eliminate new sources of lead introduced or released into the environment, which may entail banning or phasing out all remaining uses of lead in products (aviation gas, cosmetics, wheel weights, industrial paints, batteries, lubricants, and other sources), and the export of products containing lead, and setting more protective limits on emissions from battery recyclers and other sources of lead emissions; (e) provide a dedicated funding stream to enhance the resources available to identify and eliminate sources of lead exposure, and provide educational, social and clinical services to mitigate the harms of lead toxicity, particularly to protect and improve the lives of children in communities that are disproportionately exposed to lead; and (f) establish an independent expert advisory committee to develop a long-term national strategy, including recommendations for funding and implementation, to achieve the national goal of eliminating lead toxicity in pregnant women and children, defined as blood lead levels above 1 µg/dL (10 ppb).

(4) Our AMA supports requiring an environmental assessment of dwellings, residential buildings, or child care facilities following the notification that a child occupant or frequent inhabitant has a confirmed elevated blood lead level, to determine the potential source of lead poisoning, including testing the water supply.
CCB/CLRPD Rep. 3, A-14; Appended: Res. 926, I-16; Appended: Res. 412, A-17

Pollution Control and Environmental Health H-135.996
Our AMA supports (1) efforts to alert the American people to health hazards of environmental pollution and the need for research and control measures in this area; and (2) its present activities in pollution control and improvement of environmental health.
Sub. Res. 40, A-70, Reaffirmed: CLRPD, Rep. C, A-89, Reaffirmed: Sunset Report, A-00Modified: CSAPH Rep. 1, A-10, Reaffirmed: CSAPH Rep. 01, A-20

Research into the Environmental Contributors to Disease D-135.997
Our AMA will (1) advocate for greater public and private funding for research into the environmental causes of disease, and urge the National Academy of Sciences to undertake an authoritative analysis of environmental causes of disease; (2) ask the steering committee of the Medicine and Public Health Initiative Coalition to consider environmental contributors to disease as a priority public health issue; and (3) lobby Congress to support ongoing initiatives that include reproductive health outcomes and development particularly in minority populations in Environmental Protection Agency Environmental Justice policies.
Res. 402, A-03 Appended: Res. 927, I-11 Reaffirmed in lieu of: Res. 505, A-19

Environmental Health Programs H-135.969
Our AMA (1) urges the physicians of the United States to respond to the challenge for a clean environment individually and through professional groups by becoming the spokespersons for environmental stewardship; and (2) encourages state and county medical societies to establish active environmental health committees.
Res. 124, A-90 Reaffirmed: Sunset Report, I-00 Reaffirmed: CSAPH Rep. 1, A-10 Reaffirmed: CSAPH Rep. 01, A-20

Federal Programs H-135.999
The AMA believes that the problem of air pollution is best minimized through the cooperative and coordinated efforts of government, industry and the public. Current progress in the control of air pollution can be attributed primarily to such cooperative undertakings. The Association further believes that the federal government should play a significant role in these continuing efforts. This may be done by federal grants for (1) the development of research activity and (2) the encouragement of local programs for the prevention and control of air pollutants.
BOT Rep. M, A-63 Reaffirmed: CLRPD Rep. C, A-88, Reaffirmed: Sunset Report, I-98 Reaffirmation, I-06 Reaffirmation, I-07 Reaffirmed: CSAPH Rep. 01, A-17

Racism as a Public Health Threat H-65.952
1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA will identify a set of current, best practices for healthcare institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, providers, international medical graduates, and populations.

4. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
5. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
6. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.
Res. 5, I-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 603
(N-21)

Introduced by: Medical Student Section

Subject: Abolishment of the Resolution Committee

Referred to: Reference Committee F

Whereas, One of the central tenets of parliamentary procedure, including the parliamentary authority of the AMA, The American Institute of Parliamentarians Standard Code of Parliamentary Procedure (B-11.1, G-600.054), is to protect the rights of minority viewpoints[1]; and

Whereas, Robust, “actualized” democracies, defined as “"the ideal in which all citizens share full, informed, equal participation in decision making", have been touted as superior forms of government with the best potential for freedom of expression and action, protection of human rights, and transparent and responsive governance[2-6]; and

Whereas, A 2019 study published in *The Lancet* found that “when enforced by free and fair elections, democracies are more likely than autocracies to lead to health gains for causes of mortality (eg, cardiovascular diseases and transport injuries) that have not been heavily targeted by foreign aid and require health-care delivery”[7]; and

Whereas, The United Nations recognizes the value of democracy and “promotes democratic governance as a set of values and principles that should be followed for greater participation, equality, security and human development”[8]; and

Whereas, At the Annual 2002 House of Delegates, Board of Trustees Report 23 was adopted, which included a recommendation establishing a Resolution Committee “to ensure that the emphasis of the Interim Meeting is placed on advocacy and legislation”[9]; and

Whereas, At the Annual 2003 House of Delegates, Council on Constitution and Bylaws Report 2 was adopted, which codified the establishment of the Resolution Committee in the AMA Bylaws “to formally reflect the defined scope of the Interim Meeting”, as currently reflected in B-2.13.3[10]; and

Whereas, The number of resolutions not considered based on Resolutions Committee recommendations for the past eight Interim Meetings has never exceeded ten- 2 at the Interim 2019 House of Delegates, 8 at the Interim 2018 House of Delegates, 4 at the Interim 2017 House of Delegates, 3 at the Interim 2016 House of Delegates, 9 at the Interim 2015 House of Delegates, 8 at the Interim 2014 House of Delegates, 10 at the Interim 2013 House of Delegates, and 9 at the Interim 2012 House of Delegates[11], indicating that it has not been substantively constraining the business of the House of Delegates; and

Whereas, In reflecting upon the formation of the Resolution Committee, the Report of the Executive Vice President at the Interim 2002 House of Delegates noted that "while I appreciate the need to streamline, I strongly believe that everything the AMA does is advocacy," and elaborated that "this includes activities you might not initially view as advocacy, like the public stands we take on issues of public health and science"[12]; and

Whereas, At the Annual 2011 AMA Medical Student Section Assembly, in recognition of the advocacy-only criterion in place for Interim Houses of Delegates and in an attempt to limit the number of resolutions adopted by the MSS that would not be considered by the House of Delegates at the subsequent Interim Meeting, the MSS IOPs were amended by Governing Council Report A such that "Resolutions will be considered at the AMA-MSS Annual Meeting only if they pertain to AMA advocacy efforts or address issues of an urgent nature that must be addressed before the following Interim Meeting"[13-14]; and

Whereas, At the Annual 2011 Medical Student Section Assembly, the MSS IOPs were amended to establish a Resolution Committee mirroring that of the AMA House of Delegates, with the delineated purpose of "determin[ing] fairly if resolutions meet the definition of advocacy and urgency set forth by the AMA HOD"[13-14]; and

Whereas, At the Annual 2013 Medical Student Section Assembly, just two years after the institution of the MSS Resolution Committee, Governing Council Report A recommended the abolition of the "advocacy-only rule" and hence the MSS Resolution Committee, recognizing the "unintended consequences" of the rule, and this report was adopted[14-15]; and

Whereas, At the Annual 2013 Medical Student Section Assembly, Governing Council Report A observed that "the HOD criteria used for qualifying resolutions as advocacy vs. non-advocacy proved difficult to clearly quantify, causing the MSS Assembly to disagree with the recommendations of the resolution committee regarding multiple resolutions at the 2012 Annual Meeting" in justifying the elimination of the MSS Resolution Committee[14-15]; and

Whereas, AMA policy G-600.060, "Introducing Business to the AMA House,'" reaffirms the AMA's commitment to democracy and directs the AMA to "continue to safeguard the democratic process in our AMA House of Delegates and ensure that individual delegates are not barred from submitting a resolution directly to the House of Delegates"; and

Whereas, AMA policy G-640.020, "Political Action Committees and Contributions," "opposes legislative initiatives that improperly limit individual and collective participation in the democratic process"; and

Whereas, The AMA Bylaws dictate that "Reports, recommendations, resolutions or other new business presented prior to the recess of the opening session of the House of Delegates shall be referred to an appropriate reference committee for hearings and report, subject to acceptance as business of the House of Delegates" (B-2.11.4), to allow for full consideration of each item; therefore be it

RESOLVED, That our American Medical Association abolish the Resolution Committee by amending the AMA Bylaws B-2.13.3, "Resolution Committee," as follows by deletion:

~~**Resolution Committee. B-2.13.3**~~

~~The Resolution Committee is responsible for reviewing resolutions submitted for consideration at an Interim Meeting and determining compliance of the resolutions with the purpose of the Interim Meeting.~~

~~2.13.3.1 Appointment. The Speaker shall appoint the members of the committee. Membership on this committee is restricted to delegates.~~

~~2.13.3.2 Size. The committee shall consist of a maximum of 31 members.~~

~~2.13.3.3 Term. The committee shall serve only during the meeting at which it is appointed, unless otherwise directed by the House of Delegates.~~

~~2.13.3.4 Quorum. A majority of the members of the committee shall constitute a quorum.~~

~~2.13.3.5 Meetings. The committee shall not be required to hold meetings. Action may be taken by written or electronic communications.~~

~~2.13.3.6 Procedure. A resolution shall be accepted for consideration at an Interim Meeting upon majority vote of committee members voting. The Speaker shall only vote in the case of a tie. If a resolution is not accepted, it may be submitted for consideration at the next Annual Meeting in accordance with the procedure in Bylaw 2.11.3.1.~~

~~2.13.3.7 Report. The committee shall report to the Speaker. A report of the committee shall be presented to the House of Delegates at the call of the Speaker.~~ (Modify Bylaws)

Fiscal Note: Minimal - less than $1,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Our AMA's governance affects the enactment of every policy we have. One of the central tenets of parliamentary procedure, including the parliamentary authority of the AMA, The American Institute of Parliamentarians Standard Code of Parliamentary Procedure (B-11.1, G-600.054), is to protect the rights of minority viewpoints. Democratic governance has been associated with freedom of expression and action, protection of human rights, transparent and responsive governance, and even health gains. At the Annual 2002 House of Delegates, Board of Trustees Report 23 was adopted, which included a recommendation establishing a Resolution Committee "to ensure that the emphasis of the Interim Meeting is placed on advocacy and legislation," although leadership at the time expressed misgivings, stating that "everything the AMA does is advocacy." The number of resolutions not considered based on Resolutions Committee recommendations, prior to the first Special Meetings Resolution Committee of the November 2020 meeting, for the past eight Interim Meetings has never exceeded ten. AMA policy G-600.060, "Introducing Business to the AMA House", reaffirms the AMA's commitment to democracy and directs the AMA to "continue to safeguard the democratic process in our AMA House of Delegates and ensure that individual delegates are not barred from submitting a resolution directly to the House of Delegates." With many changes occurring throughout the pandemic, we believe it is vital to improve and safeguard democracy within our AMA. We consider this issue of highest import and priority.

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14. American Medical Association Medical Student Section. Summary of Actions: Medical Student Section Items of Business, 1999-2020. https://www.ama-assn.org/system/files/2020-11/mss-summary-of-actions-archive.pdf. Published November 2020. Accessed March 18, 2021.
15. Governing Council Report A, American Medical Association Medical Student Section Annual 2013 Assembly.

RELEVANT AMA POLICY

Resolution Committee. B-2.13.3

The Resolution Committee is responsible for reviewing resolutions submitted for consideration at an Interim Meeting and determining compliance of the resolutions with the purpose of the Interim Meeting.
2.13.3.1 Appointment. The Speaker shall appoint the members of the committee. Membership on this committee is restricted to delegates.
2.13.3.2 Size. The committee shall consist of a maximum of 31 members.
2.13.3.3 Term. The committee shall serve only during the meeting at which it is appointed, unless otherwise directed by the House of Delegates.
2.13.3.4 Quorum. A majority of the members of the committee shall constitute a quorum.
2.13.3.5 Meetings. The committee shall not be required to hold meetings. Action may be taken by written or electronic communications.
2.13.3.6 Procedure. A resolution shall be accepted for consideration at an Interim Meeting upon majority vote of committee members voting. The Speaker shall only vote in the case of a tie. If a resolution is not accepted, it may be submitted for consideration at the next Annual Meeting in accordance with the procedure in Bylaw 2.11.3.1.
2.13.3.7 Report. The committee shall report to the Speaker. A report of the committee shall be presented to the House of Delegates at the call of the Speaker.

Parliamentary Procedure. B-11.1

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

Procedures of the House of Delegates G-600.054

1. Our AMA reaffirms The American Institute of Parliamentarians Standard Code of Parliamentary Procedure as our parliamentary authority, including the use of the motion to table

and the motion to adopt in-lieu-of, and treat amendments by substitution as first-order amendments.
2. The rules and procedures of the House of Delegates will be amended as follows:
A. The motion to table a report or resolution that has not yet been referred to a reference committee is not permitted and will be ruled out of order.
B. A new motion is added to the House of Delegates Reference Manual, Object to Consideration. If a Delegate objects to consideration of an item of business by our HOD, the correct motion is to Object to Consideration. The motion cannot interrupt a speaker, requires a second, cannot be amended, takes precedence over all subsidiary motions and cannot be renewed. The motion requires a 3/4 vote for passage. Debate is restricted to why the item should not be considered.
3. The procedures of our House of Delegates distinguish between a motion to refer, which is equivalent to a motion to refer for report, and a motion to refer for decision and that the motion to refer for decision be one step higher in precedence.
4. The procedures of our House of Delegates specify that both sides must have been heard before a motion to close debate is in order and that absent an express reference to "all pending matters" the motion applies only to the matter under debate.
5. The procedures of our House of Delegates clarify that adjournment of any House of Delegates meeting finalizes all matters considered at that meeting, meaning that items from one meeting are not subject to a motion to recall from committee, a motion to reconsider or any other motion at a succeeding meeting.
6. The Council on Constitution and Bylaws, in consultation with the speakers, will review the House of Delegates Reference Manual and revise it accordingly.
Report of the Speakers: Rep. 02, A-16; Modified: CCB Rep. 01, A-17

Introducing Business to the AMA House G-600.060
AMA policy on introducing business to our AMA House includes the following:
1. Delegates submitting resolutions have a responsibility to review the Resolution checklist and verify that the resolution is in compliance. The Resolution checklist shall be distributed to all delegates and organizations in the HOD prior to each meeting, as well as be posted on the HOD website.
2. An Information Statement can be used to bring an issue to the awareness of the HOD or the public, draw attention to existing policy for purposes of emphasis, or simply make a statement. Such items will be included in the section of the HOD Handbook for informational items and include appropriate attribution but will not go through the reference committee process, be voted on in the HOD or be incorporated into the Proceedings. If an information statement is extracted, however, it will be managed by the Speaker in an appropriate manner, which may include a simple editorial correction up to and including withdrawal of the information statement.
3. Required information on the budget will be provided to the HOD at a time and format more relevant to the AMA budget process.
4. At the time the resolution is submitted, delegates introducing an item of business for consideration of the House of Delegates must declare any commercial or financial conflict of interest they have as individuals and any such conflict of interest must be noted on the resolution at the time of its distribution.
5. The submission of resolutions calling for similar action to what is already existing AMA policy is discouraged. Organizations represented in the House of Delegates are responsible to search for alternative ways to obtain AMA action on established AMA policy, especially by communicating with the Executive Vice President. The EVP will submit a report to the House detailing the items of business received from organizations represented in the House which he or she considers significant or when requested to do so by the organization, and the actions taken in response to such contacts.

6. Our AMA will continue to safeguard the democratic process in our AMA House of Delegates and ensure that individual delegates are not barred from submitting a resolution directly to the House of Delegates.
7. Our AMA encourages organizations and Sections of the House of Delegates to exercise restraint in submitting items on the day preceding the opening of the House.
8. Resolutions will be placed on the Reaffirmation Consent Calendar when they are identical or substantially identical to existing AMA policy. For resolutions placed on the Reaffirmation Consent Calendar, the pertinent existing policy will be clearly identified by reference to the Policy Database identification number. When practical, the Reaffirmation Consent Calendar should also include a listing of the actions that have been taken on the current AMA policies that are equivalent to the resolutions listed. For resolutions on the Reaffirmation Consent Calendar which are not extracted, the existing, pertinent AMA policy will be deemed to be reaffirmed in lieu of the submitted resolution which resets the sunset clock for ten years.
9. Updates on referred resolutions are included in the chart entitled "Implementation of Resolutions," which is made available to the House.
Sub. Res. 120, A-84; BOT Rep. D and CLRPD Rep. C, I-91; CLRPD Rep. 3 - I-94; CLRPD Rep. 5, I-95; Res. 614, and Special Advisory Committee to the Speaker of the House of Delegates, I-99; Res. 604, I-00; Consolidated: CLRPD Rep. 3, I-01; Modified: CLRPD Rep. 2, A-03; Reaffirmed: BOT Rep. 19, A-04; CC&B Rep. 3, I-08; Modified: CCB/CLRPD Rep. 1, A-12

Meetings of the House of Delegates. B-2.12
2.12.1 Regular Meetings of the House of Delegates. The House of Delegates shall meet twice annually, at an Annual Meeting and an Interim Meeting.
2.12.1.1 Business of Interim Meeting. The business of an Interim Meeting shall be focused on advocacy and legislation. Resolutions pertaining to ethics, and opinions and reports of the Council on Ethical and Judicial Affairs, may also be considered at an Interim Meeting. Other business requiring action prior to the following Annual Meeting may also be considered at an Interim Meeting. In addition, any other business may be considered at an Interim Meeting by majority vote of delegates present and voting.
2.12.2 Special Meetings of the House of Delegates. Special Meetings of the House of Delegates shall be called by the Speaker on written or electronic request by one-third of the members of the House of Delegates, or on request of a majority of the Board of Trustees. When a special meeting is called, the Executive Vice President of the AMA shall mail a notice to the last known address of each member of the House of Delegates at least 20 days before the special meeting is to be held. The notice shall specify the time and place of meeting and the purpose for which it is called, and the House of Delegates shall consider no business except that for which the meeting is called.
2.12.3 Locations. The House of Delegates shall meet in cities selected by the Board of Trustees.
2.12.3.1 Invitation from Constituent Association. A constituent association desiring a meeting within its borders shall submit an invitation in writing, together with significant data, to the Board of Trustees. The dates and the city selected may be changed by action of the Board of Trustees at any time, but not later than 60 days prior to the dates selected for that meeting.
2.12.4 Meetings.
2.12.4.1 Open. The House of Delegates may meet in an open meeting to which any person may be admitted. By majority vote of delegates present and voting, an open meeting may be moved into either a closed or an executive meeting.
2.12.4.2 Closed. A closed meeting shall be restricted to members of the AMA, and to employees of the AMA and of organizations represented in the House of Delegates.
2.12.4.3 Executive. An executive meeting shall be limited to the members of the House of Delegates and to such employees of the AMA necessary for its functioning.

Political Action Committees and Contributions G-640.020
Our AMA: (1) Believes that better-informed and more active citizens will result in better legislators, better government, and better health care;
(2) Encourages AMA members to participate personally in the campaign of their choice and strongly supports physician/family leadership in the campaign process;
(3) Opposes legislative initiatives that improperly limit individual and collective participation in the democratic process;
(4) Supports AMPAC's policy to adhere to a no Rigid Litmus Test policy in its assessment and support of political candidates;
(5) Encourages AMPAC to continue to consider the legislative agenda of our AMA and the recommendations of state medical PACs in its decisions;
(6) Urges members of the House to reaffirm their commitment to the growth of AMPAC and the state medical PACs;
(7) Will continue to work through its constituent societies to achieve a 100 percent rate of contribution to AMPAC by members; and
(8) Calls upon all candidates for public office to refuse contributions from tobacco companies and their subsidiaries.
Policy Timeline
BOT Rep. II and Res. 119, I-83; Res. 175, A-88; Reaffirmed: Sunset Report, I-98; Sub. Res. 610, A-99; Res. 610, I-00; Consolidated: CLRPD Rep. 3, I-01; Modified: CC&B Rep. 2, A-11; Reaffirmed: Joint CCB/CLRPD Rep. 1, A-21

Guiding Principles for House Elections G-610.021
The following principles provide guidance on how House elections should be conducted and how the selection of AMA leaders should occur:
(1) AMA delegates should: (a) avail themselves of all available background information about candidates for elected positions in the AMA; (b) determine which candidates are best qualified to help the AMA achieve its mission; and (c) make independent decisions about which candidates to vote for.
(2) Any electioneering practices that distort the democratic processes of House elections, such as vote trading for the purpose of supporting candidates, are unacceptable.
(3) Candidates for elected positions should comply with the requirements and the spirit of House of Delegates policy on campaigning and campaign spending.
(4) Candidates and their sponsoring organizations should exercise restraint in campaign spending. Federation organizations should establish clear and detailed guidelines on the appropriate level of resources that should be allocated to the political campaigns of their members for AMA leadership positions.
(5) Incumbency should not assure the re-election of an individual to an AMA leadership position.
(6) Service in any AMA leadership position should not assure ascendancy to another leadership position.
CLRPD Rep. 4, I-01; Reaffirmed: CC&B Rep. 2, A-11; Modified: Speakers Rep, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 604
(N-21)

Introduced by: Texas, Florida, New Jersey, California, Washington

Subject: The Critical Role of Physicians in the COVID-19 Pandemic

Referred to: Reference Committee F

Whereas, Globally there have been more than 4.7 million deaths due to COVID -19; and

Whereas, The U.S. has experienced more than 700,000 of these deaths, 3,600 of which are health care worker deaths; and

Whereas, Studies show health care workers were more than three times as likely as the general public to become infected with the coronavirus; and

Whereas, Physicians perform unique and critical roles in taking care of patients with COVID- 19; and

Whereas, Physicians remain on the front lines, often risking their own physical and emotional health, to care for so many critically ill patients in hospitals throughout the country; and

Whereas, The median age of death due to COVID-19 for health care workers is only 57, compared with the median age of 78 in the general population; and

Whereas, COVID-19 infections can cause long-term health conditions not yet fully understood; and

Whereas, Principle seven of the American Medical Association's Principles of Medical Ethics states, "A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health"; and

Whereas, Principle nine of AMA's Principles of Medical Ethics states, "A physician shall, while caring for a patient, regard responsibility to the patient as paramount"; therefore be it

RESOLVED, That our American Medical Association create and fund a public awareness campaign recognizing the vital role physicians have played in the COVID-19 pandemic and highlighting:

- Physician leadership in public health messaging, raising awareness of vital prevention and treatment recommendations;
- Medical treatment of patients during this time of great crisis;
- Remembrance of physicians who died of COVID-19 while rendering care during the pandemic;
- The personal sacrifices borne by physicians related to the pandemic; and
- The emotional stress from the long hours spent taking care of patients (Directive to Take Action); and be it further

1 RESOLVED, That the target audience for this campaign be physicians, legislators, and the
2 public (Directive to Take Action); and be it further
3
4 RESOLVED, That the purpose of this campaign is to thank our physician colleagues and make
5 government officials and the public aware of the personal costs physicians have shouldered
6 during this crisis. (Directive to Take Action)

Fiscal Note: Projects underway and included in current budget.

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

Perhaps there is no greater priority at this meeting than to recognize the work of physicians who have responded so admirably during the COVID-19 pandemic. This top priority resolution effects every physician today given the devastating consequences of COVID-19 for patients in not only for critical care but virtually every other practice setting, specialty, and location throughout the U.S. Our AMA is the best organization to lead this important campaign recognizing the hard work of physicians and this effort would have an immediate and positive impact for physicians who are treating the masses of patients, saving lives, and being leaders on the front lines against this public health crisis. Physicians responded, despite risking their own illness and at a cost that left little time for family support and self-care. Physicians also suffered their own economic losses during the crisis which have yet to be recovered. For being the heroes of COVID-19, but also recognizing the long-term consequences of bearing this burden during this crisis, this resolution asks the AMA to create a recognition campaign for recognizing physicians in their incredible work over these past 20 difficult months.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 605
(N-21)

Introduced by: Texas

Subject: Formalization of the Resolution Committee as a Standing Committee of the American Medical Association House of Delegates

Referred to: Reference Committee F

Whereas, The speakers of the American Medical Association House of Delegates appointed a Resolution Committee for the 2020 and 2021 Special Meetings of AMA with the purpose of prioritizing proposed resolutions to the House based on certain criteria to determine each resolution's urgency and appropriateness as business of the AMA House, recognizing the limitations of conducting House business in a virtual format during the COVID-19 pandemic; and

Whereas, The Resolution Committee is expected to streamline and increase the efficiency of the business of the House; and

Whereas, The Resolutions Committee should reflect the priorities of the House of Delegates, and the appointment of its membership should be diverse and represent the broad base of the House; therefore be it

RESOLVED, That the Bylaws of the American Medical Association be amended to provide that the Resolution Committee be responsible for reviewing resolutions submitted for consideration at all meetings of the American Medical Association House of Delegates and determining compliance of the resolutions with the purpose of any such meeting (Modify Bylaws); and be it further

RESOLVED, That the membership of the Resolution Committee reflect the diversity of the House of Delegates (New HOD Policy); and be it further

RESOLVED, That the Resolution Committee rules be written to produce impartial results and appropriate changes be made to the AMA Bylaws as necessary to empower the committee. (Modify Bylaws)

Fiscal Note: Minimal - less than $1,000

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

The volume of business of the AMA House of Delegates has grown to the level that many reference committees have gone way over their timelines. During Special Meetings of the House, the concept of the Resolution Committee to prioritize business has been done for 3 meetings and has worked well. In order to continue this practice at the annual and interim meetings, a change in the bylaws and rules is necessary.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 606
(N-21)

Introduced by: Texas

Subject: Increasing the Effectiveness of Online Reference Committee Testimony

Referred to: Reference Committee F

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1 Whereas, Written online testimony has been used by the American Medical Association for
2 many years; and
3
4 Whereas, Recently some in-person reference committees meetings have lasted considerably
5 longer than their allotted time; and
6
7 Whereas, Shifting the majority of the testimony to the online written form would provide the
8 reference committee members with more verifiable testimony and shorten the length of the
9 in-person reference committee while allowing all opinions to be heard; and
10
11 Whereas, There is a perception that online testimony is not as effective as in-person testimony;
12 and
13
14 Whereas, Having a good discussion in the online testimony with the development of a
15 preliminary reference committee report would give greater credence to that testimony and may
16 serve to reduce the amount of in-person testimony; therefore be it
17
18 RESOLVED, That our American Medical Association conduct a trial of no less than two-years
19 during which all reference committees, prior to the in-person reference committee hearing,
20 produce a preliminary reference committee report based on the written online testimony
21 (Directive to Take Action); and be it further
22
23 RESOLVED, That the preliminary reference committee document become the agenda for
24 discussion at the in-person reference committee (Directive to Take Action); and be it further
25
26 RESOLVED, That after the trial period there be an evaluation to determine if this procedure
27 should continue (Directive to Take Action); and be it further
28
29 RESOLVED, That AMA pursue any bylaw changes that might be necessary to allow this trial
30 (Modify Bylaws); and be it further
31
32 RESOLVED, That the period for online testimony be no longer than 10 days.) (Directive to Take
33 Action)

Fiscal Note: Minimal

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

The volume of business of the AMA House of Delegates has grown to the level that many reference committees have gone way over their timelines. AMA has allowed on-line testimony for several years but frequently there is very limited testimony provided even on the most controversial topics. Many perceive that on-line testimony is not considered as effective as in-person testimony. The TMA used the changes outlined in this resolution in our virtual house of delegates and found it to be very effective in stimulating on-line discussion and shortening the time of the in-person reference committees.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 607
(N-21)

Introduced by: American Association of Public Health Physicians

Subject: AMA Urges Health and Life Insurers to Divest From Investments in Fossil Fuels

Referred to: Reference Committee F

Whereas, Our AMA recognizes the urgent, ongoing health threats posed to our patients by global climate change,[1,5] which on its current trajectory is likely to far exceed the health impacts of COVID19 and HIV combined; and

Whereas, Our AMA has declared "the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes"[1]; and

Whereas, In 2018, our AMA adopted policy that "AMA, AMA Foundation, and any affiliated corporations will work in a timely, incremental, and fiscally responsible manner, to the extent allowed by their legal and fiduciary duties, to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels"[2]; and

Whereas, Many health and life insurance companies followed the example of the AMA by divesting from tobacco companies because the tobacco industry's products and marketing strategies so clearly threaten human health; and

Whereas, Moody's Investors Service warned investors in 2017 that the oil and gas industry faces significant credit risks due to the world's ongoing transition away from fossil fuel[3]; and

Whereas, The oil and gas industry stock prices have been the poorest performing sector of world stock markets since 2008, a period during which the prices of most other sectors have risen dramatically; and

Whereas, The top 10 U.S. health insurers, ranked by U.S. market share and for whom there are publicly disclosed fossil fuel investment data, have invested nearly $24 billion dollars in fossil fuels companies;[4] and

Whereas, Collectively, the largest nineteen health or life insurance companies have declared investments of more than over $183 billion in the fossil fuel industry[4]; therefore be it

RESOLVED, That our American Medical Association declare that climate change is an urgent public health emergency, and calls upon all governments, organizations, and individuals to work to avert catastrophe (New HOD Policy); and be it further

RESOLVED, That our AMA urge all health and life insurance companies, including those that provide insurance for medical, dental, and long-term care, to work in a timely, incremental, and fiscally responsible manner to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels (Directive to Take Action); and be it further

RESOLVED, That our AMA send letters to the nineteen largest health or life insurance companies in the United States to inform them of AMA policies concerned with climate change and with fossil fuel divestments, and urging these companies to divest (Directive to Take Action); and be it further

RESOLVED, That our AMA report the status of AMA's implementation of our 2018 fossil fuels divestment policies (D-135.969 and H-135.921), and of this resolution, at the 2022 Interim Meeting of the House of Delegates. (Directive to Take Action)

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

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

1. Climate change is the most important public health issue facing the world in 21st Century. Given its current trajectory, the cumulative impacts of climate change are likely to exceed those of COVID-19 and HIV combined. Climate change already impacts most physicians and many patients. Since then, overwhelming evidence shows the certainty of escalating damage to the world's health, safety, and peace.

2. Each year that the world fails to take meaningful action is aggravating the health impacts of climate change. We respectfully ask that this resolution not be delayed further.

3. This resolution builds upon and references key existing AMA policies.

4. AMA's voice on climate change and health is necessary and meaningful. The resolution calls for actions that will be of negligible financial cost to the AMA.

5. Our AMA's own policies on fossil fuels divestment has set an industry standard and, as with tobacco and other public health challenges, it is proper and necessary for AMA to communicate its concerns with the insurance industry. AMA can capitalize on this proposal to make a significant, positive impact at this pivotal time

6. AMA's existing policies are referenced in the resolution. This fills a significant gap.

7. It is appropriate and necessary for AMA to ask the insurance industry to follow the lead of major health professional societies by pledging to divest of fossil fuels and to instead invest in energy efficiency and renewable energy.

References:

1. AMA Policy H-135.938 Global Climate Change and Human Health
2. AMA Policies D-135.969 & H-135.921 AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies
3. https://www.moodys.com/research/Moodys-Significant-credit-risks-arise-for-oil-and-gas-industry--PR_365728 Accessed 4.30.2021
4. https://www.psr.org/wp-content/uploads/2020/10/running-out-of-time.pdf Accessed 4.30.2021

RELEVANT AMA POLICY

Global Climate Change and Human Health H-135.938
Our AMA:
1. Supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor.
2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.
3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.
4. Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.
5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort.
6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.
Citation: CSAPH Rep. 3, I-08; Reaffirmation A-14; Reaffirmed: CSAPH Rep. 04, A-19; Reaffirmation: I-19

AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies D-135.969
Our AMA, AMA Foundation, and any affiliated corporations will work in a timely, incremental, and fiscally responsible manner, to the extent allowed by their legal and fiduciary duties, to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels.
Citation: BOT Rep. 34, A-18

AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies H-135.921
1. Our AMA will choose for its commercial relationships, when fiscally responsible, vendors, suppliers, and corporations that have demonstrated environmental sustainability practices that seek to minimize their fossil fuels consumption.
2. Our AMA will support efforts of physicians and other health professional associations to proceed with divestment, including to create policy analyses, support continuing medical education, and to inform our patients, the public, legislators, and government policy makers.
Citation: BOT Rep. 34, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 608
(N-21)

Introduced by: Resident and Fellow Section

Subject: Fulfilling Medicine's Social Contract with Humanity in the Face of the Climate Health Crisis

Referred to: Reference Committee F

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1 Whereas, The Lancet Countdown on health and climate change has warned that "a rapidly
2 changing climate has dire implications for every aspect of human life, exposing vulnerable
3 populations to extremes of weather, altering patterns of infectious disease, and compromising
4 food security, safe drinking water, and clean air"[1] earning it the title of the "greatest public health
5 challenge of the 21st century"[2]; and
6
7 Whereas, Human activities since the Industrial Revolution resulting in burning fossil fuels like
8 coal and oil have increased the concentration of atmospheric carbon dioxide levels[3] higher than
9 ever before since the evolution of homo sapiens[4]; and
10
11 Whereas, At least 250,000 additional deaths are anticipated annually between 2030 and 2050
12 from heat exposure in the elderly, diarrhea, malaria, and childhood malnutrition alone[5], without
13 factoring in the myriad of other ways that climate change acts as a health risk multiplier; and
14
15 Whereas, Despite the landmark Paris Agreement in 2016, when countries committed to limit
16 global warming to "well below 2°C," global carbon dioxide (CO2) emissions continue to rise
17 steadily[6], with no convincing or sustained abatement; and
18
19 Whereas, Humans have already caused a rise in the global average temperature of 1.2°C and
20 our changing climate is already producing considerable shifts in the underlying social and
21 environmental determinants of health at the global level[7]; and
22
23 Whereas, People and communities are differentially exposed to hazards and disproportionately
24 affected by climate-related health risks; for example, some populations might experience
25 increased climate risks due to a combination of exposure and sensitivity, such as outdoor
26 workers[8], communities disproportionately burdened by poor environmental quality[9], and some
27 communities in the rural Southeastern United States[10]; and
28
29 Whereas, Across all climate risks, children, older adults, low-income communities, some
30 communities of color, and those experiencing discrimination are disproportionately affected by
31 extreme weather and climate events, partially because they are often excluded in planning
32 processes[11]; and
33
34 Whereas, According to the latest available science, in order to limit warming to 1.5°C and
35 achieve the Paris Agreement goals would require global greenhouse gas (GHG) emissions to
36 have peaked by 2020 and be reduced to zero by around 2050[12]; thus we have a vanishing
37 window of opportunity for meaningful action; and

Whereas, Many climate change mitigation interventions have immediate local air quality benefits, among others, and thus immediate health co-benefits[13]; and

Whereas, Cutting GHG emissions "may appear to be difficult and costly, but its near-term benefits outweigh its costs in many areas[14]; and

Whereas, It is estimated that worldwide 10.2 million premature deaths annually are attributable to the fossil-fuel component of PM2.5, constituting nearly 18% of premature deaths[15]; and

Whereas, Worldwide, tobacco use causes more than seven million deaths per year[16]; and

Whereas, Our AMA has extensive policy to organize physician leadership vis a vis tobacco's public health harms[17]; and

Whereas, The Tobacco Industry and Fossil Fuel Industry business models are similar in that their products are incongruous with the interests of public health and their profit interests motivate well-funded misinformation campaigns[18]; and

Whereas, "The strategy, tactics, infrastructure, and rhetorical arguments and techniques used by fossil fuel interests to challenge the scientific evidence of climate change—including cherry picking, fake experts, and conspiracy theories—come straight out of the Tobacco Industry's playbook for delaying tobacco control"[19]; and

Whereas, Physicians are uniquely trusted messengers, with a unique responsibility to advocate politically for policies to safeguard health in the face of any public health crisis, whether the COVID-19 pandemic or the climate crisis, in order to build social will for science-based policy action; and

Whereas, Our AMA has adopted multiple policies addressing climate change (H-135.919, H-135.938, H-135.977, H-135.923, D-135.968,D-135.969, H-135.973), but these policies fall short of coordinating strategic physician advocacy leadership on the scale necessary for such a health crisis; and

Whereas, In the face of the existential threat that the climate crisis poses, the aforementioned policies have not been leveraged to fulfill our AMA's Declaration of Professional Responsibility (H-140.900) which states, "We, the members of the world community of physicians, solemnly commit ourselves to 'Medicine's Social Contract with Humanity' in order to continue to earn society's trust in the healing profession, by, among other oaths, promising that we will 'Educate the public and polity about present and future threats to the health of humanity''; and

Whereas, Our AMA has no identified longitudinal body or Center for coordinating and centralizing the Association's efforts to address climate change which the WHO calls "...the greatest threat to global health in the 21st century"'[20]; and

Whereas, Our AMA Corporate Policies on Tobacco H-500.975: resolved that (1) Our AMA: (a) continues to urge the federal government to reduce and control the use of tobacco and tobacco products; (b) supports developing an appropriate body for coordinating and centralizing the Association's efforts toward a tobacco-free society; and (c) will defend vigorously all attacks by the tobacco industry on the scientific integrity of AMA publications; therefore be it

RESOLVED, That our American Medical Association reaffirm Policy H-135.949, "Support of Clean Air and Reduction in Power Plant Emissions," (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA establish a climate crisis campaign that will distribute evidence-based information on the relationship between climate change and human health, determine high-yield advocacy and leadership opportunities for physicians, and centralize our AMA's efforts towards environmental justice and an equitable transition to a net-zero carbon society by 2050. (Directive to Take Action)

Fiscal Note: Estimated cost to implement this resolution is $2M.

Received: 10/12/21

AUTHORS STATEMENT OF PRIORITY

Our AMA has adopted policy previously regarding climate change and its effects on human health, but has not developed a comprehensive advocacy plan or center regarding climate change. With the worsening of climate change, increased action is needed by our AMA in order to remain a leader in providing evidence-based solutions, advocacy and help to the nation's physicians and our patients.

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RELEVANT AMA POLICY

Support of Clean Air and Reduction in Power Plant Emissions H-135.949
Our AMA supports (1) federal legislation and regulations that meaningfully reduce the following four major power plant emissions: mercury, carbon dioxide, sulfur dioxide and nitrogen oxide; and (2) efforts to limit carbon dioxide emissions through the reduction of the burning of coal in the nation's power generating plants, efforts to improve the efficiency of power plants and continued development, promotion, and widespread implementation of alternative renewable energy sources in lieu of carbon-based fossil fuels.
Citation: Res. 429, A-03; Reaffirmation I-07; Reaffirmed in lieu of Res. 526, A-12; Reaffirmed: Res. 421, A-14; Modified: Res. 506, A-15; Modified: Res. 908, I-17

Climate Change Education Across the Medical Education Continuum H-135.919
Our AMA: (1) supports teaching on climate change in undergraduate, graduate, and continuing medical education such that trainees and practicing physicians acquire a basic knowledge of the science of climate change, can describe the risks that climate change poses to human health, and counsel patients on how to protect themselves from the health risks posed by climate change; (2) will make available a prototype presentation and lecture notes on the intersection of climate change and health for use in undergraduate, graduate, and continuing medical education; and (3) will communicate this policy to the appropriate accrediting organizations such as the Commission on Osteopathic College Accreditation and the Liaison Committee on Medical Education.
Citation: Res. 302, A-19

Global Climate Change and Human Health H-135.938
Our AMA:
1. Supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor.
2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.
3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.
4. Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.
5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort.
6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.
Citation: CSAPH Rep. 3, I-08; Reaffirmation A-14; Reaffirmed: CSAPH Rep. 04, A-19; Reaffirmation: I-19

Global Climate Change – The "Greenhouse Effect" H-135.977
Our AMA: (1) endorses the need for additional research on atmospheric monitoring and climate simulation models as a means of reducing some of the present uncertainties in climate forecasting;
(2) urges Congress to adopt a comprehensive, integrated natural resource and energy utilization policy that will promote more efficient fuel use and energy production;
(3) endorses increased recognition of the importance of nuclear energy's role in the production of electricity;
(4) encourages research and development programs for improving the utilization efficiency and reducing the pollution of fossil fuels; and
(5) encourages humanitarian measures to limit the burgeoning increase in world population.
Citation: CSA Rep. E, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmation A-12; Reaffirmed in lieu of Res. 408, A-14

AMA Advocacy for Environmental Sustainability and Climate H-135.923
Our AMA (1) supports initiatives to promote environmental sustainability and other efforts to halt global climate change; (2) will incorporate principles of environmental sustainability within its business operations; and (3) supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities.
Citation: Res. 924, I-16; Reaffirmation: I-19

Implementing AMA Climate Change Principles Through JAMA Paper Consumption Reduction and Green Health Care Leadership D-135.968
Our AMA will continue to explore environmentally sustainable practices for *JAMA* distribution.
Citation: BOT Rep. 8, I-19

AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies D-135.969
Our AMA, AMA Foundation, and any affiliated corporations will work in a timely, incremental, and fiscally responsible manner, to the extent allowed by their legal and fiduciary duties, to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels.
Citation: BOT Rep. 34, A-18

Stewardship of the Environment H-135.973
The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from

global climate change and environmental degradation.(12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues; (15) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded funding for environmental research by the federal government; and (17) encourages family planning through national and international support.
Citation: CSA Rep. G, I-89; Amended: CLRPD Rep. D, I-92; Amended: CSA Rep. 8, A-03; Reaffirmed in lieu of Res. 417, A-04; Reaffirmed in lieu of Res. 402, A-10; Reaffirmation I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 609
(N-21)

Introduced by: California

Subject: Fulfilling Medicine's Social Contract with Humanity in the Face of the Climate Health Emergency

Referred to: Reference Committee F

Whereas, Ahead of the November 2021 UN Climate Summit known as the Conference of the Parties (COP26) where governments will further the Paris Agreement commitments, over 200 international health journal editors have made an unprecedented joint statement that "*the greatest threat to global public health is the continued failure of world leaders to keep the global temperature rise below 1·5°C*"[1] to prevent catastrophic harm to health that will be impossible to reverse; and

Whereas, The Lancet Countdown on health and climate change has warned that "A rapidly changing climate has dire implications for every aspect of human life, exposing vulnerable populations to extremes of weather, altering patterns of infectious disease, and compromising food security, safe drinking water, and clean air"[2,3] earning it the title of the "greatest public health challenge of the 21st century";[4] and

Whereas, At least 250,000 additional deaths are anticipated annually between 2030 and 2050 from heat exposure in the elderly, diarrhea, malaria, and childhood malnutrition *alone*[5], without factoring in the myriad other ways that climate change acts as a health risk multiplier; and

Whereas, It is estimated that worldwide 10.2 million premature deaths annually are attributable to the particulate matter (PM) 2.5 of planet-warming fossil-fuels, constituting nearly 18% of premature deaths[6]; and

Whereas, Burning fossil fuels and other greenhouse gas (GHG) emissions have already causeda rise in the global average temperature of 1.2°C and our changing climate is already producing considerable shifts in the underlying social and environmental determinants of health at the global level[7]; and

Whereas, Across all climate risks, children, older adults, low-income communities, outdoor workers[8] some communities of color, communities disproportionately burdened by poor environmental quality[9],[10] and those experiencing discrimination are disproportionately affected by extreme weather and climate events, partially because they are often excluded in planning processes[11]; and

Whereas, Many climate change mitigation interventions have immediate local air quality benefits-- among others-- and thus immediate health co-benefits[12] which is part of why near-term benefits outweigh climate solution costs in many areas[13]; and

Whereas, According to the latest available science, to limit warming to 1.5°C and achieve the Paris Agreement goals would require global greenhouse gas (GHG) emissions to have peaked by 2020 net zero carbon emissions by 2050 at the latest[14], UN Secretary General António

Guterres on the August 2021 IPCC report[15] said: "The report *'is a code red for humanity'* but scientists say a catastrophe can be avoided if the world acts fast, thus we are in a vanishing window of opportunity for meaningful action"; and

Whereas, Physicians are uniquely trusted messengers[16], with a unique responsibility to advocate politically for policies to safeguard health in the face of any public health crisis-- whether the COVID-19 pandemic or the need for tobacco regulation-- in order to build social will for science-based policy action, and

Whereas, Our AMA House of Delegates has adopted multiple policies addressing climate change *(H-135.919, H-135.938, H-135.977, H-135.923, D-135.968, D-135.969, H-135.973*), but these policies fall short of coordinating strategic physician advocacy leadership on the scale necessary for such a health crisis; and

Whereas, In the face of the existential threat that the climate crisis poses, these policies have not been leveraged to fulfill our AMA's *Declaration of Professional Responsibility (H-140.900)* in which '*We, the members of the world community of physicians, solemnly commit ourselves to 'Medicine's Social Contract with Humanity*' in order to continue to earn society's trust in the healing profession, by, among other oaths, promising that we will '*Educate the public and polity about present and future threats to the health of humanity*', and '*Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being*;' therefore be it

RESOLVED, That our American Medical Association declare climate change is an urgent public health emergency that threatens the health and well-being of all individuals (New HOD Policy); and be it further

RESOLVED, That our AMA support equitable policies to achieve global peaking of greenhouse gas emissions as soon as possible and to achieve a climate neutral world by mid-century in alignment with Paris Agreements (New HOD Policy); and be it further

RESOLVED, That our AMA, study our existing climate change policies and report back to the House of Delegates at the 2022 Interim Meeting with specific recommendations on how AMA will enact these policies, particularly advocacy priorities, in order to fulfill our commitments as stated in the AMA's *Declaration of Professional Responsibility (H-140.900)* in the face of the climate crisis. (Directive to Take Action)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

Climate change is an existential health care crisis that must be addressed by the AMA immediately. It impacts all physician and patients. A recent Health Affairs article states, "In a warming, unequal world, it is impossible to tend to patients' health without addressing the larger environmental and social context—just as it would be absurd to ignore a raging pandemic. Doctors are essential to reframing the climate crisis to focus on people's health." The UN Secretary General called the last climate report *"A code red for humanity."* Climate change is exposing people to extremes of weather, infectious disease, and compromising food security, safe drinking water, and clean air. It is perhaps the greatest public health challenge of the century. President Biden has listed climate change as a top priority and established the new HHS Office of Climate Change and Health Equity. The National Academy of Medicine just named the climate crisis one of their "Grand Challenges" and our AMA CEO is serving on a NAM climate task force. AMA needs additional policy to respond immediately to these government efforts and the overall climate crisis. Estimated health costs of climate change already exceed $800 billion per year with additional costs for Medicare and Medicaid. Public health, health care capacity, and funding for Medicaid and Medicare physician payments are all at-risk given our current climate trajectory. As the nation's leading physician organization, it is critical that AMA speak-out on the climate crisis and it's impact on public health now. The COVID-19 pandemic demonstrated the importance of AMA's early and active leadership on the science of public health.

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RELEVANT AMA POLICY

Climate Change Education Across the Medical Education Continuum H-135.919
Our AMA: (1) supports teaching on climate change in undergraduate, graduate, and continuing medical education such that trainees and practicing physicians acquire a basic knowledge of the science of climate change, can describe the risks that climate change poses to human health, and counsel patients on how to protect themselves from the health risks posed by climate change; (2) will make available a prototype presentation and lecture notes on the intersection of climate change and health for use in undergraduate, graduate, and continuing medical education; and (3) will communicate this policy to the appropriate accrediting organizations such as the Commission on Osteopathic College Accreditation and the Liaison Committee on Medical Education.
Citation: Res. 302, A-19

Global Climate Change and Human Health H-135.938
Our AMA:
1. Supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor.
2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.
3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.
4. Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.
5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort.
6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.
Citation: CSAPH Rep. 3, I-08; Reaffirmation A-14; Reaffirmed: CSAPH Rep. 04, A-19; Reaffirmation: I-19

Global Climate Change - The "Greenhouse Effect" H-135.977
Our AMA: (1) endorses the need for additional research on atmospheric monitoring and climate simulation models as a means of reducing some of the present uncertainties in climate forecasting; (2) urges Congress to adopt a comprehensive, integrated natural resource and energy utilization policy that will promote more efficient fuel use and energy production;
(3) endorses increased recognition of the importance of nuclear energy's role in the production of electricity; (4) encourages research and development programs for improving the utilization

efficiency and reducing the pollution of fossil fuels; and (5) encourages humanitarian measures to limit the burgeoning increase in world population.
Citation: (CSA Rep. E, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmation A-12; Reaffirmed in lieu of Res. 408, A-14)

AMA Advocacy for Environmental Sustainability and Climate H-135.923
Our AMA (1) supports initiatives to promote environmental sustainability and other efforts to halt global climate change; (2) will incorporate principles of environmental sustainability within its business operations; and (3) supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities.
Citation: Res. 924, I-16; Reaffirmation: I-19

Implementing AMA Climate Change Principles Through JAMA Paper Consumption Reduction and Green Health Care Leadership D-135.968
Our AMA will continue to explore environmentally sustainable practices for *JAMA* distribution.
Citation: BOT Rep. 8, I-19

AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies D-135.969
Our AMA, AMA Foundation, and any affiliated corporations will work in a timely, incremental, and fiscally responsible manner, to the extent allowed by their legal and fiduciary duties, to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels.
Citation: BOT Rep. 34, A-18

Stewardship of the Environment H-135.973
The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation.(12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues; (15) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded

funding for environmental research by the federal government; and (17) encourages family planning through national and international support.
Citation: CSA Rep. G, I-89; Amended: CLRPD Rep. D, I-92; Amended: CSA Rep. 8, A-03; Reaffirmed in lieu of Res. 417, A-04; Reaffirmed in lieu of Res. 402, A-10; Reaffirmation I-16

A Declaration of Professional Responsibility H-140.900
Our AMA adopts the Declaration of Professional Responsibility
DECLARATION OF PROFESSIONAL RESPONSIBILITY: MEDICINE's SOCIAL CONTRACT WITH HUMANITY
Preamble
Never in the history of human civilization has the well being of each individual been so inextricably linked to that of every other. Plagues and pandemics respect no national borders in a world of global commerce and travel. Wars and acts of terrorism enlist innocents as combatants and mark civilians as targets. Advances in medical science and genetics, while promising to do great good, may also be harnessed as agents of evil. The unprecedented scope and immediacy of these universal challenges demand concerted action and response by all.
As physicians, we are bound in our response by a common heritage of caring for the sick and the suffering. Through the centuries, individual physicians have fulfilled this obligation by applying their skills and knowledge competently, selflessly and at times heroically. Today, our profession must reaffirm its historical commitment to combat natural and man-made assaults on the health and well being of humankind. Only by acting together across geographic and ideological divides can we overcome such powerful threats. Humanity is our patient.
Declaration
We, the members of the world community of physicians, solemnly commit ourselves to: (1) Respect human life and the dignity of every individual.
(2) Refrain from supporting or committing crimes against humanity and condemn any such acts.
(3) Treat the sick and injured with competence and compassion and without prejudice.
(4) Apply our knowledge and skills when needed, though doing so may put us at risk.
(5) Protect the privacy and confidentiality of those for whom we care and breach that confidence only when keeping it would seriously threaten their health and safety or that of others.
(6) Work freely with colleagues to discover, develop, and promote advances in medicine and public health that ameliorate suffering and contribute to human well-being.
(7) Educate the public and polity about present and future threats to the health of humanity.
(8) Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being.
(9) Teach and mentor those who follow us for they are the future of our caring profession.
We make these promises solemnly, freely, and upon our personal and professional honor.
Citation: CEJA Rep. 5, I-01; Reaffirmation A-07; Reaffirmed: CEJA Rep. 04, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 610
(N-21)

Introduced by: Florida

Subject: Creation of Employed Physician Section

Referred to: Reference Committee F

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1 Whereas, The rate of employed physicians climbed steadily from January 2019 to January 2020
2 from 62.5% to 64.5% and that number continues to rise; and
3
4 Whereas, Up to 70% of physicians are employed by hospitals or corporations; and
5
6 Whereas, 48,000 physicians left independent practice for employment by hospitals, health
7 systems or corporate entities; and
8
9 Whereas, Hospital medical staffs struggle with challenges associated with employed physicians,
10 and have yet to resolve numerous challenges and conflicts that arise between the demands of
11 hospital administrators and physician patient-care responsibilities; and
12
13 Whereas, There are numerous conflicts of interest for employed medical staff leaders; and
14
15 Whereas, Many employed physicians have low trust and confidence as well as sense a lack of
16 accountability that hospital administrator's goal is to provide excellence in patient care; and
17
18 Whereas, Employed physicians are in a disadvantaged position when negotiating and re-
19 negotiating contracts; and
20
21 Whereas, Less than 150,000 practicing physicians are members of the American Medical
22 Association while employed physicians currently do not appreciate any tangible benefit from
23 joining the American Medical Association; and
24
25 Whereas, Offering a section, specifically dedicated to the challenges faced by employed
26 physicians would attract new members; therefore be it
27
28 RESOLVED, That our American Medical Association study the necessity and feasibility to
29 create a Section for Employed Physicians (Directive to Take Action); and be it further
30
31 RESOLVED, That the section would work toward determining problems associated with
32 employment; recommend solutions; and utilize necessary resources when resolving conflicts
33 and challenges between employed physicians and their employers. (Directive to Take Action)

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

Received: 10/13/21

Beckers ASC Review
US Bureau of Labor Statistics
AMA analysis shows most physicians work outside of private practice May, 5, 2021

AUTHORS STATEMENT OF PRIORITY

This is a high priority resolution as it affects the majority of physicians and is consistent with our mission. Modification of current policy and creation of new policy will have a positive impact for employed physicians and the patients they care for. The majority of physicians in the US are now employed and they are at a significant disadvantage when negotiating and renegotiating contracts and have unique challenges. In order to understand the depth and breadth of the problem the AMA should study the necessity and feasibility of a Employed physicians section which could work toward determining the problems associated with employment and recommend solutions. This new section could also drive membership with this vital segment of the physician workforce.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 611
(N-21)

Introduced by: New York

Subject: September 11th as a National Holiday

Referred to: Reference Committee F

Whereas, September 11, 2001 took over 3,000 lives in an act of terrorism against the United States of America; and

Whereas, September 11, 2021 marked the twentieth anniversary of that horrific day; and

Whereas, Thousands of responders, uniformed and civilian, employed and volunteers, served at Ground Zero, the Pentagon and Shanksville, PA, risking their lives, being exposed to debris, powdered cement, fumes, vapors, dust, and a variety of other irritants, including exposure to human remains, as well as many severe psychological stressors, and the devastation to the World Trade Center site itself; and

Whereas, There are many Americans who now live with September 11 related medical and mental health conditions as well as those whose lives were prematurely shortened because of the impact of these toxic exposures; and

Whereas, The effects of the 9/11 attack have forever altered the world in every aspect of life from mental, emotional, medical, business, security, education, etc.; and

Whereas, Every American and every individual has felt the impact from lost loved ones who were taken away too early, or from the increased security and vigilance needed to protect this country; and

Whereas, Every life lost on that day represents the freedoms for which we were attacked; and

Whereas, *Patriot Day, 9/11*, is already recognized as a day of remembrance; and

Whereas, The terror attack on US soil on September 11, 2001 should never be minimized or forgotten; and

Whereas, The United States Congress holds the authority to create a Federal Holiday according to Title V of the United States Code (5 U.S.C. 6103); therefore be it

RESOLVED, That our American Medical Association support and recognize September 11th as an annual day of observance to remember and recognize all who died and who continue to suffer health consequences from the events of 9/11, to honor first- and all responders from around the country, and to recognize and forever remind us of the unity our country experienced on 9/11/01 and the months that followed. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000
Received: 10/11/21

AUTHORS STATEMENT OF PRIORITY

This year marked the passing of twenty years since the attack on both towers of the World Trade Tower and the Pentagon, and the tragedy memorialized at Shanksville, Pennsylvania. The horror of that day remains for those who lived through it and should not be ignored by those who have not. Too many innocent people lost their lives to the worst terrorist attack on US soil and many more have died or become ill as a consequence of those events. That terrible day should be recognized annually as a day of remembrance to honor America's dead resulting from that day as well as those who lost their lives or health as a consequence of "working the pile" and those subsequent effects. The unprovoked and unprecedented 9/11 attack changed the history of the United States, its people and the world. The AMA should officially recognize, remember and memorialize that day.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 612
(N-21)

Introduced by: New York

Subject: UN International Radionuclide Therapy Day Recognition

Referred to: Reference Committee F

Whereas, The General Assembly of the United Nations advocates for proclaiming International days of recognition to highlight specific values of worldwide human interest; and

Whereas, The United Nations General Assembly documents describe the purpose of proclaiming “International Days” as follows: “International days are occasions to educate the general public on issues of concern, to mobilize political will and resources to address global problems, and to celebrate and reinforce achievements of humanity”; and

Whereas, The year marks the 80th year from the first recorded use of radioiodine therapy to treat human disease; and

Whereas, Saul Hertz, MD (1905 - 1950) discovered the medical uses of radionuclides, and his breakthrough work with radioactive iodine (RAI) created a dynamic paradigm change integrating the sciences of physics, biology, physiology and medicine; and

Whereas, Radioactive iodine (RAI) is the first and remains the Gold Standard of targeted cancer therapies; and

Whereas, In early 1941, Dr. Hertz administered the first therapeutic treatment of (Cyclotron-produced) radioactive iodine (RAI) at the Massachusetts General Hospital, which led to the first series of twenty-nine patients with hyperthyroidism being treated successfully with RAI; and

Whereas, Dr. Hertz expanded the successful use of RAI of treating hyperthyroidism and Graves‘ disease to the treatment of thyroid cancer in 1946; and

Whereas, This work generating and utilizing radioactive material for medical therapy leaves an enduring legacy, impacting countless generations of patients, numerous institutions worldwide and setting the cornerstone for the field of Nuclear Medicine, and has for all future generations, augmented and forever altered the approach to medical therapies; and

Whereas, This novel work marks the advent of what we now recognize as modern medicine, utilizing molecular medicine and the ever evolving promise of targeted molecular therapies for the treatment of human disease; and

Whereas, To appropriately recognize and honor this groundbreaking scientific and medical breakthrough on its 80th year anniversary, and to honor Dr. Saul Hertz and to remember and celebrate this extraordinary accomplishment; therefore be it

1 RESOLVED, That our American Medical Association support the efforts of the American
2 College of Nuclear Medicine to create and introduce a United Nations General Assembly
3 (UNGA) Resolution for the creation of a new International Day of recognition with the suggested
4 name of "International Radionuclide Therapy Day." (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 10/11/21

AUTHORS STATEMENT OF PRIORITY

The discovery of radionuclides and their use in medical applications cannot be extolled loud enough. The number of lives that have been saved because of this discovery are too many to count. AMA should support the efforts to declare this an International Day of recognition. The uses of radionuclide therapy continue to be expanded and discovered and have benefitted innumerable patients. An entire medical specialty has been built around this discovery and its medical use, that should be honored.

Perhaps of more overall impact, this is a chance to highlight the overall importance of the science of the Practice of Medicine, nationally and internationally.

This Resolution fits the Top Priority criteria as it is:
1. Within our AMA mission plan of facilitating education to the public about the importance of evidence-based medicine
2. Requires new policy to implement
3. No current policy exists on this topic, and it is an advantageous issue on which to have policy
4. AMA action will have a positive impact
5. AMA is most appropriate body to bring this issue forward.

Also, delaying this Resolution until June would necessarily have the negative impact of delaying the development of a UNGA Resolution for an additional year, due to UN Resolution submission schedule.

Another important consideration for urgent timing is that Barbara Hertz, the daughter of Saul Hertz, is still alive and well and we should want to get this done while she can still enjoy and celebrate this commemoration of her father's work.

A few References for interest:
Hertz B. A tribute to Dr. Saul Hertz: The discovery of the medical uses of radioiodine. *World J Nucl Med*. 2019;18(1):8-12. doi:10.4103/wjnm.WJNM_107_18
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6357704/
https://endocrinenews.endocrine.org/january-2016-thyroid-month-the-saga-of-radioiodine-therapy/
https://www.intechopen.com/books/thyroid-cancer-advances-in-diagnosis-and-therapy/dr-saul-hertz-1905-1950-discovers-the-medical-uses-of-radioactive-iodine-the-first-targeted-cancer-t
Radioactive Iodine in the Study of Thyroid Physiology. VII. The Use of Radioactive Iodine Therapy in Graves' Disease. (Dec. 1946)
http://saulhertzmd.com/home

TABLE I AN ANALYSIS OF CASES "NOT CURED" BY Ra-I + KI (TO MARCH - '46)

SERIES NO.	CASE-HOSP. NO.	BMR PRIOR TO I130	DOSAGE OF I130 and DATES OF ADMINISTRATION	BMR PRIOR TO SUB-TOTAL THYROIDECT.	POST-OP BMR	THYROID WEIGHT	HISTOLOGY	TOTAL THYROID IRRADIATION (r) 12 HR	9 DAY	ESTIMATED THYROID WT. BEFORE I130	% OF Ra-I (URINE) EXCRETED - 72 HRS. FOLLOWING THE ADMINISTRATION OF I130
1	ELIZABETH D. [redacted]	+30	2.1 mC 3-31-41, 1.5 mC 4-16-41 } 3.6 mC	(-9)(-7)	(-29)	34	INVOLUTION	470 220	660 240	35	20 28
5	[redacted]	+35	5.7 mC 7-16-'41	PLANNED EXPERIMENT	(-20)	31	HYPERPLASIA NO INVOL.	1000	1150	40	27
10	[redacted]	+55	0.7 mC 2-2-'42	(+3)	(-26)	26, 30 } 56	HYPERPLASIA + MOD. INVOL.	120	80	60	38
14	[redacted]	+50	15 mC 7-13-'42	(-15)	(-24)	55	HYPERPLASIA + INVOLUTION	650	—	60	71
16	[redacted]	+25	10 mC 8-11-'42	(-8)	(-24)	28	INVOLUTION	1800	—	45	6
19	[redacted]	+65	15 mC 8-26-'42, 8 mC 3-8-'43, 5 mC 3-9-'43 } 28 mC	(+8) TO (+13)	(+36) TO (-18)	35	SL HYPERPLASIA + INVOLUTION	2000 1500	—	60	9 15 7
2	[redacted]	+35	1.4 mC 5-10-'41, 0.9 mC '41, 2.4 mC '42, 0.8 mC '42 } 5.6 mC	NOT OPERATED ← PERSISTENT THYROTOXICOSIS ANOTHER 20 mC PROPOSED				160 110 120 100	140 100 120 100	40	54* 48 78 --
4	[redacted]	+30	3.6 mC 7-14-'41, 2.2 mC 7-31-'41 } 5.8 mC	← EYES BETTER. NO GOITER. BMR (+2) OFF MED. - 4 YRS.				270 170	300 180	60	55 56
3	[redacted]	+50	3.4 mC 6-6-'41	REMISSION FOR 1 YR - THEN				430	410	45	45
			20 mC 1-9-'46	(RECENTLY FOR TRUE RECURRENCE)				4300	—	30 (RECURRENCE)	35

a

* OPHTHALMOPATHIC TYPE

TABLE II - ANALYSIS OF 20 CASES "CURED" BY Ra I + KI ON BASIS OF EXAMINATION MARCH 31, 1946

SERIES NO.	CASE-HOSP. NO.	DOSE OF I130 and DATE OF ADMINISTRATION	BMR BEFORE I130	BMR LEVEL OFF IODIDES	TIME OFF IODIDES	THYROID SIZE '46	ESTIMATED THYROID WT. (Gm.)	% OF Ra I EXCRETED 72-HOURS	ESTIMATED THYROID IRRADIATION (r) 12 HOUR	9 DAYS*
6	[redacted]	2.3 mC 7-24-'41, 1.7 mC 7-30-'41 } 4.0 mC	+45	DEC. '42 (-9) MAY '43 (-16) JAN. '46 (-7)	4 YRS.+	N	45	35 22	320 280	390 300
7	[redacted]	ET 9) 1.4 mC 8-19-'41, 1.5 mC 9-21-'41 } 2.9 mC	+65	1-8-'46 (-6)	4 YRS.	N	45	3 20 (?)	260 260 (?)	280 220 (?)
8	[redacted]	ET 9) 1.5 mC 9-24-'41	+30	7-17-'45 (-3) 5-27-'46 (+4)	7 MOS	FIRM 2 X N	40	15	300	250
9	[redacted]	4.9 mC 11-26-'41	+30	5-8-'45 (-10)	4 YRS.	N	60	17	650	420
11	[redacted]	5.8 mC 4-9-'42	+37	7-9-'42 (-12) 2-24-'44 (+9) 2-3-'46 (-13)	3.5 YRS.	N	60	17	750	380
12	[redacted]	7.5 mC 5-15-'42	+55	'45 (+11) 2-3-'46 (-13)	3 YRS.	HARD 1.5 X N	60-75	26	950	500
13	[redacted]	12 mC 6-9-'42	+30	3-'43 (+6) 2-3-'46 (-10)	3 YRS.	N	40	71	750	
15	[redacted]	6 mC 8-11-'42, 4 mC 8-11-'42 } 10 mC	+35	4-'45 (-6) 2-3-'46 (+2)	10 MOS.	N	40	10	2000	
17	[redacted]	13 mC 8-13-'42	+50	6-10-'44 (-15) 1-6-'46 (-9)	3 YRS.+	N	60	14	1300	
18	[redacted]	10.5 mC 8-15-42	+35	8-22-'44 (-10) 2-16-'46 (+1)	3 YRS.+	N	40	15	2000	
20	[redacted]	10 mC 11-14-'42	+50	4-3-'45 (-1) 2-16-'46 (-5)	2 YRS.+	N	45	20	1600	
21	[redacted]	14 mC 11-20-'42	+45	1-8-46 (-13)	3 YRS.+	N	50	15 (?)	2000	
22	[redacted]	13 mC 3-9-'43	+20	6-30-'43 (-8)	2 YRS.+	"?N" (LMD.)	55	33	2200	
23	[redacted]	8 mC 3-15-'43, 10 mC 3-16-'43 } 18 mC	+55	6-9-'43 (-11) 2-16-'46 (-3)	2 YRS.+	FIRM 1.5 X N	75	76 67	500	
24	[redacted]	10.5 mC 3-26-'43, 4.5 mC 3-27-'43 } 15 mC	+40	12-'45 (-5)	2 YRS.+	N (DR. J.C.) (ZILHARDT)	50	57? 31	1000	
25	[redacted]	16 mC 4-2-'43	+44	9-28-'44 (-7) 4-27-'45 (+9) 3-20-'46 (+4)	2 YRS.+	N (DR. J.C.) (AUG)	50	20.6 63.0	750	
26	[redacted]	12 mC 4-6-'43	+39	'45 (-8) 1-16-'46 (+2)	2 YRS.+	N	45	85	350	
27	[redacted]	13 mC 4-12-'43	+40	7-17-'45 (-16) 2-15-'46 (-10)	2 YRS.+	N	50	33	1600	
28	[redacted]	10.5 mC 4-13-'43, 11.0 mC 4-13-'43 } 21 mC	+55	12-'45 (-15) 2-3-'46 (+6)	2 YRS+	N	75	---?	2000	
29	[redacted]	8 mC 3-29-'43, 4 mC 3-30-'43 } 12 mC	+30	'46 (+4)	2 YRS+	N	55	10 53 (?)	1200 250	

* 8 DAY ISOTOPE FIGURES ASSUME NO LOSS OF IODINE FROM THYROID DURING DECAY; THEY ARE THEREFORE EXCESSIVE. THEY WERE NOT MEASURED FOR CASES 13-29 —.—

b

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 613
(N-21)

Introduced by: Mississippi, District of Columbia, New Jersey, Oklahoma, South Carolina, Tennessee

Subject: Due Process at our AMA

Referred to: Reference Committee F

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1 Whereas, Most Americans assume the US Constitution guarantees due process before the
2 government may deprive someone of "life, liberty, or property," particularly as stated in the Fifth
3 and Fourteenth Amendments to the United States Constitution, including notice, opportunity for
4 hearing, confrontation and cross-examination, discovery, basis of decision, and availability of
5 counsel in the United States" (quote from the Library of Congress at Congress.gov, Amt5.4.1
6 "The Right to Due Process: Overview);" and
7
8 Whereas, Since 1980 the AMA has supported the right of physician due process and has
9 adopted general guidelines for due process to be adapted in each instance to suit the
10 circumstances and conditions of health care organizations (Guidelines for Due Process
11 H-265.998); and
12
13 Whereas, Most American physicians believe that AMA members deserve the right to due
14 process before any adverse action may be taken against them by the Council on Ethical and
15 Judicial Affairs (CEJA), the Conduct Liaison or Committee on Conduct at AMA Meetings and
16 Events (CCAM) pursuant to the Policy on Conduct at AMA Meetings and Events H-140.837, or
17 the AMA Speakers office, or the Speakers Elections Committee, or the AMA House of
18 Delegates staff office; therefore be it
19
20 RESOLVED, That any American Medical Association member accused of any offense internal
21 to AMA, such as a complaint on/to the AMA Code of Conduct Hotline at 800-398-1496 (AMA
22 Code of Conduct for meeting attendees and employees | American Medical Association (ama-
23 assn.org) be entitled to due process based on principles of fundamental fairness before any
24 adverse action may be taken against such AMA member as a result of any such complaint,
25 including but not limited to notice of complaint and opportunity to be heard coincident with any
26 AMA based investigation (New HOD Policy); and be it further
27
28 RESOLVED, That our AMA prohibit inappropriate usage of AMA public or private media
29 platforms and take reasonable steps to enforce the existing Digital Code of Conduct (Code of
30 Conduct | American Medical Association (ama-assn.org) including but not limited to prompt and
31 thorough investigation of alleged violations of the Digital Code of Conduct as if the complaint
32 were formally filed on the Code of Ethics Hotline. (New HOD Policy)
33

Fiscal Note: Minimal - less than $1,000

Received: 10/11/21

AUTHORS STATEMENT OF PRIORITY

Due process is important to ALL physicians and particularly at our AMA. We need to act NOW to avoid further damage from our rampant recent ill-behaviors on AMA sponsored social media platforms and the Complaint Hotline. We all agree that fairness and diversity are now viewed as among our CORE AMA VALUES. We need NEW policy to rein in abuses seen over the last 12 months or so. The HOD action will obviously have positive impact and only the AMA can act on this important and timely internal action.

Reference: from the above AMA web page
Digital Code of Conduct
By accessing and using this website you agree to the following Code of Conduct. If you do not agree to the Code of Conduct, Terms of Use, and Privacy Policy, you must immediately terminate use of this site.
To help the American Medical Association (AMA) maintain dialogue that is relevant and respectful of the rights of others, you understand that when you submit comments, posts or images on AMA's digital platforms, you will not:

- Spread false and/or defamatory information.
- Include content that is discriminatory, abusive, vulgar, hateful, harassing, obscene, profane, sexually oriented, threatening, invasive of a person's privacy or right to publicity, or otherwise violative of any law.
- Infringe on copyrights, trademarks or trade secrets.
- Post content that includes private and/or personal information, such as home phone numbers and email addresses.
- Seek medical advice (consult your personal physician) or disclose personal health information.
- Promote commercial services and products or causes.
- Post in manner that would constitute spamming (e.g., posting with such frequency or repetitiveness that others may be discouraged from posting, posts that are irrelevant to the topic and/or the AMA's mission, and "follow me" posts) or trolling (defined as comments that appear intended to send the discussion in a fruitless direction).

RELEVANT AMA POLICY

Guidelines for Due Process H-265.998

While it is not possible to develop universal guidelines for due process, voluntary utilization of the following general guidelines for due process, adapted in each instance to suit the circumstances and conditions of the health care organization and within the requirements of the applicable laws of the jurisdiction, should assist in providing the type of hearing which the law in each jurisdiction requires:
(1) The physician should be provided with a statement, or a specific listing, of the charges made against him or her.
(2) The physician is entitled to adequate notice of the right to a hearing and a reasonable opportunity of no less than 30 days to prepare for the hearing.
(3) It is the duty and responsibility of the hearing officer to conduct a fair, objective, expeditious and independent hearing pursuant to established rules.
(4) The rules of procedure should clearly define the extent to which attorneys may participate in the hearing.
(5) The physician against whom the charges are made should have the opportunity to be present at the hearing and hear all of the evidence against him or her.
(6) The physician is entitled to the opportunity to present a defense to the charges against him or her.
(7) To the extent feasible, the hearing panel should evaluate the issues and evidence presented related to the proposed corrective action while blinded to the patient outcome.
(8) The hearing panel should render a decision based on the evidence produced at the hearing.
(9) The hearing panel should include in its decision the conclusions reached and actions recommended and, as an important focus if feasible, remedial steps for the physician and for the health care facility itself. When feasible, the hearing panel should include terms that permit measurement and validation of the completed remediation process.
(10) The hearing panel should endeavor to state its findings, the clinical basis and support for its findings, its recommendations, and actions as clearly as possible.

(11) Within 10 days of the receipt of the hearing panel's decision, the physician, medical executive committee or health care organization, if it brought the correction action, has the right to request an appellate review. The written request for an appellate review shall include an identification of the grounds for appeal and a clear and concise statement of the facts and/or evidence in support of the appeal. The grounds for an appeal of the decision shall be: (a) substantial non-compliance with the procedures required in the medical staff bylaws; or (b) the decision is against the manifest weight of the evidence. If an appellate review is to be conducted, the appeal board shall schedule the appellate review and provide notice to the physician, medical executive committee and the health care organization. The MEC shall appoint an appeal board consisting of members of the medical staff who did not sit on the original hearing panel, or, at the request of the MEC, the governing body or at least three members thereof may sit as the appeal board. The appeal board shall consider the record of the hearing before the hearing panel. If the appeal board determines that significant relevant evidence, which could bear on the outcome of the proceeding, was not entertained by the hearing panel, it may refer the matter back to the hearing panel for further deliberation or, at the appeal board's discretion, it may receive and consider the new evidence. Similarly, if the appeals board determines that there was not substantial compliance with the hearing procedures in the medical staff bylaws, the appeal board may refer the matter back to the hearing body or, at the appeal board's discretion, it may convene additional hearings to correct any defect in the process. Upon completion of the appeal board's deliberations, the appeal board shall present its recommendation(s) to the governing body as to whether the recommendations(s) of the hearing body should be affirmed, modified, or reversed.
(12) In any hearing, the interest of patients and the public must be protected.
Citation: BOT Rep. II, A-80; Reaffirmed: Sunset Report, I-98; Amended: BOT Action in response to referred for decision BOT Rep. 23, A-05; Reaffirmed: Res. 12, A-06; Reaffirmed: BOT Rep. 06, A-16; Reaffirmed: Res. 235, I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 614
(N-21)

Introduced by: New Jersey, District of Columbia, Oklahoma, Pennsylvania, South Carolina, Tennessee, California, American Society of Anesthesiologists, New York, Florida, American College of Allergy, Asthma and Immunology

Subject: Insurance Industry Behaviors

Referred to: Reference Committee F

Whereas, In 2000, the AMA with several state medical societies, led by Florida, California, Missouri and New York, and specialty societies, led by OB-GYN, and several individual physicians, successfully sued the commercial health insurance carriers in a RICO lawsuit. The settlement was substantial, paying costs of all parties and leading to at least two foundations, including the Physicians Foundation for Health System Excellence; and

Whereas, In 2009 the AMA again, with other partners, successfully sued the Aetna and Cigna groups of companies for $11 Million each with success for similar offences listed in the United Healthcare suit; and

Whereas, Many insurers are once again treating physicians and other claimants unfairly; and

Whereas, The recent published September 28, 2021 AMA Report "*Competition in Health Insurance: A comprehensive study of U.S. markets – an 2021 Update*" demonstrates increasing market share across the United States of certain insurance companies in certain regions of the United States and points out " Research finds evidence that insurer consolidation leads to the exercise of monopsony power vis-à-vis physicians in the form of lower physician earnings and employment." (page 3-4); and

Whereas, The health insurance industry in particular is using its market share to unfairly gain leverage against physicians and medical practices resulting in:

1) Unilateral reductions in reimbursements
2) Retroactive audits without cause
3) Manufactured claims denials
4) Egregious and unnecessary payment delays
5) Forced arbitration on abusive terms, requiring physicians to pay for the process
6) Scurrilous interpretation the AMA CPT Code and Vignettes to the disadvantage of the physician
7) Cancellation of contracts and/or arbitrary termination of certain providers and reduction of networks; therefore be it

RESOLVED, That our American Medical Association step up its ongoing review of the proper use of the AMA CPT Code and Vignettes in medical billing claims payments and its misuse by the US Health Insurance Industry (Directive to Take Action); and be it further

1 RESOLVED, That our AMA undertake as soon as practical a formal, legal review of ongoing
2 grievous behaviors of the health insurance industry including: (1) a search for potential litigation
3 partners across the medical federation; and (2) dissemination of the findings to the appropriate
4 internal AMA divisions and Councils for review and preparation for potential civil, regulatory
5 and/or legislative action by/in the US Court System, the US Federal or State regulatory
6 agencies and/or the US Congress. (Directive to Take Action)

Fiscal Note: Estimated cost to implement this resolution is $300,000 annually.

Received: 10/11/21

AUTHORS STATEMENT OF PRIORITY

Growing Insurance Industry coding and payment Misbehavior effects most physicians. We need to act at this meeting to start what might be a several year process. Protection of physician practice viability and economics is our AMA CORE ACTIVITY. We need to authorize new policy to get going on this key issue, particularly in this time of "COVID." AMA is the expected and only organization to take on such a project.

RELEVANT AMA POLICY

Third Party Payer Coverage Process Reform and Advocacy D-185.986
1. Our AMA, working with interested state medical and national specialty societies, will develop model legislation and/or regulations to require that commercial insurance companies, state Medicaid agencies, or other third party payers utilize transparent and accountable processes for developing and implementing coverage decisions and policies, and will actively seek the implementation of such model legislation and/or regulations at the national and state levels.
2. Our AMA will work with specialty and service organizations to advocate that private insurance plans and benefit management companies develop transparent clinical protocols as well as formal processes to write / revise them; that those processes should seek input from the relevant national physician organizations; and that such clinical coverage protocols should be easily and publicly accessible on their websites, just as Medicare national and local coverage determinations are publicly available.
3. Our AMA will advocate that when private insurance plans and benefit management companies make changes to or revise clinical coverage protocols, said companies must inform all insured individuals and participating providers in writing no less than 90 days prior to said change(s) going into effect.
Citation: (Res. 820, I-11; Appended: Res. 807, I-12)

Physician Reimbursement by Health Insurance and Managed Care Companies H-190.959
1. Our AMA shall make it a top priority to seek regulatory and legislative relief to ensure that all health insurance and managed care companies pay for clean claims submitted electronically within fourteen days.
2. When electronic claims are deemed to be lacking information to make the claim complete, the health insurance and managed care companies will be required to notify the health care provider within five business days to allow prompt resubmission of a clean claim.
3. Our AMA shall advocate for heavy penalties to be imposed on health insurance and managed care companies, including their employees, that do not comply with laws and regulations establishing guidelines for claims payment.
4. Our AMA will continue to encourage regulators to enforce existing prompt pay requirements.

Citation: Sub. Res. 713, A-02; Modified: Res. 714, A-03; Reaffirmation I-04; Reaffirmed: CMS Rep. 1, A-14; Reaffirmed: Res 132, A-14; Reaffirmed: Sub. Res. 715, A-15; Appended: Res. 805, I-18

Insurance Companies Use of Contractors to Recover Payments D-385.965
1. Our AMA will seek legislation to limit insurance companies, their agents, or any contractors from requesting payment back on paid claims to no more than 90 days after payment is made.
(a) Such legislation would require insurance companies, their agents, or any contractors to have a defined and acceptable process for physicians to dispute these maneuvers to get payment back on claims already processed, verified, and paid.
(b) Such legislation would ban insurance companies, their agents or contractors from using re-pricers and re-reviewers and to adhere to their own pricing and reviewing guidelines as agreed upon in their contracts with physicians.
2. Our AMA will pursue legislation to regulate self-insured plans in this regard and apply the same rules to Medicare and other federal plans.
Citation: Res. 215, A-09; Reaffirmed: BOT Rep. 09, A-19

Insurance Company Denial of Payment for Office Visit and Invasive Procedure Done on the Same Day H-385.944
Our AMA supports insurance company payment for evaluation and management services and procedures performed on the same day, where consistent with CPT guidelines.
Citation: Sub. Res. 829, I-97; Reaffirmed: CMS Rep. 9, A-07; Reaffirmation I-07; Reaffirmed: CMS Rep. 01, A-17

A Level Playing Field in Negotiations Between Health Insurance Companies and Physicians D-383.982
Our AMA will make passage of legislation in the US Congress to exempt physicians from antitrust actions in their negotiations with insurance companies a top legislative priority of the AMA, remain vigilant on this issue, continue to regularly provide updates on our AMA Web site and through other AMA communication tools, request sponsors nationally, and allocate appropriate funding and resources necessary to successfully advocate its passage into law.
Citation: Res. 202, I-11; Reaffirmed: Res. 206, A-19

Insurance Company Economic Profiling of Physicians D-406.996
Our AMA will: (1) take all appropriate steps to actively oppose all efforts by third party payers to rank, profile or otherwise "score" physicians purely for corporate cost containment purposes; and (2) widely publicize insurance industry economic profiling practices and how they impact patient care and access.
Citation: Res. 820, I-07; Reaffirmed: CMS Rep. 01, A-17

Inappropriate Bundling of Medical Services by Third Party Payers D-70.986
Our AMA will study the problems associated with inappropriate bundling of medical services, including the bundling of preoperative assessment in making the decision for surgery with the procedure, and present a report with potential solutions, including an analysis of legislative, judicial, and regulatory remedies.
Citation: (Res. 813, I-00; Rescinded: CMS Rep. 6, A-10)

Appropriate Use of Component Codes in Current Procedural Terminology (CPT) D-70.987
(1) Our AMA will pursue methods of wide distribution for existing coding products and services developed by national specialty societies in cooperation with the AMA and the CPT Editorial Panel. (2) Our AMA will advocate that the Department of Health and Human Services (DHHS) designate CPT guidelines and instructions as contained in the CPT Book and approved by the

CPT Editorial Panel as the national implementation standards for CPT codes. (3) The CPT Editorial Panel consider developing CPT coding combinations that comply with CPT coding rules and guidelines and that could serve as a basis for payer software programs.
Citation: BOT Rep. 8, I-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: CMS Rep. 01, A-20

Transition to ICD-10 Code Sets D-70.954
Our American Medical Association will develop systems to help physicians transition to the ICD-10 coding system.
Citation: Res. 810, I-09; Rescinded: CEJA Rep. 03, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 615
(N-21)

Introduced by: Oklahoma, Alabama, District of Columbia, Georgia, Mississippi, New Jersey, North Carolina, South Carolina, Tennessee

Subject: Employed Physicians

Referred to: Reference Committee F

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1 Whereas, The percentage of practicing US physicians who are employed is now heading
2 towards 75% and may go higher with early retirement of older “private practice” physicians; and
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4 Whereas, The Southeastern Delegation to AMA (SED) supports both pluralistic health insurer or
5 payor mix and pluralistic physician practice styles and settings; and
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7 Whereas, Many physicians are losing influence in the health care system under some
8 employment models; and
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10 Whereas, Physicians’ employment by a hospital completely changes any past relationships to
11 the hospital administration, whether the hospital has an active Organized Medical Staff or not;
12 and
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14 Whereas, Many physicians are naïve about contract negotiations and terms and can’t afford
15 legal or accounting review; and
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17 Whereas, Many employed physicians are naïve about contract renewals and supporting
18 employer accounting systems and can’t afford their own forensic accountants; and
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20 Whereas, The AMA is currently limited in the scope of its potential work with employed
21 physicians and hospital or corporate medical staffs; and
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23 Whereas, The SED believes that continued membership growth of AMA will depend on the AMA
24 adapting to the needs of employed physicians; and
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26 Whereas, The process of providing additional support for employed physicians may take several
27 years; may involve input from the AMA Councils; may require input from internal AMA or
28 contract legal counsel; may require input and study by the AMA Board and AMA CEO; and
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30 Whereas, The SED believes our AMA should start “the process” for change now; therefore be it
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32 RESOLVED, That our American Medical Association dedicate full-time staff to the Employed
33 Physician to aggressively address relevant AMA Policy pertaining to the Employed Physician
34 (Directive to Take Action); and be it further

RESOLVED, That our AMA study amending Policy G-615.105 to read as follows:

Employed Physicians and the AMA G-615.105
1. Our AMA will become the lead association for physicians who maintain employment or contractual relationships with hospitals, health systems, and other entities.
2. As a benefit of membership our AMA will provide assistance, such as information, advice, and legal opinions, as appropriate, to employed physicians, physicians in independent practice, and independent physician contractors in matters pertaining to their relationships with hospitals, health systems, and other entities, including, but not limited to, breach of contracts, contract negotiations and contract renewals, medical staff bylaws, sham peer review, economic credentialing, and the denial of due process.
3. Our AMA will also work through the Organized Medical Staff Section and other sections and special groups as appropriate to represent and address the unique needs of physicians who maintain employment or contractual relationships with hospitals, health systems, and other entities. (Directive to Take Action); and be it further

RESOLVED, That the representation of the Organized Medical Staff Section (OMSS) in the AMA House of Delegates be increased from the current one Delegate to many Delegates based on AMA membership numbers of employed physicians using the mathematical model(s), to calculate the numbers of the New OMSS Delegates, currently being used at AMA for the Medical Student and Resident and Fellows Sections to calculate the numbers of Regional Medical Students and the numbers of Regional Resident/Fellows in the AMA House of Delegates. The AMA would develop a practical meaning of the phrase “Employed Physician” for the purposes of AMA membership counting, but as an editorial comment, the SED suggests starting with employed Non-Resident/Non-Fellow physicians who have no ownership interest (or, say, less than 1% ownership each) in their employer organization (New HOD Policy); and be it further

RESOLVED, That the Organized Medical Staff Section have one designated member who is a defined employed physician on all AMA Boards and Committees and Councils to match the MSS, the RFS and the YPS. (New HOD Policy)

Fiscal Note: Estimated cost to implement this resolution is $720,000 annually.

Received: 10/11/21

AUTHORS STATEMENT OF PRIORITY

Over 70% of physicians are now employed. This time of COVID has placed employed physicians at INCREASED vulnerability and disadvantage for practice and personal sustainability as employers and insurance companies have taken advantage of the difficult COVID health care system situation. THIS is our top Core Value, Physician and Physician practice sustainability. This will start a process that could take several years, BUT THIS IS THE TIME TO START with important NEW POLICY and a new AMA Office of the Employed Physicians. Obviously, AMA can make a positive impact and of course is really the only organization to undertake this important task.

HISTORY
H – 225.947 Physician Employment Trends
H - 225.950 Principles of Physician Employment
G – 615.105 Employed Physicians
D – 225.973 Employed Physicians Bill of Rights
References
The early Clinic histories from relevant Wikipedia articles.
Representation of Physicians in Emerging Delivery Systems; AMA Council on Long Range Planning and Development Report, 1994.
Rosemary Strevens. Health Care in the Early 1960's. Health Care Financing Review. Winter issue, 1996. Vol 1, #2.
Travis Singleton and Phillip Miller. The Physician Employment Trend: What you need to know. Fam Pract Manage 2015: August (4) 11-15.
The Physician Employment Movement. Career Letter, NEJM, July 23, 2014
Laura Dyrda. 70% Physicians now Employed by Hospitals or Corporations. July 1, 2021. VMG Health at info@vmghealth.com
The AMA OMSS web page: Organized Medical Staff | American Medical Association (ama-assn.org)

EMPLOYMENT CONTRACTS
AMA Policy
H - 225.964 Hospital Employed/Contracted Physicians Reimbursement
H – 285.946 Fair Physician Contracts
References
Scott Backer, Gretchen Townsend, Holly Carnell, Melesa Freerks and McGuire Woods. Physician Compensation. In the Beckers Hospital Review, August 19, 2013
Kim Stanger. Physician Contract Check List. Proprietary to the Holland and Hurt Law Firm, from Shaw Publications

EMPLOYED PHYSICIAN SAFEGUARDS
AMA Policy
D – 215. 990 AMA Assistance to Physician-Hospital/Healthcare System Relationships
H – 383.999 Physician Negotiations
H – 385.976 Physician Collective Bargaining
D – 225.977 Physician Independence
H – 235.999 All Physicians Employed by Hospitals Required to be on Staff

References
Brendan Murphy, AMA staff writer - So, you are an employed physician: what you need to know. June 2017.
https://es4p.com - Essentials for Physicians – Business Podcasts and Seminars
Travis Singleton and Phillip Miller. Physician Employment. August 2015 from the FPM Journal by the AAFP
Winn Halverhout, Husch Blackwell, Barbara Yosses. Compliance in Physician Employment. Proprietary to the Husch Blackwell Law Firm, published by the Health Care Compliance Association, 2010.
from the American College of Surgeons
https://www.facs.org/-/media/files/advocacy/regulatory/2018_employed_surgeons_primer.ashx

RELEVANT AMA POLICY

Employed Physicians and the AMA G-615.105

1. Our AMA will strive to become the lead association for physicians who maintain employment or contractual relationships with hospitals, health systems, and other entities.
2. As a benefit of membership our AMA will provide, through the Sections and Special Groups, assistance, such as information and advice, but not legal opinions or representation, as appropriate, to employed physicians, physicians in independent practice, and independent physician contractors in matters pertaining to their relationships with hospitals, health systems, and other entities, including, but not limited to, breach of contracts including medical staff bylaws, sham peer review, economic credentialing, and the denial of due process.
3. Our AMA will work through the Organized Medical Staff Section and other sections and special groups as appropriate to represent and address the unique needs of physicians who maintain employment or contractual relationships with hospitals, health systems, and other entities.

Citation: Res. 601, I-11; Reaffirmed: Joint CCB/CLRPD Rep. 1, A-21

Physician Employment Trends and Principles H-225.947

1. Our AMA encourages physicians who seek employment as their mode of practice to strive for employment arrangements consistent with the following principles: A. Physician clinical autonomy is preserved. B. Physicians are included and actively involved in integrated leadership opportunities. C. Physicians are encouraged and guaranteed the ability to organize

under a formal self-governance and management structure. D. Physicians are encouraged and expected to work with others to deliver effective, efficient and appropriate care. E. A mechanism is provided for the open and transparent sharing of clinical and business information by all parties to improve care. F A clinical information system infrastructure exists that allows capture and reporting of key clinical quality and efficiency performance data for all participants and accountability across the system to those measures.
2. Our AMA encourages continued research on the effects of integrated health care delivery models (that employ physicians) on patients and the medical profession.
Citation: CMS Rep. 5, I-15; Reaffirmed: CMS Rep. 05, A-17; Reaffirmed: CMS Rep. 07, A-19

AMA Principles for Physician Employment H-225.950
1. Addressing Conflicts of Interest
a) A physician's paramount responsibility is to his or her patients. Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address.
b) Employed physicians should be free to exercise their personal and professional judgement in voting, speaking and advocating on any manner regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests. Employed physicians also should enjoy academic freedom to pursue clinical research and other academic pursuits within the ethical principles of the medical profession and the guidelines of the organization.
c) In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.
d) Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients.
(i) No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to his/her religious beliefs or moral convictions; and
(ii) No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because he/she either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates his/her religious beliefs or moral convictions.
e) Assuming a title or position that may remove a physician from direct patient-physician relationships--such as medical director, vice president for medical affairs, etc.--does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.
Refer to the AMA Code of Medical Ethics for further guidance on conflicts of interest.
2. Advocacy for Patients and the Profession
a) Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated.
b) Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.
3. Contracting

a) Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession.
b) Physicians should never be coerced into employment with hospitals, health care systems, medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.
c) When a physician's compensation is related to the revenue he or she generates, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based.
d) Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under his/her care. When a physician's employment status is unilaterally terminated by an employer, the physician and his or her employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in his or her new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of his or her patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician.
(e) Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. When such cause relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff, the physician should be afforded full due process under the medical staff bylaws, and the agreement should not be terminated before the governing body has acted on the recommendation of the medical staff. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges. When such cause is non-clinical or not otherwise a concern of the medical staff, the physician should be afforded whatever due process is outlined in the employer's human resources policies and procedures.
(f) Physicians are encouraged to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions. Employers should never terminate agreements without cause when the underlying reason for the termination relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff.
(g) Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment.
(h) Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved.
Refer to the AMA Annotated Model Physician-Hospital Employment Agreement and the AMA Annotated Model Physician-Group Practice Employment Agreement for further guidance on physician employment contracts.

4. Hospital Medical Staff Relations
a) Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs.
b) Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes.
c) Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.
d) Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.
Refer to the AMA Conflict of Interest Guidelines for the Organized Medical Staff for further guidance on the relationship between employed physicians and the medical staff organization.
5. Peer Review and Performance Evaluations
a) All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings.
b) Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status.
c) Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians--not lay administrators--should be ultimately responsible for all peer review of medical services provided by employed physicians.
d) Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician's independent exercise of medical judgment.
e) Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc.
(f) Upon termination of employment with or without cause, an employed physician generally should not be required to resign his or her hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws. Automatic rescission of medical staff membership and/or clinical privileges following termination of an employment agreement is tolerable only if each of the following conditions is met:
i. The agreement is for the provision of services on an exclusive basis; and
ii. Prior to the termination of the exclusive contract, the medical staff holds a hearing, as defined by the medical staff and hospital, to permit interested parties to express their views on the matter, with the medical staff subsequently making a recommendation to the governing body as to whether the contract should be terminated, as outlined in AMA Policy H-225.985; and
iii. The agreement explicitly states that medical staff membership and/or clinical privileges must be resigned upon termination of the agreement.

Refer to the AMA Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations (AMA Policy H-375.965) for further guidance on peer review.

6. Payment Agreements

a) Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.

b) Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.

Our AMA will disseminate the AMA Principles for Physician Employment to graduating residents and fellows and will advocate for adoption of these Principles by organizations of physician employers such as, but not limited to, the American Hospital Association and Medical Group Management Association.

Citation: BOT Rep. 6, I-12; Reaffirmed: CMS Rep. 6, I-13; Modified in lieu of Res. 2, I-13; Modified: Res. 737, A-14; Reaffirmed: BOT Rep. 21, A-16; Reaffirmed: CMS Rep. 05, A-17; Reaffirmed: CMS Rep. 07, A-19; Reaffirmed: CMS Rep. 11, A-19; Modified: BOT Rep. 13, A-19

Hospital Employed/Contracted Physicians Reimbursement H-225.964

AMA policy states that: (1) all hospital employed/contracted physicians be prospectively involved if the hospital negotiates for them for capitation and global billing contracts; (2) hospital employed/contracted physicians be informed about the actual payment amount allocated to the physician component of the total hospital payment received by the contractual arrangement; and (3) all potential hospital/contracted physicians request a bona fide hospital plan which delineates the actual payment amount allocated to the employed or contracted physicians.

Citation: (Sub. Res. 723, I-96; Reaffirmed: Res. 812, A-02; Reaffirmed: CMS Rep. 4, A-12; Reaffirmed: BOT Rep. 4, I-12)

All Physicians Employed by Hospitals Required to be on Staff H-235.999

The AMA believes that physicians having contractual or financial arrangements with hospitals should be members of the organized medical staff and responsible to it, should be subject to the bylaws of the medical staff, and should conduct their professional activities according to the standards, rules and regulations adopted by it.

Citation: BOT Rep. R, Rec. 3, A-77; Reaffirmed: I-81; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Reaffirmed: CMS Rep. 01, A-18

Fair Physician Contracts H-285.946

Our AMA will develop national (state) standards and model legislation for fair managed care/physician contracts, thereby requiring full disclosure in plain English of important information, including but not limited to:

(1) disclosure of reimbursement amounts, conversion factors for the RBRVS system or other formulas if applicable, global follow-up times, multiple procedure reimbursement policies, and all other payment policies;

(2) which proprietary "correct coding" CPT bundling program is employed;

(3) grievance and appeal mechanisms;

(4) conditions under which a contract can be terminated by a physician or health plan;

(5) patient confidentiality protections;

(6) policies on patient referrals and physician use of consultants;
(7) a current listing by name and specialty of the physicians participating in the plan; and
(8) a current listing by name of the ancillary service providers participating in the plan.
Citation: Res. 727, A-97; Amended by CMS Rep. 3, A-98; Reaffirmed: Res. 814, A-00; Reaffirmation A-06; Reaffirmation A-08; Reaffirmation I-08; Reaffirmed: CMS Rep. 01, A-18

Physician Negotiation H-383.999
1. All activities of our American Medical Association regarding negotiation by physicians maintain the highest level of professionalism, consistent with the Principles of Medical Ethics and the Current Opinions of Council on Ethical and Judicial Affairs.
2. Our AMA continue to support the development of independent house staff organizations for employed, resident and fellow physicians and support the development and operation of local negotiating units as an option for all employed, resident and fellow physicians authorized to organize labor organizations under the National Labor Relations Act.
3. Our AMA continues to advance its private sector advocacy programs and explore, develop, advocate, and implement other innovative strategies, including but not limited to initiating litigation, to stop egregious health plan practices and to help physicians level the playing field with health care payers.
Citation: Sub. Res. 901, A-99; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation I-01; Reaffirmation A-02; Reaffirmation A-06; Reaffirmation A-08; Modified: BOT Rep. 09, A-18

Physician Collective Bargaining H-385.976
Our AMA's present view on the issue of physician collective negotiation is as follows: (1) There is more that physicians can do within existing antitrust laws to enhance their collective bargaining ability, and medical associations can play an active role in that bargaining. Education and instruction of physicians is a critical need. The AMA supports taking a leadership role in this process through an expanded program of assistance to independent and employed physicians.
(2) Our AMA supports continued intervention in the courts and meetings with the Justice Department and FTC to enhance their understanding of the unique nature of medical practice and to seek interpretations of the antitrust laws which reflect that unique nature.
(3) Our AMA supports continued advocacy for changes in the application of federal labor laws to expand the number of physicians who can bargain collectively.
(4) Our AMA vigorously opposes any legislation that would further restrict the freedom of physicians to independently contract with Medicare patients.
(5) Our AMA supports obtaining for the profession the ability to fully negotiate with the government about important issues involving reimbursement and patient care.
Citation: BOT Rep. P, I-88; Modified: Sunset Report, I-98; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation I-03; Reaffirmation A-04; Reaffirmed in lieu of Res. 105, A-04; Reaffirmation A-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmed: BOT Rep. 17, A-09; Reaffirmation I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: Res. 215, A-11; Reaffirmed: BOT action in response to referred for decision Res. 201, I-12; Reaffirmed: Res. 206, A-19

AMA Assistance for Members in Matters Pertaining to Physician-Hospital/Health System Relationships D-215.990
1. As a benefit of membership our AMA will provide assistance, such as information and advice (but not legal opinions or representation), as appropriate to employed physicians, physicians in independent practice, and independent physician contractors in matters pertaining to their relationships with hospitals, health systems, and other similar entities, including, but not limited to, breach of contracts including medical staff bylaws, sham peer review, economic credentialing, and the denial of due process.

2. Our AMA encourages the Federation of Medicine and its members to provide assistance, such as information and advice (but not legal opinions or representation), as appropriate to employed physicians, physicians in independent practice, and independent physician contractors in matters pertaining to their relationships with hospitals, health systems, and other similar entities, including, but not limited to, breach of contracts including medical staff bylaws, sham peer review, economic credentialing, and the denial of due process.
Citation: Res. 826, I-11; Reaffirmed: BOT Action in response to referred for decision Res. 816, I-16

Employed Physician Bill of Rights and Basic Practice Professional Standards D-225.973
Our AMA will advocate that employed physicians should be provided sufficient administrative and clinical support to ensure that they can appropriately care for their patients.
Citation: BOT Rep. 13, A-19

Physician Independence and Self-Governance D-225.977
Our AMA will: (1) continue to assess the needs of employed physicians, ensuring autonomy in clinical decision-making and self-governance; and (2) promote physician collaboration, teamwork, partnership, and leadership in emerging health care organizational structures, including but not limited to hospitals, health care systems, medical groups, insurance company networks and accountable care organizations, in order to assure and be accountable for the delivery of quality health care.
Citation: (Res. 801, I-11; Modified: BOT Rep. 6, I-12)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 616
(N-21)

Introduced by: Michigan

Subject: Financial Impact and Fiscal Transparency of the American Medical Association Current Procedural Terminology® System

Referred to: Reference Committee F

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1 Whereas, The COVID-19 pandemic and restrictions brought unprecedented financial strain
2 upon physicians, with the most recent Physician Foundation survey showing 12 percent of
3 physicians either closing or planning to close their practice within the next year (75 percent of
4 those physicians are in private practice), and nearly 75 percent of physicians reported lost
5 income; and
6
7 Whereas, During this time, physicians also had to implement the new Current Procedural
8 Terminology® (CPT®) Evaluation and Management (E/M) code revisions, which became
9 effective January 1, 2021; and
10
11 Whereas, This was the first major change to the codes and guidelines for office and other
12 outpatient evaluation and management (E/M) services in 24 years; and
13
14 Whereas, Although the Centers for Medicare and Medicaid Services (CMS) signaled its intent to
15 update E/M coding and documentation guidelines when it requested stakeholder feedback in
16 the proposed 2017 Medicare Physician Fee Schedule rules and continued to propose updates
17 in future rules, some stakeholders were hopeful for a delay as physicians were still reeling from
18 the pandemic; and
19
20 Whereas, Given that each patient encounter and experience is unique, medical coding system
21 to accurately reflect the care given within hundreds of specialties and thousands of patient visits
22 may be difficult or have a disparate impact on physicians in different specialties; and
23
24 Whereas, The AMA reported that when the revisions became effective, the AMA received
25 feedback on areas causing confusion, in response to which the CPT Editorial Panel issued
26 technical corrections to add clarity and answer questions concerning the E/M code revisions;
27 and
28
29 Whereas, The intent of these E/M coding changes - to modernize billing and documentation,
30 reduce administrative burdens on physicians, and recognize time spent evaluating and managing
31 patients' care - is commendable; however, actual experiences and consequences should be
32 studied and modified as necessary to further simplify E/M documentation and ease
33 administrative burdens and to fairly and accurately reflect the evaluation and management
34 services provided by private and employed physicians, reflective of the complexity of care within
35 all specialties, and respectful of uncompensated care by our specialist colleagues; therefore be it

1 RESOLVED, That our American Medical Association survey physicians about and study the
2 impact of the 2021 CPT® Evaluation and Management coding reform on physicians, among all
3 specialties, in private and employed practices and report the findings and any recommendations
4 at the June 2022 meeting of the House of Delegates. (Directive to Take Action)

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

Received: 10/13/21

AUTHOR'S STATEMENT OF PRIORITY

The 2021 American Medical Association (AMA) Current Procedural Terminology® (CPT®) Evaluation and Management code set went live on January 1, 2021. It is currently affecting physician reimbursement. Failure to address any potential harm in a timely manner will result in more practice closures and worsen patient access to physicians. This resolution asks the AMA to study an issue that is very pertinent to practicing physicians right now.

Source:
1. http://physiciansfoundation.org/wp-content/uploads/2020/08/20-1278-Merritt-Hawkins-2020-Physicians-Foundation-Survey.6.pdf

RELEVANT AMA POLICY

AMA CPT Editorial Panel and Process H-70.973
The AMA will continue (1) to work to improve the CPT process by encouraging specialty societies to participate fully in the CPT process; (2) to enhance communications with specialty societies concerning the CPT process and subsequent appeals process; and (3) to assist specialty societies, as requested, in the education of their members concerning CPT coding issues.
Citation: Sub. Res. 806, A-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17; Reaffirmation: I-17

Preservation of Evaluation/Management CPT Codes H-70.985
It is the policy of the AMA to (1) oppose the bundling of procedure and laboratory services within the current CPT Evaluation/Management (E/M) services;
(2) oppose the compression of E/M codes and support efforts to better define and delineate such services and their codes;
(3) seek feedback from its members on insurance practices that advocate bundling of procedures and laboratory services with or the compression of codes in the CPT E/M codes, and express its views to such companies on behalf of its members;
(4) continue to work with the PPRC and all other appropriate organizations to insure that any modifications of CPT E/M codes are appropriate, clinically meaningful, and reflective of the considered views of organized medicine; and
(5) work to ensure that physicians have the continued opportunity to use CPT as a coding system that is maintained by the medical profession.
Citation: Sub. Res. 98, A-90; Reaffirmed by Res. 850, A-98; Reaffirmed: Res. 814, A-00; Reaffirmation I-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: CMS Rep. 01, A-20

Use of CPT Editorial Panel Process H-70.919
Our AMA reinforces that the CPT Editorial Panel is the proper forum for addressing CPT code set maintenance issues and all interested stakeholders should avail themselves of the well-established and documented CPT Editorial Panel process for the development of new and revised CPT codes, descriptors, guidelines, parenthetic statements and modifiers.

Citation: BOT Rep. 4, A-06; Reaffirmation A-07; Reaffirmation I-08; Reaffirmation A-09; Reaffirmation A-10; Reaffirmation A-11; Reaffirmation I-14; Reaffirmed: CMS Rep. 4, I-15; Reaffimation A-16; Reaffirmed in lieu of: Res. 117, A-16; Reaffirmed in lieu of: Res. 121, A-17; Reaffirmation: A-18; Reaffirmation: I-18; Reaffirmed: Res. 816, I-19

CPT Coding System H-70.974
1. The AMA supports the use of CPT by all third party payers and urges them to implement yearly changes to CPT on a timely basis.
2. Our AMA will work to ensure recognition of and payment for all CPT codes approved by the Centers for Medicare & Medicaid Services (CMS) retroactive to the date of their CMS approval, when the service is covered by a patient's insurance.
Citation: Sub. Res. 809, A-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmation A-07; Appended: Res. 803, I-11; Reaffirmed: CMS Rep. 1, A-21

Physicians' Current Procedural Terminology H-70.972
The AMA (1) continues to seek ways to increase its efforts to communicate with specialty societies and state medical associations concerning the actions and deliberations of the CPT Maintenance process; (2) urges the national medical specialty societies to ensure that their representatives to the CPT process are fully informed as to their association's policies and coding preferences; and (3) urges those specialty societies that have not nominated individuals to serve on the CPT Advisory Committee to do so.
Citation: BOT Rep. MM, A-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 617
(N-21)

Introduced by: Louisiana

Subject: Together We are Stronger Marketing Campaign

Referred to: Reference Committee F

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1 Whereas, The AMA unveiled a new brand marketing campaign in 2005 that included the tagline
2 "Together We are Stronger"; and
3
4 Whereas, The "Together We are Stronger" campaign was abandoned at sometime during 2018
5 for a new campaign "Members Move Medicine"; and
6
7 Whereas, Since the "Together We are Stronger" campaign was replaced, our AMA has become
8 fractured and often exclusive of some members; and
9
10 Whereas, Our AMA's recent Organizational Strategic Plan to Embed Racial Justice and
11 Advance Health Equity highlights has further weakened our AMA's reputation among many
12 members; therefore be it
13
14 RESOLVED, That our American Medical Association consider readoption of the "Together We
15 are Stronger" tagline as the main marketing slogan and campaign for the organization.
16 (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

On June 1, 2021, Russ Kridel, MD, Chair, AMA Board of Trustees, issued a message to the members of the American Medical Association House of Delegates regarding certain recent events pertaining to the *AMA's Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity, 2021–2023.* As noted by Dr. Kridel, "Our House has always dealt with challenging topics with the same professionalism that we try to exhibit daily as practicing physicians". However, many at recent meetings of the AMA House, particularly those held virtually, we have witnessed a loss of professionalism during comments regarding the Strategic Plan. Some members of our House are being personally attacked and threatened by others for their thoughts and ideas. Name calling, unsettling calls to family members, and other unprofessional communications have occurred. As the strategic plan will once again be discussed at the November 2021 meeting, the debate and hopefully the adoption of these policies and principles are paramount in order to have a professional and courteous conversation regarding the production and contents of the equity report. We believe the Speakers saw this firsthand during the June meeting.

Reference Committee G

CMS Report(s)

02 Access to Health Plan Information Regarding Lower-Cost Prescription Options

04 Financing of Home and Community-Based Services

Joint Report(s)

01 CMS/CSAPH Joint Report - Reducing Inequities and Improving Access to Insurance for Maternal Health Care

Resolution(s)

701 Coverage of Pregnancy-Associated Healthcare for 12 Months Postpartum for Uninsured Patients who are Ineligible for Medicaid

702 System Wide Prior and Post-Authorization Delays and Effects on Patient Care Access

703 Clear Statement Regarding the Use of CPT E/M Outpatient Visit Codes

704 Expanding the AMA's Study on the Economic Impact of COVID-19

705 Advocating for Program Stability in the Merit-Based Incentive Payment System

706 Support for State Medical Record Retention Laws

707* Fifteen Month Lab Standing Orders

708* Insurance Coverage for Scalp Cooling (Cold Cap) Therapy

709* Prior Authorization - CPT Codes for Fair Compensation

710* Physician Burnout is an OSHA Issue

* Contained in the Handbook Addendum

REPORT 2 OF THE COUNCIL ON MEDICAL SERVICE (NOV-21)
Access to Health Plan Information regarding Lower-Cost Prescription Options
(Resolution 213-NOV-20)
(Reference Committee G)

EXECUTIVE SUMMARY

At the November 2020 Meeting, the House of Delegates referred Resolution 213, "Pharmacies to Inform Physicians when Lower Cost Medication Options are on Formulary," which was sponsored by the American College of Allergy, Asthma and Immunology. Resolution 213 asked the American Medical Association (AMA) to support legislation or regulatory action to require that in the event a patient cannot afford the medication prescribed, either because it is not on the formulary or it is priced higher than other medications on the formulary, the pharmacist must communicate to the prescriber a medication option in the same class prescribed with the lowest out-of-pocket cost to the patient. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates.

Resolution 213-NOV-20 highlights the untenable position patients and their physicians encounter as they attempt to choose among appropriate prescription drug options with incomplete information. When recommending a pharmaceutical to a patient, physicians consider not only clinical appropriateness, but also patient preferences and patient ability to afford the prescribed medication. Nevertheless, at the point of joint decision-making, patients and their physicians often lack access to critical prescription drug price information. Instead, patients and their physicians may choose a clinically appropriate prescription drug, but without access to accurate, patient-specific insurance plan and/or Pharmacy Benefit Manager (PBM) formulary and utilization management information, they may not know until the patient attempts to purchase the drug at a pharmacy that the selected pharmaceutical was unaffordable for the patient.

This report studies the communication challenges that arise among patients, physicians, pharmacies, and health plans when patients are unable to afford prescribed medication and health information technology solutions that can help. In addition, this report highlights ongoing AMA advocacy to improve prescription drug price transparency and presents policy recommendations.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-N-21

Subject: Access to Health Plan Information regarding Lower-Cost Prescription Options (Resolution 213-NOV-20)

Presented by: Asa C. Lockhart, MD, MBA, Chair

Referred to: Reference Committee G

At the November 2020 Meeting, the House of Delegates referred Resolution 213, "Pharmacies to Inform Physicians when Lower Cost Medication Options are on Formulary," which was sponsored by the American College of Allergy, Asthma and Immunology. Resolution 213 asked the American Medical Association (AMA) to support legislation or regulatory action to require that in the event a patient cannot afford the medication prescribed, either because it is not on the formulary or it is priced higher than other medications on the formulary, the pharmacist must communicate to the prescriber a medication option in the same class prescribed with the lowest out-of-pocket cost to the patient. Reference committee testimony at the meeting was mixed regarding Resolution 213. While testimony supported the intent of Resolution 213, testimony also expressed concern that Resolution 213 could lead to unintended consequences of creating unnecessary administrative burdens on physicians, confusion for patients, and potential pharmacy scope of practice expansion. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates. This report studies the communication challenges that arise among patients, physicians, pharmacies, and health plans when patients are unable to afford prescribed medication and health information technology (HIT) solutions that can help. In addition, this report highlights ongoing AMA advocacy to improve prescription drug price transparency and presents policy recommendations.

BACKGROUND

Patients are directly impacted by high prescription drug prices when they are still in the deductible period of their insurance plans, when the drugs prescribed are not covered by their insurance, when a nonpreferred formulary status for a particular drug leads to a higher patient cost-share, when Medicare Part D beneficiaries are in the "donut hole," or when patients are uninsured. As the number of patients enrolled in high-deductible health plans and Medicare Part D continues to rise, more patients may struggle with prescription affordability challenges. Resolution 213-NOV-20 highlights the untenable position patients and their physicians encounter as they attempt to choose among appropriate prescription drug options with incomplete information. When recommending a pharmaceutical to a patient, physicians consider not only clinical appropriateness, but also patient preferences and patient ability to afford the prescribed medication. Nevertheless, at the point of joint decision-making, patients and their physicians often lack access to critical prescription drug price information. Instead, patients and their physicians may choose a clinically appropriate prescription drug, but without access to accurate, patient-specific insurance plan and/or Pharmacy Benefit Manager (PBM) formulary and utilization management information, they may not know until patients attempt to purchase their drugs at the pharmacy that the selected pharmaceuticals are unaffordable for the patient.

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Pharmacists play an important role in identifying instances of prescription drug prices impairing access to care. Critically, a pharmacist may be the first, and potentially only health care professional, who knows that a patient has declined a prescribed medication due to cost. The prescribing physician should be informed when a patient declines to fill a prescription as soon as possible, but as noted in testimony on Resolution 213-NOV-20, requiring pharmacists to communicate to the prescriber a lower-cost medication option can be problematic. Ideally, patient out-of-pocket costs associated with prescription options would be easily available through the electronic systems used by physicians and pharmacists, but that information is not currently universally available. In the absence of a technology tool, the only way to know which medications are on the formulary is for the physician, pharmacist, or patient to research the formulary and/or call the insurance plan or PBM. Clearly, such a process is burdensome for everyone. Since the ultimate decision regarding which medication is most appropriate for a patient is made directly between physicians and patients, requiring pharmacists to research patients' formularies and discuss their research with the physician unnecessarily adds burden to both physicians and pharmacists. Moreover, unnecessarily inserting pharmacists into the prescribing process may increase confusion among patients and scope of practice concerns as patients seek prescription guidance from their pharmacists. Rather than imposing burdensome new legal requirements on pharmacists, the goal of improved prescription drug price transparency at the point of prescribing could be accomplished via improved HIT.

PRICE TRANSPARENCY AT POINT OF PRESCRIBING AND REAL-TIME PRESCRIPTION BENEFIT TECHNOLOGY

To empower informed joint decision-making, patients and physicians must have a way to obtain real-time, patient-specific prescription drug coverage information at the point of prescribing in physicians' electronic health records (EHR)s.[1] Having access to accurate, current information about a patient's prescription benefit will enable physicians and patients to evaluate drug costs and consider possible alternative therapies when selecting a medication regimen. Drug price transparency at the point of care has the potential to reduce drug costs for patients (and public and private payers). Additionally, provision of such data within the e-prescribing workflow will ensure physician awareness of utilization management requirements, such as prior authorization requirements, step therapy protocols, and quantity limitations at the point of prescribing. Transparency of patient out-of-pocket costs and coverage restrictions in EHRs can therefore help mitigate medication nonadherence and treatment abandonment. Finally, by leveraging a technology solution embedded into existing EHRs, neither patients, physicians, pharmacists, nor payers would be burdened with the time-consuming process of manually cross-checking current formularies and potential medication alternatives. This technology solution currently exists in proprietary form, and a standardized version is on the horizon.

Real-Time Prescription Benefit (RTPB) technology, also known as Real-Time Benefit Tool (RTBT) technology in federal regulatory language, is a prescription drug decision-making tool that embeds real-time, patient-specific benefit information in the e-prescribing workflow.[2] RTPB tools allow prescribers to access accurate, patient-specific coverage and benefit information, including the expected out-of-pocket cost, for a chosen medication and pharmacy. RTPB tools also present prescribers with utilization management restrictions and plan-preferred alternative medication options, which may be more cost-effective for the patient.[3] RTPB tools represent a significant improvement over the drug formulary information otherwise incorporated into EHRs and e-prescribing. Existing drug formulary information is often inaccurate, outdated, and generally unreliable due to delayed updates and lack of patient specificity. The significant limitations in drug formulary information embedded into EHRs have caused some physicians to distrust (and consequently ignore) the formulary data currently available in EHRs.

Several proprietary RTPB tools are already being used by some physicians and health systems, but the proprietary nature of these tools limits their impact. Currently, physicians' ability to access RTPB information for a specific patient depends on whether there is a business relationship between the physician practice's RTPB tool software provider and the patient's drug plan. For example, Surescripts is collaborating with several EHR companies and leveraging information from the PBMs CVS Health and Express Scripts to provide RTPB tools for the patients and physicians in their network.[4] Similarly, OptumRx and UnitedHealthcare are collaborating to provide a similar tool, specifically for their enrollees.[5] Accordingly, some physicians may have access to RTPB tools for some patients, but physicians cannot yet access comprehensive benefit information across all prescription drug plans, and tools do not yet integrate with all EHRs/e-prescribing systems. To achieve that level of universal access and transparency, a non-proprietary RTPB standard is required.

To test the hypothesized benefits of a standard RTPB tool, a research team at Johns Hopkins Medicine recently studied the impact of an RTPB tool integrated into the EHR at their institution.[6] The study found that the RTPB tool reduced physician prior authorization burden, achieved patient cost savings, and facilitated improved medication adherence. Specifically, the cost and day-supply information provided by the RTPB tool frequently led physicians and patients to choose a 3-month supply of medication instead of a 1-month supply, as many PBMs discount the copay on 3-month supplies, making the 3-month supply more cost effective. This has important health outcomes implications, as medication adherence increases with longer day-supply of prescriptions.[7] The most common changes in drug selection involved switching to alternatives with minimal clinical, but notable financial, significance. In addition, the information provided by the RTPB tool was able to guide prescribers in choosing medication alternatives without prior authorization requirements, and to convert from an agent covered with restrictions to one covered without restrictions, or to convert from an agent not covered to one covered with restrictions. These features reduced administrative burden on prescribers and increased the likelihood of patients being able to obtain their medication without delay. The study found patient cost savings of up to $2,370 when a prescription was switched from a retail to mail order pharmacy. The average patient out-of-pocket cost savings due to changes in prescription was approximately $21. Essential to building physician trust in the tool, the study found that the price estimates provided by the RTPB tool were accurate in 98 percent of the orders. The research team emphasized that webinars and in-person meetings were held to promote increased adoption and appropriate use of the RTPB tool, and since going live with the tool, they observed a significant increase in awareness from prescribers about the tool.

CMS intensified the need for standardized RTPB technology with its May 2019 final rule requiring that each Medicare Part D plan adopt one or more RTBTs that are capable of integrating with at least one EHR or e-prescribing system by January 1, 2021.[8] While this mandate could potentially help accelerate physician practices' access to RTPB tools, the CMS rule is significantly limited. The CMS rule allows Medicare Part D plans to support a single RTBT that is required to integrate with only one physician EHR/e-prescribing system. As such, physicians and their EHR vendors could presumably need to support a different RTBT for every Medicare Part D plan in order to have access to prescription benefit information for every Medicare patient treated by the practice. This would be an overwhelming, expensive, and burdensome proposition for vendors and physicians and would likely discourage adoption of this technology. Alternatively, since CMS is only requiring *one* RTBT capable of integrating with at least *one* e-prescribing system or EHR, some physicians may find that they have RTPB information for some, but not all, of their patients. Such incomplete access to RTPB information may lead to greater confusion and frustration, both among physicians and patients. An RTPB standard is needed to progress beyond the current proprietary and incomplete RTPB technology landscape and allow all physicians access through any EHR to any patient's specific benefit information.

The National Council for Prescription Drug Programs (NCPDP) has been developing an electronic standard for RTPB technology since 2014.[9] The NCPDP's Real Time Prescription Benefit Standard Task Group (RTPB Task Group) is responsible for developing the RTPB standard,[10] and the AMA has participated in the RTPB Task Group since its inception. At its August 2021 Virtual Interim Work Group meeting, the RTPB Task Group agreed to recommend that CMS recognize, via the federal rulemaking process, the RTPB standard that has been developed by NCPDP.[11] It is anticipated that the RTPB standard will have an implementation time-period of 2 years following the publication of a final rule.

As articulated in Resolution 213-NOV-20, currently it can be impossible for insured patients and their physicians to know at the point of prescribing what a prescribed drug will cost the patient. A standardized RTPB tool embedded into physicians' EHRs will close the current information gap among insurance plans, PBMs, pharmacies, patients and their physicians. The universality of a standardized RTPB tool is expected to significantly improve interoperability, expand transparency, increase prescription drug adherence, and promote informed communication and trust between patients and their physicians.[12]

ENHANCED PHYSICIAN EDUCATION REGARDING APPLICATION OF RTPB TECHNOLOGY

The Council commends the resolution sponsors for highlighting the critical problem of cost-related non-adherence and prescription abandonment and the urgent need for tools that will enhance communication among physicians and pharmacists on behalf of patients. Resolution 213-NOV-20 also illustrates that RTPB technology is not currently a top-of-mind solution for the majority of physicians. The AMA's 2020 Physician Practice Benchmark Survey (2020 Benchmark Survey), which is a nationally representative survey of US physicians who provide patient care, and which included an explanation of RTPB technology, found that only 35.7 percent of physicians had heard of RTPB technology prior to taking the survey.[13] Moreover, among that portion of the physician population who had heard of RTPB technology, only about 55 percent of those physicians had access to RTPB technology. This may be due to the proprietary nature of the currently available RTPB tools. However, the physicians who have access to RTPB technology overwhelmingly choose to take advantage of the tool. In fact, the 2020 Benchmark Survey found that physicians who have access to RTPB tools are over four times as likely to use the RTPB technology available to them than not. Accordingly, not only is there an urgent need for a standard RTPB tool that will provide all physicians access to all patients' specific benefit information at the point of prescribing, but there is also an urgent need to help the approximately 64 percent of physicians who are unfamiliar with RTPB technology understand the tool's significant value so that they will be prepared to optimally utilize RTPB technology, once it is available to them.

ADDITIONAL TOOLS TO FILL PRESCRIPTION DRUG COST INFORMATION GAPS

The Council recognizes that RTPB technology is not a panacea that can solve the much broader problem of prescription drug cost transparency in all contexts. As the "Benefit" element of the RTPB name implies, RTPB tools will only increase point of prescribing price transparency for insured patients. Yet, out-of-pocket prescription drug cost transparency is essential for all patients. Some patients are uninsured or underinsured, and formulary status may not be relevant to these patients. Some local pharmacies may charge lower retail prices for certain prescription drugs than others, and there may be prescription discount programs available for some medications (e.g., directly through manufacturers or through drug discount aggregator websites, such as GoodRx). Clearly, there is an urgent need for ongoing HIT innovation to enhance prescription drug price transparency in all contexts, and the AMA continues to advocate for improvements.

While the health care industry awaits implementation of a standard RTPB tool to provide price transparency for insured patients and awaits additional future tools to provide optimal prescription out-of-pocket cost information at the point of prescribing for all patients, physicians may want to further explore how tools within their current EHR systems could be used to mitigate concerns about prescription abandonment. Among the features that are legally required to be included in all EHR software are tools that facilitate communication between pharmacies and prescribers, and these tools could be used to help identify and respond to patients who encounter cost barriers when attempting to fill their prescriptions. For example, the "RxFill transaction" can be used to communicate between a pharmacy and a prescriber, informing a prescriber whether a specific prescription was dispensed (or partially dispensed) to a patient.[14] Accordingly, if a physician is notified that a patient has never picked up an essential medication, the physician can follow-up with the patient to determine why the prescription was abandoned and if an alternative medication is appropriate. Physicians can choose to receive RxFill notifications for certain patients who are prescribed certain medications (e.g., insulin for patients with diabetes), but not for others (e.g., prescriptions for seasonal allergy medication). EHRs may allow physicians to further customize how and when they are notified. Similarly, physicians can communicate electronically with pharmacies to discuss prescription options. If a patient declines a drug, pharmacies can use the "RxChangeRequest Transaction" to send prescribers options regarding potential alternatives to originally prescribed medications.[15] For example, pharmacists may suggest a generic alternative to a brand-name drug, or they may suggest another drug that is available at a cheaper price. Upon receiving an RxChangeRequest, a prescriber can respond with an "RxChangeResponse transaction" to either approve or decline the RxChangeRequest, and the prescriber is able to provide additional comments in the response.[16] Importantly, both EHR vendor implementation and pharmacy information systems technology implementation of these e-prescribing tools varies. Physicians who believe that the use of RxFill and/or RxChangeRequest and RxChangeResponse could support their practice are encouraged to seek additional information from their EHR vendor and local pharmacies.

Physicians can also encourage their patients to utilize currently available consumer-facing prescription drug price transparency tools. For example, when shopping for a Medicare plan, Medicare patients can look-up the cost of their prescription medications under various Medicare plan options.[17] There are a variety of drug discount programs, including drug discount aggregator websites, that allow patients to compare prescription drug prices and obtain coupons that can be used at local pharmacies. Drug discount aggregator websites allow patients to view and compare prices of brand name and generic versions of prescription drugs and provide coupons that patients may choose to use when filling their prescriptions. These coupons can be especially helpful and straightforward for patients who do not have insurance coverage for prescription drugs, but because medications purchased using a coupon may not automatically be counted towards insured patients' deductibles, they may not always provide overall cost-savings for insured patients.[18] A federal regulation finalized in 2020 provides insured patients with greater out-of-pocket cost transparency beginning in 2023.[19] The Transparency in Coverage final rule requires most individual and group health plans to make available to participants, beneficiaries and enrollees personalized out-of-pocket cost information for all covered health care items and services, including prescription drugs, through an internet-based self-service tool and in paper form upon request.[20] This will allow patients to obtain real-time, accurate out-of-pocket cost estimates that they can share with their physicians as they engage in joint decision-making and care planning. In addition to providing greater real-time cost transparency for patients and their physicians, starting in 2022, the Transparency in Coverage final rule will require disclosure of in-network negotiated rates and historical net prices for all covered prescription drugs by plan or issuer at the pharmacy location level.[21] Researchers and third-party developers and innovators can use this data to create private sector solutions to achieve greater price transparency.[22]

AMA POLICY AND ADVOCACY

Long-standing AMA policy supports ongoing advocacy for the development of HIT tools, such as an RTPB standard, that enhance prescription drug price transparency. Policy H-450.938 states that physicians should have easy access to and review the best available data associated with costs at the point of decision-making, which necessitates cost data to be delivered in a reasonable and useable manner by third-party payers and purchasers. In addition, the policy calls for physicians to seek opportunities to improve their information technology infrastructures to include new and innovative technologies to facilitate increased access to needed and useable evidence and information at the point of decision-making. Related, Policy H-125.979 encourages PBMs, health insurers, and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing, and promotes the value of online access to up-to-date and accurate prescription drug formulary plans from all insurance providers nationwide. Similarly, Policy H-110.990 supports the development and use of tools and technology that enable physicians and patients to determine the actual price and out-of-pocket costs of individual prescription drugs prior to making prescribing decisions, so that physicians and patients can jointly decide on treatment. Recent Policy H-125.974 states that our AMA will advocate to the Office of the National Coordinator for Health Information Technology (ONC) and CMS to work with physician and hospital organizations, and HIT developers, in identifying RTPB implementations and published standards that provide real-time information across all prescription drug plans, patient portals and other viewing applications, and EHR vendors. This policy also states that the AMA will advocate to the ONC and CMS that any policies requiring HIT developers to integrate RTPB within their products do so with minimal disruption to EHR usability and cost to physicians and hospitals. Moreover, the policy establishes that the AMA will support alignment and real-time accuracy between the prescription drug data offered in physician-facing and consumer-facing RTPB tools.

Additionally, AMA policy and advocacy promote open communication between pharmacists and physicians when issues of prescription unaffordability arise and increased price transparency at the pharmacy. Policy H-285.965 urges pharmacists to contact the prescribing physician if a prescription written by the physician violates the managed care drug formulary under which the patient is covered, so that the physician has an opportunity to prescribe an alternative drug, which may be on the formulary. Moreover, Policy H-110.991 advocates for greater prescription drug price transparency at the pharmacy point of sale by: (1) advocating that both the retail price and the patient's copay be listed on prescription receipts, (2) pursuing legislation that would require pharmacies to inform patients of the cash price as well as the formulary price of any medication prior to purchase, and (3) opposing provisions in contracts between pharmacies and PBMs that would prohibit pharmacies from disclosing when a patient's copay is higher than the drug's cash price (so called "gag clauses"). The AMA developed model legislation consistent with Policy H-110.991, similar bills have been enacted in several states, and federal legislation was enacted to prohibit gag clauses in Medicare, Medicare Advantage,[23] group, and individual health insurance plans.[24] Related, in response to Policy H-110.987, the AMA developed model state legislation entitled, "An Act to Increase Drug Cost Transparency and Protect Patients from Surprise Drug Cost Increases during the Plan Year" which addresses the issue of timely prescription decision support and would authorize a pilot study to integrate transparency data at the point of care, with information such as medicines' formulary status, cost-sharing tier, patient out-of-pocket cost, and coverage restrictions being integrated into EHRs or e-prescribing systems.

The AMA continues to advocate extensively in support of an RTPB standard. Since 2014, the AMA has been actively engaged in the development of the NCPDP RTPB standard to ensure that any mandated standard will meet the needs of physician end-users and their patients. The AMA serves as a member of the NCPDP's RTPB Task Group which is comprised of stakeholders from

across the health care industry, including organized medicine, hospitals, payers, HIT vendors, and pharmaceutical/life sciences companies. NCPDP has quarterly workgroup meetings, and the RTPB Task Group meets weekly to discuss and continue developing the RTPB standard. Collectively, the RTPB Task Group is committed to the goal of developing and publishing an RTPB standard that will meet the needs of and benefit every sector of the health care industry and that will be readily adopted by CMS.

During recent testimony at the Congressional Hearing, "Lowering Prescription Drug Prices: Deconstructing the Drug Supply Chain," the AMA emphasized the challenges patients and physicians encounter due their inability to access patient-specific formulary and cost-sharing information at the point of care.[25] The AMA has also recently submitted written comments to CMS[26] and presented to the ONC Health Information Technology Advisory Committee (HITAC) Intersection of Clinical and Administrative Data Task Force (ICAD) strongly supporting an RTPB standard. Additionally, the AMA recently submitted comments to CMS that highlighted the importance of physicians having access to real-time, patient-specific prescription drug coverage information at the point of prescribing in physicians' EHRs, supported CMS' efforts to expedite industry implementation of RTBT, and recommended that CMS require plans to support a single RTBT standard, when made available.[27]

Finally, in 2016, the AMA launched a grassroots campaign and website, TruthinRx.org, the goal of which is to address the opaque process that pharmaceutical companies, PBMs, and health insurers engage in when pricing prescription drugs. TruthinRx.org provides a platform through which individuals can sign petitions to members of Congress and template letters that website visitors can customize and directly send to their US Senators and US Representatives, calling on them to support increased transparency in prescription drug prices. Coordinated with AMA model legislation, and state and national engagement, TruthinRx.org is updated to reflect advances in AMA policy and pharmaceutical industry activities.

DISCUSSION

Resolution 213-NOV-20 highlighted physicians' need for patient-specific, real-time formulary and cost-sharing information, and an RTPB standard would fill that need. A standardized RTPB tool integrated into EHR systems will allow physicians to have real-time access, at the point of prescribing, to a current report of whether a specific medication is on a specific patient's prescription formulary. A standardized RTPB tool will provide patient-specific out-of-pocket cost for a selected medication at that patient's designated primary pharmacy, and it will alert physicians to applicable utilization management restrictions. A standardized RTPB tool will present physicians with options of alternative medications that are covered by a patient's insurance plan, and this will empower physicians and patients to decide together, before the patient leaves the examination room, whether the medication is not only clinically, but also financially, well-suited for the patient. If the medication is unaffordable, the physician can pull up this same information for other medications equally clinically appropriate for the specific patient, and it will allow physicians to see the drug discount program prices for the queried pharmacy. Accordingly, the Council recommends that the AMA continue to zealously advocate for the development, publication, adoption, and mandated use of standardized RTPB tools with minimal burden on physicians. In addition, the Council recognizes that many practicing physicians have not been made aware of how a standard RTPB tool will enhance their practice, or how HIT tools already available within their EHR and/or e-prescribing systems can enhance communication between physicians and pharmacists. For this reason, the Council recommends that the AMA develop and disseminate educational materials that will empower physicians to leverage these HIT tools to enhance their practices.

The Council recognizes that the question of whether a particular prescription drug is on a patient's insurance formulary is just one component of the much larger prescription drug affordability challenge. The AMA will continue to advocate for technology tools to efficiently address the broad range of prescription price transparency and affordability challenges unrelated to insurance benefits. For these reasons, the Council recommends amending Policy H-110.990 to specifically call for the development and use of tools and technology that enable physicians and patients to determine the actual price and patient-specific out-of-pocket costs of individual prescription drugs, taking into account insurance status or payer type, prior to making prescribing decisions, so that physicians and patients can work together to determine the most efficient and effective treatment for the patient's medical condition. Related, the Council recommends amending Policy H-125.974 which supports alignment and real-time accuracy between the prescription drug data offered in physician-facing and consumer-facing RTPB tools, and advocates that regulators work with physician and hospital organizations, and HIT developers, in identifying real-time pharmacy benefit implementations and published standards that provide real-time or near-time formulary information across all prescription drug plans, patient portals and other viewing applications, and EHR vendors. The Council recommends adding to this strong policy to also specify that the AMA will advocate that regulators include proven and established real-time pharmacy benefit criterion within EHR certification programs and that integration of RTPB tools within HIT be accomplished without disruption to EHR usability and minimal to no cost to physicians and hospitals. Finally, the Council recommends reaffirming Policy H-450.990 which calls for physician access to the best available cost data at the point of decision-making.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 213-NOV-20 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) continue to support efforts to publish a Real-Time Prescription Benefit (RTPB) standard that meets the needs of all physicians, utilizing any electronic health record (EHR), and prescribing on behalf of any insured patient. (New HOD Policy)

2. That our AMA advocate that all payers (i.e., public and private prescription drug plans) be required to implement and keep up to date an RTPB standard tool that integrates with all EHR vendors, and that any changes that must be made to accomplish RTPB tool integration be accomplished with minimal disruption to EHR usability and cost to physicians and hospitals. (New HOD Policy)

3. That our AMA develop and disseminate educational materials that will empower physicians to be prepared to optimally utilize RTPB tools and other health information technology tools that can be used to enhance communications between physicians and pharmacists to reduce the incidence of prescription abandonment. (Directive to Take Action)

4. That our AMA amend Policy H-110.990[3] by addition, as follows:

   Our AMA: … 3. supports the development and use of tools and technology that enable physicians and patients to determine the actual price and <u>patient-specific</u> out-of-pocket costs of individual prescription drugs<u>, taking into account insurance status or payer type,</u> prior to making prescribing decisions, so that physicians and patients can work together to determine the most efficient and effective treatment for the patient's medical condition. (Modify Current HOD Policy)

5. That our AMA amend Policy H-125.974 by addition and deletion as follows:

   Our AMA will: . . .
   (4) will advocate to the Office of the National Coordinator for Health Information Technology (ONC) and the Centers for Medicare & Medicaid Services (CMS) to work with physician and hospital organizations, and health information technology developers, in identifying real-time pharmacy benefit implementations and published standards that provide real-time or near-time formulary information across all prescription drug plans, patient portals and other viewing applications, and electronic health record (EHR) vendors;
   (5) will advocate to the ONC to include proven and established real-time pharmacy benefit criteria within its certification program;
   (~~5~~6) will advocate to the ONC and the CMS that any policies requiring health information technology developers to integrate real-time pharmacy benefit systems (RTPB) within their products do so without ~~minimal~~ disruption to EHR usability and minimal to no cost to physicians and hospitals; and… (Modify Current HOD Policy)

6. That our AMA reaffirm Policy H-450.938 which states that physicians should have easy access to and review the best available data associated with costs at the point of decision-making, which necessitates that cost data be delivered in a reasonable and useable manner by third-party payers and purchasers. The policy also calls for physicians to seek opportunities to improve their information technology infrastructures to include new and innovative technologies to facilitate increased access to needed and useable evidence and information at the point of decision-making. (Reaffirm HOD Policy)

Fiscal Note: Less than $2,500.

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APPENDIX

Policy Recommended for Amendment or Reaffirmation

H-110.990 Cost Sharing Arrangements for Prescription Drugs
Our AMA:
1. believes that cost-sharing arrangements for prescription drugs should be designed to encourage the judicious use of health care resources, rather than simply shifting costs to patients;
2. believes that cost-sharing requirements should be based on considerations such as: unit cost of medication; availability of therapeutic alternatives; medical condition being treated; personal income; and other factors known to affect patient compliance and health outcomes; and
3. supports the development and use of tools and technology that enable physicians and patients to determine the actual price and out-of-pocket costs of individual prescription drugs prior to making prescribing decisions, so that physicians and patients can work together to determine the most efficient and effective treatment for the patient's medical condition. (CMS Rep. 1, I-07 Reaffirmation A-08 Reaffirmed: CMS Rep. 1, I-12 Reaffirmed in lieu of Res. 105, A-13 Reaffirmed in lieu of: Res. 205, A-17 Reaffirmed in lieu of: Res. 207, A-17 Reaffirmed: CMS Rep. 07, A-18)

H-125.974 Continuity of Care for Patients Discharged from Hospital Settings
Our AMA:
(1) will advocate for protections of continuity of care for medical services and medications that are prescribed during patient hospitalizations, including when there are formulary or treatment coverage changes that have the potential to disrupt therapy following discharge;
(2) supports medication reconciliation processes that include confirmation that prescribed discharge medications will be covered by a patient's health plan and resolution of potential coverage and/or prior authorization (PA) issues prior to hospital discharge;
(3) supports strategies that address coverage barriers and facilitate patient access to prescribed discharge medications, such as hospital bedside medication delivery services and the provision of transitional supplies of discharge medications to patients;
(4) will advocate to the Office of the National Coordinator for Health Information Technology (ONC) and the Centers for Medicare & Medicaid Services (CMS) to work with physician and hospital organizations, and health information technology developers, in identifying real-time pharmacy benefit implementations and published standards that provide real-time or near-time formulary information across all prescription drug plans, patient portals and other viewing applications, and electronic health record (EHR) vendors;
(5) will advocate to the ONC and the CMS that any policies requiring health information technology developers to integrate real-time pharmacy benefit systems (RTPB) within their products do so with minimal disruption to EHR usability and cost to physicians and hospitals; and
(6) supports alignment and real-time accuracy between the prescription drug data offered in physician-facing and consumer-facing RTPB tools. (CMS Rep. 2, A-21)

H-450.938 Value-Based Decision-Making in the Health Care System
PRINCIPLES TO GUIDE PHYSICIAN VALUE-BASED DECISION-MAKING
1. Physicians should encourage their patients to participate in making value-based health care decisions.
2. Physicians should have easy access to and consider the best available evidence at the point of decision-making, to ensure that the chosen intervention is maximally effective in reducing morbidity and mortality.
3. Physicians should have easy access to and review the best available data associated with costs at the point of decision-making. This necessitates cost data to be delivered in a reasonable and

useable manner by third-party payers and purchasers. The cost of each alternate intervention, in addition to patient insurance coverage and cost-sharing requirements, should be evaluated.
4. Physicians can enhance value by balancing the potential benefits and costs in their decision-making related to maximizing health outcomes and quality of care for patients.
5. Physicians should seek opportunities to improve their information technology infrastructures to include new and innovative technologies, such as personal health records and other health information technology initiatives, to facilitate increased access to needed and useable evidence and information at the point of decision-making.
6. Physicians should seek opportunities to integrate prevention, including screening, testing and lifestyle counseling, into office visits by patients who may be at risk of developing a preventable chronic disease later in life. (CMS Rep. 7, A-08 Reaffirmed in lieu of Res. 5, A-12 Reaffirmation I-14 Reaffirmation: I-17 Reaffirmed: CMS Rep. 06, A-19)

REPORT 4 OF THE COUNCIL ON MEDICAL SERVICE (NOV-21)
Financing of Home and Community-Based Services
(Reference Committee G)

EXECUTIVE SUMMARY

The Council on Medical Service initiated this report to provide an overview of the current financing mechanisms for home and community-based services (HCBS) and to raise awareness about the importance of identifying sustainable methods of broader long-term services and supports (LTSS) financing. This report builds on the long-standing policy of the American Medical Association (AMA) regarding LTSS and presents policy recommendations to modify the current financing structure of HCBS.

The United States (US) is undergoing a population shift. By 2040, about one in five Americans will be 65 or older. By 2050, those over age 85 are projected to more than triple, and it is estimated that 70 percent of seniors reaching age 65 are expected to require some type of long-term care (LTC) assistance in their lifetime. LTC includes both medical and non-medical care, such as assistance with activities of daily living (ADLs). ADLs include a range of activities such as help with bathing, dressing, meal preparation, medication management, housekeeping, and transportation. Hundreds of thousands of older and disabled individuals live in institutionalized care settings not because they need the level of specialized medical care provided in those settings, but because Medicaid payment rules make that the only option with daily care that they can afford. The current LTSS financing structure and incentives generally favor expensive institutional care settings like skilled nursing facilities over less expensive and usually more desirable care settings like adult day care and home care. However, under the Medicaid statute, states must cover institutional LTSS services, but covering HCBS like home health aides and adult day care is optional. Therefore, Medicaid coverage for services in the home or community varies by state with some states not offering HCBS altogether.

Concurrent with demographic shifts, the COVID-19 pandemic has exposed the vulnerabilities of institutionalized care settings such as LTC facilities and the weaknesses in the nation's system of caring for older adults and individuals with disabilities and limitations. It is estimated that nursing home deaths are believed to account for about one-third of total COVID-19 deaths. This grim reality has highlighted the need for a better system of caring for these older and disabled populations.

The Council believes the AMA should seize this opportunity to rethink the current long-term care system and to build upon the AMA's current body of long-term care policy to recommend fundamental reforms, specifically reforms strengthening the nation's system of HCBS. HCBS presents a compelling shift away from institutionalized care. Not only is there currently an unmet need for HCBS, but also, this need is expected to increase with a growing elderly population. Through the Council's set of recommendations, states and the federal government are encouraged to develop and expand HCBS offerings as lower-cost and more preferred alternatives to providing institutional care.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 04-N-21

Subject: Financing of Home and Community-Based Services

Presented by: Asa Lockhart, MD, Chair

Referred to: Reference Committee G

The COVID-19 pandemic has exposed the vulnerabilities of institutionalized care settings such as long-term care (LTC) facilities and the weaknesses in the nation's system of caring for older adults and individuals with disabilities and limitations. It is estimated that about eight percent of people living in LTC facilities have died of COVID-19, a percentage that is considered an undercount.[1] In particular, nursing home deaths are believed to account for about one-third of total COVID-19 deaths. This grim reality has highlighted the need for a better system of caring for these older and disabled populations. The Council recognizes that COVID-19 pandemic has created an opportunity to review the current LTC system and to build upon the American Medical Association's (AMA's) current body of LTC policy to recommend fundamental reforms, specifically reforms strengthening the nation's system of home and community-based services (HCBS).

This report, initiated by the Council, provides an overview of LTC needs in the United States (US), highlights the myriad ways that HCBS is funded, outlines current HCBS legislative proposals, summarizes relevant AMA policy, and recommends policy to create a stronger foundation and financing structure for HCBS.

BACKGROUND

The US is undergoing a population shift. By 2040, about one in five Americans will be 65 or older. By 2050, those over age 85 are projected to more than triple.[2] According to the US Department of Health and Human Services (HHS), 70 percent of seniors reaching age 65 are expected to require some type of LTC assistance in their lifetime.[3] LTC includes both medical and non-medical care, such as assistance with activities of daily living (ADLs). ADLs include a range of activities such as help with bathing, dressing, meal preparation, medication management, help with housekeeping, and transportation.

Hundreds of thousands of older and disabled individuals live in institutionalized care settings not because they need the level of specialized medical care provided in those settings, but because Medicaid payment rules make that the only option with daily care that they can afford. The current long-term services and supports (LTSS) financing structure and incentives generally favor expensive institutional care settings like skilled nursing facilities over less expensive and usually more desirable care settings like adult day care and home care. The average annual cost for a nursing home room is $105,850. Alternatively, the average annual cost for a full-time home health aide is about $48,000, and the cost of adult day care is about $17,000.[4,5] However, under the Medicaid statute, states must cover institutional LTSS services, but covering HCBS like home health aides and adult day care is optional.[6] Therefore, Medicaid coverage for services in the home or community varies by state with some states not offering HCBS altogether. According to

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Congressional Budget Office projections, federal LTSS expenditures under Medicaid are projected to reach $113 billion per year by 2025 compared with the $74 billion spent in 2014.[7]

Many residents in institutional facilities only need assistance with ADLs, and many would prefer to be living in their own communities. Seventy-six percent of people aged 50 and older would prefer to remain in their home for as long as possible, and 90 percent would prefer to age in place either in their homes or community settings such as adult day care centers.[8] Access to HCBS has emerged as an alternative to institutionalized care settings to help older Americans and those with disabilities live independently while receiving assistance with daily needs.

Medicaid beneficiaries with LTSS needs account for 6.4 percent of the Medicaid population but 45.6 percent of Medicaid expenditures.[9] Exacerbating the financial challenge of providing LTSS care to an aging population is a significant birth decline. The latest US census revealed that the US has one of the slowest rates of population growth in decades. The decline is largely due to declining immigration and a declining birthrate, which means there will continue to be fewer workers to support the aging population.[10] Today, there are 2.8 workers per Medicare beneficiary. However, that number is expected to decline to 2.3 workers by 2030.[11] This demographic shift puts a substantial strain on state and federal budgets and causes great instability in the programs on which the elderly and disabled rely. Therefore, it is critical to explore financially stable alternatives to providing LTSS to this population. In keeping people out of more expensive institutions and in the community, HCBS provides one method to stabilize LTSS funding.

MECHANISMS TO PROVIDE HCBS FINANCING AND SERVICES

Section 1915(c) and Section 1115 Waivers

For the last 40 years, states have used waivers to provide HCBS to Medicaid beneficiaries. Nearly all HCBS beneficiaries receive services through an optional authority. Section 1915(c) of the Social Security Act authorizes a waiver program allowing states to meet the care needs of their populations through LTSS in their homes or communities rather than in an institutional care setting. Section 1115 waivers give states the option to waive certain Medicaid requirements and allow states to use Medicaid funds for pilot or demonstration projects.[12] For example, states can target waivers to areas of the state where need is the greatest. States can also make waiver services available to certain groups of people who are at risk of institutionalization, such as those with a particular diagnosis. States can provide Medicaid to people who would otherwise only be eligible for coverage in an institutional setting. Using their waiver authority, states are permitted to offer a variety of services. Therefore, states can use waivers to provide a combination of standard medical and non-medical services. Services may include case management, home health aides, personal care, adult day care centers, and respite care. Moreover, states can implement other types of services that may assist in diverting or transitioning individuals from institutional care settings.[13,14]

Nearly all states and DC offer services through HCBS waivers. However, states continue to face an arduous federal waiver process. Obtaining a waiver generally requires negotiations between states and the federal government. There currently are more than 300 HCBS waiver programs in effect nationwide. Relying upon such a patchwork system makes the availability of HCBS services highly dependent on the state in which a beneficiary resides.[15]

State Plan Amendments

A Medicaid state plan is an agreement between the state and the federal government detailing how the state administers its Medicaid program. In it, the state attests that it will follow federal rules and

may claim federal matching funds for its Medicaid program activities. Additionally, the state plan outlines who will be covered under its activities, what services will be provided, payment methodologies for providers, and the state's administrative activities.[16]

States can amend their plans through a state plan amendment (SPA). States can submit a proposed SPA to Centers for Medicare & Medicaid Services (CMS) for review and approval. Over the years, Congress has enacted several SPAs designed to make it easier for states to expand HCBS. Using an SPA, states can provide Medicaid to people who would otherwise only be eligible for coverage in an institutional setting. States can also target services to individuals with particular needs, risk factors, or those with a specific disease or condition.[17]

Money Follows the Person

Medicaid's Money Follows the Person (MFP) demonstration has been in place since 2008. The initiative's intent is to rebalance Medicaid's bias for institutional care and seek to move seniors and people with disabilities from institutions and into the community. The program uses enhanced federal matching funds to incentivize states to operationalize the program. Since its inception, the MFP program has helped more than 100,000 individuals transition from institutional to community care settings. Notably, the national MFP program evaluation found that enrollees experienced significant increases in quality-of-life measures after transitioning back to their communities. The evaluation also found that some individuals would not have made the transition away from institutional care if not for MFP. The program also helped states control spending, which is attributed to the fact that HCBS typically costs less than institutional care. The evaluation found that state Medicaid programs saved about $978 million during the first year after transition for MFP enrollees.[18] The availability of the program relies on federal funding reauthorization, which is set to expire in 2023.[19]

Federal Medical Assistance Percentages

The Federal Medical Assistance Percentages (FMAPs) are used to determine the federal share for most Medicaid health care services.[20] It is calculated by a formula that is designed so that the federal government pays a larger portion of Medicaid costs in states with lower per capita incomes compared to the national average.[21] For example, the FMAP rate in Mississippi is 84.51 percent while the rate in Massachusetts is 56.2 percent.[22]

The FMAP is critical to the provision of Medicaid services in states. Medicaid accounts for nearly 30 percent of state budgets, and state budgets are particularly constrained due to the economic strain of the COVID-19 pandemic. State budgets require Medicaid predictability and limiting the number of beneficiaries and services allows states to accurately estimate HCBS expenditures.[23] Absent increased federal matching funds, states are unlikely to expand HCBS services and eligibility despite significant unmet need.

WORKFORCE

A key barrier to meaningful expansion of HCBS is an unstable workforce. States regularly mention workforce shortages as an obstacle to expanding HCBS, and the shortages have only been exacerbated by the COVID-19 pandemic. Currently, there are about 4.5 million direct care workers (DCWs) providing care to older adults and individuals with disabilities. Between 2019 and 2029, the Bureau of Labor Statistics estimates a 1.9 million increase in family caregiving jobs, which represents a 37 percent increase in over 10 years. The expected increased demand for DCWs is more than any other occupation in the economy.[24]

The current workforce is primarily comprised of women of color who earn low wages and do not receive employee benefits such as paid leave, health care, job training, or advancement opportunities. On average, DCWs make about $16,200 per year. Despite their valuable work, one in eight DCWs lives in poverty.[25] Due to these suboptimal benefits and demanding working conditions, DCW turnover is about 60-80 percent annually.[26]

Additionally, the current workforce lacks standardization, which could provide beneficiaries with more consistent and reliable care. The federal government currently requires nursing home and home health aides to undergo 75 hours of training before they can provide care, and some states do not require personal care aides certified through Medicaid to be trained at all.[27] Moreover, certification often costs DCWs hundreds of dollars, and three-quarters of the workforce earn less than the average state living wage. The financial obstacle requirements exemplify the lack of consideration and value placed on a critical workforce.

As of 2018, Medicare's conditions of participation formally recognize home health aides as members of the interdisciplinary care team who are expected to report on a beneficiary's change in condition. Despite this responsibility, little has been done to help integrate aides into care teams. This lack of team integration is unfortunate because home health aides could demonstrate value on care team models including post-acute home care, hospital at home, and ambulatory case management.

FEDERAL AGENCIES AND HOME AND COMMUNITY-BASED SERVICES

The current administration of HCBS services relies on five federal agencies. The agencies include the CMS, the Administration on Aging, the Department of Housing and Urban Development, the Department of Transportation, and the Department of Agriculture. Collectively, the agencies fund multiple programs that aid the elderly population with services like nutrition assistance, in-home care, affordable housing, and transportation.[28]

The Older Americans Act of 1965 requires HHS's Administration on Aging to facilitate cross-agency collaboration to administer HCBS. However, a recent US Government Accountability Office (GAO) report found that the five agencies operate largely independently of one another with minimal collaboration.[29] The GAO's report studied interagency collaboration and found that, though cross-agency collaboration is important for federal efforts, limited resources and competing priorities can preclude cooperation.

HOSPITAL AT HOME

Several countries pay for delivering services equivalent to hospital inpatient care to patients in their own homes. These "hospital at home" services have been successful in allowing patients with specific conditions that qualify for inpatient care to receive services in the home and avoid the risks associated with inpatient admission. Patients with conditions such as congestive heart failure, chronic obstructive pulmonary disease, and cellulitis are often candidates for the model. Patients must be sick enough to be hospitalized but stable enough to be treated at home. The at-home care is provided by visiting physicians, nurses, and other clinical staff. The services are more intensive than can be supported through traditional home health care payments. The care model has been shown to reduce costs, improve patient outcomes, and enhance the patient experience.[30]

Although some hospitals in the US have been delivering hospital at home care and some Medicare Advantage plans are paying for it, the service is difficult to sustain or expand without payment from Medicare because a minimum number of patients need to participate for the service to be

cost-effective. The Physician-Focused Payment Model Technical Advisory Committee has recommended two different "hospital at home" payment models to HHS, but neither has been implemented to date.[31]

The pandemic has highlighted the flaws of institutionalized care and accelerated the availability of hospital at home. During the pandemic, CMS has allowed hospitals to deliver services in non-traditional settings, and it pressed many private insurers to do the same. The CMS program, the Acute Hospital Care at Home Program, gives participating hospitals the ability to reduce inpatient volume by treating certain acute care patients at home using a telehealth platform that allows for daily check-ins and monitoring. Telehealth has been successfully employed in the care model to help transition patients away from institutional care settings, and the technology has greatly assisted physicians and patients at a time when maintaining physical distance is critical to health and safety. The Brigham and Women's Hospital was one hospital to take advantage of CMS's program. A 95-day study took place evaluating the model, which cared for 65 acutely ill patients. Throughout the study, the hospital at home program was staffed by one physician, one or two nurses, and one mobile integrated health paramedic. The study showed that the program cost a fraction of the cost of caring for patients in the hospital and that such programs can serve as complements to traditional hospital-based care.[32] However, it is unclear whether CMS's Hospital Care at Home Program will be extended after the COVID-19 public health emergency ends.

In May 2021, Mayo Clinic and Kaiser Permanente announced that they were teaming up to scale the hospital at home model. The two health care giants join a growing list of hospitals around the country that have implemented this model of care. It is estimated that 30 percent of hospitalized patients can benefit from the hospital at home model.[33,34]

AMA POLICY

Policy H-280.945 was established with the adoption of CMS Report 5-A-18 on the financing of LTSS. The policy states that our AMA supports policies that standardize and simplify private long-term care insurance (LTCI) to achieve increased coverage and improved affordability; supports adding transferable and portable LTCI coverage as part of workplace automatic enrollment with an opt-out provision potentially available to both current employees and retirees; supports allowing employer-based retirement savings to be used for LTCI premiums and LTSS expenses, including supporting penalty-free withdrawals from retirement savings accounts for purchase of private LTCI; and supports innovations in LTCI product design, including the insurance of HCBS and the marketing of LTC products with health insurance, life insurance and annuities. The policy also supports expanding LTSS benefits by permitting Medigap plans to offer a limited LTSS benefit as an optional supplemental benefit or as a separate insurance policy and Medicare Advantage plans offering LTSS in their benefit packages. In addition, the policy supports permitting Medigap and Medicare Advantage plans to offer a respite care benefit as an optional benefit and supports a back-end public catastrophic LTCI program. Particularly salient to this report, the policy also supports incentivizing states to expand the availability of and access to home and community-based services and calls for better integration of health and social services and supports, including the Program of All-Inclusive Care for the Elderly.

Policy H-280.991 addresses financing of LTC and outlines relevant principles and policy proposals for LTC. It states that programs to finance LTC should cover needed services in a timely and coordinated manner in the least restrictive setting appropriate to the health care needs of the individual and coordinate benefits across different LTC financing programs. The policy suggests providing coverage for the medical components of LTC through Medicaid for all individuals with income below 100 percent of the poverty level and providing sliding scale subsidies for the

purchase of LTCI coverage for individuals with income between 100-200 percent of the poverty level. Policy H-290.958 supports increases in states' FMAPs or other funding during significant economic downturns to allow state Medicaid programs to continue serving Medicaid patients and cover rising enrollment.

Policy H-280.991 supports tax incentives and employer-based LTC coverage to help fund LTC including creating tax incentives to allow individuals to prospectively finance the cost of LTC coverage and encouraging employers to offer such policies as a part of employee benefit packages and otherwise treat employer-provided coverage in the same fashion as health insurance coverage and allow tax-free withdrawals from Individual Retirement Accounts and Employee Trusts for payment of LTCI premiums and expenses. Additionally, the policy supports the use of a tax deduction or credit to encourage family caregiving. Policy H-280.991 states that consumer information programs should be expanded to emphasize the need for funding anticipated costs for LTC and to describe the coverage limitations of Medicare, Medicaid, and traditional Medigap policies. State medical associations should be encouraged to seek appropriate legislation or regulation in their jurisdictions to provide an environment within their states that permit innovative LTC financing and delivery arrangements and assure that private LTC financing and delivery systems, once developed, provide the appropriate safeguards for the delivery of high-quality care. Additionally, consistent with other AMA policy on state-based innovation, Policy H-280.991 supports health system reform legislative initiatives that could increase states' flexibility to design and implement long-term care delivery and financing programs.

Policy H-290.982 supports allowing states to use LTC eligibility criteria that distinguish between persons who can be served in a home or community-based setting and those who can only be served safely and cost-effectively in a nursing facility. Such criteria should include measures of functional impairment that account for impairments caused by cognitive and mental disorders and measures of medically related LTC needs. The policy supports buy-ins for home and community-based care for persons with incomes and assets above Medicaid eligibility limits and supports providing grants to states to develop new LTC infrastructure and to encourage expansion of LTC financing to middle-income families who need assistance.

CURRENT HCBS PROPOSALS

In Spring 2021, the Biden Administration announced a $400 billion plan to expand Medicaid HCBS and support home care workers as part of his American Jobs Plan infrastructure package. The plan does not increase funding for non-Medicaid programs critical to living at home, and it does not help middle-income Americans who make too little to pay for LTCI but earn too much to qualify for Medicaid. However, the plan proposes extending and expanding the MFP program.

Subsequently, in June 2021, a bipartisan congressional team introduced the Better Care Better Jobs Act, which would expand HCBS. The legislation formed the basis of President Biden's $400 billion plan to expand HCBS access. A main provision of the bill calls to permanently increase the FMAP by 10 percent. To receive the increase, states would have to address payment rates to promote the recruitment and retention of DCWs.[35] Another key provision would make the MFP program permanent.

However, in late June 2021, President Biden agreed to forego his $400 billion plan to expand HCBS as a concession to reach a deal with congressional leaders on a broader infrastructure bill. Nonetheless, a scaled-back iteration of the $400 billion plan may be incorporated into the $3.5 trillion 2022 domestic spending reconciliation bill that will be considered in Fall 2021, and provisions of the Better Care Better Jobs Act are anticipated to be included.

DISCUSSION

As the US population ages, beneficiary preferences evolve, and demographic shifts continue, HCBS provides a desirable and cost-effective way of delivering LTSS to seniors and those with disabilities. State Medicaid programs will confront increasing pressure to meet the LTSS needs of an aging population. Meanwhile, the COVID-19 pandemic has exposed the vulnerabilities of institutionalized care settings such as nursing homes and represents an opportunity to expand HCBS. The Council believes the AMA should seize this moment to establish fundamental policy to address the fractured LTSS system through a multi-pronged approach. The Council notes that this important issue is relevant to Council on Medical Service Report 1-NOV-21, which specifically addresses end of life payment. Notably, CMS Report 1-NOV-21 recommends supporting Medicare coverage of supportive care services, including assistance with activities of daily living, under Medicare's hospice benefit, and appropriate payment for those services.

Acknowledging the AMA's existing policy on LTSS and laying the foundation for new recommendations, the Council recommends reaffirming Policy H-280.945. The policy provides a comprehensive set of principles to improve the financing of LTSS and supports incentivizing states to expand the availability of and access to HCBS. Recognizing the importance of federal matching funds to the continuation and expansion of LTSS services, the Council also recommends reaffirming Policy H-290.958 supporting increases in states' FMAP or other funding during significant economic downturns to allow state Medicaid programs to continue serving Medicaid patients and cover rising enrollment.

Moreover, the Council recommends that states simplify their state plan options and Medicaid waivers to allow states additional flexibility to offer HCBS. By streamlining the current patchwork system of HCBS waivers and SPAs, states could promote infrastructure development, increase administrative efficiency, improve budget predictability, and better care for beneficiaries. The Council believes that continued use of CMS waiver templates is a positive step forward. Streamlining state plan options and waivers can help eliminate Medicaid's bias for institutional care and provide states the flexibility to offer services that better meet the needs of their populations.

The Council also recommends that Medicaid's MFP program, set to expire in 2023, be extended or made permanent. Doing so would enable states to expand the settings that qualify as community care settings, create broader eligibility pathways, and offer new HCBS benefits. The program has demonstrated that it saves state Medicaid programs money and provides increased and sustained enrollee quality-of-life. The Council believes that the program has made important contributions to the rebalancing of LTSS away from institutional settings and into community settings and believes that these state efforts should be continued with the requisite support.

Investing in the HCBS workforce is critical to meeting the needs of an aging population and modernizing the LTSS system. To address the needs of this aging population and to support the needed caregivers, the Council recommends supporting federal funding for payment rates that promote access and greater utilization of HCBS. The Council also recommends supporting policies that help to train, retain, and develop the HCBS workforce. Steps must be taken to professionalize the HCBS workforce. The Council notes that the training and skills required will vary yet workforce standardization is critical. For example, the skills required to care for a hospital at home patient will differ from the skills required to care for an adult needing basic ADL assistance. HCBS workforce reforms would help build a pipeline of workers while stabilizing the workforce and improving quality of care. Ultimately, HCBS and LTSS reforms will only be effective if the supporting workforce is invested in and valued. Increased federal funding for payment and policy

changes to promote the workforce will help serve the needs of individuals in the most appropriate care settings.

The Council believes that strategic coordination between the five federal agencies that fund and implement HCBS activities could ensure that resources are being used efficiently and effectively for not only the government but also for beneficiaries. Accordingly, the Council recommends supporting cross-agency and federal-state strategies that can help avoid disconnects among HCBS programs and streamline funding and the provision of services. To further streamline programs, the Council recommends that HCBS programs track protocols and outcomes. Doing so could help make meaningful comparisons across states and identify best practices. It can also help promote quality care and ensure that care is aligned with patient goals.

Finally, the hospital at home model is an important component of the shift away from institutionalized care and has been successful in allowing patients with particular conditions to remain in their homes and avoid risks associated with inpatient admission and care. Accordingly, the Council recommends that CMS and private insurers offer flexibility to implement hospital at home programs for the subset of patients who meet the criteria.

HCBS presents a compelling shift away from institutionalized care. Not only is there currently an unmet need for HCBS, but also, this need is expected to increase with a growing elderly population. States and the federal government should be encouraged to develop and expand HCBS offerings as lower-cost and more preferred alternatives to providing institutional care.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) support federal funding for payment rates that promote access and greater utilization of home and community-based services (HCBS). (New HOD Policy)

2. That our AMA support policies that help train, retain, and develop an adequate HCBS workforce (New HOD Policy)

3. That our AMA support efforts to simplify state plan amendments and Medicaid waivers to allow additional state flexibility to offer HCBS. (New HOD Policy)

4. That our AMA support that Medicaid's Money Follows the Person demonstration program be extended or made permanent. (New HOD Policy)

5. That our AMA support cross-agency and federal-state strategies that can help improve coordination among HCBS programs and streamline funding and the provision of services. (New HOD Policy)

6. That our AMA support HCBS programs tracking protocols and outcomes to make meaningful comparisons across states and identify best practices. (New HOD Policy)

7. That our AMA support that the Centers for Medicare & Medicaid Services and private insurers offer flexibility to implement hospital at home programs for the subset of patients who meet the criteria used by hospital at home programs. (New HOD Policy)

8. That our AMA reaffirm Policy H-280.945, which provides a comprehensive set of principles to improve the financing of long-term services and supports and supports incentivizing states to expand the availability of and access to HCBS and permitting Medigap and Medicare Advantage plans to offer a respite care benefit. (Reaffirm HOD Policy)

9. That our AMA reaffirm Policy H-290.958 which supports increases in states' Federal Medical Assistance Percentages or other funding during significant economic downturns to allow state Medicaid programs to continue serving Medicaid patients and cover rising enrollment. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

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JOINT REPORT OF THE COUNCIL ON MEDICAL SERVICE
AND THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (N-21)
Reducing Inequities and Improving Access to Insurance for Maternal Health Care
(Reference Committee G)

EXECUTIVE SUMMARY

The Council on Medical Service and the Council on Science and Public Health present this joint report as our first in an anticipated series of reports focused on improving maternal health. The Councils decided to pursue this report in light of the enduring maternal health crisis in the United States (US). The US is one of only 13 countries in the world where the maternal mortality rate (MMR) is worse now than it was 25 years ago, and it is the only industrialized country with a rising MMR.[1] In addition to maternal deaths, at least 50,000 women experience potentially life-threatening complications in childbirth each year, and the rate of severe maternal morbidity (SMM) doubled between 1998 and 2011.[2]

The reasons for the overall increase in pregnancy-related mortality are complex and multifactorial, and the CDC highlights "considerable racial/ethnic disparities in pregnancy-related mortality."[3] These disparities reflect the unique nature of maternal health at the intersection of race and gender. In addition, health insurance is critical to obtaining access to maternal health care, but maternity coverage under Medicaid (which covers nearly half of American deliveries[4]) ends at 60 days postpartum.[5] While some women successfully transition to other sources of coverage, many are left uninsured shortly after a major medical event.[6]

The maternal health crisis is a challenge that cannot be adequately addressed in a single report. Instead, the Councils present this narrowly focused initial report to strengthen American Medical Association (AMA) existing policy foundation and empower advocacy on two especially urgent issues:

- Expanding access to insurance for the most vulnerable new mothers, and
- Addressing inequities in maternal health care.

This initial report discusses challenges women face in pursuing maternal health care, highlights especially relevant AMA policy and advocacy, and presents a series of policy recommendations. The AMA is committed to continuing to study issues essential to improving maternal health, to take action where appropriate, and to recommend actions to be taken by others to improve maternal health and eliminate maternal health inequities.

JOINT REPORT OF THE COUNCIL ON MEDICAL SERVICE
AND THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CMS/CSAPH Joint Report N-21

Subject: Reducing Inequities and Improving Access to Insurance for Maternal Health Care

Presented by: Asa C. Lockhart, MD, MBA, Chair, Council on Medical Service
Alexander Ding, MD, MS, MBA, Chair, Council on Science and Public Health

Referred to: Reference Committee G

The Council on Medical Service and the Council on Science and Public Health present this joint report as our first in an anticipated series of reports focused on improving maternal health. Our first report is narrowly focused on two issues that are especially timely and foundational: expanding access to insurance for the most vulnerable new mothers and addressing inequities in maternal health care. The Councils decided to pursue this report in light of the enduring maternal health crisis in the United States (US). We discuss challenges women face in pursuing maternal health care, highlight especially relevant American Medical Association (AMA) policy and advocacy, and present a series of policy recommendations.

TERMINOLOGY

In our report we use the terms "women" and "mothers" to describe people who are pregnant or recently gave birth because these terms align with the language in the Social Security Act, which defines Medicaid eligibility for pregnant and postpartum women.[7] Nevertheless, the Councils acknowledge that not all people who become pregnant or give birth identify as women, and the Councils are committed to use of respectful, inclusive language. Additionally, the Councils acknowledge that this report uses several different terms when referring to the death of a patient prenatal, peripartum, or postpartum. A variety of data collection methods are used throughout the country that count prenatal, peripartum, and postpartum deaths differently (see Appendix B). Similarly, this report uses several different terms to describe stages of maternal health care. To ensure accurate characterization of research findings, this report preserves the terminology used in the source material.

REPORT SCOPE

The US maternal health crisis is a complex, multifactorial challenge that cannot be adequately addressed in a single report. Instead, the Councils present this narrowly focused initial report, the first in an anticipated series of reports, to strengthen the AMA's existing policy foundation and empower advocacy on two especially urgent issues:

- Expanding access to insurance for the most vulnerable new mothers, and
- Addressing inequities in maternal health care.

The AMA is committed to continuing to study issues essential to improving maternal health. Key topics for future study may include:

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- Maternal behavioral health (including substance use disorder and suicide), and
- Roles that health care payers (including insurance plans and employers) can play in promoting the health of growing families.

BACKGROUND

The maternal health crisis in the US is well-documented and continues to be well-studied; nevertheless, it endures. The US is one of only 13 countries in the world where the maternal mortality rate (MMR) is worse now than it was 25 years ago, and it is the only industrialized country with a rising MMR.[8] The Centers for Disease Control and Prevention (CDC) defines a "pregnancy-related death" as the death of a woman while pregnant or within one year of the end of pregnancy from any cause related to or aggravated by the pregnancy.[9] Approximately 700 to 900 pregnancy-related deaths occur in the US per year.[10] Approximately two-thirds of these deaths are preventable, and an increasing percentage are happening in the late postpartum period (more than 43 days after the end of pregnancy).[11] Moreover, the US' MMR is widely considered to be an underestimate, as varying methods are used to count deaths related to pregnancy, and reporting is inconsistent.[12] In addition to maternal deaths, at least 50,000 women experience potentially life-threatening complications in childbirth each year, and the rate of severe maternal morbidity (SMM) doubled between 1998 and 2011.[13]

The reasons for the overall increase in pregnancy-related mortality are complex and multifactorial, and the CDC highlights "considerable racial/ethnic disparities in pregnancy-related mortality."[14] These disparities reflect the unique nature of maternal health at the intersection of race and gender. During 2014 to 2017, the pregnancy-related mortality ratios were (in deaths per 100,000 live births): 41.7 for non-Hispanic Black (Black) women, 28.3 for non-Hispanic American Indian or Alaska Native women, 13.8 for non-Hispanic Asian or Pacific Islander women, 13.4 for non-Hispanic White (White) women, and 11.6 for Hispanic or Latina women.[15] Black women have been found to be at an elevated risk regardless of income, education, or geographical location.[16] The CDC explains that racial and ethnic disparities may be due to several factors including access to care, quality of care, prevalence of chronic diseases, structural racism, and implicit biases.[17] In addition to being three to four times more likely to die from pregnancy-related causes, Black women have more than a twofold greater risk of SMM than White women.[18] SMM is also higher in other racially minoritized women than in White women.[19] For example, elevated risks of morbidity and mortality (MMM) also have been reported for Native American women and some Asian and Latinx population subgroups of women.[20] As with pregnancy-related mortality, the factors underlying racial and ethnic disparities in SMM are unclear, but most studies have found that these differences persist after adjustment for sociodemographic and clinical characteristics.[21] Moreover, aggregated data can obscure critical distinctions within broad racial or ethnic categories. Robust MMM data that accurately reflect patient race and ethnicity information is needed to better identify, understand, and eliminate inequities.

In addition to this stark quantitative evidence of the crisis in US maternal health, the tragic stories of families devastated by the loss of mothers drives efforts to advance public policy and evidence-based interventions to promote maternal health and compels the health care system to strive to provide better care. Regardless of medical knowledge, education, socioeconomic status, and presence of supportive loved ones, women are dying. Three recent examples can be found within the medical community alone. Dr. Chaniece Wallace, a 30-year old chief resident in pediatrics at the Indiana University School of Medicine, died four days after her daughter was born.[22] Dr. Shalon Irving, a 36-year old Lieutenant Commander in the US Public Health Service Commissioned Corps and a CDC epidemiologist with a dual doctorate in sociology and gerontology, died three weeks after giving birth to her daughter.[23] Drs. Wallace's and Irving's

deaths demonstrate the racial disparities in maternal mortality for Black women in the US. Extensive medical and health system knowledge and experience could not protect the Bloomstein family, either—Lauren Bloomstein, a 33-year-old neonatal intensive care nurse, supported by her physician husband, died shortly after giving birth to her daughter, in the hospital where both health care professionals had worked.[24]

Health insurance is critical to obtaining access to maternal health care. Insurance coverage for births in the US is essentially split between private insurance (49 percent of births in 2018) and Medicaid (43 percent of births in 2018).[25] However maternity coverage under Medicaid ends at 60 days postpartum.[26] While some women successfully transition to other sources of coverage, many are left uninsured shortly after the major medical event of childbirth.[27] In general, one in three women in the US experiences discontinuous insurance coverage ("churn") before, during, or after pregnancy.[28] Reducing this churn in the postpartum period can help to decrease disparities in maternal health outcomes.[29]

CRITICAL CHALLENGES IN MATERNAL HEALTH CARE

While pursuing a narrow focus on improving access to affordable health insurance for the most vulnerable new mothers and eliminating racial and ethnic inequities in maternal care, it is important to place the US maternal health crisis in context. Doing so requires recognition of the complex and interconnected causes of MMM: challenges in accessing essential prenatal, peripartum, and postpartum care; stark racial and ethnic inequities in care and outcomes; and challenges posed by uninsurance. Moreover, structural inequities embedded into the current health care system can create the illusion that patients who have been minoritized and marginalized are more susceptible to certain chronic conditions and poorer outcomes.[30] Specifically, both intra-hospital disparities, where minoritized communities have been found to receive lower-quality care within a given facility, along with inter-hospital disparities, where minoritized patients tend to receive care at facilities with lower quality scores, underlie minoritized patients' poorer health outcomes.[31] HealthyPeople 2030 defines the social determinants of health (SDOH) as "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."[32] As the CDC explains, differences in SDOH contribute to the stark and persistent chronic disease disparities in the US among racial, ethnic, and socioeconomic groups, systematically limiting opportunities for members of some groups to be healthy.[33] Ultimately, to improve maternal health in general and eliminate racial and ethnic inequities in health outcomes, the health care community must strive to improve the many interconnected factors at issue, both at the level of individual patients and at the broader structural and systemic levels of the communities where they live.[34]

Multifactorial Causes of Maternal Morbidity and Mortality

Given the largely preventable nature of MMM, it is logical to seek straightforward causes that could be mitigated, but MMM results from a complex web of many interconnecting factors. According to the CDC, for every pregnancy-related death, an average of three to four contributing factors were identified, at multiple levels, including community, health facility, patient/family, provider, and system.[35] One may be inclined to look to poverty, lack of education, age, geography, or the prevalence of comorbidities as logical root causes. However, research shows that while each of those factors plays a role in the US maternal health crisis, none of them is dispositive. Studies adjusting for sociodemographic and reproductive factors have not explained the racial gap in pregnancy-related mortality in most studies.[36] For example, in one study, adjustment for maternal age, income, hypertension, gestational age at delivery, and receipt of prenatal care only reduced the odds ratios for pregnancy-related mortality from 3.07 to 2.65.[37] Moreover, another study found the

largest racial disparity among women with the lowest risk of pregnancy-related disease.[38] Patients with Medicaid have been found to have similar rates of SMM to those with private insurance within the same hospital.[39] Additionally, college-educated Black women have been found to be at a 60 percent greater risk for a maternal death than White or Hispanic women with less than a high school education.[40] Pregnancy exacerbates existing chronic diseases, including hypertension, but deaths from hypertensive disorders in pregnancy are preventable. Studies that control for age, chronic disease, and obesity have found that the MMR in the US far exceeds rates in similarly wealthy nations,[41] and that women in other wealthy countries with similarly increased rates of pregnancy comorbidities are not facing the rising MMR found in the US.[42] The health care community is increasingly recognizing the role that structural racism and implicit bias inherent in American society, including in the health care system, play in contributing to stark health inequities.

As physicians and scientists, our instinct is to scour the data to find root causes that can be directly addressed to solve glaring problems. However, current understanding of MMM, and especially the disparities in outcomes, remains incomplete,[43] and efforts to eliminate racial and ethnic inequities and promote equity in maternal health have been constrained by a lack of reliable data.[44] While extensive work is underway to collect accurate, reliable, standardized data on MMM, the data cannot yet provide the answers. As outlined by the CDC, there are three essential sources of data on maternal mortality: (1) CDC's National Center for Health Statistics' National Vital Statistics System (NVSS), (2) the CDC's Pregnancy Mortality Surveillance System (PMSS), and (3) state and local Maternal Mortality Review Committees (MMRCs).[45] The data collected by each of these sources are not standardized—they apply different definitions of maternal mortality, and they draw on different sources. Appendix B provides an overview of essential differences among these data sources and their impact on how maternal mortality is counted. In addition, there is no systematic ongoing data collection for population-based maternal morbidity in the US.[46] The source of data for CDC's national SMM estimates is the Nationwide Inpatient Sample (NIS). The Pregnancy Risk Assessment Monitoring System (PRAMS) also provides insights into health problems among mothers and babies. Appendix B also discusses NIS and PRAMS in more detail. Contributing to data challenges is the fact that while patient identity data such as race, ethnicity, and language is essential to understanding sources of disparities, patients may be hesitant to divulge private information, especially if they do not know how their data may be used.[47] Moreover, for these data to be useful, they must elicit information that accurately reflects the diversity within racial and ethnic categories, and they must be collected and reported consistently. Accordingly, it is critical to educate health care staff responsible for data collection on best practices to earn patient trust, elicit candid responses, and accurately record and report the information. Similarly, data collection and reporting legal requirements and policy must also include anti-discrimination protections to ensure that the collection of race, ethnicity, and language data is used to reduce, rather than create or exacerbate, inequities that harm individuals and populations. For additional discussion of the critical need for improvements in public health data collection and reporting, including MMM data, see CSAPH Rep. 2- NOV-21, "Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems."

<u>Accessing Prenatal, Peripartum, and Postpartum Care</u>

The full range of prepregnancy, prenatal, delivery, and postpartum care are closely linked, and care at each phase across the continuum can impact morbidity and mortality,[48] so access to care at each stage is essential. Specifically, leading causes of maternal death have been found to be hemorrhage and cardiovascular conditions during pregnancy, infection at birth and shortly after, and cardiomyopathy and behavioral health conditions (including substance use and suicide) in the postpartum period.[49] Notably, the recognized leading causes of death may vary among data reporting organizations, as

methods of investigation and reporting vary.[50] Further, timing and receipt of prenatal care vary by race and ethnicity,[51] and it is important to understand potential barriers to care. First trimester prenatal care initiation has been found to be highest among White and Asian women, followed by multiple race and Hispanic women, and lowest for Black, American Indian/Alaska Native, and Native Hawaiian/other Pacific Island women.[52] Yet, accessing prenatal care sets the stage for pursuing appropriate postpartum care, and the American College of Obstetricians and Gynecologists (ACOG) specifically recommends developing a postpartum care plan during pregnancy, especially for women at higher risk, and emphasizes the importance of providing anticipatory guidance and coordinated care.[53]

Women's health care outside of pregnancy is also essential to maternal health outcomes—it is essential that women are cared for and provided the resources they need throughout their lives, not only when they are pregnant. It is well-accepted that improving preconception health and reproductive planning can improve pregnancy outcomes by improving the overall health of women.[54] A variety of AMA policy continues to be instrumental in supporting advocacy to improve maternal health, and the full text of these polices is provided in Appendix C. For example, as outlined in Policy H-425.976, the AMA strongly supports access to and health insurance coverage for preventive women's health and preconception and inter-conception care. Moreover, the policy supports the education of physicians and the public about the importance of preconception care as a vital component of a woman's reproductive health, as well as integrating contraceptive screening into routine well-care for both women and men. As recognized in Policy H-180.958, contraception is essential preventive health care, and contraception is an important strategy to reduce MMM, especially for women with certain medical conditions.[55] Accordingly, physicians should ask their patients about their family planning goals so that they can jointly discuss and anticipate any factors that may lead to higher-risk pregnancies, such as health conditions or short interpregnancy intervals.[56]

Managing Chronic Conditions Before, During, and After Pregnancy

Chronic diseases have emerged as key contributors to MMM,[57] so access to health care from prepregnancy, through pregnancy, and postpartum is critical. An increasing number of pregnant women in the US have been found to have chronic health conditions such as hypertension, diabetes, and chronic heart disease,[58] and with these underlying conditions, preconception care is essential.[59] It is also essential to recognize the significant racial and ethnic inequities in the presence of comorbidities and maternal health outcomes. Compared with White women, Black and Hispanic women have been found to experience higher rates for several comorbidities.[60] Data also suggest that minoritized women, especially Black women, develop comorbid conditions at earlier ages, are less likely to have their conditions adequately managed, and are more likely to have complications and mortality from these conditions.[61] Even when Black women do not have preexisting chronic diseases, they have been found to experience higher rates of certain types of hemorrhage and preeclampsia.[62] Hispanic women have greater odds of postpartum hemorrhage, diabetes, and major puerperal infections than White women.[63] In addition, studies suggest that rates of postpartum hemorrhage, third and fourth degree lacerations, and major puerperal infections are higher among Asian women than White women.[64] Finally, in addition to physical comorbidities, antepartum depression affects 14 to 23 percent of women, and this can significantly affect the health of mothers and developing babies.[65] Especially for women with chronic general medical and behavioral health conditions, postpartum care, coordination of care, and treatment optimization is essential,[66] as exacerbation of underlying illness can occur in the immediate postpartum period.[67] Moreover, pregnancy-related complications can predict risk for subsequent diabetes and cardiovascular disease.[68]

Access to maternal-fetal medicine specialists and medicine subspecialists is recommended to improve outcomes among pregnant women with chronic illnesses and pregnancy-related complications, but many women are not referred for specialty care.[69] The extent of inequities in access to specialists and subspecialists for high risk pregnant women is unknown, but one survey found 31 percent of generalist obstetrician/gynecologists (OB/GYNs) were not satisfied with the maternal-fetal medicine services available to their patients.[70] Professional organizations and the CDC have developed resources to help clinicians and public health decision makers evaluate risk-appropriate care so that pregnant women at high risk for complications can receive care at facilities prepared to provide the level of specialized care that they need.[71]

Elevated Risks for 12 Months Postpartum

Postpartum care is essential not only for monitoring the health of women after the acute major medical event of childbirth, but also for managing women's chronic conditions, promoting overall health and well-being, and serving as a link for vulnerable women to the health care system.[72] The "fourth trimester," (the first 12 weeks postpartum) can present considerable physical and behavioral health challenges.[73] Nearly 70 percent of women describe at least one physical health problem during the 12-month postpartum period, and 45 percent of these problems are deemed to be moderate to severe.[74] For example, during the 12-month postpartum period, women may experience urinary incontinence, fecal incontinence, perineal or genital pain, and impaired sexual function.[75] In addition to these physical complications, maternal behavioral health conditions (including depression, anxiety, and other illnesses) are the most common complications during pregnancy and 12 months postpartum, affecting one in five women.[76] Critically, both parents may experience behavioral health challenges postpartum, as 2 to 25 percent of fathers experience depression, with this statistic increasing to 50 percent when the mother experiences postpartum depression.[77]

More than half of pregnancy-related deaths occur after the birth of the infant.[78] Specifically, and critical to policy decisions regarding postpartum care, support, and insurance coverage, approximately 16 percent of pregnancy-related deaths occurred between 1-6 days postpartum, 19 percent occurred between 7-42 days postpartum, and 24 percent occurred between 43-365 days postpartum.[79] ACOG recommends that postpartum care be an ongoing process, rather than a single visit, with services and support tailored to each woman's needs.[80] Nevertheless, approximately 40 percent of women do not attend a postpartum visit.[81] Critical barriers to obtaining postpartum care include lack of child care, inability to get an appointment, mistrust of health care providers, and limited understanding of the value of the visit.[82] These barriers are even more challenging for patients with limited resources, decreasing attendance rates and contributing to disparities.[83] Notably, 23 percent of employed women return to work within 10 days of giving birth, and an additional 22 percent return to work between days 10 and 42 postpartum. Only 14 percent of American workers—and only five percent of low-wage workers—have access to paid leave.[84] ACOG recommends that obstetric care physicians ensure that women, their families, and their employers understand the need for continued recovery and support for postpartum women.[85] Recognizing the burden of traveling to and attending an office visit, especially with the new responsibility of an infant, ACOG explains that in-person care may not always be required.[86] Telephone support during the postpartum period can reduce depression, improve breastfeeding outcomes, and increase patient satisfaction.[87]

Stark Inequities in Maternal Health

In searching for the root causes of maternal health inequities, it is essential to examine the individual, social, and systemic factors impacting women's health. On an individual level, in

addition to a woman's medical history, SDOH impact health. SDOH include economic stability, neighborhood, education and life opportunities, access to food, quality and safety of housing, community/social support, and access to health care. While economic vulnerability contributes to racial and ethnic disparities in maternal outcomes, socioeconomic factors alone do not account for these disparities.[88] Instead, evidence from a variety of disciplines demonstrates that the pervasive stress of racism within communities of color, combined with disinvestment in these communities (including food deserts, discriminatory housing policies, and/or unequal funding for schools and hospitals) are upstream to the SDOH and are root causes of health inequities.[89]

Racial discrimination is a toxic stressor that is associated with poorer physical and psychological health.[90] A growing body of research shows that centuries of racism in the US have had a profoundly negative effect on communities of color.[91] In maternal health, the intersectionality of gender and race is synergistic, with Black women subjected to high levels of racism, sexism, and discrimination at levels not experienced by Black men or White women.[92] The "weathering" hypothesis posits that Black individuals experience early health deterioration due to the acute and chronic stress produced by social or economic adversity and political marginalization.[93] Black individuals not only experience poor health at earlier ages than White individuals, but deterioration in health of Black individuals accumulates, producing ever-greater racial inequality in health with age through middle adulthood.[94]

Related, ethno-racial trauma has been defined as "individual and/or collective psychological distress and fear of danger that results from experiencing or witnessing discrimination, threats of harm, violence, and intimidation directed at ethno-racial minority groups."[95] Like other trauma- and stress-related disorders, the chronic stress of untreated symptoms of ethno-racial trauma can increase risk of physical illnesses such as hypertension, obesity, and cardiovascular disease—key risk factors in maternal health.[96] Researchers emphasize the importance of recognizing that current maternal health disparities have evolved within an historical context of servitude, exclusion, and codified public policy inequities.[97] Moreover, further research is needed to better understand the complex web of interconnecting factors of racial and gender discrimination, chronic stress, and maternal health outcomes.

To eliminate racial and ethnic inequities in maternal care, it is essential to think of these inequities as among the root causes of poor health outcomes, and "directly address factors that disadvantage women based on race and ethnicity *per se*."[98] There may be a tendency to focus on general quality improvement efforts directed toward improvement of specific and well-defined pathologies, such as postpartum hemorrhage or hypertension.[99] While such quality improvement efforts may improve outcomes for all women, they may allow differential outcomes related to race and ethnicity to persist.[100] Instead, "the goal of equity in care and outcomes can be accomplished only if it is treated the same as the goal of other quality improvement initiatives—namely, as a desired end in and of itself, embedded within a culture of safety, that is specifically acknowledged, discussed, measured, monitored, and the subject of continuous quality improvement efforts."[101]

At the medical team and health care facility levels, there is a growing body of evidence demonstrating that implicit and explicit biases negatively impact quality of care and patient safety.[102] This was described originally in the Institute of Medicine (now the National Academy of Medicine) report, *Unequal Treatment*, in 2003.[103] More recently, the Agency for Healthcare Research and Quality (AHRQ) highlighted that Black patients received significantly worse quality of care relative to White patients in 40 percent of examined quality measures.[104] Racial and ethnic inequities exist both between hospitals and within hospitals.[105] For example, Black patients more commonly receive treatment in hospitals of poorer quality, and receive poorer quality care within a

given hospital.[106] To mitigate facility level inequities, standardized approaches to addressing obstetric emergencies can be implemented in hospitals that provide delivery services.[107]

Researchers explain how clinicians' implicit biases play a role in maternal health care disparities.[108] Implicit bias refers to attitudes that are subconscious and activated involuntarily, but that affect understanding, actions, and decisions.[109] Adverse outcomes are frequently related to patient-provider interactions, and this underscores the importance of communication and the impact of clinician implicit biases.[110] Moreover, implicit biases are more likely to be activated and used in situations involving cognitive overload or high stress, such as in emergency departments and in labor and delivery.[111] It is important to distinguish implicit bias from overt and intentional discrimination. Recognition of implicit bias "is not meant to evoke guilt but spur awareness and the concomitant commitment to overcome its effects; yet, given that implicit bias is unconscious, with consequences that may thwart the explicit intentions of individuals devoted to equity, attempts to counter its effects are challenging."[112] To mitigate implicit bias and improve communication, patient-physician shared decision-making is a key communication strategy that may reduce perinatal racial and ethnic disparities. However, best practices for shared decision-making are often not used.[113]

Focusing on the lived experiences of minoritized women, a variety of qualitative initiatives have been underway to better understand and respond to the challenges that pregnant individuals and new mothers face. For example, national surveys found that, compared with White women, Black women were more likely to report: being treated unfairly and with disrespect by providers because of their race, not having decision autonomy during labor and delivery, feeling pressured to have a cesarean section, and not exclusively breastfeeding at one week and six months postpartum.[114] Moreover, the Black Mamas Matter Alliance (BMMA) emphasizes the importance of health care teams knowing and acknowledging the history of non-consensual medical experimentation on Black women in the US and the impact that history continues to have on patients.[115]

Availability of Affordable Health Care Insurance

Access to affordable, comprehensive health care and insurance throughout a woman's life is critical to achieving optimal maternal health outcomes,[116] yet systemic barriers, including racism and sexism, and inequities in SDOH impact income levels and insurance status.[117] Two key provisions of the Affordable Care Act (ACA) contributed to insurance coverage gains: Medicaid expansion to adults with incomes of up to 138 percent of the federal poverty level (FPL) in some states, and the availability of subsidized insurance coverage through Marketplace plans for people with incomes of up to 400 percent of FPL. The ACA Medicaid expansion has been found to be associated with reductions in maternal mortality.[118] Expanding Medicaid reduced uninsurance among women of reproductive age overall, and specifically, it reduced uninsurance preconception, during pregnancy, and postpartum.[119] Expanding Medicaid led to improved access to care, increased use of health services, and better self-reported health among women of reproductive age.[120] Insurance preconception and postpartum improves women's health in multiple ways, including increasing opportunities for managing chronic conditions and family planning.[121] Expansion states also experienced significant reductions in Black–White disparities in adverse birth outcomes.[122] Despite these gains, nearly 12 percent of new mothers were uninsured in 2016 to 2018.[123] Moreover, in 2015 to 2017, approximately 29 percent of new mothers experienced a change in insurance status between delivery and six months postpartum.[124] While the ACA provided incentives for states to expand Medicaid, as of this writing, 12 states have chosen not to do so.[125] In addition, immigration status prevents some women from qualifying for publicly subsidized health insurance.[126]

Accordingly, uninsurance challenges during and after pregnancy are due, in part, to the patchwork nature of publicly supported coverage options potentially available for pregnant and postpartum women that vary by state of residence, income, and immigration status.[127] For women with higher incomes, a steep "subsidy cliff" makes premium payments for Marketplace plans far more expensive as soon as income exceeds 400 percent FPL, potentially preventing women from obtaining affordable insurance.[128] This can be especially challenging when women unexpectedly lose access to employer-sponsored insurance, as has frequently been the case during the COVID-19 pandemic.[129] Coverage options for women with lower incomes are even more complicated. In all but two states, the income thresholds for Medicaid and State Children's Health Insurance Program (CHIP) qualification are higher for pregnancy-related coverage than for nonpregnant parents or other adults.[130] As a result, women who were insured by Medicaid or CHIP due to their pregnancy status, but who lose access to pregnancy-related coverage at 60 days postpartum, experience insurance churn in several ways:[131]

a) In states that expanded Medicaid, some women will be able to continue Medicaid coverage postpartum.[132] For other women, premium tax credits could help them purchase subsidized insurance through the Marketplace.[133] However, Marketplace plans may require women to incur additional out-of-pocket costs and/or change physicians, and women recovering from giving birth and caring for an infant may not undertake the effort of finding a suitable Marketplace plan.[134]
b) In states that have not expanded Medicaid, adult Medicaid eligibility is typically below the FPL. Low-income residents in these states fall into a "coverage gap," having incomes that are too high to qualify for their state's Medicaid but that are below the FPL, which is the minimum threshold for subsidized Marketplace coverage.[135] When women lose pregnancy-based Medicaid, they may not have an affordable coverage option.
c) Six states build on Medicaid's foundation and offer CHIP coverage to pregnant women at higher income levels.[136] Accordingly, to protect new mothers in these six states, policies to extend public coverage until 12 months postpartum must reference both Medicaid and CHIP.
d) Due to their immigration status, some women will not qualify for Medicaid, CHIP, or subsidized insurance through the Marketplace, even if they meet the income qualifications.[137] Accordingly, they may not have an affordable coverage option.

Of course, women's need for medical care and insurance does not end at the 60th day postpartum. As outlined above, women are at elevated physical and behavioral health risk for 12 months following childbirth, so access to health care, and insurance coverage for that care, is essential.

OPPORTUNITIES TO IMPROVE EQUITABLE MATERNAL HEALTH CARE

To improve maternal health outcomes in the US, two foundational first steps are expanding access to affordable health insurance and eliminating racial and ethnic inequities in care and outcomes. A clear policy improvement is to extend Medicaid and CHIP to cover new mothers for the full 12-month postpartum period. Eliminating inequities that are deeply rooted in US history and policy is more complicated. The AMA can begin by committing itself to strengthening patient-physician relationships, especially relationships with marginalized and/or minoritized patients. To do so, it will be important to enhance the diversity of health care teams, strengthen patient-physician trust, improve communication, appropriately incorporate telehealth, collaborate with community leadership, and improve data collection (with safeguards) to facilitate research.

Extend Medicaid and CHIP to 12 Months Postpartum

If Medicaid and CHIP coverage were extended for the entire year of the postpartum period, an estimated 70 percent of uninsured new mothers would be eligible for some kind of publicly subsidized coverage.[138] Notably, nonexpansion states are home to 83 percent of the uninsured new mothers who would become newly eligible for Medicaid/CHIP under a postpartum extension.[139] It is also essential to recognize that while a Medicaid/CHIP extension would help reduce maternal health disparities, it cannot eliminate the inequities that persist due to race, ethnicity, immigration status, and geography (such as proximity to a hospital with obstetric care).[140]

AMA policy supports a variety of mechanisms to expand affordable access to insurance coverage, including supporting increased affordability of and auto-enrollment in Marketplace plans, elimination of the "subsidy cliff" and "coverage gap," state expansion of Medicaid, and presumptive eligibility for Medicaid. (See Appendix C.) Specific to maternal health care, AMA policy supports an extension of Medicaid coverage for 12 months postpartum, and several state and federal-level initiatives are underway to accomplish that goal in varying ways. For example, three states have received federal approval to extend coverage—Georgia, Illinois, and Missouri—and several other state legislatures have instructed their states to seek such coverage. (See Appendix D.)

Eliminating Inequities and Strengthening the Patient-Physician Relationship

The AMA recognizes racism in all forms as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care. The elimination of racial and ethnic inequities in health care is an issue of high priority for the AMA. The AMA joins leadership nationwide in striving toward improved, equitable maternal health care and commends the many advocates who have paved the way for this issue to capture the attention of public policy makers, the media, and the broader health care sector. For example, the California Maternal Quality Care Collaborative and the National Birth Equity Collaborative are leaders and advocates striving to improve health outcomes, eliminate racial disparities, and amplify patient stories. ACOG is the lead partner in the Alliance for Innovation on Maternal Health (AIM).[141] AIM is a national data-driven maternal safety and quality improvement initiative that is funded through a cooperative agreement with the Maternal and Child Health Bureau (MCHB)-Health Resource Services Administration.[142] AIM works through state and community-based teams to align national, state, and hospital level quality improvement efforts to improve maternal health outcomes and prevent maternal mortality and SMM. AIM has developed 10 patient safety bundles, and they have engaged 33 states and more than 1400 hospitals to implement these bundles.[143] Diversification of the health care workforce so that clinical teams reflect the populations they serve and improved communication between patients and their health care teams are two essential elements promoted through the AIM program.[144] ACOG has also published a Committee Opinion on Racial and Ethnic Disparities in Obstetrics and Gynecology, in which it makes several recommendations to reduce disparities.[145] Similarly, our AMA *Code of Medical Ethics,* Opinion 8.5, Disparities in Health Care, speaks to the challenge of subtle biases contributing to poorer health outcomes, and it outlines steps that individual physicians should implement within their practices (see Appendix C).[146] Critically, *Code of Medical Ethic*s Opinion 8.5 calls for physicians to strive to increase the diversity of the physician workforce, encourage shared decision-making, and cultivate effective communication and trust by seeking to better understand factors that can influence patients' health care decisions, such as health beliefs, health literacy, and fears or misperceptions about the health care system.

Diversifying of Health Care Teams

To provide optimal care for diverse patients, greater diversity is needed on physician-led health care teams. For example, research indicates that race and language concordance between patients and clinicians may improve communication and outcomes.[147]A recent study found that while maternal health care physician-led teams are making strides in gender representation (approximately 59 percent of practicing OB/GYNs are women), they are lacking in racial and ethnic diversity (only approximately 11 percent of OB/GYNs are Black and only approximately 6 percent are Hispanic).[148] Moreover, 49 percent of the counties in the US, home to more than 10 million women, lack an OB/GYN.[149] In addition to OB/GYNs, family medicine physicians can play an essential role in reducing inequities in MMM due to their training in providing comprehensive care across the life course, including prenatal, perinatal, and postpartum care for the individuals in the communities where they live.[150] At the same time, the American Academy of Family Physicians (AAFP) has highlighted studies finding that while recent family medicine graduates have felt more prepared than previous cohorts, family medicine graduates are providing significantly less OB care.[151] Only approximately eight percent of family medicine physicians include OB deliveries in their practice, and this is especially challenging in rural areas where family medicine physicians provide the majority of maternity care and where labor and delivery units are closing.[152] Diversity is also needed throughout entire physician-led teams. For example, more than half of all OB/GYN offices employ "physician extenders" such as nurse practitioners, certified nurse-midwives, and physician assistants.[153] However, a recent survey demonstrated the lack of racial and ethnic diversity among nurses, as nearly 81 percent of respondent registered nurses (RNs) and nearly 70 percent of respondent Licensed Practical/Vocational Nurse (LPN/VNs) reported being White/Caucasian.[154]

Non-clinical Support for Laboring Patients

When considering the people present in a delivery room, in addition to the importance of more diverse clinical care teams, it is also important to consider the non-clinical support present for laboring patients. ACOG suggests that, "in addition to regular nursing care, continuous one-to-one emotional support provided by support personnel, such as a doula, is associated with improved outcomes for women in labor."[155] ACOG cites evidence of shortened labor, decreased need for analgesia, fewer operative deliveries, and fewer reports of dissatisfaction with the experience of labor.[156] ACOG further explains that it may be effective to teach labor-support techniques to a friend or family member, as this approach has also resulted in significantly shorter duration of labor and higher Apgar scores.[157] ACOG further states that continuous labor support also may be cost-effective given the associated lower cesarean rate.[158] Accordingly, ACOG suggests physicians and health care organizations may want to develop programs and policies to integrate trained support personnel into the intrapartum care environment to provide continuous one-to-one emotional support for laboring women.[159] Recently, some state and federal policy support has emerged specifically for doulas. For example, six states provide or are preparing to cover doula services through their Medicaid programs,[160] and the 2021 Mothers and Offspring Mortality and Morbidity Awareness (MOMMA)'s Act provides guidance and options for states to adopt and pay for doula support services.[161]

Rebuilding Trust and Enhancing Communication

Narratives from the experiences of Black women indicate a rupture of trust between Black women and the health care system that must be repaired.[162] As BMMA asserts, "Care partnership—where Black female patients plan for their care alongside their provider—is the only way forward."[163] Similarly, AIM safety bundles, and others, recommend that educating clinicians and staff about

racial and ethnic disparities in maternal outcomes, and emphasizing the importance of shared-decision making, cultural competency and humility, implicit bias, and enhanced communication skills are important steps to rebuild trust and eliminate disparities in maternal health care.[164]

Effective communication can have a profound impact on how patients and families perceive their care.[165] Research demonstrates that patient engagement in health care leads to measurable improvements in safety and quality.[166] Open communication between the medical team and patients and families can broaden perspectives and reduce patient avoidance of physicians/facilities and/or medical care in general.[167] To promote patient engagement, the AHRQ developed an evidence-based resource called, "The Guide to Patient and Family Engagement in Hospital Quality and Safety" to help hospitals partner with patients and families.[168] The Guide was developed, implemented, and evaluated with the input of patients, family members, clinicians, hospital staff, and hospital leaders, and it includes sections devoted to improving communication among patients, family members, and clinicians and preparing patients and families to transition from hospital to home. Similarly, AHRQ developed a "Guide to Improving Patient Safety in Primary Care Settings by Engaging Patients and Families" with evidence-based strategies including those to improve communication, engagement, health literacy, and handoffs among the health care team.[169]

The mutual trust built between pregnant patients and their physicians is essential, but maternal health care presents unique continuity of care challenges where patients may be handed off from their primary physician to an in-hospital clinical team for delivery, and then handed again to their primary team for postpartum care. Accordingly, effective clinician-to-clinician communication is imperative to strengthen continuity of care, eliminate preventable errors, and provide a safe patient environment.[170] There is clear room for improvement, as a systematic review found that timely communication of discharge summaries between hospital-based and primary care physicians was low, and approximately ten percent of discharge summaries were never transferred.[171] Use of structured and codified communication practices can promote consistent communication among clinicians and reduce risk of adverse events stemming from breakdowns in communication.[172] With due attention paid to the privacy of maternal health information, health information technology, including electronic health records (EHRs) and technology enabling women to access their health information from any place at any time, can also help to build information bridges during potentially fragmented maternal health care.[173]

In addition to effective clinician-to-clinician communication, striving toward optimal patient-clinician communication is also essential. Patient-centered communication, cultural humility, and trauma-informed care offer principles that can improve communication and build trust. Patient-centered communication that offers options and asks patients about how they can be made most comfortable can lessen anxiety and promote trust and rapport.[174] Additionally, the patient-centered care approach of "centering at the margins" facilitates clinicians engaging with "the experience of disenfranchised groups and [acknowledging] the role of society and history in influencing both their own understanding of their patient and their patient's understanding of them."[175]

Cultural humility is an approach that focuses on optimizing interactions between patients and clinicians with different values, backgrounds, and experiences, and it has been shown to strengthen the therapeutic alliance and improve outcomes.[176] Hallmark features of cultural humility include critical self-reflection, openness, nonjudgement, and curiosity.[177] Researchers and clinicians have developed a variety of resources to support the adoption of cultural humility in clinical practice, from clinician coaching tools to assessment measures.[178] A focus on structural determinants of health and health inequities in medical education and clinical training may facilitate cross-cultural understanding of individual patients and shift the way clinicians recognize the social and economic forces that produce health outcomes.[179]

A trauma-informed approach to care has been defined as, "a strengths-based service delivery approach that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both practitioners and survivors, and that creates opportunities to rebuild a sense of control and empowerment."[180] ACOG highlights high rates of trauma experienced across communities.[181] For example, a survey of adults who had completed high school found that approximately 83 percent of the respondents reported at least one standard or community-level adversity, and approximately 37 percent reported four or more.[182] Traumatic birth experiences, which may include unexpected outcomes, procedures, obstetric emergencies, and neonatal complications continue to impact patients.[183] ACOG also notes the impact of "obstetric violence," which is a nonmedical term that is used to refer to situations in which a pregnant or postpartum individual experiences disrespect, indignity, or abuse from a health care practitioner or system that can stem from and lead to loss of autonomy.[184] Experiences of trauma can affect individuals' physical and behavioral health and such experiences can profoundly impact their attitude toward medical care, leading to anxiety related to specific examinations or procedures or anxiety about being in a medical setting.[185] ACOG emphasizes, "True trauma-informed care empowers individuals by recognizing the significance of power differentials and the historical diminishing of voice and choice in past coercive exchanges."[186]

Public health communication is essential to raising awareness among both clinicians and patients regarding maternal health challenges. The CDC recently launched the Hear Her campaign to raise awareness of potentially life-threatening warning signs during and after pregnancy and improve communication between patients and their medical teams.[187] As part of this campaign, women share personal stories of pregnancy-related complications, such as a vignette about a woman named Valencia who reports that "she felt like no one heard her or took her seriously" as she struggled during a difficult first pregnancy.[188] The Hear Her campaign also provides guidance and resources specifically for health care providers including: guidance to promote communication with patients about urgent maternal warning signs, guidance regarding management of chronic conditions, opportunities to get involved with ACOG's "Every mom. Every time." awareness campaign, professional education regarding post-birth warning signs, information about toolkits and safety bundles, and information about causes and contributors to maternal mortality.[189] The AMA continues to support and amplify the reach of the Hear Her campaign on social media.[190] Physicians seeking additional professional education regarding maternal health care can also look to a CDC listing of selected activities, including activities relating to healthier pregnancy and perinatal behavioral health.[191] The AMA also provides educational resources for physicians with focuses on pregnant[192] and postpartum[193] patients, as well as inequities in maternal and infant care.[194] In addition, the AMA Ed Hub™ Health Equity Education Center continues to publish continuing medical education (CME) and other educational activities aimed at addressing the root causes of inequities, including racism and other structural determinants of health.[195] These educational activities will equip physicians and other learners with core health equity concepts needed to support them as they continue to take action and confront health injustice.

Utilizing Telehealth and Remote Patient Monitoring

The Health Resources and Services Administration's (HRSA's) Maternal and Child Health Bureau describes the current paradigm for prenatal care as including 15 face-to-face visits between the patient and her maternal health care team, which provide critical medical services, risk assessments, patient education, and opportunities to build trust.[196] However, many patients, both in rural and urban communities, face personal barriers (e.g., work, childcare, transportation, education, culture, or language), health system barriers (e.g., limited hours of operation, or lack of services), and environmental barriers (e.g., location or connectivity) that prevent them from attending some or all of their planned prenatal visits.[197] HRSA's Remote Pregnancy Monitoring

Challenge strives to reduce these barriers by supporting innovative technology-based solutions that help medical teams remotely monitor pregnant women, which can promote building trusting, ongoing relationships among patients and their medical teams and empowering women to make informed decisions about their care.[198]

The expansion of telehealth services during the COVID-19 pandemic has provided evidence of the potential benefits of telehealth and remote patient monitoring. For example, a recent study conducted at a hospital predominantly serving Medicaid patients found that access to virtual prenatal care for some of the standard prenatal appointments was associated with greater attendance rates compared with in-person appointments alone, and there were no deleterious outcomes among the women or infants participating in virtual prenatal care.[199] To ensure that all participating clinicians and patients had access to the resources needed for telehealth visits, the study utilized synchronous audio-only visit types.[200] Consistent with these findings, ACOG states that remote patient monitoring interventions result in fewer high-risk obstetric monitoring visits while maintaining maternal and fetal outcomes.[201] ACOG specifically supports facilitating access to telehealth and remote patient monitoring, broadening durable medical equipment benefits, and eliminating financial barriers and other inequities for patients.[202] These maternal health-specific considerations are all consistent with AMA Policies D-480.963 and H-480.937.

Collaborating with Community Leadership

There is growing evidence that programs that partner with communities may have a substantial impact on improving quality of care and reducing disparities.[203] Collaboration among clinicians, public health professionals, and community partners (including nonprofit organizations, faith-based organizations, and residents) has been essential in efforts to improve maternal health and reduce disparities.[204] ACOG specifically suggests that physicians work to educate staff and colleagues about community resources available to patients and that they work collaboratively with local public health authorities to address disparities in environmental exposures, health education and literacy, and women's health services and outcomes.[205] Community-engaged interdisciplinary initiatives can cultivate trust and promote education, and they can also leverage a variety of innovative and traditional methods to do so. For example, New York City recently implemented the Severe Maternal Morbidity Project (Project), which worked directly with clinical and community partners to improve maternal outcomes, promote health equity, and reduce racial/ethnic disparities in SMM in New York City.[206] The Project team worked to cultivate trust and it engaged with the community via innovative social media projects and in-person community public meetings. The social media initiatives amplified the voices and experiences of women navigating maternal care and provided an educational platform for content from the Preeclampsia Foundation and District II of ACOG. In-person presentations intended to increase awareness were delivered at community board meetings in neighborhoods experiencing the highest rates of SMM and those adjacent to Project-affiliated hospitals.

Improving Data

The CDC states that robust, comprehensive data collection and analysis through state and local MMRCs offers the best opportunity for identifying and prioritizing strategies to reduce disparities.[207] In addition, the US Department of Health and Human Services (HHS) Office on Women's Health (OWH) initiated an $8 million nationwide contract with Premier, Inc. to improve maternal health data and create a network of at least 200 hospitals to deploy clinical, evidence-based best practices in maternity care. The Maternal Morbidity and Mortality Data and Analysis Initiative builds upon HHS's Improving Maternal Health in America Initiative as outlined in the President's FY 2021 Budget. These data would inform policy and validate evidence-based practice

to improve maternal health outcomes.[208] One of the most common examples of using data to improve quality of prenatal care is via perinatal quality collaboratives (PCQs). Almost all states have PCQs available or in development, and these PCQs identify health care processes that need improvement and apply quality improvement principles to address gaps in care as quickly as possible.[209] Nevertheless, the lack of standardized data on maternal health outcomes and disparities constrains both clinical and policy-driven prevention efforts.[210] For additional discussion of the critical need for improvements in public health data collection and reporting, including MMM data, see CSAPH Rep. 2-NOV-21, "Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems."

AMA POLICY

The AMA is deeply committed to improving maternal health and eliminating disparities, as evidenced by extensive policy and activity throughout the AMA. (See Appendix C.) The AMA has developed a strong body of policy striving to eliminate racial and ethnic disparities in care, including Policies H-65.952 acknowledging racism as public health threat; H-65.953 explaining how racism and systemic oppression result in racial health disparities; D-350.981 calling for AMA collaboration to identify and address aspects of medical education and board examinations that may perpetuate institutional and structural racism; H-165.822 outlining health plan initiatives addressing social determinants of health; H-350.974 stating the AMA's position of zero tolerance toward racially or culturally based disparities in care, commitment to eliminating racial and ethnic disparities in care, and support for implicit bias training; D-350.995 striving to reduce racial and ethnic disparities in health care via studies, collaboration, and promoting diversity in the profession; D-420.993 supporting initiatives to reduce disparities in maternal mortality such as asking the Commission to End Health Care Disparities to issue recommendations on the issue, collaborating with federal, state, and county health departments to decrease maternal mortality rates, encouraging development of maternal mortality surveillance systems, and encouraging research on evidence-based practices to reduce MMM; and *Code of Medical Ethics* 8.5 Disparities in Health Care. In addition, Policy H-200.955 recognizes the need to enhance diversity both in medical schools and in the physician workforce to improve access to care for minoritized and marginalized patients, and Policy D-200.985 outlines strategies the AMA will deploy as a leader and key collaborator in striving to enhance diversity in the physician workforce.

Strong AMA policy on expanded insurance coverage for prenatal and postpartum care, and on adequate physician compensation to ensure access to this care, continues to be critical to AMA advocacy on improving maternal health care. (See Appendix C.) Examples include Policies D-290.974 supporting extension of Medicaid coverage for 12 months postpartum; D-290.979 supporting collaborative efforts with state medical societies to advocate for expanded Medicaid eligibility as authorized by ACA; H-165.855 supporting 12-month continuous eligibility across Medicaid, CHIP, and exchange plans and presumptive assessment of eligibility and retroactive coverage; H-165.823 supporting auto-enrollment in health insurance coverage; H-165.824 supporting expanded eligibility for and generosity in premium tax credits and cost-sharing reductions for exchange plans; H-160.896 supporting payment reform policy proposals that incentivize screening for SDOH and referral to community support systems, D-480.963 and H-480.937 supporting equitable access to and coverage for telehealth services that maximize both physician and patient opportunities for participation; and D-290.979, H-290.987, H-290.997 speaking to the need for adequate physician payment to secure access to care. In addition, recognizing the untenable challenges faced by low-income patients whose income is too high to qualify for their state's Medicaid, yet who live below the FPL, Policy H-290.966 supports identifying coverage options for adults currently in the coverage gap and encourages states that are not participating in the Medicaid expansion to develop waivers that support expansion plans to best

meet the needs and priorities of their low-income adult populations. CMS Report 3-NOV-21, "Covering the Remaining Uninsured," provides additional analysis and policy development.

DISCUSSION

The AMA is committed to being a leader and collaborating with stakeholders to prevent maternal MMM, and specifically to promote increased access to affordable health insurance and to eliminate racial and ethnic inequities. A first step in this leadership is to publicly acknowledge the roles that structural racism and bias play in negatively impacting health care, including maternity care, for people of color. Similarly, the Councils recommend reaffirming Policy H-350.974 to emphasize that the elimination of racial and ethnic disparities in health care is an issue of highest priority for the AMA. In addition to these acknowledgements, the Councils believe that the AMA and the medical profession should use their platforms to amplify other voices essential to the maternal health discussion.

First, within physician-led health care teams, the Councils recommend that physician team leaders embrace opportunities to learn more about the unique physical and behavioral health risks associated with pregnancy and the 12-month postpartum period, the stark disparities in health outcomes that persist for patients of color, and how they can enhance their equitable, patient-centered approaches to care. Physician team leaders should encourage their physician and non-physician team members and hospital administrators to similarly embrace such professional education. Physicians should also raise awareness among their colleagues about the prevalence and health outcomes impact of racial and ethnic inequities, work to eliminate these inequities, and promote an environment of trust. Additionally, reaffirming Policy H-350.974 encourages physicians to examine their practices to help increase awareness within the profession of racial disparities in medical treatment decisions, supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs, and supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes.

Next, to allow for greater understanding of the root causes of MMM and the stark racial and ethnic disparities in maternal health, additional research is essential, and accurate, standardized data are needed to empower research. Accordingly, the Councils recommend that the AMA continue to monitor and promote ongoing research regarding the impacts of societal (e.g., racism or unaffordable health insurance), 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. Furthermore, the Councils recommend that the AMA promote the adoption of federal standards for collection of patient-identified race and ethnicity information in clinical and administrative data to better identify inequities. Critically, these federal standards must be 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 reflects diverse populations and highlights, rather than obscures, critical distinctions that may exist within broad racial or ethnic categories. These federal standards must also be carefully crafted in conjunction with clinician and patient input to protect patient privacy and provide non-discrimination protections. These federal standards should be accompanied by best practices to guide respectful and non-coercive collection of accurate, standardized data relevant to maternal health outcomes. In addition, 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, the Councils recommend that the AMA support the development of a standardized definition of maternal mortality and the allocation

of resources to states to collect and analyze maternal mortality data (i.e., Maternal Mortality Review Committees and vital statistics). The AMA remains committed to collaborating with the HHS, CDC, and state and local health departments to decrease maternal mortality rates in the US, and the Councils recommend reaffirming Policy D-420.993 which affirms this commitment and promotes state and local health department efforts to develop maternal mortality surveillance systems.

To strengthen trusting patient-physician relationships, the AMA and the physician profession should prioritize listening to and amplifying the voices of their patients, patients' families, and patients' communities. The Councils recognize that non-clinical community organizations often develop close bonds with members of minoritized and marginalized communities. Non-clinical community organizations can play a key role in connecting women and families who may be reluctant to, or face barriers preventing them from, seeking medical care. Accordingly, the Councils recommend that the AMA encourage hospitals, health systems, and state 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 women and new families. Similarly, health care literacy and awareness of the unique needs of women while pregnant and during the 12-month postpartum period is essential. The Councils recommend that the AMA encourage 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 women to pursue both physical and behavioral health care and strive to reduce barriers to pursuing care, including by highlighting care that is available at little or no cost to the patient. Finally, the Councils recognize that access to affordable health insurance is essential to improving maternal health. Broadly, the Councils recommend that the AMA develop policy supporting adequate payment for the full spectrum of evidence-based prepregnancy, prenatal, peripartum, and postpartum physical and behavioral care.

With Medicaid and CHIP covering nearly half of all deliveries in the US, adequate Medicaid and CHIP coverage is critical. The Councils commend the strong policy foundation the AMA has built to empower advocacy for access to adequate Medicaid coverage. For example, Policy D-290.974, which supports extension of Medicaid coverage for 12 months postpartum, has provided an excellent foundation for the AMA's ongoing zealous maternal health advocacy. To clarify the policy base for ongoing advocacy, the Councils recommend amending Policy D-290.974 to explicitly include extension of CHIP coverage for at least 12 months after the end of pregnancy. Additionally, the Councils recommend reaffirming policies that can continue to propel advocacy to increase access to affordable health insurance and reduce inequities. Attempting to reach the 12 states that have not yet chosen to expand Medicaid, Policy D-290.979 supports collaborative efforts with state and specialty medical societies to advocate for expanded Medicaid eligibility as authorized by the ACA. To limit patient churn and promote continuity and coordination of care, Policy H-165.855 supports 12-month continuous eligibility across Medicaid, CHIP, and exchange plans, and it supports development of a safety net mechanism that would allow for presumptive assessment of eligibility and retroactive coverage to the time at which an eligible person seeks medical care. The narrow focus of the Councils' recommendations establishes foundational policy on improving maternal health care, and we are committed to exploring additional policy development.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) acknowledge that structural racism and bias negatively impact the ability to provide optimal health care, including maternity care, for people of color. (New HOD Policy)

2. That our AMA encourage 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. (New HOD Policy)

3. That our AMA encourage 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 encourage physician leaders of health care teams to support similar appropriate professional education for all members of their teams. (New HOD Policy)

4. That our AMA continue to monitor and promote ongoing research regarding the impacts of societal (e.g., racism or unaffordable health insurance), 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. (New HOD Policy)

5. That our AMA 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. (Directive to Take Action)

6. That our AMA support the development of a standardized definition of maternal mortality and the allocation of resources to states 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. (New HOD Policy)

7. That our AMA encourage 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. (New HOD Policy)

8. That our AMA encourage 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. (New HOD Policy)

9. That our AMA support adequate payment from all payers for the full spectrum of evidence-based prepregnancy, prenatal, peripartum, and postpartum physical and behavioral health care. (New HOD Policy)

10. That our AMA amend Policy D-290.974 by addition and deletion as follows:

    Our AMA will work with relevant stakeholders to support, at the state and federal levels, extension of Medicaid and State Children's Health Insurance Program (CHIP) coverage to at least 12 months after the end of pregnancy ~~postpartum~~. (Modify Current HOD Policy)

11. That our AMA reaffirm Policy H-350.974, which highlights the elimination of racial and ethnic disparities in health care as an issue of highest priority for the AMA; encourages physicians to examine how their own practices help increase the awareness within the profession of racial disparities in medical treatment decisions; supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons; supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; and supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations. (Reaffirm HOD Policy)

12. That our AMA reaffirm Policy D-420.993, which states that the AMA will work with the Centers for Disease Control and Prevention, United States (US) Department of Health and Human Services, state and county health departments to decrease maternal mortality rates in the US; encourage and promote all state and county health departments to develop a maternal mortality surveillance system; and work with stakeholders to encourage research on identifying barriers and developing strategies toward the implementation of evidence-based practices to prevent disease conditions that contribute to poor obstetric outcomes, maternal morbidity and maternal mortality in racial and ethnic minorities. (Reaffirm HOD Policy)

13. That our AMA reaffirm Policy D-290.979, which supports collaborative efforts with state and specialty medical societies to advocate at the state level for expanded Medicaid eligibility as authorized by the Affordable Care Act. (Reaffirm AMA Policy)

14. That our AMA reaffirm Policy H-165.855, which supports 12-month continuous eligibility across Medicaid, Children's Health Insurance Program, and exchange plans to limit patient churn and promote continuity and coordination of care; and also supports development of a mechanism to allow for the presumptive assessment of eligibility and retroactive coverage to the time at which an eligible person seeks medical care. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

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Reducing Inequities and Improving Access to Insurance for Maternal Health Care
Appendix A – AMA Advocacy and Activity

Advocacy

Over the last several years, the AMA has been increasingly active in advocating for maternal health. The COVID-19 pandemic has highlighted inequities in our health care system, including maternal health, and as a result, there has been an even greater focus on maternal mortality and morbidity at the federal level. The potential for maternal mortality bills introduced during the 117th Congressional Session being passed and signed into law is higher than in years past.

AMA Advocacy in 2021 (on-going)

- In July 2021, the AMA joined a sign-on letter urging Congress to direct $20M to the U.S. Centers for Disease Control & Prevention (CDC) Hospitals Promoting the Breastfeeding line item in the Fiscal Year (FY) 2022 Labor, Health and Human Services, and Related Agencies appropriations bill, an increase of $10.5M above the President's budget level.
- In July 2021, the AMA sent a letter expressing our support for H.R. 3407, the "Mothers and Offspring Mortality and Morbidity Awareness Act" or the "MOMMA's Act."
- In July 2021, the AMA sent a letter voicing our support for the "Medicaid Reentry Act" which would provide states with the flexibility to allow Medicaid payment for medical services furnished to an incarcerated individual during the 30-day period preceding the individual's release. (House; Senate)
- In June 2021, the AMA sent a letter expressing our support for S. 1675, the "Maternal Health Quality Improvement Act." This legislation would provide grants to identify, develop, and disseminate best practices to improve maternal health care quality and outcomes. Additionally, provisions within this bill would encourage collaboration with state maternal mortality review committees to identify issues and reduce preventable maternal mortality and severe maternal morbidity, promote perinatal quality collaborative activities, and implement integrated health care services for pregnant and postpartum women.
- In June 2021, the AMA signed onto a letter urging Congress, as they develop the appropriations legislation for Fiscal Year 2022, to prioritize the highest possible funding level for programs that seek to prevent maternal deaths, eliminate inequities in maternal health outcomes, and improve maternal health overall.
- In May 2021, the AMA sent letters to the House and Senate voicing our support for H.R.1218 and S. 198, the "Data Mapping to Save Moms' Lives Act." This legislation would instruct the Federal Communications Commission to consult with the CDC to determine ways to incorporate data on maternal health outcomes for at least one year postpartum into broadband health mapping tools in an effort to reduce maternal mortality and morbidity in the U.S.
- In May 2021, the AMA also sent letters voicing our support for S. 796 and H.R. 958, the "Protecting Moms Who Served Act." The AMA believes that all women should have access to reproductive health services, especially those who have served our country. The Protecting Moms Who Served Act would require the Department of Veterans Affairs (VA) to implement the maternity care coordination program with community maternity care providers (i.e., non-VA maternity care providers) who have the necessary training to address the unique needs of pregnant and postpartum veterans. Additionally, the legislation would require the U.S. Government Accountability Office (GAO) to produce reports on maternal mortality and severe

maternal morbidity among pregnant and postpartum veterans, with a focus on veteran racial and ethnic disparities in maternal health outcomes.

- In May 2021, the AMA submitted a Statement for the Record to the U.S. House of Representatives Committee on Oversight and Reform as part of the hearing entitled, Birthing While Black: Examining America's Black Maternal Health Crisis.
- In April 2021, the AMA signed onto a letter urging the House and Senate to direct $20M to the CDC for the Hospitals Promoting Breastfeeding line item in the Fiscal Year (FY) 2022 Labor, Health and Human Services, and Related Agencies appropriations bill.
- In April 2021, the AMA sent a comment letter to the US Senate in support of the "Connected Maternal Online Monitoring Act" (or the "Connected MOM Act"), which would require CMS to send a report to Congress that identifies barriers to coverage of remote physiologic devices (e.g., pulse oximeters, blood pressure cuffs, scales, blood glucose monitors) under State Medicaid programs to improve maternal and child health outcomes for pregnant and postpartum women. This bipartisan legislation would also require CMS to update state resources, such as state Medicaid telehealth toolkits, to align with evidence-based recommendations to help decrease maternal mortality and morbidity.
- Maternal health was among the top issues we encouraged AMA members to advocate for and discuss during their Members of Congress during the AMA National Advocacy Conference (NAC) February 23-24, 2021 and during the AMA Medical Student Advocacy Conference (MAC) on March 4, 2021. During these Conferences, AMA members and medical students urged their Members of Congress to cosponsor the Mothers and Offspring Mortality and Morbidity Awareness (MOMMA) Act, S. 411, that was introduced on February 24, 2021. The MOMMA Act uses a six-pronged approach to address and reduce maternal deaths by: (1) establishing national obstetric emergency protocols through a federal expert committee, (2) ensuring dissemination of best shared practices and coordination amongst maternal mortality review committees, (3) standardizing data collection and reporting, (4) improving access to culturally competent care throughout the care continuum, (5) providing guidance and options for states to adopt and pay for doula support services, and (6) expanding Medicaid coverage to new mother's entire post-partum period (1 year).
- In February 2021, in response to the AMA's comments to the CMS' Request for Information regarding, "Maternal and Infant Health Care in Rural Communities" and the 2021 Medicare Physician Fee Schedule proposed rule, the agency agreed to apply the increased relative values the agency adopted for standalone office visits to the office visit components of maternal (MMM) global codes to recognize the importance of preventive prenatal and postpartum care for the health of women and infants.
- In February 2021 the AMA joined a sign-on letter urging CMS to act expeditiously and to approve pending section 1115 demonstration projects aimed at extending the Medicaid postpartum coverage to a full year after the end of pregnancy.
- The AMA has voiced its support for the Connected Maternal Online Monitoring Act" (or the "Connected MOM Act"), which would require the CMS to send a report to Congress that identifies barriers to coverage of remote physiologic devices (e.g., pulse oximeters, blood pressure cuffs, scales, blood glucose monitors) under State Medicaid programs to improve maternal and child health outcomes for pregnant and postpartum women. This bipartisan legislation would also require CMS to update state resources, such as state Medicaid telehealth toolkits, to align with evidence-based recommendations to help decrease maternal mortality and morbidity.
- The AMA also urged Congressional leaders to support at least $750 million for the Title V Maternal and Child Health (MCH) Services Block Grant in the FY2022 Labor, Health and Human Services, Education & Related Agencies Appropriations bill. Continued robust support

of the MCH Services Block Grant is important in furthering our national goal of improving the health of mothers and children.

- The AMA also urged House Congressional leaders to support the highest possible funding level in FY2022 for programs at HRSA, CDC, and NIH that seek to prevent maternal deaths, eliminate inequities in maternal health outcomes, and improve maternal health.

AMA Advocacy in 2020

- In December 2020, the AMA submitted extensive comments and suggested edits on the Black Maternal Health Momnibus Act of 2021 (a collection of 12 standalone bills) to the bill sponsor, Rep. Lauren Underwood. Below is a very brief, non-exhaustive, top-line summary of some of the concerns that AMA staff raised with the office.

    - The bill does not provide 12 months postpartum coverage (neither Medicaid nor CHIP).
    - Though other health care providers are specifically named and included on task forces the MOMNIBUS creates (e.g., the Task Force on Maternal Health Data and Quality Measures; or the Task Force to Coordinate Efforts to Address Social Determinants of Health for Women in the Prenatal and Postpartum Periods), physicians such as OBGYNs and fetal-medicine specialists are not.
    - Though grant programs were established for other health care providers, including nurse practitioners, physicians are not included in the grant programs to grow the health care workforce, despite a need for additional OBGYNs, fetal-medicine specialists, and rural physicians. The AMA also suggested, as an alternative, that perhaps a separate HRSA scholarship or loan forgiveness program could be developed as a targeted approach to grow and/or diversify OBGYNs/fetal-medicine specialists/rural physicians, providing some additional training and/or resources to deliver babies for high-risk mothers. This program would be more robust than the National Health Service Corps (NHSC) Loan Repayment Program (LRP). However, this suggestion was not incorporated into the current version of the bill.
    - The bill requires midwives to meet the International Confederation of Midwives standards but the AMA supports the American College of Nurse-Midwives (ACNM) standards (a higher threshold) and state scope of practice requirements. [NOTE: Although ACNM is a member association of ICM, there are gaps in the standards which can be found here.]
    - The bill supports the establishment of the Respectful Maternity Care Compliance Programs to address bias and racism, and to promote accountability in maternity care settings. While the AMA supports the goal of this provision, we expressed concerns that as the bill is currently written, patients or their families could potentially ultimately report disrespect or evidence of bias and then upon the completion of the studies noted in the bill, result in an accountability mechanism against the physician for a claim that may be later found to be baseless. It is unclear what the full potentially negative impact of the studies and their findings could have on physicians, especially in a rural setting where there may be only a few OBGYNs. It is also unclear how much of the information, if later found unsubstantiated, would be made public via the HHS study/GAO report.

- On July 27, Dr. Patrice Harris participated in the 2nd Annual Black Maternal Health Caucus (BMHC) Stakeholder Summit hosted by Caucus co-chairs U.S. Reps. Lauren Underwood (D-IL) and Alma Adams (D-NC). The Caucus has over 100 House members of Congress; its mission is to eliminate health disparities and in particular, address the Black maternal health crisis in the U.S.
- In May, the AMA, along with a coalition of national physician organizations and heart health experts, launched a campaign called, Release the Pressure, with ESSENCE—the nation's leading lifestyle magazine brand for Black women—aimed at partnering with Black women to improve their heart health and be part of a movement for healthy blood pressure. The prevalence of high blood pressure among Black adults in the U.S. is among the highest in the world, with the prevalence of high blood pressure in Black women nearly 40% higher than white women in the U.S. Two of the leading causes of pregnancy-related deaths are heart conditions and stroke, which cause more than 1 in 3 deaths.
- On May 28, in response to a request for information regarding "Maternal and Infant Health Care in Rural Communities" by CMS, the AMA submitted comments outlining actions that CMS could take to improve health outcomes for pregnant women.
- Also, on May 28, AMA Advocacy staff participated in a U.S. Senate Committee on Finance staff briefing on maternal health. During the briefing, AMA Advocacy staff reiterated many of the AMA's policies on this important issue, such as expanding access to health care and social services for women for one-year postpartum under Medicaid and CHIP. We also noted several areas where the AMA, under the leadership of the Center for Health Equity, is working to address these issues, such as West Side United, a $6 million collaborative social impact investment pact aimed at closing health equity gaps in Chicago's west side.
- On April 1, the AMA submitted comments to the U.S. Senate Committee on Finance's request for information regarding, "Solutions to Improve Maternal Health." The AMA urged Congress to take several actions, such as working in a bipartisan manner to ensure Medicaid and CHIP coverage for women for one-year postpartum in an effort to reduce and prevent rising rates of maternal mortality and serious or near-fatal maternal morbidity.
- The AMA supported H.R. 1897/S. 916, the Mothers and Offspring Mortality and Morbidity Awareness (MOMMA's) Act, introduced by Rep. Robin Kelly (D-IL). The bill would enhance federal efforts to support states in collecting, standardizing, and sharing maternal mortality and morbidity data, and authorizes and expands existing federal grant programs dedicated to scaling best practices to improve maternity care. The MOMMA's Act would also authorize states to expand coverage under Medicaid, CHIP, and the Special Supplemental Nutrition Program for Women, Infants, and Children through a longer post-partum period for women. The bill would also ensure improved access to culturally competent care training and workforce practices throughout the care delivery system. **Note*: This bill has been reintroduced in the 117th Congress as S. 411.
- The AMA supported H.R. 4996, the Helping MOMS Act of 2019, introduced by Rep. Robin Kelly (D-IL) which would allow states to provide one year of postpartum coverage under Medicaid and CHIP; current law allows only 60 days of postpartum coverage. Additionally, the Medicaid and CHIP Payment and Access Commission must report on specified information relating to coverage of doula services under the state Medicaid program, including coverage barriers and recommendations for improvement.
- The AMA supported H.R. 4995, the Maternal Health Quality Improvement Act of 2019, introduced by Rep. Eliot Engel (D-NY-16), which would improve data collection in rural communities, support the Alliance for Innovation on Maternal Health, and promote perinatal

quality collaborative activities. The bill also directs the U.S. Department of Health and Human Services (HHS) to promote best practices to reduce and prevent implicit bias.

- The AMA supported S. 1365/H.R. 2569, the Comprehensive Addiction Resources Emergency (CARE) Act, introduced by Sen. Elizabeth Warren (D-MA) and the late Rep. Elijah E. Cummings (D-MD). The CARE Act was modeled directly on the Ryan White Comprehensive AIDS Resources Emergency Act, which passed in Congress in 1990 to provide significant new funding to help state and local governments combat the HIV/AIDS epidemic. The CARE Act would provide emergency assistance to States, territories, Tribal nations, and local areas affected by the opioid epidemic to provide for the development, organization, coordination, and operation of more effective and cost-efficient systems for the delivery of essential services to individuals with substance use disorder and their families. There are three sections of the bill that provide for the treatment of pregnant women.
- The AMA supported H.R. 1329, the Medicaid Reentry Act, introduced by Rep. Paul Tonko (D-NY). The bill would provide states with the flexibility to allow Medicaid payment for medical services furnished to an incarcerated individual during the 30-day period preceding the individual's release. Such coverage is critical to help start treatment for individuals with substance use disorders (SUDs) before they are released back to the community and will help prevent opioid and other drug overdose deaths following release. By allowing Medicaid assistance for eligible incarcerated individuals up to 30 days prior to their release, the bill would help to provide for critically needed health care services, care coordination activities, and linkages to care for these individuals. **Note*: This bill has been reintroduced in the 117th Congress as H.R. 955.
- In February 2020, the AMA joined the Healthy Mothers, Healthy Babies Coalition of Georgia and successfully supported enactment of Georgia H.B. 1114 in June 2020 to extend Medicaid coverage for six-months postpartum.

AMA Advocacy in 2019

- The AMA provided both written and oral testimony to the Committee on Energy & Commerce, Subcommittee on Health, as part of the hearing on Improving Maternal Health.
- The AMA also gave written and oral testimony to the Committee on Ways & Means as part of the hearing on the Maternal Mortality Crisis.
- The AMA participated in the BMHC's first Black Maternal Health Stakeholder Summit on Capitol Hill.

AMA Advocacy in 2018

- The AMA supported H.R. 1318, the Preventing Maternal Deaths Act of 2018.
- The AMA supported S. 1112, the Maternal Health Accountability Act of 2017.
- The AMA joined stakeholders in a sign-on letter supporting H.R. 1318 and S. 1112.

Additional AMA Business Unit Activity

From Health, Science, and Ethics, to the Center for Health Equity (CHE), to Improving Health Outcomes, to Medical Education, business units across the AMA continue to be actively engaged in initiatives to improve maternal health care and reduce disparities. The AMA is deeply committed to addressing the social conditions that impact health, increase health workforce diversity,

advocating for equity in health care access, promoting equity in care, and ensuring equitable practices and processes in research and data collection/reporting. Key highlights include:

- The AMA supports efforts designed to integrate training in the Social Determinants of Health (SDOH) and cultural competence into physician education.
    - In 2013, the AMA launched the "Accelerating Change in Medical Education" initiative. Currently, the 37-member consortium, which represents almost one-fifth of allopathic and osteopathic medical schools, is delivering forward thinking educational experiences to approximately 19,000 medical students—students who will provide care to a potential 33 million patients annually.
    - In 2019, the AMA announced its Reimaging Residency Initiative, designed to transform residency training to best address the workforce needs of our current and future health care system.
    - For practicing physicians, the AMA launched STEPSforward,™ an interactive practice transformation series offering innovative strategies that will allow physicians and their staff to thrive in the evolving health care environment. This series includes a continuing medical education module on "Addressing Social Determinants of Health: Beyond the Clinic Walls" that helps physicians identify how to best understand the needs of their community, define a plan to begin addressing the SDOH, and explains the tools available to screen patients and link them to resources.

- The AMA also demonstrates its commitment to health equity broadly and women's health equity specifically though its development of and support for CHE, leading the Release the Pressure collaboration aimed at ensuring Black communities have the power, knowledge, opportunities and resources to achieve optimal health, and amplifying the reach of the CDC's Hear Her campaign.

Reducing Inequities and Improving Access to Insurance for Maternal Health Care
Appendix B – Data Sources

Maternal Mortality Data

(1) CDC's National Center for Health Statistics' National Vital Statistics System (NVSS)

NVSS only counts deaths that occur while pregnant for within 42 days postpartum, and it does not include accidental or incidental causes of death. Further, NVSS relies upon only two pieces of information to identify maternal deaths – the pregnancy checkbox on the death certificate (which was not consistently used across all 50 states until 2017[210]) and the certified recording of the cause of death.[210] PLEASE NOTE THAT ALL THE FOOTNOTES GOING FORWARD ARE LISTED AS 210 – THAT NEEDS TO BE FIXED.

(2) the CDC's Pregnancy Mortality Surveillance System (PMSS)

PMSS casts a wider net in counting pregnancy-related deaths. PMSS includes deaths during pregnancy through one year postpartum, and in addition to the data reviewed by NVSS, in its identification process, PMSS reviews information from linkages between death records of women of reproductive age to birth and fetal death records within one year of the death, media searches, and reporting from public health agencies, health care providers and the public.[210] These records are reviewed by medical epidemiologists to determine the pregnancy-related mortality ratio.

(3) State and local Maternal Mortality Review Committees (MMRCs)[210]

The most comprehensive data is collected at the state and local level by MMRCs.[210] Like PMSS, MMRCs reviews deaths that occur during or within one year of pregnancy. MMRCs have access to multiple sources of information that can provide a deeper understanding of the circumstances surrounding a death. This also allows MMRCs to make determinations of pregnancy-relatedness on a broader set of deaths than is possible for PMSS, such as deaths due to injury. However, there are substantial differences in the quality of state maternal mortality data, and for many states, the data are based on small numbers that are statistically unreliable.[210]

The CDC has granted 24 awards, supporting 25 states for the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) Program.[210] This funding directly supports agencies and organizations that coordinate and manage MMRCs to identify, review, and characterize maternal deaths and identify prevention opportunities. This work builds understanding of drivers of maternal mortality and morbidity and the associated disparities; determines what interventions at patient, provider, facility, system, and community levels will have the most effect; and informs implementation of initiatives to help the families and communities who need them most.

Maternal Health and Morbidity Data

(1) Nationwide Inpatient Sample (NIS)

The NIS is the source of data for CDC's national SMM estimates, and it is the largest all-payer hospital inpatient care database in the US. The NIS is a stratified sample of approximately 20 percent of all community hospitals.[210]

(2) Pregnancy Risk Assessment Monitoring System (PRAMS)

PRAMS is a surveillance project of the CDC and state health departments that collects state-specific, population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy.[210] PRAMS data are used by researchers to investigate emerging issues in the field of reproductive health and by state and local governments to plan and review programs and policies aimed at reducing health problems among mothers and babies.

Reducing Inequities and Improving Access to Insurance for Maternal Health Care
Appendix C – Key AMA Policy

Expanding Coverage

D-290.974 Extending Medicaid Coverage for One Year Postpartum
Our AMA will work with relevant stakeholders to support extension of Medicaid coverage to 12 months postpartum. (Res. 221, A-19)

D-290.979 Medicaid Expansion
Our AMA, at the invitation of state medical societies, will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133 percent (138 percent FPL including the income disregard) of the Federal Poverty Level as authorized by the ACA and will advocate for an increase in Medicaid payments to physicians and improvements and innovations in Medicaid that will reduce administrative burdens and deliver healthcare services more effectively, even as coverage is expanded. (Res. 809, I-12; Reaffirmed: CMS Rep. 02, A-19)

H-165.823 Options to Maximize Coverage under the AMA Proposal for Reform
1. Our AMA will advocate that any public option to expand health insurance coverage must meet the following standards:
a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.
b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits.
c. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.
d. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option.
e. The public option is financially self-sustaining and has uniform solvency requirements.
f. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.
g. The public option shall be made available to uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost.
2. Our AMA supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets the following standards:
a. Individuals must provide consent to the applicable state and/or federal entities to share their health insurance status and tax data with the entity with the authority to make coverage determinations.
b. Individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would, therefore, include individuals eligible for Medicaid/Children's Health Insurance Program (CHIP) or zero-premium marketplace coverage.

c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled.
d. Individuals should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto-enrollment.
e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values.
f. Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze and silver plans, to maximize the value of zero-premium plans to plan enrollees.
g. Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing reductions should be notified of the cost-sharing advantages of enrolling in silver plans.
h. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and establishing a special enrollment period. (CMS Rep. 1, I-20)

H-165.824 Improving Affordability in the Health Insurance Exchanges
1. Our AMA will: (a) support adequate funding for and expansion of outreach efforts to increase public awareness of advance premium tax credits; (b) support expanding eligibility for premium tax credits up to 500 percent of the federal poverty level; (c) support providing young adults with enhanced premium tax credits while maintaining the current premium tax credit structure which is inversely related to income; and (d) encourage state innovation, including considering state-level individual mandates, auto-enrollment and/or reinsurance, to maximize the number of individuals covered and stabilize health insurance premiums without undercutting any existing patient protections.
2. Our AMA supports: (a) eliminating the subsidy "cliff", thereby expanding eligibility for premium tax credits beyond 400 percent of the federal poverty level (FPL); (b) increasing the generosity of premium tax credits; (c) expanding eligibility for cost-sharing reductions; and (d) increasing the size of cost-sharing reductions. (CMS Rep. 02, A-18 Appended: CMS Rep. 02, A-19)

H-165.855 Medical Care for Patients with Low Incomes
It is the policy of our AMA that:
(1) states be allowed the option to provide coverage to their Medicaid beneficiaries who are nonelderly and nondisabled adults and children with the current Medicaid program or with premium tax credits that are refundable, advanceable, inversely related to income, and administratively simple for patients, exclusively to allow patients and their families to purchase coverage through programs modeled after the state employee purchasing pool or the Federal Employee Health Benefits Program (FEHBP) with minimal or no cost-sharing obligations based on income. Children qualified for Medicaid must also receive Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program benefits and have no cost-sharing obligations.
(2) in order to limit patient churn and assure continuity and coordination of care, there should be adoption of 12-month continuous eligibility across Medicaid, Children's Health Insurance Program, and exchange plans.
(3) to support the development of a safety net mechanism, allow for the presumptive assessment of eligibility and retroactive coverage to the time at which an eligible person seeks medical care.
(4) tax credit beneficiaries should be given a choice of coverage, and that a mechanism be developed to administer a process by which those who do not choose a health plan will be assigned a plan in their geographic area through auto-enrollment until the next enrollment opportunity.

Patients who have been auto-enrolled should be permitted to change plans any time within 90 days of their original enrollment.
(5) state public health or social service programs should cover, at least for a transitional period, those benefits that would otherwise be available under Medicaid, but are not medical benefits per se.
(6) as the nonelderly and nondisabled populations transition into needing chronic care, they should be eligible for sufficient additional subsidization based on health status to allow them to maintain their current coverage.
(7) our AMA encourages the development of pilot projects or state demonstrations, including for children, incorporating the above recommendations. (Modify Current HOD Policy)
(8) our AMA should encourage states to support a Medicaid Physician Advisory Commission to evaluate and monitor access to care in the state Medicaid program and related pilot projects. (CMS Rep. 1, I-03 Reaffirmed in lieu of Res. 105, A-06 Reaffirmation I-07 Modified: CMS Rep. 1, A-12 Reaffirmed in lieu of Res. 101, A-13 Reaffirmed: CMS Rep. 02, A-16 Reaffirmation: A-18)

H-180.958 Coverage of Contraceptives by Insurance
1. Our AMA supports federal and state efforts to require that every prescription drug benefit plan include coverage of prescription contraceptives.
2. Our AMA supports full coverage, without patient cost-sharing, of all contraception without regard to prescription or over-the-counter utilization because all contraception is essential preventive health care. (Res. 221, A-98 Reaffirmation A-04 Reaffirmed: CMS Rep. 1, A-14 Reaffirmation: I-17 Modified: BOT Rep. 10, A-18)

H-290.966 Medicaid Expansion Options and Alternatives
1. Our AMA encourages policymakers at all levels to focus their efforts on working together to identify realistic coverage options for adults currently in the coverage gap. 2. Our AMA encourages states that are not participating in the Medicaid expansion to develop waivers that support expansion plans that best meet the needs and priorities of their low income adult populations. 3. Our AMA encourages the Centers for Medicare & Medicaid Services to review Medicaid expansion waiver requests in a timely manner, and to exercise broad authority in approving such waivers, provided that the waivers are consistent with the goals and spirit of expanding health insurance coverage and eliminating the coverage gap for low-income adults. 4. Our AMA advocates that states be required to develop a transparent process for monitoring and evaluating the effects of their Medicaid expansion plans on health insurance coverage levels and access to care, and to report the results annually on the state Medicaid web site. (CMS Rep. 5, I-14 Reaffirmed: CMS Rep. 02, A-16)

H-290.982 Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured
AMA policy is that our AMA: (1) urges that Medicaid reform not be undertaken in isolation, but rather in conjunction with broader health insurance reform, in order to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients;
(2) <u>encourages physicians to participate in efforts to enroll children in adequately funded Medicaid and State Children's Health Insurance Programs using the mechanism of "presumptive eligibility", whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be, in fact, eligible.</u>
(3) encourages states to ensure that within their Medicaid programs there is a pluralistic approach to health care financing delivery including a choice of primary care case management, partial

capitation models, fee-for-service, medical savings accounts, benefit payment schedules and other approaches;
(4) calls for states to create mechanisms for traditional Medicaid providers to continue to participate in Medicaid managed care and in State Children's Health Insurance Programs;
(5) calls for states to streamline the enrollment process within their Medicaid programs and State Children's Health Insurance Programs by, for example, allowing mail-in applications, developing shorter application forms, coordinating their Medicaid and welfare (TANF) application processes, and placing eligibility workers in locations where potential beneficiaries work, go to school, attend day care, play, pray, and receive medical care;
(6) urges states to administer their Medicaid and SCHIP programs through a single state agency;
(7) strongly urges states to undertake, and encourages state medical associations, county medical societies, specialty societies, and individual physicians to take part in, educational and outreach activities aimed at Medicaid-eligible and SCHIP-eligible children. Such efforts should be designed to ensure that children do not go without needed and available services for which they are eligible due to administrative barriers or lack of understanding of the programs;
(8) supports requiring states to reinvest savings achieved in Medicaid programs into expanding coverage for uninsured individuals, particularly children. Mechanisms for expanding coverage may include additional funding for the SCHIP earmarked to enroll children to higher percentages of the poverty level; Medicaid expansions; providing premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level; providing some form of refundable, advanceable tax credits inversely related to income; providing vouchers for recipients to use to choose their own health plans; using Medicaid funds to purchase private health insurance coverage; or expansion of Maternal and Child Health Programs. Such expansions must be implemented to coordinate with the Medicaid and SCHIP programs in order to achieve a seamless health care delivery system, and be sufficiently funded to provide incentive for families to obtain adequate insurance coverage for their children;
(9) advocates consideration of various funding options for expanding coverage including, but not limited to: increases in sales tax on tobacco products; funds made available through for-profit conversions of health plans and/or facilities; and the application of prospective payment or other cost or utilization management techniques to hospital outpatient services, nursing home services, and home health care services;
(10) supports modest co-pays or income-adjusted premium shares for non-emergent, non-preventive services as a means of expanding access to coverage for currently uninsured individuals;
(11) calls for CMS to develop better measurement, monitoring, and accountability systems and indices within the Medicaid program in order to assess the effectiveness of the program, particularly under managed care, in meeting the needs of patients. Such standards and measures should be linked to health outcomes and access to care;
(12) supports innovative methods of increasing physician participation in the Medicaid program and thereby increasing access, such as plans of deferred compensation for Medicaid providers. Such plans allow individual physicians (with an individual Medicaid number) to tax defer a specified percentage of their Medicaid income;
(13) supports increasing public and private investments in home and community-based care, such as adult day care, assisted living facilities, congregate living facilities, social health maintenance organizations, and respite care;
(14) supports allowing states to use long-term care eligibility criteria which distinguish between persons who can be served in a home or community-based setting and those who can only be served safely and cost-effectively in a nursing facility. Such criteria should include measures of

functional impairment which take into account impairments caused by cognitive and mental disorders and measures of medically related long-term care needs;
(15) supports buy-ins for home and community-based care for persons with incomes and assets above Medicaid eligibility limits; and providing grants to states to develop new long-term care infrastructures and to encourage expansion of long-term care financing to middle-income families who need assistance;
(16) supports efforts to assess the needs of individuals with intellectual disabilities and, as appropriate, shift them from institutional care in the direction of community living;
(17) supports case management and disease management approaches to the coordination of care, in the managed care and the fee-for-service environments;
(18) urges CMS to require states to use its simplified four-page combination Medicaid / Children's Health Insurance Program (CHIP) application form for enrollment in these programs, unless states can indicate they have a comparable or simpler form; and
(19) urges CMS to ensure that Medicaid and CHIP outreach efforts are appropriately sensitive to cultural and language diversities in state or localities with large uninsured ethnic populations.
(BOT Rep. 31, I-97 Reaffirmed by CMS Rep. 2, A-98 Reaffirmation A-99 and Reaffirmed: Res. 104, A-99 Appended: CMS Rep 2, A-99 Reaffirmation A-00 Appended: CMS Rep. 6, A-01 Reaffirmation A-02 Modified: CMS Rep. 8, A-03 Reaffirmed: CMS Rep. 1, A-05 Reaffirmation A-05 Reaffirmation A-07 Modified: CMS Rep. 8, A-08 Reaffirmation A-11 Modified: CMS Rep. 3, I-11 Reaffirmed: CMS Rep. 02, A-19)

H-290.987 Medicaid Waivers for Managed Care Demonstration Projects

(1) Our AMA adopts the position that the Secretary of Health and Human Services should determine as a condition for granting waivers for demonstration projects under Section 1115(a) of the Medicaid Act that the proposed project: (i) assist in promoting the Medicaid Act's objective of improving access to quality medical care, (ii) has been preceded by a fair and open process for receiving public comment on the program, (iii) is properly funded, (iv) has sufficient provider reimbursement levels to secure adequate access to providers, (v) does not include provisions designed to coerce physicians and other providers into participation, such as those that link participation in private health plans with participation in Medicaid, and (vi) maintains adequate funding for graduate medical education. (2) Our AMA advocates that CMS establish a procedure which state Medicaid agencies can implement to monitor managed care plans to ensure that (a) they are aware of their responsibilities under EPSDT, (b) they inform patients of entitlement to these services, and (c) they institute internal review mechanisms to ensure that children have access to medically necessary services not specified in the plan's benefit package. (BOT Rep. 24, A-95; Reaffirmation A-99; Reaffirmation A-00; Reaffirmation I-04; Modified: CMS Rep. 1,
A-14)

H-290.997 Medicaid - Towards Reforming the Program

Our AMA believes that greater equity should be provided in the Medicaid program, through adoption of the following principles: (1) the creation of basic national standards of uniform eligibility for all persons below poverty level income (adjusted by state per capita income factors); (2) the creation of basic national standards of uniform minimum adequate benefits; (3) the elimination of the existing categorical requirements; (4) the creation of adequate payment levels to assure broad access to care; and (5) establishment of national standards that result in uniform eligibility, benefits and adequate payment mechanisms for services across jurisdictions. (BOT Rep. UU, A-88; Reaffirmed: CMS Rep. G, A-93; Reaffirmation I-96; Reaffirmation A-00; Reaffirmed:

BOT Action in response to referred for decision Res. 215, I-00; Reaffirmation A-05; Reaffirmed: Res. 804, I-09; Reaffirmed: CMS Rep. 01, A-19)

H-420.972 Prenatal Services to Prevent Low Birthweight Infants
Our AMA encourages all state medical associations and specialty societies to become involved in the promotion of public and private programs that provide education, outreach services, and funding directed at prenatal services for pregnant women, particularly women at risk for delivering low birthweight infants. (Res. 231, A-90 Reaffirmed: Sunset Report, I-00 Reaffirmation A-07 Reaffirmation I-07 Reaffirmed: Res. 227, A-11)

H-420.978 Access to Prenatal Care
(1) The AMA supports development of legislation or other appropriate means to provide for access to prenatal care for all women, with alternative methods of funding, including private payment, third party coverage, and/or governmental funding, depending on the individual's economic circumstances. (2) In developing such legislation, the AMA urges that the effect of medical liability in restricting access to prenatal and natal care be taken into account. (Res. 33, I-88 Reaffirmed: Sunset Report, I-98 Reaffirmation A-05 Reaffirmation A-07 Reaffirmed: Res. 227, A-11)

H-425.976 Preconception Care
1. Our AMA supports the 10 recommendations developed by the Centers for Disease Control and Prevention for improving preconception health care that state:
(1) Individual responsibility across the lifespan--each woman, man, and couple should be encouraged to have a reproductive life plan;
(2) Consumer awareness--increase public awareness of the importance of preconception health behaviors and preconception care services by using information and tools appropriate across various ages; literacy, including health literacy; and cultural/linguistic contexts;
(3) Preventive visits--as a part of primary care visits, provide risk assessment and educational and health promotion counseling to all women of childbearing age to reduce reproductive risks and improve pregnancy outcomes;
(4) Interventions for identified risks--increase the proportion of women who receive interventions as follow-up to preconception risk screening, focusing on high priority interventions (i.e., those with evidence of effectiveness and greatest potential impact);
(5) Inter-conception care--use the inter-conception period to provide additional intensive interventions to women who have had a previous pregnancy that ended in an adverse outcome (i.e., infant death, fetal loss, birth defects, low birth weight, or preterm birth);
(6) Pre-pregnancy checkup--offer, as a component of maternity care, one pre-pregnancy visit for couples and persons planning pregnancy;
(7) Health insurance coverage for women with low incomes--increase public and private health insurance coverage for women with low incomes to improve access to preventive women's health and preconception and inter-conception care;
(8) Public health programs and strategies--integrate components of pre-conception health into existing local public health and related programs, including emphasis on inter-conception interventions for women with previous adverse outcomes;
(9) Research--increase the evidence base and promote the use of the evidence to improve preconception health; and
(10) Monitoring improvements--maximize public health surveillance and related research mechanisms to monitor preconception health.

2. Our AMA supports the education of physicians and the public about the importance of preconception care as a vital component of a woman's reproductive health.
3. Our AMA supports the use of pregnancy intention screening and contraceptive screening in appropriate women and men as part of routine well-care and recommend it be appropriately documented in the medical record. (Res. 414, A-06 Reaffirmation I-07 Reaffirmed: CSAPH Rep. 01, A-17 Appended: Res. 401, A-19)

Disparities, Bias, and Racism

8.5 Disparities in Health Care (Code of Medical Ethics)
Stereotypes, prejudice, or bias based on gender expectations and other arbitrary evaluations of any individual can manifest in a variety of subtle ways. Differences in treatment that are not directly related to differences in individual patients' clinical needs or preferences constitute inappropriate variations in health care. Such variations may contribute to health outcomes that are considerably worse in members of some populations than those of members of majority populations.
This represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics.
To fulfill this professional obligation in their individual practices physicians should:
(a) Provide care that meets patient needs and respects patient preferences.
(b) Avoid stereotyping patients.
(c) Examine their own practices to ensure that inappropriate considerations about race, gender identify, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment.
(d) Work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients.
(e) Encourage shared decision making.
(f) Cultivate effective communication and trust by seeking to better understand factors that can influence patients' health care decisions, such as cultural traditions, health beliefs and health literacy, language or other barriers to communication and fears or misperceptions about the health care system.
The medical profession has an ethical responsibility to:
(g) Help increase awareness of health care disparities.
(h) Strive to increase the diversity of the physician workforce as a step toward reducing health care disparities.
(i) Support research that examines health care disparities, including research on the unique health needs of all genders, ethnic groups, and medically disadvantaged populations, and the development of quality measures and resources to help reduce disparities.
AMA Principles of Medical Ethics: I, IV, VII, VIII, IX
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law. (Issued: 2016)

D-200.985 Strategies for Enhancing Diversity in the Physician Workforce
1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups.

2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.
10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.
13. Our AMA: (a) supports the publication of a white paper chronicling health care career pipeline programs (also known as pathway programs) across the nation aimed at increasing the number of programs and promoting leadership development of underrepresented minority health care professionals in medicine and the biomedical sciences, with a focus on assisting such programs by identifying best practices and tracking participant outcomes; and (b) will work with various stakeholders, including medical and allied health professional societies, established biomedical science pipeline programs and other appropriate entities, to establish best practices for the sustainability and success of health care career pipeline programs.
14. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs. (CME Rep. 1, I-06 Reaffirmation I-10 Reaffirmation A-13 Modified: CCB/CLRPD Rep. 2, A-14 Reaffirmation: A-16 Appended: Res. 313, A-17 Appended: Res. 314, A-17 Modified: CME Rep. 01, A-18 Appended: Res. 207, I-18 Reaffirmation: A-19 Appended: Res. 304, A-19 Appended: Res. 319, A-19)

Infant Mortality D-245.994
1. Our AMA will work with appropriate agencies and organizations towards reducing infant mortality by providing information on safe sleep positions and preterm birth risk factors to physicians, other health professionals, parents, and child care givers.
2. Our AMA will work with Congress and the Department of Health and Human Services to improve maternal outcomes through: (a) maternal/infant health research at the NIH to reduce the prevalence of premature births and to focus on obesity research, treatment and prevention; (b) maternal/infant health research and surveillance at the CDC to assist states in setting up maternal mortality reviews; modernize state birth and death records systems to the 2003-recommended guidelines; and improve the Safe Motherhood Program; (c) maternal/infant health programs at HRSA to improve the Maternal Child Health Block grant; (d) comparative effectiveness research into the interventions for preterm birth; (e) disparities research into maternal outcomes, preterm birth and pregnancy-related depression; and (f) the development, testing and implementation of quality improvement measures and initiatives. (Res. 410,
A-10 Reaffirmed: CSAPH Rep. 01, A-20)

D-350.981 Racial Essentialism in Medicine
1. Our AMA recognizes that the false conflation of race with inherent biological or genetic traits leads to inadequate examination of true underlying disease risk factors, which exacerbates existing health inequities.
2. Our AMA encourages characterizing race as a social construct, rather than an inherent biological trait, and recognizes that when race is described as a risk factor, it is more likely to be a proxy for influences including structural racism than a proxy for genetics.
3. Our AMA will collaborate with the AAMC, AACOM, NBME, NBOME, ACGME and other appropriate stakeholders, including minority physician organizations and content experts, to identify and address aspects of medical education and board examinations which may perpetuate teachings, assessments, and practices that reinforce institutional and structural racism.
4. Our AMA will collaborate with appropriate stakeholders and content experts to develop recommendations on how to interpret or improve clinical algorithms that currently include race-based correction factors.
5. Our AMA will support research that promotes antiracist strategies to mitigate algorithmic bias in medicine. (Res. 10, I-20)

D-350.984 Reducing Discrimination in the Practice of Medicine and Health Care Education
Our AMA will pursue avenues to collaborate with the American Public Health Association's National Campaign Against Racism in those areas where AMA's current activities align with the campaign. (BOT Action in response to referred for decision Res. 602, I-15)

D-350.990 Collaboration with the National Medical Association to Address Health Disparities
Our American Medical Association will continue to work with the National Medical Association on issues of common concern, that include opportunities to increase underrepresented minorities in the health care professional pipeline including leadership roles and will continue to support efforts to increase the cultural competence of clinicians, and reduce health disparities. (BOT Action in response to referred for decision Res. 606, A-09 Modified: CSAPH Rep. 01, A-19)

D-350.991 Guiding Principles for Eliminating Racial and Ethic Health Care Disparities
Our AMA: (1) in collaboration with the National Medical Association and the National Hispanic Medical Association, will distribute the Guiding Principles document of the Commission to End Health Care Disparities to all members of the federation and encourage them to adopt and use these

principles when addressing policies focused on racial and ethnic health care disparities; (2) shall work with the Commission to End Health Care Disparities to develop a national repository of state and specialty society policies, programs and other actions focused on studying, reducing and eliminating racial and ethnic health care disparities; 3) urges medical societies that are not yet members of the Commission to End Health Care Disparities to join the Commission, and 4) strongly encourages all medical societies to form a Standing Committee to Eliminate Health Care Disparities. (Res. 409, A-09 Appended: Res. 416, A-11)

D-350.995 Reducing Racial and Ethnic Disparities in Health Care
Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations:
(1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.
(2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.
(3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities. (BOT Rep. 4, A-03 Reaffirmation A-11 Reaffirmation: A-16 Reaffirmed: CMS Rep. 10, A-19)

D-420.993 Disparities in Maternal Mortality
Our AMA: (1) will ask the Commission to End Health Care Disparities to evaluate the issue of health disparities in maternal mortality and offer recommendations to address existing disparities in the rates of maternal mortality in the United States; (2) will work with the CDC, HHS, state and county health departments to decrease maternal mortality rates in the US; (3) encourages and promotes to all state and county health departments to develop a maternal mortality surveillance system; and (4) will work with stakeholders to encourage research on identifying barriers and developing strategies toward the implementation of evidence-based practices to prevent disease conditions that contribute to poor obstetric outcomes, maternal morbidity and maternal mortality in racial and ethnic minorities. (CSAPH Rep. 3,
A-09 Appended: Res. 403, A-11 Appended: Res. 417, A-18)

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. (Res. 5, I-20)

H-65.953 Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice
1. Our AMA recognizes that race is a social construct and is distinct from ethnicity, genetic ancestry, or biology.
2. Our AMA supports ending the practice of using race as a proxy for biology or genetics in medical education, research, and clinical practice.
3. Our AMA encourages undergraduate medical education, graduate medical education, and continuing medical education programs to recognize the harmful effects of presenting race as biology in medical education and that they work to mitigate these effects through curriculum change that: (a) demonstrates how the category "race" can influence health outcomes; (b) that supports race as a social construct and not a biological determinant and (c) presents race within a socio-ecological model of individual, community and society to explain how racism and systemic oppression result in racial health disparities.
4. Our AMA recommends that clinicians and researchers focus on genetics and biology, the experience of racism, and social determinants of health, and not race, when describing risk factors for disease. (Res. 11, I-20)

H-65.963 Discriminatory Policies that Create Inequities in Health Care
Our AMA will: (1) speak against policies that are discriminatory and create even greater health disparities in medicine; and (2) be a voice for our most vulnerable populations, including sexual, gender, racial and ethnic minorities, who will suffer the most under such policies, further widening the gaps that exist in health and wellness in our nation. (Res. 001, A-18)

H-165.822 Health Plan Initiatives Addressing Social Determinants of Health
Our AMA:
1. recognizing that social determinants of health encompass more than health care, <u>encourages new and continued partnerships among all levels of government, the private sector, philanthropic organizations, and community- and faith-based organizations to address non-medical, yet critical health needs and the underlying social determinants of health</u>;
2. supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs;
3. encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health, including through such mechanisms as professional development and other training;
4. supports mechanisms, including the establishment of incentives<u>, to improve the acquisition of data related to social determinants of health, while minimizing burdens on patients and physicians;</u>
5. supports research to determine how best to integrate and finance non-medical services as part of health insurance benefit design, and the impact of covering non-medical benefits on health care and societal costs; and
6. encourages coverage pilots to test the impacts of addressing certain non-medical, yet critical health needs, for which sufficient data and evidence are not available, on health outcomes and health care costs. (CMS Rep. 7, I-20)

H-245.986 Infant Mortality in the United States
It is the policy of the AMA: (1) to continue to address the problems that contribute to infant mortality within its ongoing health of the public activities. In particular, the special needs of adolescents and the problem of teen pregnancy should continue to be addressed by the adolescent health initiative; and (2) to be particularly aware of the special health access needs of pregnant women and infants, especially racial and ethnic minority group populations, in its advocacy on behalf of its patients. (BOT Rep. U, I-91 Modified by BOT Rep. 8, A-97 Reaffirmed: CSAPH Rep. 3, A-07 Reaffirmation A-07 Modified: CSAPH Rep. 01, A-17)

H-295.897 Enhancing the Cultural Competence of Physicians
1. Our AMA continues to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula.
2. Our AMA continues to support research into the need for and effectiveness of training in cultural competence, using existing mechanisms such as the annual medical education surveys.
3. Our AMA will assist physicians in obtaining information about and/or training in culturally effective health care through dissemination of currently available resources from the AMA and other relevant organizations.
4. Our AMA encourages training opportunities for students and residents, as members of the physician-led team, to learn cultural competency from community health workers, when this exposure can be integrated into existing rotation and service assignments.
5. Our AMA supports initiatives for medical schools to incorporate diversity in their Standardized Patient programs as a means of combining knowledge of health disparities and practice of cultural competence with clinical skills.
6. Our AMA will encourage the inclusion of peer-facilitated intergroup dialogue in medical education programs nationwide. (CME Rep. 5, A-98 Reaffirmed: Res. 221, A-07 Reaffirmation A-11Appended: Res. 304, I-16 Modified: CME Rep. 01, A-17 Appended: Res. 320, A-17 Reaffirmed: CMS Rep. 02, I-17 Appended: Res. 315, A-18)

H-350.971 AMA Initiatives Regarding Minorities
The House of Delegates commends the leaders of our AMA and the National Medical Association for having established a successful, mutually rewarding liaison and urges that this relationship be expanded in all areas of mutual interest and concern. Our AMA will develop publications, assessment tools, and a survey instrument to assist physicians and the federation with minority issues. The AMA will continue to strengthen relationships with minority physician organizations, will communicate its policies on the health care needs of minorities, and will monitor and report on progress being made to address racial and ethnic disparities in care. It is the policy of our AMA to establish a mechanism to facilitate the development and implementation of a comprehensive, long-range, coordinated strategy to address issues and concerns affecting minorities, including minority health, minority medical education, and minority membership in the AMA. Such an effort should include the following components:
(1) Development, coordination, and strengthening of AMA resources devoted to minority health issues and recruitment of minorities into medicine;
(2) Increased awareness and representation of minority physician perspectives in the Association's policy development, advocacy, and scientific activities;
(3) Collection, dissemination, and analysis of data on minority physicians and medical students, including AMA membership status, and on the health status of minorities;
(4) Response to inquiries and concerns of minority physicians and medical students; and

(5) Outreach to minority physicians and minority medical students on issues involving minority health status, medical education, and participation in organized medicine. (CLRPD Rep. 3, I-98CLRPD Rep. 1, A-08Reaffirmed: CEJA Rep. 01, A-20)

H-350.972 Improving the Health of Black and Minority Populations
Our AMA supports:
(1) A greater emphasis on minority access to health care and increased health promotion and disease prevention activities designed to reduce the occurrence of illnesses that are highly prevalent among disadvantaged minorities.
(2) Authorization for the Office of Minority Health to coordinate federal efforts to better understand and reduce the incidence of illness among U.S. minority Americans as recommended in the 1985 Report to the Secretary's Task Force on Black and Minority Health.
(3) Advising our AMA representatives to the LCME to request data collection on medical school curricula concerning the health needs of minorities.
(4) The promotion of health education through schools and community organizations aimed at teaching skills of health care system access, health promotion, disease prevention, and early diagnosis. (CLRPD Rep. 3, I-98 Reaffirmation A-01 Modified: CSAPH Rep. 1, A-11)

H-350.974 Racial and Ethnic Disparities in Health Care
1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. <u>The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.</u>
2. The AMA emphasizes three approaches that it believes should be given high priority:
A. <u>Greater access</u> - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for <u>Medicaid reform.</u>
B. <u>Greater awareness</u> - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.
C. <u>Practice parameters</u> - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision-making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities
3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of <u>evidence-based guidelines to promote the consistency and equity of care for all persons</u>.
4. Our AMA: (a) actively supports the development and implementation of <u>training regarding implicit bias, diversity and inclusion</u> in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard

to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations. (CLRPD Rep. 3, I-98 Appended and Reaffirmed: CSA Rep.1, I-02 Reaffirmed: BOT Rep. 4, A-03 Reaffirmed in lieu of Res. 106, A-12 Appended: Res. 952, I-17 Reaffirmed: CMS Rep. 10, A-19)

H-440.869 Establishment of State Commission / Task Force to Eliminate Racial and Ethnic Health Care Disparities
Our AMA will encourage and assist state and local medical societies to advocate for creation of statewide commissions to eliminate health disparities in each state. (Res. 914, I-07 Modified: BOT Rep. 22, A-17)

H-450.943 Effects of Pay-for-Performance on Minority Health Disparities
Our AMA urges that physicians with expertise in eliminating racial and ethnic health disparities be involved in the design, implementation and evaluation of pay-for-performance programs. (Res. 210, A-06 Reaffirmed: CMS Rep. 01, A-16)

Maternal Mortality Review Committees

H-60.909 State Maternal Mortality Review Committees
Our AMA supports: (1) the important work of maternal mortality review committees; (2) work with state and specialty medical societies to advocate for state and federal legislation establishing Maternal Mortality Review Committees; and (3) work with state and specialty medical societies to secure funding from state and federal governments that fully supports the start-up and ongoing work of state Maternal Mortality Review Committees. (Res. 911, I-17)

Reducing Inequities and Improving Access to Insurance for Maternal Health Care
Appendix D – Advances Toward Medicaid Extension

Recent state and federal-level progress towards extension of Medicaid coverage for 12 months postpartum includes:

- The Mothers and Offspring Mortality and Morbidity Awareness (MOMMA's) Act, S. 411, seeks to reduce the rising maternal and infant mortality rate in the US, especially for mothers and babies of color. Its many proposals include an extension of Medicaid and CHIP coverage for 12 months postpartum.[1] In April 2021, the AMA sent a comment letter to the Senate in support of the MOMMA's Act.

- The Medicaid and CHIP Payment and Access Commission (MACPAC) has recommended a mandatory extension of the postpartum coverage period for individuals who were eligible and enrolled in Medicaid or CHIP while pregnant to a full year of coverage, regardless of changes in income, with 100 percent federal matching rate.[2] MACPAC also recommended requiring states to provide full Medicaid benefits to individuals enrolled in pregnancy-related pathways.[3]

- The Department of Health and Human Services (HHS), through CMS, has approved several Medicaid Section 1115 waivers to extend postpartum Medicaid coverage in some states. Illinois' waiver will allow the state to extend its postpartum Medicaid coverage up to 12 months. The Biden Administration specifically invited all states to provide full Medicaid benefits during pregnancy and the extended postpartum period.[4] Subsequently, CMS approved Georgia's waiver request to extend Medicaid coverage to six months postpartum,[5] and CMS approved Missouri's request to extend postpartum coverage to one year postpartum, but only for beneficiaries diagnosed with a substance use disorder.[6] As of this writing, several states are awaiting approval for 1115 waiver requests related to postpartum Medicaid extensions.[7] In February 2021, the AMA joined a letter signed by 113 national organizations and 151 state and local organizations urging the CMS to approve pending section 1115 demonstration projects aimed at extending Medicaid coverage to 12 months postpartum.

- Several states have enacted and/or are pursuing legislation to extend postpartum Medicaid coverage.[8] For example, West Virginia[9] and Washington[10] have passed legislation to extend Medicaid coverage to 12 months postpartum, and Georgia[11] has passed legislation to extend Medicaid coverage to six months postpartum.

- The March 2020 Families First Coronavirus Response Act provides a temporary extension of Medicaid coverage beyond 60 days postpartum for the duration of the COVID-19 national emergency declaration.[12]

- The American Rescue Plan Act of 2021[13] gives states a new option to extend Medicaid and CHIP postpartum coverage from 60 days to 12 months. States that elect the new option must provide full Medicaid benefits during pregnancy and the extended postpartum period. The new option can take effect starting April 1, 2022 and would be available to states for five years.

- In April 2021, President Biden issued a discretionary funding request that includes significant funding to reduce maternal mortality and morbidity rates, improve health equity, and end race-

based disparities, including funding to implement implicit bias training for medical team members, create State pregnancy medical home programs, support MMRCs, and expand the Rural Maternity and Obstetrics Management Strategies (RMOMS) program.[14]

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 701
(N-21)

Introduced by: Medical Student Section

Subject: Coverage of Pregnancy-Associated Healthcare for 12 Months Postpartum for Uninsured Patients Ineligible for Medicaid

Referred to: Reference Committee G

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1 Whereas, From 2008 to 2017 across 14 states, the US Centers for Disease Control and
2 Prevention (CDC) reported that across 14 states from 2008 to 2017, 23.6% of pregnancy-
3 related deaths take place between 42 days and 12 months postpartum[1]; and
4
5 Whereas, From 2008 to 2017 across 14 states, the CDC reported that 65% of pregnancy-
6 related deaths occurring before 12 months postpartum were preventable, with causes including
7 cardiovascular conditions, hemorrhage, infection, embolism, preeclampsia and eclampsia, and
8 mental illness (including suicide and overdose)[1]; and
9
10 Whereas, The 2010 Affordable Care Act (ACA) expanded Medicaid and provides federal
11 subsidies to purchase private health insurance plans depending on an individual's income, but
12 10.8 million women in the US remain uninsured[2]; and
13
14 Whereas, More than 1 million women fall into the Medicaid coverage gap, in which they remain
15 uninsured because their income is too high to qualify for Medicaid, but too low to qualify for
16 federal subsidies to purchase private health insurance plans on ACA marketplaces[2]; and
17
18 Whereas, In most states, some patients who are usually ineligible for Medicaid can temporarily
19 qualify if they become pregnant, but in many states, this coverage expires after 60 days
20 postpartum, and undocumented immigrants are still often barred from qualifying at all[3]; and
21
22 Whereas, Undocumented immigrants are often uninsured and in many states are ineligible for
23 public assistance for healthcare coverage, such as Medicaid, the Children's Health Insurance
24 Program (CHIP), and federal subsidies for ACA marketplace private health insurance plans[2,4];
25 and
26
27 Whereas, Even if they become pregnant, undocumented immigrants are still often barred from
28 qualifying for public assistance for healthcare coverage[2,4]; and
29
30 Whereas, Based on the recommendations of many state maternal mortality review committees,
31 the American College of Obstetricians and Gynecologists (ACOG) supports the extension of
32 Medicaid coverage from 60 days (the limit in many states) to 12 months postpartum to improve
33 pregnancy-associated mortality and morbidity outcomes[5]; and
34
35 Whereas, The AMA's existing Policy D-290.974, "Extending Medicaid Coverage for One Year
36 Postpartum," states that the AMA "will work with relevant stakeholders to support the extension
37 of Medicaid coverage to 12 months postpartum"[6]; and

Whereas, Existing AMA policy does not adequately address the lack of pregnancy-associate healthcare coverage for patients ineligible for Medicaid due to state restrictions or immigration status[2,3]; and

Whereas, Seventeen states offer pregnancy-associated healthcare coverage to patients ineligible for Medicaid under CHIP, but vary in how long coverage may last, with Texas offering only two postpartum visits for the mother[7,8]; and

Whereas, In 2016, the US Centers for Medicare & Medicaid Services (CMS)' Center for Medicaid & CHIP Services stated that "state Medicaid agencies may cover maternal depression screening as part of a well-child visit," which created precedent for some parental healthcare coverage under both Children's Medicaid and CHIP, and provided uninsured parents ineligible for Medicaid a path to receiving some care[9]; and

Whereas, As of 2018, screening for peripartum depression during the pediatric well-child visit is a covered benefit under state Children's Medicaid programs in twenty-five states[10]; and

Whereas, Screening for peripartum depression is a cost-effective healthcare intervention, with one study showing upwards of $13,000 gained per Quality Adjusted Life Year (QALY) compared to no intervention[11]; and

Whereas, If extension of Medicaid coverage to 12 months postpartum is important for public health, this benefit should also be extended to uninsured patients ineligible for Medicaid, including those who fall into the Medicaid coverage gap or are undocumented[1,2]; therefore be it

RESOLVED, That our American Medical Association amend Policy H-290.974, "Extending Medicaid Coverage for One Year Postpartum," by addition as follows to read as follows:

Extending Medicaid Coverage for One Year Postpartum D-290.974

1) Our AMA will work with relevant stakeholders to support extension of Medicaid coverage to 12 months postpartum~~.~~; and
2) Our AMA will work with relevant stakeholders to expand Medicaid eligibility for pregnant and postpartum non-citizen immigrants. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA amend Policy H-165.828, “Health Insurance Affordability,” by addition as follows:

H-165.828 – HEALTH INSURANCE AFFORDABILITY

1. Our AMA supports modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered employer-sponsored coverage by lowering the threshold that determines whether an employee's premium contribution is affordable to that which applies to the exemption from the individual mandate of the Affordable Care Act (ACA).
2. Our AMA supports legislation or regulation, whichever is relevant, to fix the ACA's "family glitch," thus determining the affordability of employer-sponsored coverage with respect to the cost of family-based or employee-only coverage.
3. Our AMA encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to a health savings account (HSA) partially funded by an amount determined to be equivalent to the cost-sharing subsidy.
4. Our AMA supports capping the tax exclusion for employment-based health insurance as a funding stream to improve health insurance affordability, including for individuals impacted by the inconsistency in affordability definitions, individuals impacted by the "family glitch," and individuals who forego cost-sharing subsidies despite being eligible.
5. Our AMA supports additional education regarding deductibles and cost-sharing at the time of health plan enrollment, including through the use of online prompts and the provision of examples of patient cost-sharing responsibilities for common procedures and services.
6. Our AMA supports efforts to ensure clear and meaningful differences between plans offered on health insurance exchanges.
7. Our AMA supports clear labeling of exchange plans that are eligible to be paired with a Health Savings Account (HSA) with information on how to set up an HSA.
8. Our AMA supports the inclusion of pregnancy as a qualifying life event for special enrollment in the health insurance marketplace. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Maternal mortality is an urgent crisis in the U.S., with our country ranking 59th worldwide in terms of maternal deaths. Our numbers are even worse when broken down by race and ethnicity, revealing large and unconscionable health disparities. People who wish to have a child should not have to fear preventable death as a result of the birth. This ongoing crisis merits the continued application of evidence-based, innovative policy changes. Data have identified that 65% of deaths in the 12 months postpartum are preventable, and a lack of health insurance is associated with worse outcomes. This resolution aims to address both issues by supporting the expansion of Medicaid eligibility to pregnant and postpartum non-citizen immigrants, and further by supporting the inclusion of pregnancy as a qualifying life event for special enrollment in the health insurance marketplace. These issues are timely and important, and they align well with our AMA's priorities. It is vital that our AMA continue the momentum toward addressing maternal health, especially as the effects of COVID-19 are being shown to be particularly catastrophic for pregnant women. This resolution represents and actionable, evidence-based, and timely avenue by which to do so.

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RELEVANT AMA POLICY

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

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

perinatal and postpartum depression, anxiety and psychosis, and substance use disorder through research, public awareness, and support programs.
Res. 102, A-12; Modified: Res. 503, A-17

Extending Medicaid Coverage for One Year Postpartum D-290.974
Our AMA will work with relevant stakeholders to support extension of Medicaid coverage to 12 months postpartum.
Res. 221, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 702
(N-21)

Introduced by: Ohio

Subject: System Wide Prior and Post-Authorization Delays and Effects on Patient Care Access

Referred to: Reference Committee G

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1 Whereas, The time and effort spent on prior authorization is a burden which negatively impacts
2 the time physicians can spend caring for patients, negatively impacts the resiliency of
3 physicians and the ability to provide high quality access to all patients; and
4
5 Whereas, The AMA has policy prioritizing advocacy to ease prior authorization burdens and
6 further advance prior authorization reforms (H-320.939, D-285.960); and
7
8 Whereas, Current AMA policy, H-320.939, D-285.960 and related policies, have neither
9 satisfactorily unyoked the practicing physicians' burdens on the topic of prior authorizations, nor
10 created widespread real-time authentication best practice applications as may be seen in other
11 industries, and
12
13 Whereas, Health care insurers and Medicaid/Medicare Products have communication systems
14 that cause excessive response times through creation of websites that are difficult to navigate,
15 and submissions to these websites have neither a response to submissions nor a received
16 confirmation; and
17
18 Whereas, Prior authorization websites are inherently dysfunctional and promote delay, through
19 excessive downtime, phone systems that take an average of 45 minutes or often greater than
20 85 minutes in order to speak to a human insurance specialist, a high rate of disconnection while
21 waiting on the phone with no call back option, limitation of the number of patients that can be
22 authorized upon waiting with instructions to call back again to authorize other patients, Prior
23 Authorization taking up to 14 days from the time submitted to await a decision, etc. to just name
24 a few; and
25
26 Whereas, There is no overseeing entity to review these unfair business practices which are
27 substandard as compared with other entities who have upgraded their business models to
28 ensure end user functionality and efficiency; and
29
30 Whereas, It appears that these business practices by Health Care Insurers and
31 Medicaid/Medicare Products are indirectly limiting, restricting or delaying patient care and
32 unintentionally rationing of health care services; therefore be it
33
34 RESOLVED, That our American Medical Association encourage and advocate health care
35 insurers and Medicare/Medicaid Products to ensure that the systems of communication for prior
36 authorization include: live personnel access, simplification of website navigation, immediate
37 response with confirmation number of submission and an expedient decision for authorizations.
38 (Directive to Take Action)

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

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

The time and effort spent on prior authorization is a burden which negatively impacts the time physicians can spend caring for patients, negatively impacts the resiliency of physicians and the ability to provide high quality access to all patients. The American Medical Association has policy prioritizing advocacy to ease Prior Authorization burdens and further advance Prior Authorization reforms (H-320.939, D-285.960).

Current AMA policy, H-320.939, D-285.960 and related policies, have neither satisfactorily un-yoked the practicing physicians' burdens on the topic of Prior Authorizations, nor created widespread real-time authentication best practice applications as may be seen in other industries.

Prior authorization websites are inherently dysfunctional and promote delay. Prior authorization may take up to 14 days from the time submitted awaiting a decision. There is no overseeing entity to review these unfair business practices, hence AMA action is necessary.

These business practices by Health Care Insurers and Medicaid/Medicare Products are indirectly limiting, restricting or delaying patient care and unintentionally rationing of health care services.

While this issue is important, it is one on which the AMA should take a stand and has a realistic potential to have a positive impact by modification of existing policy, we would classify it as a medium priority in that policy currently exists but it would benefit from the additions called for in our resolution.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 703
(N-21)

Introduced by: American Academy of Pediatrics

Subject: Clear Statement Regarding the Use of CPT E/M Outpatient Visit Codes

Referred to: Reference Committee G

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1 Whereas, The AMA 2021 Updates to Outpatient Office or Other Outpatient E/M Codes were
2 implemented on January 1, 2021 and include in the description of the CPT codes the
3 appropriate use based on Medical Decision Making or Time; and
4
5 Whereas, There are multiple instances where payers use means other than the code
6 descriptors to evaluate the appropriateness of E/M CPT code choice and adjudicate claims
7 based on a different level of CPT code; and
8
9 RESOLVED, That our American Medical Association identify and collect data regarding payer
10 deviation from CPT code descriptors to adjudicate claims, assess efficacy of and challenges in
11 existing appeals and hassle factor processes available to physicians, and prepare and present a
12 report at the 2022 House of Delegates Interim Meeting. (Directive to Take Action)

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

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

Effective Jan. 1, 2021, the CMS adopted updated Current Procedural Terminology (CPT®) Evaluation and Management (E/M) codes. The revisions only apply to office visits and directly address the ongoing need for administrative simplification for physicians. The AMA has been working closely with EHR vendors, medical specialties, and payers to educate them about the changes and new requirements. Specifically, the goals of these changes are to reduce the administrative burden of documentation and coding, reduce the need for audits, reduce unnecessary documentation in the medical record (which is not needed for patient care), and to ensure that payment for E/M is resource-based and that there is no direct goal for payment redistribution between specialties.
The AAP has heard from its members that many payors have not implemented these updates, often resulting in CPT down-coding. Primary Care practices are already under financial strain due to COVID, and these coding updates are a welcome improvement. The lack of consistent implementation by health plans is adversely affecting Primary Care practices, making this a priority issue.

Current relevant AMA policy:
Improper Use of AMA-CPT by Carriers/Software Programs H-70.954
Bundling and Downcoding of CPT Codes H-70.937

These policies include language asking for a national policy for intervention with payers who use unreasonable business practices to recode or inappropriately bundle physician services, and calls on its members to identify specific CPT code bundling problems and that our AMA develop a mechanism for assisting our members in dealing with these problems with payers.

RELEVANT AMA POLICY

Improper Use of AMA-CPT by Carriers/Software Programs H-70.954
Our AMA: (1) continues to seek endorsement of Current Procedural Terminology (CPT) as the national coding standard for physician services; in collaboration with state and specialty societies, will urge the Secretary of HHS and CMS and all other payers to adopt CPT as the single uniform coding standard for physician services in all practice settings; and will oppose the incorrect use of CPT by insurers and others, taking necessary actions to insure compliance with licensing agreements, which include provisions for termination of the agreement;
(2) will work with the American Academy of Pediatrics and other specialty societies to support state and federal legislation requiring insurers to follow the coding as defined in the Current Procedural Terminology Manual and interpreted by the CPT Assistant for all contracts in both the public and private sectors, as long as the CPT process is simple, user friendly, and does not undergo frequent changes; and
(3) seeks legislation and/or regulation to ensure that all insurance companies and group payers recognize all published CPT codes including modifiers.
Citation: Sub. Res. 801, A-97; Appended: Res. 806, A-98; Appended: Res. 814, I-99; Reaffirmed: BOT Rep. 8, I-00; Reaffirmation I-04; Reaffirmation A-06; Reaffirmation A-07; Reaffirmation A-10; Reaffirmed: CMS Rep. 01, A-20

Bundling and Downcoding of CPT Codes H-70.937
Our AMA:
(1) vigorously opposes the practice of unilateral, arbitrary recoding and/or bundling by all payers;
(2) makes it a priority to establish national standards for the appropriate use of CPT codes,

guidelines, and modifiers and to advocate the adoption of these standards;
(3) formulates a national policy for intervention with carriers or payers who use unreasonable business practices to unilaterally recode or inappropriately bundle physician services, and support legislation to accomplish this; and
(4) along with medical specialty societies, calls on its members to identify to our AMA specific CPT code bundling problems by payers in their area and that our AMA develop a mechanism for assisting our members in dealing with these problems with payers.
Citation: Res. 802, I-98; Reaffirmed: Res. 814, A-00; Modified: Sub. Res. 817; Reaffirmed: BOT Rep. 8, I-00; Reaffirmation I-01; Reaffirmation I-04; Reaffirmation A-06; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 704
(N-21)

Introduced by: Resident and Fellow Section

Subject: Expanding the AMA's Study on the Economic Impact of COVID-19

Referred to: Reference Committee G

Whereas, The 2019 Coronavirus Disease (COVID-19) pandemic has had a large impact on healthcare spending, utilization, and employment; and

Whereas, The American healthcare system and hospital revenue drastically declined as a result of COVID-19, experiencing monthly financial losses on average exceeding $50 billion dollars during the earliest months of the COVID-19 pandemic;[1] and

Whereas, It has been estimated that the cancellation of elective surgeries and procedures as a result of the COVID-19 pandemic could cost the healthcare system and hospitals $20-50 billion in revenue each month, with monthly net income losses exceeding $5 billion dollars[1,2,3]; and

Whereas, The economic support for offsetting the financial strain of the COVID-19 pandemic that was provided by the 2020 Coronavirus Aid, Relief, and Economic Security (CARES) Act likely disadvantaged healthcare systems treating at-risk populations because it initially used a formula based on Medicare fee-for-service billings to distribute financial aid to hospitals[3,4]; and

Whereas, Urban and rural hospitals, and other medical centers that disproportionately treat underserved populations may face higher existential threats due to lost revenue, higher costs, and other the economic burdens incurred during the COVID-19 pandemic[3,5]; and

Whereas, The economic impact on residents and fellows seems to have been significant regarding job loss[6]; and

Whereas, The AMA has become a predominant source of information regarding the economic impact on physicians and their practices during the COVID-19 pandemic[7,8]; and

Whereas, The AMA has yet to study how the economic impact of the COVID-19 pandemic on hospitals, clinics, surgeons, students, residents, fellows, and patients with respect to lost revenue and unanticipated healthcare costs; therefore be it

RESOLVED, That our American Medical Association work with relevant organizations and stakeholders to study the economic impact and long-term recovery of the COVID-19 pandemic on healthcare institutions in order to identify and better understand which groups of physicians, patients and organizations may have been disproportionately affected by the financial burdens of the COVID-19 pandemic (Directive to Take Action); and be it further

RESOLVED, That our AMA work with relevant organizations and stakeholders to study the overall economic impact of office closures, cancellations of elective surgeries and interruptions in patient care, as well as the economic impact of utilizing telemedicine for an increasing percentage of patient care. (Directive to Take Action)

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

Received: 10/12/21

AUTHORS STATEMENT OF PRIORITY

As we continue to proceed through the COVID-19 pandemic, so many groups including hospitals, clinics, physicians, trainees of all stages and our patients have experienced drastic changes in health care delivery, compensation, and opportunities. The AMA has been a leader in disseminating information during the pandemic, particularly regarding how physicians have been affected. This resolution seeks to have the AMA continue its advocacy and leadership to better understand the economic impact of the pandemic on our practice and our patients.

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RELEVANT AMA POLICY

Physician Payment Advocacy for Additional Work and Expenses Involved in Treating Patients During the Covid-19 Pandemic and Future Public Health Emergencies D-390.947
Our AMA: (1) will work with interested national medical specialty societies and state medical associations to advocate for regulatory action on the part of the Centers for Medicare & Medicaid Services to implement a professional services payment enhancement, similar to the HRSA COVID-19 Uninsured Program, to be drawn from additional funds appropriated for the public health emergency to recognize the additional uncompensated costs associated with COVID-19 incurred by physicians during the COVID-19 Public Health Emergency; (2) will work with interested national medical specialty societies and state medical associations to continue to advocate that the Centers for Medicare & Medicaid Services and private health plans compensate physicians for the additional work and expenses involved in treating patients during a public health emergency, and that any new payments be exempt from budget neutrality; and (3) encourages interested parties to work in the CPT Editorial Panel and AMA/Specialty Society RVS Update Committee (RUC) processes to continue to develop coding and payment solutions for the additional work and expenses involved in treating patients during a public health emergency.
Citation: Res. 114, I-20

Creating a Congressionally-Mandated Bipartisan Commission to Examine the U.S. Preparations for and Response to the COVID-19 Pandemic to Inform Future Efforts D-440.923
1. Our AMA will advocate for passage of federal legislation to create a congressionally-mandated bipartisan commission composed of scientists, physicians with expertise in pandemic

preparedness and response, public health experts, legislators and other stakeholders, which is to examine the U.S. preparations for and response to the COVID-19 pandemic, in order to inform and support future public policy and health systems preparedness.
2. In advocating for legislation to create a congressionally-mandated bipartisan commission, our AMA will seek to ensure key provisions are included, namely that the delivery of a specific end product (i.e., a report) is required by the commission by a certain period of time, and that adequate funding be provided in order for the commission to complete its deliverables.
Citation: Res. 211, I-20

Cares Act Equity and Loan Forgiveness in the Medicare Accelerated Payment Program D-305.953
In the setting of the COVID-19 pandemic, our AMA will advocate for additional financial relief for physicians to reduce medical school educational debt.
Citation: Res. 202, I-20

Cares Act Equity and Loan Forgiveness in the Medicare Accelerated Payment Program D-385.951
Our AMA and the federation of medicine will work to improve and expand various federal stimulus programs (e.g., the CARES Act and MAPP) in order to assist physicians in response to the Covid-19 pandemic, including:
● Restarting the suspended Medicare Advance payment program, including significantly reducing the re-payment interest rate and lengthening the repayment period;
● Expanding the CARES Act health care provider relief pool and working to ensure that a significant share of the funding from this pool is made available to physicians in need regardless of the type of patients treated by those physicians; and
● Reforming the Paycheck Protection Program, to ensure greater flexibility in how such funds are spent and lengthening the repayment period.
Citation: Res. 202, I-20

Crisis Payment Reform Advocacy D-405.979
Our AMA will continue to promote national awareness of the loss of physician medical practices and patient access to care due to COVID-19, and continue to advocate for reforms that support and sustain physician medical practices.
Citation: Res. 218, I-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 705
(N-21)

Introduced by: Texas

Subject: Advocating for Program Stability in the Merit-Based Incentive Payment System

Referred to: Reference Committee G

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1 Whereas, On Jan. 1, 2022, under current law, Medicare participating physicians will receive a
2 9.75% payment cut; and
3
4 Whereas, Potential penalties under the Merit-Based Incentive Payment System (MIPS), which
5 apply to Medicare Physician Fee Schedule services, will increase, causing a 9% payment cut in
6 2022; and
7
8 Whereas, There is a statutory freeze in annual Medicare Physician Fee Schedule updates
9 under the Medicare Access and CHIP Reauthorization Act (MACRA) that is scheduled to last
10 until 2026; and
11
12 Whereas, Published studies report that the mean per-physician cost of participating in MIPS
13 was more than $12,000 per year, consuming more than 200 hours of physician and
14 administrator time each year; and
15
16 Whereas, The alternative payment model pathway for physicians under MACRA has yet to be
17 realized, leaving the majority of practices trapped in the MIPS portion of the MACRA program;
18 and
19
20 Whereas, Physician practices are amid the COVID-19 public health emergency, requiring
21 continued infection control protocols that, while necessary, have increased the costs of
22 providing care; and
23
24 Whereas, The Centers for Medicare & Medicaid Services continues to propose annual changes
25 to MIPS that create additional complexity and confusion for physicians and patients; therefore
26 be it
27
28 RESOLVED, That our American Medical Association call on the Centers for Medicare &
29 Medicaid Services to implement an automatic hardship exception for participants in the
30 Merit-Based Incentive Payment System for the 2021 performance year due to the COVID-19
31 public health emergency. (Directive to Take Action)

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

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

The complexities and annual changes to the MIPS affect and burden all physicians.

With MIPS becoming increasingly punitive, it is important for the AMA to act at this meeting to avoid further financially punitive and administratively burdensome impacts that MIPS has on physician practices and their patients.

Reducing administrative burdens and avoiding payment penalties fits squarely within the AMA mission and strategic plan.

In reaction to the 2022 proposed MPFS, AMA needs additional policy to call on CMS to maintain the MIPS performance threshold at 50 points. Furthermore, AMA needs additional policy calling for hardship exceptions for the 2021 MIPS performance year due to the COVID-19 PHE.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 706
(N-21)

Introduced by: Texas

Subject: Support for State Medical Record Retention Laws

Referred to: Reference Committee G

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1 Whereas, The Centers for Medicare & Medicaid Services proposed in the 2022 Medicare
2 Physician Fee Schedule to modify the Provide Patients Electronic Access to Their Health
3 Information measure (a Merit-Based Incentive Payment System Promoting Interoperability
4 performance measure) to require that patient health information remain available for the patient
5 (or patient-authorized representative) to access indefinitely, starting with a date of service of
6 Jan.1, 2016; and
7
8 Whereas, State medical boards set medical record retention requirements for each state that
9 should not be superseded by a federal agency's policy; and
10
11 Whereas, This proposed requirement is a far reach beyond what Congress intended when the
12 Medicare Access and CHIP Reauthorization Act was designed; and
13
14 Whereas, The growing number of mergers and acquisitions in health care and the change in
15 technological platforms make it problematic and cost-prohibitive to maintain data records and
16 information as far back as 2016 in an electronic fashion; and
17
18 Whereas, Although patients' electronic access to their health information could be available
19 upon request, the Jan. 1, 2016, date can create problems for many practices that have changed
20 electronic health record systems or practice ownership, with information from older systems
21 having to be stored separately; and
22
23 Whereas, While it is important for patients to have access to their health information, American
24 Medical Association policy holds that medical considerations are the primary basis for deciding
25 how long to retain medical records; and
26
27 Whereas, Additional administrative burdens and compliance costs for physicians must be
28 avoided so they can focus on caring for patients; and
29
30 Whereas, The expectation that physicians can indefinitely maintain patient health information
31 adds a financial and workforce burden that is not feasible, and this kind of government
32 overreach will frustrate physicians and patients, causing further physician burnout and other
33 unintended consequences; and
34
35 Whereas, In addition to cost concerns and physician burden are privacy concerns when
36 maintaining the troves of data this requirement would create; therefore be it
37
38 RESOLVED, That our American Medical Association advocate that the Centers for Medicare &
39 Medicaid Services do not supersede state medical record retention laws in the U.S. (Directive to
40 Take Action)

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

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

The CMS proposal in the 2022 proposed Medicare Physician Fee Schedule to require physicians to make patient health information to remain available to the patient (or patient-authorized representative) indefinitely, starting with a date of service of January 1, 2016 affects all Medicare participating physicians and their patients.

Given this agency proposal is not reflected in MACRA, AMA must act on this now as to not have a seriously deleterious impact on physician practices and their use of EHRs.

Given the proposals impact on all physicians, the resolution fits squarely within AMA's mission and strategic plan

The final 2022 regulation is expected in the Fall, thus AMA must advocate against the proposal in the near-term.

AMA policy on medical record retention is specific to medical considerations, but no AMA policy exists calling for the federal government to not supersede state medical record retention laws.

Due to the complexity and burden of complying with this proposal, immediate AMA action will have a positive impact and the AMA is most appropriate entity to tackle this issue.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 707
(N-21)

Introduced by: New York

Subject: Fifteen Month Lab Standing Orders

Referred to: Reference Committee G

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1 Whereas, Federal Medicaid rules limits a laboratory standing order's validity to six months which
2 necessitates practitioners to reorder laboratory studies every six months for regular and routine
3 laboratory studies that often are required for a patient's lifetime (such as standard of care
4 monitoring of HemoglobinA1Cs every three to six months for diabetics); and
5
6 Whereas, There is no documented benefit to limiting laboratory orders to six months and
7 expiration of standing lab orders has led to patient and physician dissatisfaction; and
8
9 Whereas, "Busywork" that is not perceived as meaningful contributes to burnout which is a harm
10 negatively impacting the American medical work force and has deleterious implications on
11 patient care quality, outcomes and patient satisfaction; and
12
13 Whereas, Reordering laboratory studies only for the sake of a regulation leads to unnecessary
14 and not meaningful work, the kind of activity that contributes to burnout among practitioners and
15 increases the cost of healthcare because of the time and labor required for each practice to
16 reorder routine laboratory studies; therefore be it
17
18 RESOLVED, That our American Medical Association advocate the Centers for Medicare and
19 Medicaid Services to allow standing laboratory orders to be active for fifteen (15) months.
20 (Directive to Take Action)

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

Received: 10/11/21

AUTHORS STATEMENT OF PRIORITY

The current CMS regulation requiring lab orders to be renewed every six months with the concomitant review of results and reissue of prescriptions is unnecessary for patients who have been on maintenance medications for months and years. Many state regulations permit prescriptions to be valid for 12 months or more, therefore lab orders should be commensurate with that regulation. There is no benefit to the requirement of having patients be tested every 6 months especially in the case of patients who have been on longstanding maintenance medications and who have fared well. This would save patient, insurance and physician expense in addition to saving staff time and unnecessary paperwork and processing time. This change would also reduce administrative paperwork which contributes to physician burnout and stress.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 708
(N-21)

Introduced by: New York

Subject: Insurance Coverage for Scalp Cooling (Cold Cap) Therapy

Referred to: Reference Committee G

Whereas, Scalp Cooling (Cold Cap Therapy) has been cleared by the FDA for use during chemotherapy treatment to reduce the likelihood of chemotherapy-induced alopecia in cancer patients with solid tumors such as ovarian, breast, colorectal, bowel, and prostate cancers; and

Whereas, The National Comprehensive Cancer Network® (NCCN) has given Scalp cooling a Category 2A designation indicating uniform NCCN consensus that the intervention is appropriate; and

Whereas, Peer-reviewed studies have shown Scalp Cooling (Cold Cap Therapy) prevented hair loss in 53-66.3% of patients with breast cancer receiving adjuvant chemotherapy, compared to a control group where all patients experienced significant hair loss; and

Whereas, Scalp cooling treatment (Cold Cap Therapy) in peer reviewed studies was well-tolerated with no scalp metastases observed; and

Whereas, Minimizing hair loss during cancer treatment helps patients to preserve personal identity and self-esteem and appear normal as opposed to sick; and

Whereas, Protecting privacy and gaining the ability to choose whether to disclose a cancer diagnosis is significant to many patients; and

Whereas, Scalp cooling can give patients a sense of control in what can be an overwhelming experience; and

Whereas, The American Medical Association (AMA) has issued two (2) separate Category III CPT codes for "mechanical scalp cooling": 0662T and 0663T, effective July 1, 2020; and

Whereas, Aetna, issued a policy statement in 2017 stating that they consider scalp cooling medically necessary as a means to prevent hair loss during chemotherapy but insurance coverage for scalp cooling is not yet standard in the United States; and

Whereas, Reimbursement varies depending on plan, coverage, and location with some insurance companies covering up to $2,000 for wigs but denying coverage for scalp cooling in similar price range ($1,500-$3,000); and

Whereas, Many patients have encountered the circumstance where their health insurance carrier will not provide coverage for scalp cooling therapy, forcing patients to pay out of pocket for this essential therapy; and

Whereas, This significant out of pocket expense puts this treatment out of range for many; and

Whereas, Our AMA advocates for health equity; therefore be it

RESOLVED, That our American Medical Association advocate for and seek through legislation and/or regulation, universal insurance coverage for Scalp Cooling (Cold Cap) Therapy (Directive to Take Action); and be it further

RESOLVED, That our AMA work with consumer and advocacy groups to challenge insurers on medical necessity denials for Scalp Cooling (Cold Cap) Therapy and encourage appeals to independent third-party reviewers. (Directive to Take Action)

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

Received: 10/11/21

AUTHORS STATEMENT OF PRIORITY

Whether through personal experience or interactions with patients, physicians understand the devastating diagnosis of cancer. Patients requiring chemotherapy will undoubtedly experience hair loss as a result, adding to their misery. Scalp Cooling Therapy is proven to alleviate hair loss during chemo and would therefore improve a patient's self-image and positive outlook with regard to their cancer treatment. A positive response to chemo is not just about the treatments themselves, equally important is the patient's outlook and expectation that their health is improving from those treatments. Patients will not see (nor feel) improvement if the image in a mirror is one of themselves with no hair. Our sense of self is based in large part on physical appearance. Advocating for insurance coverage of Scalp Cooling Therapy would improve patient response to chemotherapy both physically and mentally. Because routine cancer screenings were in large part ignored during the COVID crisis, the expectation is that once resumed, the diagnoses of cancer will increase. Whereas Medicare and some health insurers will provide coverage for this therapy, other companies do not. An increase in cancer diagnoses makes this issue urgent and one that should be addressed with the insurance industry by the AMA as soon as possible.

1. NCCN scalp cooling recommendations from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®). NCCN provides the following recommendations: breast cancer (Version 1.2019), ovarian caner (Version 1.2020)

References

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Number: 0290
Policy Effective Date 10/13/1998
Last Review: 7/1/2021
Aetna considers scalp cooling (i.e., using ice-filled bags/bandages, cryogel packs, or specially designed products (e.g., Chemo Cold Cap, DigniCap, ElastoGel, Paxman Scalp Cooling System and Penguin Cold Cap)) medically necessary as a means to prevent hair loss during chemotherapy.
Note: Cooling caps and other products for scalp cooling are considered incidental to the chemotherapy administration and are not separately reimbursed. Cooling caps and other scalp cooling products purchased by the member are considered supplies that are generally excluded from coverage under plans that exclude supplies. See benefit plan descriptions.

RELEVANT AMA POLICY

Symptomatic and Supportive Care for Patients with Cancer H-55.999
Our AMA recognizes the need to ensure the highest standards of symptomatic, rehabilitative, and supportive care for patients with both cured and advanced cancer. The Association supports clinical research in evaluation of rehabilitative and palliative care procedures for the cancer patient, this to include such areas as pain control, relief of nausea and vomiting, management of complications of surgery, radiation and chemotherapy, appropriate hemotherapy, nutritional support, emotional support, rehabilitation, and the hospice concept. Our AMA actively encourages the implementation of continuing education of the practicing American physician regarding the most effective methodology for meeting the symptomatic, rehabilitative, supportive, and other human needs of the cancer patient.
Citation: CSA Rep. H, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Sub. Res. 514, I-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 709
(N-21)

Introduced by: New York

Subject: Prior Authorization – CPT Codes for Fair Compensation

Referred to: Reference Committee G

Whereas, The American Medical Association (AMA) has previously affirmed that physicians and physician practices should be fairly compensated for work involved in prior authorizations; and

Whereas, AMA CPT® Editorial Panel is authorized by the AMA Board of Trustees to revise, update, or modify CPT codes, descriptors, rules and guidelines; and

Whereas, Studies have shown that wrongful adverse determinations by health plans are common, including denial of prior authorization and denial of payment for previously provided services; and

Whereas, Costs involved in prior authorizations provide perverse disincentives and lead to sub-optimal healthcare outcomes, especially for marginalized and economically vulnerable communities; and

Whereas, Good public and economic policy must align costs, benefits and incentives; currently, all costs are incurred by physician practices, and all financial savings and benefits from prior authorization accrue to health insurance plans leading to perverse incentives that disadvantage patients and endanger their health; and

Whereas, Compensation for work performed by physician practices is accomplished via CPT codes; therefore be it

RESOLVED, That our American Medical Association include in any model legislation and as a basis for all advocacy, fair compensation based on CPT codes for appeal of wrongfully denied services, including those for prior authorization reforms and that CPT codes must fully reflect the aggregated time and effort expended by physician practices (Directive to Take Action); and be it further

RESOLVED, That our AMA evaluate and propose a CPT code for consideration by the CPT® Editorial Panel to account for administrative work involved in prior authorizations that reflects the actual time expended by physician practices to advocate on behalf of patients and to comply with insurer requirements (Directive to Take Action); and be it further

RESOLVED, That our AMA evaluate and propose a CPT code for consideration by the CPT® Editorial Panel to account for administrative work that reflects the actual time expended by physician practices and their billing vendors involved in successfully appealing wrongful pre-and post-service denials. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000
Received: 10/11/21

AUTHORS STATEMENT OF PRIORITY

The amount of time and effort physicians spend on administrative work rather than patient care continues to increase. Recognition of this burden and its contribution to physician burnout, career dissatisfaction, and patient dissatisfaction must be made. Repeated requests for documentation in order to pay denied claims, increased denial of claims, obtain pre-authorization for services continue to absorb more time in physician practices. These administrative tasks are not adequately compensated by the insurance industry. Physicians should not have to take time from patient care to deal with such matters. The AMA is the advocate for physicians in the United States and has a responsibility to address the issue of compensation for extensive administrative work. Appealing claim denials can drag on for months putting and additional burden on physician practices in terms of finances. Increased time spent on administrative work deserves compensation.

RELEVANT AMA POLICY

Prior Authorization and Utilization Management Reform H-320.939
1. Our AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.
2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.
3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.
4. Our AMA will advocate for health plans to minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending prior authorization requests.
Citation: CMS Rep. 08, A-17; Reaffirmation: I-17; Reaffirmed: Res. 711, A-18; Appended: Res. 812, I-18; Reaffirmed in lieu of: Res. 713, A-19; Reaffirmed: CMS Rep. 05, A-19; Reaffirmed: Res. 811, I-19; Reaffirmed: CMS Rep. 4, A-21 Appended: CMS Rep. 5, A-21

Remuneration for Physician Services H-385.951
1. Our AMA actively supports payment to physicians by contractors and third party payers for physician time and efforts in providing case management and supervisory services, including but not limited to coordination of care and office staff time spent to comply with third party payer protocols.
2. It is AMA policy that insurers pay physicians fair compensation for work associated with prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements and that compensates physicians fully for the legal risks inherent in such work.
3. Our AMA urges insurers to adhere to the AMA's Health Insurer Code of Conduct Principles including specifically that requirements imposed on physicians to obtain prior authorizations, including pre-certifications and prior notifications, must be minimized and streamlined and health insurers must maintain sufficient staff to respond promptly.
Citation: Sub. Res. 814, A-96; Reaffirmation A-02; Reaffirmation I-08; Reaffirmation I-09; Appended: Sub. Res. 126, A-10; Reaffirmed in lieu of Res. 719, A-11; Reaffirmed in lieu of Res.

721, A-11; Reaffirmation A-11; Reaffirmed in lieu of Res. 822, I-11; Reaffirmed in lieu of Res. 711, A-14; Reaffirmed: Res. 811, I-19

Prior Authorization Reform D-320.982
Our AMA will explore emerging technologies to automate the prior authorization process for medical services and evaluate their efficiency and scalability, while advocating for reduction in the overall volume of prior authorization requirements to ensure timely access to medically necessary care for patients and reduce practice administrative burdens.
Citation: Res. 704, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 710
(N-21)

Introduced by: New York

Subject: Physician Burnout is an OSHA Issue

Referred to: Reference Committee G

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1 Whereas, Repetitive Strain (Stress) Injury or RSI is defined as a category of injuries "to the
2 musculoskeletal and nervous systems that may be caused by repetitive tasks, forceful
3 exertions, vibrations, mechanical compression, or sustained or awkward positions; and
4
5 Whereas, RSI is a known work-related injury which falls under the purview of the Occupational
6 Safety and Health Administration (OSHA); and
7
8 Whereas, Most RSI results from cumulative trauma rather than a single event; and
9
10 Whereas, Repeated exposure to work-related stressors can result in physician burnout; and
11
12 Whereas, Cerebral centers and activity are most certainly within the domain of the nervous
13 system; and
14
15 Whereas, Physician burnout resulting from work-related stressors should be regarded as RSI
16 and, as such, should fall under the aegis of OSHA; therefore be it
17
18 RESOLVED, That our American Medical Association seek legislation/regulation to add
19 physician burnout as a Repetitive Strain (Stress) Injury and subject to Occupational Safety and
20 Health Administration (OSHA) oversight. (Directive to Take Action)

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

Received: 10/13/21

AUTHOR'S STATEMENT OF PRIORITY

New York ranked this as vitally important – it has to do with physician health and well-being which has been sorely tested during the last year. Physicians are under enormous stress each and every day, and the COVID pandemic added immeasurably to that stress. The incidence of physician suicide increased during the last year – a clear indication of the added stress of COVID. Working without the necessary and proper equipment during the pandemic and watching colleagues die of COVID while doing their job has all added to the burden of being a physician. Physicians have few protections for their wellbeing and good health. Many feel that physicians should be "super-heroes" unaffected by the stress of providing health care in today's very different environment. Adding physician burnout as an RSI subject to OSHA oversight would go a long way toward ensuring physicians work situation is monitored to ensure that they do not burnout.

Informational Reports

BOT Report(s)

01 Racial Essentialism in Medical Education
03 Redefining the AMA's Position on ACA and Healthcare Reform
04 2021 AMA Advocacy Efforts
06 Mitigating the Effects of Racism in Health Care: "Best Practices"
07 Improving Clinical Algorithms: Moving Beyond Race and Ethnicity

CEJA Opinion(s)

01 Amendment to Opinion 9.3.2, "Physician Responsibilities to Impaired Colleagues"

CSAPH Report(s)

01 Drug Shortages: 2021 Update

REPORT OF THE BOARD OF TRUSTEES

B of T Report 1-N-21

Subject: Racial Essentialism in Medical Education

Presented by: Bobby Mukkamala, MD, Chair

INTRODUCTION

This informational report submitted to the House of Delegates summarizes American Medical Association (AMA) activities in combatting racial essentialism in medical education and is written in response to AMA Policy D-350.981, "Racial Essentialism in Medicine."

RACIAL ESSENTIALISM IN MEDICAL EDUCATION

"Racial essentialism" is defined as the belief in a genetic or biological essence that defines all members of a racial category.[1,2] However, this theory is grounded in fallacy, as science has proven that race is a social construct based on a human-invented classification system to define physical differences among people.[3] There is ample evidence that race is a poor proxy for genetic differences and "phenotypic" features commonly referenced in discussions of race fail to correspond to discrete categories or underlying physiology.[4] Additionally, the categorizations of race have led physicians and medical students alike to draw conclusions about the hierarchical organization of humans, which connect an individual to a larger preconceived geographically circumscribed or socially constructed group. This belief contributes to the cultivation of structural racism, which refers to the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice. These patterns and practices in turn reinforce discriminatory beliefs, values, and distribution of resources.[5]

Current Manifestations of Racial Essentialism in Medical Education

Racial essentialism has been preserved in medicine and medical education in multiple ways.

Foundational scientific content and clinical teaching is based upon research that commonly lacks diverse representation among subjects. This can lead to teaching of outdated or ill-informed practices, such as race-based calculation of estimated glomerular filtration rate (eGFR). Renal function estimated glomerular filtration rate (eGFR) calculations have historically been adjusted up for Black/African American race to account for "increased muscle mass," though no robust scientific evidence exists to support this claim, and patients have been categorized as "Black" and "non-Black." This practice minimizes the severity of illness in Black patients, has led to the overestimation of kidney function among Black patients, and has translated to devastating consequences such as delayed referrals for treatment, disqualification for transplants, and misguided treatment and counseling. It also creates a blind spot for the treatment of others who may be inaccurately aggregated under one homogeneous "non-Black" label regardless of their genetics or biological ancestry, health profile, or social circumstances. In 2020-2021, following a review of the practice and mirroring the precedent set by Beth Israel Deaconess Medical Center, Mass General Brigham and New York City Health + Hospitals eliminated the use of race as a

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factor when calculating kidney function and implemented that renal function eGFR calculations would be solely based on creatinine levels, age, and sex for all patients.[6] Additionally, the National Kidney Foundation (NKF) and the American Society of Nephrology (ASN) established the NKF-ASN Task Force on Reassessing the Inclusion of Race in Diagnosing Kidney Disease, a joint task force to examine the inclusion of race in the estimation of GFR and its implications for the diagnosis and subsequent management of patients with, or at risk for, kidney diseases. The task force released an interim report entitled "Reassessing the Inclusion of Race in Diagnosing Kidney Diseases: An Interim Report from the NKF-ASN Task Force" which detailed the process, initial assessment of evidence, and values defined regarding the use of race to estimate GFR in June 2021.[7]

Lack of diverse representation in educational practices is another challenge. There is a paucity of educational materials on non-white skin tones and the lack of curriculum devoted to the care of diverse skin and hair textures of patients demonstrates the lack of inclusion in training materials for medical students.[8,9] A recent study of race and skin tone depicted in images in textbooks assigned at top medical schools found that while the textbooks did approximate the racial distribution of the U.S. population—62.5% white, 20.4% Black, and 17.0% Person of Color—the skin tones in the illustrations—74.5% light, 21% medium, and 4.5% dark—overrepresent light skin tone and underrepresent dark skin tone. There is also an absence of skin tone diversity at the chapter and topic level.[10] The lack of training on diverse skin tones extends into patient care, and patients have expressed frustration with dermatologists who lack experience and knowledge in the care of disorders of diverse skin tones and hair textures. Fortunately, dermatology residency programs are making efforts to incorporate training on treatment of skin of color into their curriculum.[11] Similarly, simulations and clinical skills frequently lack diverse representation.

Perpetuation of stereotypes in the learning environment include naming of implicit bias and social elements included in clinical case vignettes and examination items. These stereotypes lead to incomplete framing of social determinants of health and presenting social determinants of health as a matter of personal choice or unfortunate personal circumstances rather than acknowledging systemic and structural drivers of those social factors. Stereotyping is a cognitive process in which individuals use a social category to acquire, process, and recall information about people. Stereotyping can both lead to and stem from unconscious bias. These processing patterns unconsciously help individuals organize complex information. The conscious effort to reduce automatic stereotyping requires considerable cognitive resources and, under heavy cognitive load—including during clinical training and decision-making—individuals rely more heavily on stereotyping to process information. Indeed, while structured clinical vignettes have long been utilized as a resource to illustrate or highlight some aspect of medicine that the clinician can use to improve one's knowledge and clinical skills, clinical vignettes are not immune from stereotypes. Evidence of unconscious bias was found in a study of emergency department physicians' treatment of pain using clinical vignettes and found that socially desirable information increased the prescribing rates by a small but statistically significant percentage.[12] Additionally, a 2019 meta-analysis of studies conducted from 1990 to 2018 found that Black patients were 40% less likely and Hispanic patients were 25% less likely to receive medication to ease acute pain compared to white patients.[13] Equally concerning are patients' interpersonal experiences of unfair treatment while seeking care due to their race ethnicity, gender identity, sexual orientation. These experiences can lead people to delay or forgo care, and to experience adverse health consequences.[14]

Clinical reasoning strategies and algorithms that support clinical decision making frequently lack diverse representation. Many data repositories collect race and ethnicity data on thousands if not millions of Americans, and it is not uncommon for multivariate analyses to test whether certain

patient characteristics, such as gender, age, co-morbidities, race and ethnicity contribute significantly to the predictive accuracy of estimates of risks and benefits of the various preventative and therapeutic options. With race now understood as a social, not biological construct, and as proxies for non-biological factors including social determinants of health and structural racism, considerable scholarship has been focused on determining whether race and ethnicity should continue to be included in clinical algorithms and in teaching of clinical reasoning.

EFFORTS TO ADDRESS RACIAL ESSENTIALISM IN MEDICAL EDUCATION

There have been efforts to examine practices of racial essentialism in medical education at an institutional level. These efforts include review and modernization of outdated material such as slides and clinical case vignettes to mitigate bias, explicit training in health system science, structural competency, structural drivers of social determinants of health and structural racism as well as training in metacognition, implicit bias and common forms of error in clinical reasoning. Institutions are also seeking diverse representation in clinical skills training and simulation (e.g., ophthalmologic examinations). In addition, institutional efforts have strived to actively foster diversity in classroom and clinical learning environments, explicitly consider perspectives missing from any given environment and improve the diversity of the profession by promoting holistic selection into medical school and residency by providing implicit bias training to gatekeepers and supporting pathway programs.

The AMA's Accelerating Change in Medical Education initiative has led to the development and scaling of innovations influencing the full continuum of medical training. The core initiative objectives focus on competency-based approaches to medical education and individualized pathways for students; training in health systems science; and enhancing the learning environment. This initiative has been successful in stimulating change at the consortium schools and propagating those innovations broadly, with outputs involving medical students, faculty, medical schools, affiliated health systems, and the broader educational landscape.

In 2020, this initiative conducted a 4-week series entitled "Combatting structural racism in UME and GME," which featured interactive sessions addressing the structural racism embedded in medical educational programs. Each session was convened for 2 hours and approximately 50 medical educational programs were represented. Structural racism in both undergraduate and graduate medical education was addressed and topics of focus included "The Educational Milieu," "Appraising Programmatic Outcomes," and "Microaggressions."

During the series, member schools of the Accelerating Change in Medical Education Consortium explored the AMA curricular diversity and inclusion self-study process at a high level, with each institution to develop its own plan to follow up. The outline for self-study and action plans can be found at: https://www.ama-assn.org/system/files/2020-07/curricular-diversity-inclusion-self-study.pdf. In addition, the series highlighted a session on "Structural racism embedded in educational materials and approaches," which included the naming of implicit bias in training examples, incomplete framing of equity issues, biologic versus sociologic construct of race, and bias in historical clinical protocols taught in basic science and clinical training. During this series, medical schools such as the Warren Alpert Medical School of Brown University and the George Washington University School of Medicine and Health Sciences shared their struggles and strategies for shifting the curriculum from race-based medicine to race-conscious medicine as an alternative to improve health outcomes for all.

Since 2020, the AMA has also conducted the following webinars on the topic of structural racism in medical education:

- Applying systems thinking to address structural racism in health professions education
- Combating racism in med ed to address health care disparities
- Uprooting structural racism in medical education

The AMA has also hosted *Prioritizing Equity* episodes devoted to this topic, including:

- Examining race-based medicine
- Getting to justice in education
- Moving Upstream
- The Root Cause & Considerations for Health Care Professionals

These (and other) *Prioritizing Equity* episodes will be featured in the Health Equity Education Center, a new part of the AMA Ed Hub launched by the Center for Health Equity. These videos will be further supported by new educational modules developed in partnership with COVID Black, an organization that helps healthcare systems, academic institutions, non-profit organizations, and companies solve problems around racism and health by developing custom e-learning content based on modern instructional design and visual design principles to create an impactful learning experiences about race, health disparities, health equity, and medicine. The first module serves as an introduction to racism in medicine, with substantial analysis and exploration of the history of racial essentialism and the social construction of race. Modules in development for publication later in 2021 will further examine racism in other aspects of health care, from COVID vaccination inequities to maternal and child health to health communications to public health data.

CONCLUSION

The AMA remains committed to pushing for a shift in thinking from race as a biological risk factor to a deeper understanding of racism as a social determinant of health.

APPENDIX - Relevant AMA Policy

H-65.953, "Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice,"
1. Our AMA recognizes that race is a social construct and is distinct from ethnicity, genetic ancestry, or biology. 2. Our AMA supports ending the practice of using race as a proxy for biology or genetics in medical education, research, and clinical practice. 3. Our AMA encourages undergraduate medical education, graduate medical education, and continuing medical education programs to recognize the harmful effects of presenting race as biology in medical education and that they work to mitigate these effects through curriculum change that: (a) demonstrates how the category "race" can influence health outcomes; (b) that supports race as a social construct and not a biological determinant and (c) presents race within a socio-ecological model of individual, community and society to explain how racism and systemic oppression result in racial health disparities. 4. Our AMA recommends that clinicians and researchers focus on genetics and biology, the experience of racism, and social determinants of health, and not race, when describing risk factors for disease.

D-350.981, Racial Essentialism in Medicine
1. Our AMA recognizes that the false conflation of race with inherent biological or genetic traits leads to inadequate examination of true underlying disease risk factors, which exacerbates existing health inequities. 2. Our AMA encourages characterizing race as a social construct, rather than an inherent biological trait, and recognizes that when race is described as a risk factor, it is more likely to be a proxy for influences including structural racism than a proxy for genetics. 3. Our AMA will collaborate with the AAMC, AACOM, NBME, NBOME, ACGME and other appropriate stakeholders, including minority physician organizations and content experts, to identify and address aspects of medical education and board examinations which may perpetuate teachings, assessments, and practices that reinforce institutional and structural racism. 4. Our AMA will collaborate with appropriate stakeholders and content experts to develop recommendations on how to interpret or improve clinical algorithms that currently include race-based correction factors. 5. Our AMA will support research that promotes antiracist strategies to mitigate algorithmic bias in medicine.

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.

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 3-N-21

Subject: Redefining AMA's Position on ACA and Healthcare Reform

Presented by: Bobby Mukkamala, MD, Chair

At the 2013 Annual Meeting of the House of Delegates (HOD), the HOD adopted Policy D-165.938, "Redefining AMA's Position on ACA and Healthcare Reform," which called on our American Medical Association (AMA) to "develop a policy statement clearly outlining this organization's policies" on several specific issues related to the Affordable Care Act (ACA) as well as repealing the SGR and the Independent Payment Advisory Board (IPAB). The adopted policy went on to call for our AMA to report back at each meeting of the HOD. Board of Trustees Report 6-I-13, "Redefining AMA's Position on ACA and Healthcare Reform," accomplished the original intent of the policy. This report serves as an update on the issues and related developments occurring since the most recent meeting of the HOD.

IMPROVING THE AFFORDABLE CARE ACT

Our AMA continues to engage policymakers and advocate for meaningful, affordable health care for all Americans to improve the health of our nation. Our AMA remains committed to the goal of universal coverage, which includes protecting coverage for the 20 million Americans who acquired it through the ACA. Our AMA has been working to fix the current system by advancing solutions that make coverage more affordable and expanding the system's reach to Americans who fall within its gaps. Our AMA also remains committed to improving health care access so that patients receive timely, high quality care, preventive services, medications and other necessary treatments.

Our AMA continues to advocate for policies that would allow patients and physicians to be able to choose from a range of public and private coverage options with the goal of providing coverage to all Americans. Specifically, our AMA has been working with Congress, the Administration, and states to advance our plan to cover the uninsured and improve affordability as included in the "2021 and Beyond: AMA's Plan to Cover the Uninsured." The current COVID-19 pandemic has led to many people losing their employer-based health insurance. This has only increased the need for significant improvements to the Affordable Care Act. We also continue to examine the pros and cons of a broad array of approaches to achieve universal coverage as the policy debate evolves.

Our AMA has been advocating for the following policy provisions:

Cover Uninsured Eligible for ACA's Premium Tax Credits

- Our AMA advocates for increasing the generosity of premium tax credits to improve premium affordability and incentivize tax credit eligible individuals to get covered. Currently, eligible individuals and families with incomes between 100 and 400 percent federal poverty level (FPL) (133 and 400 percent in Medicaid expansion states) are being provided with refundable and advanceable premium tax credits to purchase coverage on health insurance exchanges.
- Our AMA has been advocating for enhanced premium tax credits to young adults. In order to improve insurance take-up rates among young adults and help balance the individual health

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insurance market risk pool, young adults ages 19 to 30 who are eligible for advance premium tax credits could be provided with "enhanced" premium tax credits—such as an additional $50 per month—while maintaining the current premium tax credit structure which is inversely related to income, as well as the current 3:1 age rating ratio.

- Our AMA also is advocating for an expansion of the eligibility for and increasing the size of cost-sharing reductions. Currently, individuals and families with incomes between 100 and 250 percent FPL (between 133 and 250 percent FPL in Medicaid expansion states) also qualify for cost-sharing subsidies if they select a silver plan, which leads to lower deductibles, out-of-pocket maximums, copayments and other cost-sharing amounts. Extending eligibility for cost-sharing reductions beyond 250 percent FPL, and increasing the size of cost-sharing reductions, would lessen the cost-sharing burdens many individuals face, which impact their ability to access and afford the care they need.

<u>Cover Uninsured Eligible for Medicaid or Children's Health Insurance Program</u>

Before the COVID-19 pandemic, in 2018, 6.7 million of the nonelderly uninsured were eligible for Medicaid or Children's Health Insurance Program (CHIP). Reasons for this population remaining uninsured include lack of awareness of eligibility or assistance in enrollment.

- Our AMA has been advocating for increasing and improving Medicaid/CHIP outreach and enrollment.
- Our AMA has been opposing efforts to establish Medicaid work requirements. The AMA believes that Medicaid work requirements would negatively affect access to care and lead to significant negative consequences for individuals' health and well-being.

<u>Make Coverage More Affordable for People Not Eligible for ACA's Premium Tax Credits</u>

Before the COVID-19 pandemic, in 2018, 5.7 million of the nonelderly uninsured were ineligible for financial assistance under the ACA, either due to their income, or because they have an offer of "affordable" employer-sponsored health insurance coverage. Without the assistance provided by ACA's premium tax credits, this population can continue to face unaffordable premiums and remain uninsured.

- Our AMA advocates for eliminating the subsidy "cliff," thereby expanding eligibility for premium tax credits beyond 400 percent FPL.
- Our AMA has been advocating for the establishment of a permanent federal reinsurance program, and the use of Section 1332 waivers for state reinsurance programs. Reinsurance plays a role in stabilizing premiums by reducing the incentive for insurers to charge higher premiums across the board in anticipation of higher-risk people enrolling in coverage. Section 1332 waivers have also been approved to provide funding for state reinsurance programs.
- Our AMA also is advocating for lowering the threshold that determines whether an employee's premium contribution is "affordable," allowing more employees to become eligible for premium tax credits to purchase marketplace coverage.

EXPAND MEDICAID TO COVER MORE PEOPLE

Before the COVID-19 pandemic, in 2018, 2.3 million of the nonelderly uninsured found themselves in the coverage gap—not eligible for Medicaid, and not eligible for tax credits because they reside in states that did not expand Medicaid. Without access to Medicaid, these individuals do not have a pathway to affordable coverage.

- Our AMA has been encouraging all states to expand Medicaid eligibility to 133 percent FPL.

TEXAS VS. AZAR SUPREME COURT CASE

The Supreme Court agreed on March 2, 2020, to address the constitutionality of the ACA for the third time, granting the petitions for certiorari from Democratic Attorneys General and the House of Representatives. Oral arguments were presented on November 10, 2020, and a decision was expected before June 2021. The AMA filed an amicus brief in support of the Act and the petitioners in this case.

On February 10, 2021, the U.S. Department of Justice under the new Biden Administration submitted a letter to the Supreme Court arguing that the ACA's individual mandate remains valid, and, even if the court determines it is not, the rest of the law can remain intact.

This action reversed the Trump Administration's brief it filed with the Court asking the justices to overturn the ACA in its entirety. The Trump Administration had clarified that the Court could choose to leave some ACA provisions in place if they do not harm the plaintiffs, but as legal experts pointed out, the entire ACA would be struck down if the Court rules that the law is inseparable from the individual mandate—meaning that there would be no provisions left to selectively enforce.

On June 17, 2021, the Supreme Court in a 7-2 decision ruled that neither the states nor the individuals challenging the law have a legal standing to sue. The Court did not touch the larger issue in the case: whether the entirety of the ACA was rendered unconstitutional when Congress eliminated the penalty for failing to obtain health insurance.

AMERICAN RESCUE PLAN OF 2021

On March 11, 2021, President Biden signed into law the American Rescue Plan (ARPA) of 2021. This legislation included the following ACA-related provisions that will:

- Provide a temporary (two-year) 5 percent increase in the Medicaid FMAP to states that enact the Affordable Care Act's Medicaid expansion and covers the new enrollment period per requirements of the ACA.
- Invest nearly $35 billion in premium subsidy increases for those who buy coverage on the ACA marketplace.
- Expand the availability of ACA advanced premium tax credits (APTCs) to individuals whose income is above 400 percent of the federal poverty line (FPL) for 2021 and 2022; and
- Give an option for states to provide 12-month postpartum coverage under State Medicaid and CHIP.

ARPA represents the largest coverage expansion since the Affordable Care Act. Under the ACA, eligible individuals and families with incomes between 100 and 400 percent of the federal poverty level (FPL) (between 133 and 400 percent FPL in Medicaid expansion states) have been provided with refundable and advanceable premium credits that are inversely related to income to purchase coverage on health insurance exchanges. However, consistent with Policy H-165.824, ARPA eliminated ACA's subsidy "cliff" for 2021 and 2022. As a result, individuals and families with incomes above 400 percent FPL ($51,040 for an individual and $104,800 for a family of four based on 2020 federal poverty guidelines) are eligible for premium tax credit assistance. Individuals eligible for premium tax credits include individuals who are offered an employer plan that does not

have an actuarial value of at least 60 percent or if the employee share of the premium exceeds 9.83 percent of income in 2021.

Consistent with Policy H-165.824, ARPA also increased the generosity of premium tax credits for two years, lowering the cap on the percentage of income individuals are required to pay for premiums of the benchmark (second-lowest-cost silver) plan. Premiums of the second-lowest-cost silver plan for individuals with incomes at and above 400 percent FPL are capped at 8.5 percent of their income. Notably, resulting from the changes, eligible individuals and families with incomes between 100 and 150 percent of the federal poverty level (133 percent and 150 percent FPL in Medicaid expansion states) now qualify for zero-premium silver plans, effective until the end of 2022. In addition, individuals receiving unemployment compensation who qualify for exchange coverage are eligible for a zero-premium silver plan in 2021.

In addition, individuals and families with incomes between 100 and 250 percent FPL (between 133 and 250 percent FPL in Medicaid expansion states) also qualify for cost-sharing subsidies if they select a silver plan, which reduces their deductibles, out-of-pocket maximums, copayments, and other cost-sharing amounts.

FY 2022 BUDGET RESOLUTION AND POSSIBLE EXTENSION OF ARPA PROVISIONS

The Senate and House of Representatives are working on a proposed FY 2022 Budget Resolution framework for up to $3.5 trillion in new federal spending that may allow funding for an extension of the aforementioned ACA subsidies included within the ARPA well as provisions to close the Medicaid “coverage gap” in the States that have not chosen to expand.

The budget plan is expected to move through what is known as the budget reconciliation process. Congress must first approve budget instructions for legislation that affects spending, revenue, or debt. Under Congressional rules, the legislation can then advance on an expedited basis and pass in the Senate with a simple majority, circumventing the threat of filibuster.

ACA SPECIAL ENROLLMENT PERIOD

President Biden, during his first weeks in office, opened a new ACA special enrollment period, citing an increased need for coverage during the current economic and health crises. On March 23, 2021, the Biden administration announced its decision to lengthen the ACA special enrollment period from May 15 to August 15.

The U.S. Department of Health and Human Services (HHS) announced on July 14, 2021, that a total of 1.5 million Americans have enrolled in coverage through healthcare.gov throughout the special enrollment period, while another 600,000 signed up using the 15 state-based marketplaces. HHS subsequently launched the "Summer Sprint to Coverage" campaign as part of robust efforts to get more Americans to sign up for health coverage in the final 30 days of the special enrollment period on HealthCare.gov.

SGR REPEAL

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 repealing and replacing the SGR was signed into law by President Obama on April 16, 2015.

INDEPENDENT PAYMENT ADVISORY BOARD REPEAL

The Bipartisan Budget Act of 2018 signed into law by President Trump on February 9, 2018, included provisions repealing IPAB. Currently, there are not any legislative efforts in Congress to replace the IPAB.

CONCLUSION

Our AMA will remain engaged in efforts to improve the health care system through policies outlined in Policy D-165. 938 and other directives of the House of Delegates.

REPORT 4 OF THE BOARD OF TRUSTEES (N-21)
2021 AMA Advocacy Efforts

EXECUTIVE SUMMARY

While COVID-19 response efforts remain at the forefront of AMA advocacy in 2021, there has also been continuous activity on many other important issues for physicians and patients at the federal and state levels. This report contains updates on 2021 AMA advocacy efforts on:

- COVID-19 – tackling the public health and practice challenges of the pandemic;
- Scope of practice – protecting patients from unwarranted scope expansions;
- Insurer issues – reducing obstacles based on health insurer practices, specifically:
  - Prior authorization,
  - Surprise billing, and
  - Copay accumulators;
- Medicare payment – seeking to stave off payment cuts and reduce reporting burdens;
- Telemedicine – promoting appropriate telehealth use while protecting patients;
- Maternal mortality – pressing for legislation to address this crisis – particularly for Black mothers;
- Drug overdose and death – advocating for ways to reduce overdoses and death while removing barriers to care;
- Competition in health care – monitoring major mergers for their effect on patients and physicians;
- Access to health care – fighting the Title X "gag clause" and eliminating Medicaid work requirements;
- Anti-racism efforts – supporting hate crime legislation to protect Asian Americans and Pacific Islanders;
- LGBTQ+ health – advocating for the Equality Act and efforts to stop discrimination against transgender individuals;
- Immigration – speaking up for H1-B visa petitioners and "dreamers;"
- Restrictive covenants – created a legislative template for state advocates to use; and
- Medical liability – advancing and defending hard-fought state reforms.

The AMA has made significant progress on many of these challenging issues so far in 2021 and will continue to advocate powerfully for physicians and patients in the second half of the year.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 4-N-21

Subject: 2021 AMA Advocacy Efforts

Presented by: Bobby Mukkamala, MD, Chair

BACKGROUND

Policy G-640.005, "AMA Advocacy Analysis," calls on the Board of Trustees (the Board) to provide a report to the House of Delegates (HOD) at each Interim Meeting highlighting the year's advocacy activities and should include efforts, successes, challenges, and recommendations/actions to further optimize advocacy efforts. The Board has prepared the following report to provide an update on American Medical Association (AMA) advocacy activities for the year. (Note: The report was prepared in August based on approval deadlines and may be updated if warranted.)

DISCUSSION OF 2021 ADVOCACY EFFORTS

While COVID-19 response efforts remain at the forefront of AMA advocacy in 2021, there has also been continuous activity on many other important issues for physicians and patients at the federal and state levels. On the COVID-19 front, our AMA is working with policymakers to address the public health aspects of the pandemic while at the same time seeking fixes for the practice issues that COVID-19 has created for physicians. The AMA is also working to quell other practice obstacles, such as payment concerns, harmful insurer practices, unwarranted scope of practice expansions, and hurdles to the appropriate use of technology in providing care. At the same time, the AMA is working on legislative and regulatory efforts to improve public health and reduce health care disparities including pursuing solutions to increased maternal mortality and drug overdose and death. Updates on these key issues follow.

COVID-19 Response

The COVID-19 pandemic has been an absolute tragedy for many Americans and their families with over 600,000 deaths and over 33 million cases reported nationwide. The global impact is astounding as well with over 4 million deaths. The physical and emotional toll will reverberate world-wide for many years to come, and it has had a significantly disproportionate impact on minoritized and marginalized communities. During this time of pandemic, the AMA has sought ways to reduce the impact of the virus and its variants. From following the science to social distancing to getting tested to wearing masks to getting vaccinated, the AMA has been out front in promoting best practices to the American public. At the same time, the AMA has been promoting policies that assist physicians in fighting the harsh financial realities their practices face due to stay-at-home recommendations, the temporary halts on elective procedures, and general patient hesitance to resuming regular care.

After the Biden administration assumed office, it established a national plan and issued executive orders to address the pandemic that included several AMA priorities: testing; health care worker safety; science as the basis for reopening schools; a COVID-19 Health Equity Task Force; urgent inventory of supplies; use of the Defense Production Act (DPA); enhanced COVID-19 data

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collection; strengthening public health infrastructure; requiring masks on domestic forms of transportation; and extending the pause on student loan payments. The Biden administration is also encouraging states to supply more vaccines to primary care physician offices to address immunization inequities and better reach patients who are hesitant to get vaccinated against COVID-19.

Our AMA also advocated to assist physician practices in mitigating the financial impact of the pandemic and made progress on several aspects of this concern, including:

- The Centers for Medicare & Medicaid Services (CMS) announced it will automatically hold physicians harmless from the up to 9% Merit-based Incentive Payment System (MIPS) penalties due to the significant disruptions of the COVID-19 public health emergency on physician practices' performance in 2020 and is accepting hardship exception applications from physicians who need an exemption from MIPS in 2021 due to the ongoing COVID-19 pandemic (for which the maximum performance adjustment will also be +/-9% in 2023).
- CMS also reopened the hardship exception application for group practices, virtual groups, and alternative payment model entities who missed the previous 2020 deadline.
- CMS announced that the 2020 MIPS Cost Performance Category will be reweighted to 0% of the final score even if eligible physicians or groups submitted 2020 data in other MIPS categories in light of the impact of the COVID-19 pandemic.
- Legislation has been introduced to ensure Provider Relief Fund grants do not count as taxable income.
- The American Rescue Plan Act (ARPA) included following provisions:
  - Added an additional $8.5 billion dollars to the Provider Relief Fund;
  - Directs the utilization of the Defense Production Act to boost domestic production of personal protective equipment (PPE), vaccines, and onshore production of rapid COVID-19 tests;
  - Adds $15 billion in new funding for Targeted Economic Injury Disaster Loan (EIDL); and
  - Grants funds to provide hard-hit, underserved small businesses with increased flexible monetary relief.
- The Biden administration nearly doubled Medicare payment for administration of the COVID-19 vaccine, including administration of vaccines requiring two doses, to $40 per administration.

The AMA has also hosted eight webinars with federal officials on key COVID-19 developments which have been viewed by thousands of physicians. The AMA has also partnered with grassroots groups such as Made to Save that focus on ensuring hard-hit populations have access to COVID-19 vaccines and accurate, timely information. For more information on the AMA's COVID-19 advocacy efforts, please see a full report on the AMA website.

Scope of Practice

As expected, 2021 was filled with numerous bills related to scope of practice, and the AMA worked to protect patients with 35 state medical associations and other Federation partners to help defeat scope legislation this year, including bills related to Advanced Practice Registered Nurses (APRN) (nurse practitioners, nurse anesthetists, nurse midwives, clinical nurse specialists), naturopaths, optometrists, pharmacists, physician assistants, psychologists, and podiatrists. Due to the tremendous efforts of organized medicine at all levels and physician leaders across the country there have been many wins, but some tough losses as well.

- APRNs – Key bills that would have significantly expanded APRN scope of practice were defeated in eight states this year, including Florida, Kansas, Kentucky, Louisiana, Maine, Mississippi, Tennessee, and Texas. Unfortunately, Delaware, Massachusetts, and Utah also enacted legislation to allow independent practice of APRNs.
- Physician Assistants – Physician Assistants introduced the American Academy of physician assistants (AAPA) Optimal Team Practice Act, their model independent practice legislation, in multiple states this year. Such bills were defeated in Colorado, Indiana, South Dakota, and Texas. Other states also had physician assistant legislation, but state medical associations were able to secure favorable amendments. Unfortunately, a concerning bill was enacted in Utah (S.B. 27), which replaces physician supervision of physician assistants with collaboration, requiring such collaboration with a physician only for the first 4,000 hours of practice. Oregon and Wyoming also enacted legislation replacing physician supervision of physician assistants with a weakened definition of collaboration. In addition to this legislative activity, AAPA adopted new policy at their Annual House of Delegates to change the title of physician assistants to "physician associate." The AMA stands in strong opposition to this title change.
- Optometrists – Legislation that would have allowed optometrists to perform eye surgery was defeated in Alabama and Florida, while favorable amendments were secured in Texas. Unfortunately, however, legislation expanding optometrist scope of practice passed in Mississippi and Wyoming.

The AMA is working to stop a Department of Veterans Affairs (VA) initiative known as the Supremacy Project, which would develop national standards for practice for 48 health care occupations. As the name of the initiative implies, the VA is invoking the Supremacy Clause of the Constitution to preempt state laws potentially including practice laws for nonphysician health care professionals. The AMA is concerned this will have negative repercussions for both patient safety and quality of care available to our nation's veterans. The AMA also has concerns with the feasibility of developing a national standard of practice for all physicians.

Insurer Practices

The AMA continues to oppose harmful insurer practices through federal, state, and private sector efforts. Prior authorization requirements remain frustrating for physicians and detrimental to patients. The AMA conducted and released its annual physician survey to quantify the impact of prior authorization on patients and physician practices. According to the results, 94% of physicians surveyed indicated that prior authorization results in care delays; 79% reported that prior authorization can lead to care abandonment; and 30% stated that prior authorization has resulted in an adverse outcome for a patient. In addition, the survey data captured the lack of progress made on prior authorization reforms agreed to by insurers over three years ago.

At the federal level, the AMA successfully advocated for the reintroduction of the Improving Seniors' Timely Access to Care Act, which would require Medicare Advantage plans to abide by many of the key prior authorization reforms outlined in the 2018 Consensus Statement. The AMA has also been closely monitoring federal rulemaking on prior authorization and submitted extensive comments on a proposed rule issued late last year that would require Medicaid, CHIP, and federally facilitated health plans to automate medical services prior authorization using technology embedded in physicians' EHRs. At the state level, it has been a busy year for prior authorization legislation as well, with new legislation enacted in Georgia, Texas, and Illinois, and many other state legislative efforts underway. Many state prior authorization bills are based on the AMA's model legislation on this issue. The AMA continues to build its grassroots advocacy campaign with its dedicated FixPriorAuth website and associated social media presence. One of the newer features

to the website is an employer-oriented track, which seeks to educate and engage this new and important audience.

The AMA is also heavily engaged on the surprise billing issue at the federal and state levels as well. The Consolidated Appropriations Act signed into law on Dec. 27, 2020, included "No Surprises Act" provisions that allow for price transparency, more accurate provider directories, and patient financial protections against surprise medical bills or unexpected gaps in health insurance coverage. The final provisions reflect significant advocacy by the AMA and Federation groups, including an independent dispute resolution provision. In 2021, the Department of Health and Human Services (HHS), the Department of Labor, and the Department of the Treasury (Tri-Agencies), along with the Office of Personnel Management (OPM) released an interim final rule with comment period (IFR) entitled the Requirements Related to Surprise Billing; Part I implementing many of the provisions of the NSA. The IFR clarifies the Qualified Payment Amount (QPA) by specifying cost sharing calculations for emergency services provided by out-of-network emergency facilities and out-of-network providers, and certain non-emergency services furnished by out-of-network providers at certain in-network facilities. In addition, the IFR clarifies certain notice and consent requirements for health care providers and facilities. The AMA is closely reviewing the IFR after submitting comments to the Tri-Agencies on the implementation and calculation of the QPA and the QPA audit process, among other provisions, as well as comments on the Independent Dispute Resolution Process and prepared a detailed summary to help physicians with this topic.

Meanwhile, states continue to evaluate the impact of the new federal law on state regulation of surprise medical bills and determine their options. It seems that most comprehensive state laws will continue to apply to fully insured plans, and those states can establish opt-ins for self-insured ERISA plans. (Georgia enacted such an opt-in earlier this year.) Several states that have not taken action or have laws that do not meet the NSA requirements are considering if legislating during the NSA implementation is a worthwhile effort or if a wait-and-see approach allows for less confusion for patients, physicians, and plans. Most medical societies are advocating for the latter.

The AMA also released the National Managed Care Legal Database in 2021, which pulls in over 1,000 patient and physician protections passed at the state and federal levels and seeks to empower physicians, patients and their advocates in their dealings with health insurers and to inform policymakers, legislators and regulators about key issues—e.g., surprise billing—involving health insurers, physicians and patients. The AMA is holding Federation-wide webinars to alert state medical and national specialty societies about the Database.

In response to strong advocacy by the AMA, state medical associations, and national medical specialty medical societies, UnitedHealthcare (UHC) made positive changes to several problematic programs/policies:

- Optum Pay™ modified its electronic payment program to offer downloadable remittance information, up to 13 months of payment data for UHC claims, and unlimited users for each account at no cost through its basic service option. Previously, Optum Pay had required enrollment in its premium program, which assessed a 0.5% per payment fee, to continue access to these critical revenue cycle functionalities.
- UHC announced an implementation delay for its emergency department coverage policy, under which it could retroactively deny claims deemed nonemergent, through at least the end of the COVID-19 national public health emergency. The AMA will continue to advocate for complete rescission of this dangerous policy that could discourage patients from appropriately seeking emergency care.

- UHC modified its Designated Diagnostic Provider (DDP) program for outpatient laboratory services from a strict coverage/no-coverage model to a tier-based system, under which UHC patients pay lower cost shares for labs performed by DDPs. In response to AMA and Federation concerns, UHC also is launching extensive educational outreach to both physicians and patients about the DDP program.

Finally, the AMA joined the All Copays Count Coalition and signed onto model legislation to prohibit insurers' copay accumulator programs. More than a dozen bills based on Coalition's model have been introduced in the states, with Alaska, Kentucky, and Oklahoma, enacting new laws.

Medicare/MIPS

In addition to the COVID-19 payment relief cited earlier in this report, Congress also enacted legislation that provided relief from the 2% Medicare sequester payment cut through 2021. The AMA led a grassroots effort in support of this legislation that garnered over 5,400 emails to Congress and over 50,000 engagements. Congress also enacted a one year 3.75% increase in Medicare payments to offset the impact of a budget neutrality adjustment required by law to offset the costs in fee schedule policy changes largely related to evaluation and management (E/M) services.

CMS released the proposed rule for the 2022 Medicare physician fee schedule in July 2021. AMA staff continue to analyze the rule and have developed a summary of the 1,700+ page proposal, it is important to highlight that the 2022 Medicare conversion factor would be reduced by approximately 3.75% from $34.8931 to $33.5848. This is largely a result of the expiration of a 3.75% increase to the conversion factor at the end of calendar year 2021, as averted for 2021 by Congressional action. The AMA will strongly advocate that Congress avert this significant cut and extend the 3.75% increase for 2022. The AMA developed a chart (pages 10-11) to show the proposed rule's specialty impact with and without the 3.75% cut to use in AMA advocacy efforts.

On another front, the AMA and the Physicians Foundation funded novel research about how much time and money it costs to participate in MIPS and physicians' perspectives about whether MIPS improves patient care. On average, practices spent $12,800 per physician per year on MIPS and 200 hours per physician per year on MIPS during the 2019 MIPS performance period. Regarding perceptions of MIPS, physician practices are conflicted about whether it improves care but overwhelmingly agree that MIPS is overly burdensome, and that the costs of successful participation generally outweigh any payment incentives received. The findings are based on interviews with small, medium, and large physician practices in primary care, general surgery, and multispecialty groups across the U.S. The AMA will use these concerning findings to bolster advocacy to reduce burden and improve the clinical relevance of MIPS for physicians in every specialty, practice size, and location.

Telemedicine

During the pandemic, telehealth services emerged as a critical tool to provide care to patients while supporting physical distancing efforts and reducing the spread of COVID-19 and other infectious diseases by avoiding unnecessary in-person patient encounters. In response, Congress acted to temporarily expand access to Medicare covered telehealth services to all Medicare beneficiaries by authorizing HHS to waive outdated statutory restrictions on where telehealth services may be provided. Stories poured in from all over the country from physicians and patients alike about the

positive effects of expanded telehealth benefits. It has continued to allow physicians to provide high-quality care using new digital tools.

The AMA is now strongly advocating for enactment of legislation introduced in both the House and Senate that, if passed, would make the expanded access to telehealth services permanent. The Telehealth Modernization Act of 2021 (H.R. 1332/S. 368) would lift the rural-only restriction and add any site where a patient is located as a potential originating site and ensure all Medicare patients may receive covered Medicare telehealth benefits, including at home and via mobile technologies as appropriate. The CONNECT for Health Act (H.R. 2903/S. 1512) would provide HHS with permanent authority to waive these restrictions, similar to the authority the agency has for the duration of the COVID-19 public health emergency (PHE). The success of telehealth technology adoption during the COVID-19 PHE has made it abundantly clear that Medicare covered telehealth benefits should be available to all Medicare patients regardless of where they live or how they access telehealth services.

The AMA has also been advocating that CMS maintain Medicare coverage and payment for the many services that were temporarily added to the Medicare telehealth list during the PHE for two years after the PHE ends. The COVID-19 PHE was most recently renewed in July 2021 and is expected to continue through the end of 2021. In the Medicare physician payment schedule proposed rule, CMS has proposed to continue paying for services placed temporarily on the telehealth list through the end of 2023, consistent with the AMA's recommendation to provide a glide path to evaluate whether the services should be permanently added to the telehealth list following the COVID-19 PHE.

Telehealth continues to be a priority for state medical associations and legislators across the country as states seek opportunities to make permanent policies expanding coverage, payment, and access to care provided via telehealth. While there has been overwhelming support of telehealth generally, issues around payment, establishment of patient physician relationships via telehealth, acceptable modalities, prescribing via telehealth, and licensure continue to be topics of debate. The AMA worked closely with 18 states reviewing legislative or regulatory language, providing data and additional resources to help states enact strong telehealth laws aligned with AMA policy.

The AMA is also engaged with multiple national organizations developing model state telehealth legislation. We have provided written comments to the National Conference of Insurance Legislators (NCOIL) Health Insurance and Long-Term Care Issues Committee, regarding its draft Telemedicine Authorization and Reimbursement Model Act. In addition, the AMA serves as an official observer to the Uniform Laws Commission drafting committee on telehealth.

Finally, with the increased mobility of physicians and patients and increased utilization of telehealth, the ability of physicians to provide care to patients across state lines has become increasingly important as has the ability of physicians to expeditiously gain licensure in multiple states. The Interstate Medical Licensure Compact (IMLC) continues to gain steam with three more states (Delaware, Ohio, and Texas) enacting legislation to join the IMLC, bringing the total number of IMLC members to 35 (33 states plus DC and Guam). Four states still have legislation pending.

Maternal Mortality

The AMA is committed to tackling the issues surrounding maternal mortality and morbidity. The U.S. has the highest maternal mortality rate among developed countries. A 2019 report by the Centers for Disease Control and Prevention (CDC) found that Black women are 3-4 times more likely to die from pregnancy-related causes than White women. The AMA understands that there

are a multitude of considerations necessary to address this epidemic, including lack of insurance or inadequate coverage prior to, during, and after pregnancy; closures of maternity units in many rural and urban communities; and a lack of inter-professional teams trained in best practices. There are concrete actions that should be taken to reduce and prevent rising rates of maternal mortality and serious or near-fatal maternal morbidity in the U.S. The AMA urges policymakers to:

- Expand Medicaid and CHIP coverage to 12-months postpartum;
- Increase support for Maternal Mortality Review Committees;
- Implement equitable standardized data collection methods;
- Expand access to medical and mental health care and social services for post-partum women;
- Continue to develop a health care workforce that is diverse in background and experience;
- Address shortcomings in our institutions; and
- Adopt standards to ensure respectful, safe, and quality care before, during, and after delivery.

So far in 2021, HHS approved a postpartum Medicaid expansion for Georgia, Illinois, and Missouri. Fifteen state legislatures have also enacted legislation to seek federal approval for coverage expansions for postpartum women. The AMA has also successfully sought introduction of the "Mothers and Offspring Mortality and Morbidity Awareness Act," also known as the MOMMA Act which would extend coverage for postpartum care from the existing 60 days to 12 months under Medicaid and CHIP and would also support training clinicians on implicit bias and health equity issues. The AMA also supports the Connected Maternal Online Monitoring Act which would require CMS to identify barriers to coverage of remote physiologic devices under state Medicaid programs to improve maternal and child health outcomes for pregnant and postpartum women.

Drug Overdose and Death

The AMA remains engaged in fighting the drug overdose and death epidemic. Recent statistics have shown that the epidemic has worsened during the COVID-19 pandemic, but significant progress has been made on the advocacy front on these issues in 2021:

- The Biden administration adopted policies to address overdose and substance use disorder in ways that will reduce stigma, more effectively prevent overdose deaths, and remove barriers to treatment—and in ways that are consistent with AMA policy recommendations.
- The Biden administration is waiving burdensome administrative requirements so that all physicians will be able to prescribe buprenorphine for their patients with opioid use disorder.
- Using national principles and working with coalition partners, the AMA supported five state laws directing opioid litigation funds to be earmarked for public health uses.
- As part of a national coalition, the AMA helped support six new state mental health and substance use disorder parity laws that will help enhance oversight and enforcement to protect patients. Our AMA also helped secure a new rule in Colorado that will be the nation's first to meaningfully measure substance use disorder network adequacy and provide regulators with actionable information to help hold insurers accountable for inadequate networks.
- Developed a new issue brief focused on actions employers can take to help improve access to evidence-based care for opioid use disorder and pain, as well as to support harm reduction efforts; worked with the Milken Institute and the DEA to present highlights of the issue brief at multiple regional DEA-sponsored events.
- Held a national webinar with Manatt Health featuring medical, legal and public health experts identifying ways to remove barriers to evidence-based treatment for opioid use disorder in justice-involved settings; a second webinar with Manatt Health focused on evidence-based

initiatives to support harm reduction efforts, including the first overdose prevention site in the nation.

- Highlighting physician advocacy efforts to help their patients with a substance use disorder or chronic pain and detailed the effects of COVID-19 on physicians and patients with respect to barriers to care for patients with as well as physicians' uptake of new federal telemedicine and other flexibilities.
- AMA Immediate Past President Susan R. Bailey, MD, provided a keynote address on the AMA's advocacy efforts to end the overdose epidemic at the National Rx Drug Abuse and Heroin Summit and to the American Bar Association.

The AMA also urged advisers to the Centers for Disease Control and Prevention Injury Center to recommend an overhaul of the agency's problematic guideline on opioid prescriptions. Mirroring recommendations of the Opioid Workgroup, the AMA urged the removal of arbitrary thresholds to restore balance and support comprehensive, compassionate care, noting that the opioid epidemic has become more lethal due to illicit rather than prescribed drugs. States and insurers have turned the existing guidelines into laws and unbending regulations that prevent physicians from treating patients as individuals with specific needs, including patients with cancer and sickle cell disease, as well as those in hospice care.

Competition in Health Care

The AMA is continuing to monitor key health care mergers and acquisitions for their effects on physicians and patients. On July 9, President Biden signed a new executive order aimed at limiting anticompetitive actions and promoting competition in several sectors, including health care. The "Promoting Competition in the American Economy" executive order includes directives to several federal departments and agencies, including HHS, Food and Drug Administration (FDA), and Federal Trade Commission (FTC), that could potentially impact issues such as prescription drug pricing and access, hospitals, and insurer mergers, use of non-compete clauses in employment contracts, and occupational licensing. Broadly, the order notes its opposition to consolidation in any industry and specifically notes concerns about monopoly and monopsony powers in health care markets. Specifically, the order directs the FTC to curtail the use of non-compete agreements and other clauses that may limit employee mobility and to address the use of "unfair occupational licensing restrictions." The order also includes several directives to HHS, FDA, and CMS to promote competition in the prescription drug space aimed at decreasing prescription drug costs and increasing access to generics and biosimilars. The AMA will review forthcoming agency activity on these issues and provide AMA recommendations as appropriate. Further, the AMA initiated engagement with U.S. Department of Justice, asking for a more thorough investigation, of the proposed merger of United/Optum and Change Healthcare and its potential effects on the U.S. health system.

The AMA also continues to help state medical associations with respect to legislation that improves competition in health care. For example, the AMA worked closely with the Nevada State Medical Association on a piece of legislation that was enacted that, in part, limits the ability of large health care systems to use their market power to injure competition, raise consumer prices, and reduce health care quality.

Access

Access to health care remains a priority for the AMA in its advocacy work. Positive developments in 2021 include the Biden administration starting the process of lifting the Title X "gag clause" rule. It is also repealing approvals of state Medicaid work requirements. The American Rescue

Plan Act (ARPA) contained provisions to extend postpartum coverage under Medicaid and CHIP, increase premium subsidies for ACA marketplace plans, and invest in trust and treaty obligations to provide essential safety-net programs that serve Native American communities. The American Families Plan announced by the President on April 28 would make ARPA's Affordable Care Act (ACA) subsidy enhancements permanent. Finally, a special enrollment period for the ACA was opened in 2021 to expand access to coverage. Based on this, 2 million Americans have signed up for coverage.

Anti-racism Efforts

As the AMA continues to focus on anti-racist and social justice policies, it was pleased that the CDC recognized racism as a "serious public health threat." The AMA also supported the Asian American and Pacific Islander federal hate crime legislation, which was signed into law on May 20 after widespread reports of violence against this community. The AMA also successfully opposed state legislation that would have barred state-funded entities from conducting trainings on diversity and inclusion. Moving forward, AMA advocacy efforts will incorporate elements of the AMA's strategic plan to embed racial justice and advance health equity as it promotes AMA health equity policy at the federal and state levels.

LGBTQ+ Health

The AMA was very active in supporting LGBTQ+ health in 2021. Efforts include endorsing H.R. 5, the Equality Act, passed by the House, which prohibits discrimination based on sex, sexual orientation, and gender identity in areas including public accommodations and facilities, education, federal funding, employment, housing, credit, and the jury system. The Biden administration withdrew a Trump Administration proposal restricting transgender people in homeless shelters. It also announced it would provide protections against discrimination in health care based on gender identity and sexual orientation, reversing a rule issued by the previous administration that allowed discrimination against transgender individuals. The AMA strongly opposed the previous policy and had urged the Biden Administration to reverse it. The AMA was also pleased that the new administration withdrew the previous administration's proposed rule that would have weakened the Equal Access Rule which ensures that all individuals—regardless of sexual orientation or gender identity—have equal access to the Office of Community Planning and Development programs, shelters, other buildings and facilities, benefits, services, and accommodations. The AMA also contributed to the defeat of harmful anti-transgender legislation in over a dozen states that would have criminalized the provision of medically necessary gender-affirming care to minor patients. The AMA also sent a letter to the National Governors Association urging the nation's governors to reject legislation that would discriminate against transgender individuals.

Gun Violence

Gun violence is a public health crisis, and the AMA remains committed to finding solutions that help reduce the impact it has nationwide. Some positive steps occurred in 2021. The Biden administration issued rules to require background checks for "ghost guns." The House of Representatives passed two bills supported by the AMA that would close the so-called "Charleston Loophole" by extending the time period the FBI has to determine whether a buyer is qualified to purchase a gun and to expand the existing background check system to cover all firearm sales, while providing exceptions for law enforcement and family and friend transfers. The AMA also helped to successfully secure FY 2021 federal appropriations of $25 million for the National Institutes of Health and $25 million for the Centers for Disease Control and Prevention for research on gun violence.

Immigration

In 2021, the AMA promoted its policy on immigration issues. There were several beneficial developments under the new administration. First, it delayed implementation of a problematic Department of Homeland Security (DHS) final rule regarding cap-subject H-1B visa petitioners. The Biden administration also continued the policy to defer the removal of certain undocumented immigrants who were brought to the United States as children, have obeyed the law, and stayed in school or enlisted in the military (DACA). Also consistent with AMA advocacy, the Biden administration lifted the immigration ban on Muslim countries and rescinded rules that would deem immigrants inadmissible on public charge grounds. The AMA is currently advocating for a broad range of immigration and border security policy changes, including those that would ease visa restrictions for foreign-born physicians seeking to train or practice in the U.S.

Restrictive Covenants

Pursuant to AMA House of Delegates action at the AMA's 2020 Special Meeting, the AMA developed a 60+ page, comprehensive legislative template on restrictive covenants to help the Federation develop legislative proposals that would address concerns that restrictive covenants raise while, at the same time, be cognizant of the interests of physicians who own their own practices and may view the use of reasonable restrictive covenants as a means of protecting their practices' financial viability and their relationships with their patients, and making it easier to bring new physicians into the practice. The AMA also continues to assist individual state medical associations with analyzing and drafting restrictive covenant legislative language.

State Medical Liability Efforts

2021 was a very busy year for state medical liability legislative proposals. These proposals gave qualified immunity from medical liability for physicians, health care professionals, and health care facilities for care that they provided during, or as a result of, the COVID-19 pandemic. Thus far, over half of the states have enacted some form of medical liability immunity legislation. The AMA provided comprehensive resources to state medical associations working on this issue to help them advocate for enactment of liability immunity laws. The AMA also proactively contacted all state medical associations working on this issue to provide support. The AMA helped state medical associations analyze and draft medical liability immunity legislation that became law. Aside from medical liability immunity advocacy, the AMA helped persuade the Illinois Governor to veto legislation that would have imposed prejudgment interest in medical liability cases starting on the day the alleged liability occurred and supported the New Mexico Medical Society in reaching a successful result concerning amendments to its MLR law. The AMA also published the 2021 edition of MLR NOW!.

CONCLUSION

Our AMA has made significant progress on a challenging group of advocacy issues so far in 2021 and will continue to advocate powerfully for physicians and patients in the second half of the year. The situation is somewhat fluid with the Delta variant becoming the dominant COVID-19 strain in the U.S. and hitting unvaccinated pockets of the country very hard. However, the AMA will continue to stress "following the science" in its COVID-19 response. And the AMA will seek to make further progress on the other issues confronting physicians and patients.

REPORT 6 OF THE BOARD OF TRUSTEES (N-21)
Mitigating the Effects of Racism in Health Care: "Best Practices"
(Informational)

EXECUTIVE SUMMARY

This report responds to the call for AMA to identify "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" (H-65.952). It presents preliminary findings from reviews of statements declaring racism a public health threat from state, county, and local governments as well as public health and educational organizations and of anti-racism and/or equity initiatives by health care systems. In addition, it summarizes AMA engagement around issues of anti-racist practice in health care.

The report concludes that strong practice will explicitly acknowledge racism, address racism at the institutional and interpersonal level, and pair commitment with specific, actionable policies and practices to create change. Strong practice cannot be defined globally but must be responsive to the needs and histories of local communities and the institutions that serve them. Strong practice will, at minimum:

- Acknowledge and respond to the unique intersecting local histories of racism within the institution, the community, and their constituent populations.
- Partner with the community to identify local values, needs, and assets and develop concrete plans to meet the full range of needs among the populations served. Secure additional resources as needed to build local capacity.
- Align institutional mission and strategic planning with the needs and values of the local community and populations served.
- Promote and provide resources to support critical self-reflection and transformation on the part of the institution and its staff.
- Collaborate with the community and populations served to design and implement meaningful measures of success and hold the institution accountable for meeting those measures.
- Ensure that at all levels of the institution polices are equity focused, actionable, and aligned with the institution's community-informed values and mission.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 6-N-21

Subject: Mitigating the Effects of Racism in Health Care: "Best Practices"

Presented by: Bobby Mukkamala, MD, Chair

At its November 2020 Special Meeting the House of Delegates of the American Medical Association (AMA) adopted three policies directed toward the ongoing impact of racism in medicine: D-350.981, "Racial Essentialism in Medicine," H-65.952, "Racism as a Public Health Threat," and H-65.953, "Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice."

These policies variously direct AMA to take action to address racism and racial essentialism as they manifest in medical education, clinical practice, and the development and use of new medical technologies, notably clinical algorithms. Staff from the Center for Health Equity and AMA's Health, Science & Ethics group tasked with co-implementing these directives realized that three key themes cut across individual policies: identifying best practices to respond to the effects of racism, addressing algorithmic bias and race-corrected algorithms, and collaborating with key stakeholders to address how medical education perpetuates mistaken beliefs about race as a biologic risk factor. Staff concluded that the most effective approach to accomplishing the goals of these policies would be to engage these cross-cutting themes as organizing rubrics for three separate reports on best practices, clinical algorithms, and medical education, respectively.

The working group concluded that the most effective approach for responding to the HOD's directives would be to engage these cross-cutting themes as its organizing rubric in a series of reports, rather than speak to individual directives policy by policy.

The present report responds to the directive to "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" (H-65.952).

The broad scope of this directive requires distinguishing best practices first, at the level of institutionalized or structural racism as well as the level of "personally mediated" racism,[1] and second, doing so across multiple contexts of practice, from small private offices to large integrated health systems. As evidenced below, the complexity of the task and the problem(s) to be addressed argue against defining any single set of "best" practices. Rather, this report seeks to identify essential features of strong anti-racist practice applicable across multiple levels and settings as they emerge in anti-racism declarations made by public health departments and local/state governments and in equity and anti-racism initiatives being undertaken by health care institutions across the country.

To that end, in addition to literature review, as discussed below preliminary reviews were carried out of (a) declarations regarding racism as a public health crisis posted to the American Public Health Association's online database, and (b) publicly available descriptions of programs and initiatives on the part of health care institutions to address racism and health equity.

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DECLARATIONS ON RACISM AS A PUBLIC HEALTH CRISIS

The American Public Health Association maintains a database of declarations of racism as a public health crisis or emergency. Submissions to the database are crowd-sourced; thus, it certainly does not include every existing anti-racism declaration. As of May 18, 2021, the database included 208 declarations from city/town governments (102 declarations), county boards (51), state governments (7), public health organizations (44), and educational organizations (4). The working group evaluated a randomly chosen sample of 19 declarations, which surfaced three core themes focused around declaring entities' commitments to acknowledge racism, address racism, and mitigate racism.

Acknowledge Racism

All but one of the nineteen declarations reviewed explicitly named and condemned systemic racism (one used the term "endemic racism"). Declarations gave examples of historical and present-day government sanctioned colonization, genocide, and racism in housing, including redlining and segregation; voting rights; immigration; incarceration; as well as hiring, promotion, compensation, and retention practices. Thirteen acknowledged historical, intergenerational, or contemporary racial trauma; none provided an apology for their role in creating or perpetuating it.

For example, the declaration from Multnomah County, Oregon included the following statement:

> Multnomah County recognizes that the entirety of Multnomah County rests on the homelands, villages and ceded territories of the Indigenous Tribal nations. We acknowledge the genocide, forced removal, and systemic erasure of Indigenous peoples that have allowed us to ignore and deny this history and our responsibility to Indigenous people. Further, the state of Oregon was founded on the notion of creating a white utopia, and around the functional and implicit removal, exploitation and/or exclusion of BIPOC individuals and communities. From Black exclusion laws and restrictions that barred Black and Chinese people from voting to a steady stream of discriminatory laws and the practice of redlining in Portland, the legacies of Oregon's founding ideals continue to perpetuate harm, oppression, and marginalization within communities of color today. Racism is codified into our laws and institutions, which were created on a foundation of the ideology of white supremacy; it upholds systems, structures and policies that were created to advantage white people while neither serving nor benefiting people of color.[2]

Address Racism

All but four of the examined declarations included specific anti-racism actions the organization was committing to. Among the actions at the individual, institutional, and community level set out by the 15 organizations that included them are commitments to:

- Providing anti-racism training for all staff, students and volunteers.
- Instituting anti-racism policies and practices in Human Resources; building a workplace culture that promotes racialized repair.
- Developing policies and practices to ensure equity and incorporating anti-racism principles in budgets and contracting; using an equity lens in vendor selection processes.
- Using racial impact assessments in the development of all policy resolutions and ordinances; expanding documented equity decision-making frameworks that are transparent to the public.
- Conducting research, analyzing and collecting data, and monitoring progress to ensure policy approaches are data driven and have built-in accountability measures; improving data systems

in order to disaggregate health data by race, ethnicity, gender, transgender, age, sexual orientation and income and facilitate data-informed decision-making processes to address health inequities.

- Sharing power in partnering with community organizations; systematically lifting up the voices of community members; applying an anti-racism lens to government outreach with all communities.
- Seeking upstream solutions to address health inequities at the population level, recognizing that racism is a social determinant of health outcomes; working to mitigate housing and job displacement from driving further racial and income segregation by developing strategic initiatives such as land use and affordable housing finance regulations and housing stability programs.

Mitigate the Effects of Racism

The declarations reviewed gave significantly less attention to addressing activities to mitigate the effects of racism. None committed to a strategy for making reparations. Many did not acknowledge the need for additional funding or resources to support mitigation. Of those that did, only two promised specific dollar amounts, while the remainder simply advocated in general for additional funding.

ANTI-RACISM INITIATIVES AMONG HEALTH CARE INSTITUTIONS

Launched in 2016, the Healthcare Anchor Network is a collaboration among now 60 hospitals and health systems committed to serving as "anchor institutions"[3] in their communities. Network members recognize that

> Hospitals and health systems are critical local economic engines and mission-driven organizations inextricably linked to the long-term well-being of those we serve—because of this, we as healthcare leaders, are uniquely positioned and incentivized to play a more active role in supporting our local economies. We have an opportunity and obligation to improve health and well-being outcomes in the communities we serve and confront economic and social instability in our nation that remain obstacles to that goal.[4]

Collectively, Network members called for action to address racism as a public health crisis, pledging as institutions to:

- Re-examine institutional policies with an equity lens and make policy changes that promote equity and opportunity.
- Improve access to primary and specialty care.
- Continue to focus on helping our communities overcome chronic conditions like diabetes, heart disease, and asthma.
- Continue to advocate for investments that create innovative solutions to achieve enduring improvements in access, quality, and health outcomes for our communities.
- Commit to hiring locally and promoting and retaining leaders of color.
- Renew and expand the organizations' commitment to providing anti-racism and unconscious bias training for our administrators, physicians, nurses, and staff.
- Advocate for increased funding for social needs, social services and programs that promote social justice.[5]

Members have further "co-created the Anchor Institution Reporting Standard to develop a shared set of national metrics for anchor strategies."

In 2015 the American Hospital Association's Institute for Diversity and Health Equity (IFDHE) launched the #123forEquity Campaign to eliminate health care disparities, which to date has received a total of 1,771 organizational pledges, with 1,711 being hospitals and health systems. The campaign encourages hospital and health system leaders to:

- Increase the collection and use of race, ethnicity, language preference and socio-demographic data.
- Increase cultural competency training.
- Increase diversity in leadership and governance.
- Improve and strengthen community partnerships.[6]

The goal of the campaign is to ensure every person in every community receives high-quality, equitable and safe care.

The working group delved into the declarations and strategic plans of 11 health systems among these two initiatives: Rush University Medical Center, Health Partners, Ohio State University Wexner Medical Center, MetroHealth, Ascension, Kaiser Permanente, Mass General Brigham, John Hopkins Medicine, UC Davis Health, Yale New Haven Health, and RWJBarnabas Health.

Themes among these materials include:

- Recognizing the need to understand the historical context of the institution and its community, to embed equity in the institution's strategic plan, promote diversity among leadership and staff and adopt equitable processes for decision making that do not perpetuate racism and inequity.
- Commitment to:
  - ensuring equitable policies and practices for recruiting and managing personnel; adopting zero-tolerance policy with respect to racism, harassment and discrimination within the institution; and providing a living wage and equitable benefits; and
  - providing anti-racism and implicit bias training and cultivating a safe environment in which staff are comfortable addressing racism.
- Promoting quality improvement activities to eliminate variations in care and outcomes.
- Funding research to address and eliminate racism.
- Designing data systems that are able to collect, stratify, and report data on race, ethnicity, language, sexual orientation, and gender identity.
- Identifying community health assets and needs and building partnerships to address those needs and social determinants of health.
- Centering the most marginalized/minoritized communities within and outside the institution in designing solutions to address community needs.
- Building coalitions with other health care and community institutions to create resources and opportunities and redistribute power to further the interests and well-being of the local community.
- Advocating on behalf of and supporting community members in advocating for themselves.

The Institute for Healthcare Improvement's (IHI) Pursuing Equity initiative also brings together some twenty institutions committed to addressing the needs of marginalized and minoritized communities to improve health. (Several institutions are members of both the IHI initiative and the Healthcare Anchor Network.) The IHI's *Framework to Improve Health Equity* focuses on the need to make health equity a priority, build infrastructure to support health equity, address the multiple determinants of health, eliminate racism and other forms of oppression, and partner with the community to improve health equity.

The IHI identifies five strategies for eliminating racism:[7]

- Understanding the historical context for racism and other forms of oppression nationally, locally, and within the institution itself, including:
  - gaining understanding of the historically marginalized populations in the community where the institution is located; and
  - committing to ongoing learning and transformation regarding race, racism, and inequity.
- Addressing institutional racism and its impact on health equity by:
  - normalizing discussion about racism, oppression, advantage and power,
  - identifying institutional racism as a root cause of inequities;
  - setting organizational priorities to explicitly address racism; and
  - listening to patients, partners, and communities to understand their experiences and partner on solutions.
- Establishing policies and practices to promote workforce diversity and racial equity by:
  - setting specific targets for workforce diversity at all levels; and
  - ensuring that organizational policies and practices promote diversity.
- Implementing business policies and practices that support and promote racial equity by:
  - developing or revising policy through a racial equity lens; and
  - investing in the community.
- Improving clinical processes and outcomes to narrow equity gaps and improve equity for all:
  - building data systems that can identify and track equity gaps in clinical outcomes;
  - using quality improvement to narrow equity gaps and improve care for all; and
  - breaking down silos between departments to motivate clinical teams to work together to reduce equity gaps.

ADDRESSING "PERSONALLY MEDIATED RACISM"

Although addressing prejudice and discrimination in the behavior of individuals can never be a sufficient response to racism in health care, it is nonetheless essential for promoting strong anti-racist practice. Differential assumptions about individuals' abilities or intentions based on race and differential action toward individuals based on race both reflect and help to perpetuate structural inequities.

Prejudice or discrimination by health care personnel toward patients, family members, or fellow health care workers runs counter to the norms of the healing professions and undermines efforts on the part of the institution to mitigate the effects of racism. This has led to calls for providing training to all staff in implicit bias and "cultural competence," or more properly, cultural humility and structural competence. are needed? are appropriate?

Prejudice on the part of patients or families toward health care personnel also presents a challenge for health care institutions, which have a responsibility to support and protect the dignity and well-being of personnel. Strong practice includes ensuring a safe and respectful working environment by setting clear expectations for the behavior of all parties during health care encounters and ensuring that those expectations are upheld.

Analogous to institutions' responsibility to collect data on inequities in access to care and outcomes, institutions should collect and analyze data on incidents of prejudiced or discriminatory behavior by health care personnel and patients or families to better understand how such incidents arise and inform efforts to improve the institution's response. Moreover, institutions have a responsibility to reflect critically on how they treat their staff, how they permit staff to treat one

another and members of the community, and how they permit members of the community to interact with health care personnel and align policies and practices to foster compassion and respect for all stakeholders.[8]

AMA ENGAGEMENT

The AMA Center for Health Equity is designing and launching large-scale national initiatives to advance a more equitable and healthy society in which physicians use their individual, institutional, and collective power to advance health equity and public health (upstream approaches). These initiatives are focused on three key levels of action: cross-sector engagement, health care institutions, and health care professionals.

Cross-Sector Engagement. Coordinate across sectors—including public health, social care, health care, and beyond—to promote people- and community-centered, collective action addressing social and structural drivers of health, and dismantling intersecting systems of oppression. The Center's *IHI-AMA Equity Campaign*, a two-and-a-half-year initiative, will engage individuals, health systems, payers, biotech/pharma, and professional societies to transform the health care ecosystem to promote optimal health for historically marginalized populations. The *AMA-ACGME Racial Justice and Equity Grand Rounds* will launch a national lectureship and practice lab focused on amplifying high-impact strategies and practices in racial justice and equity across sectors to promote people- and community-centered collective action to address the social and structural drivers of health, and to dismantle intersecting systems of oppression.

Health Care Institutions. Eliminate harmful variation in health care delivery, access, and outcomes, by embedding equity in the DNA of hospital operations, including quality, safety, data, and education; and promoting a place-based, equity-focused anchor mission strategy that centers community and marginalized voices. The *AMA-BWH Q&S For Impact in Racial Justice an Equity Peer Network* is designed to equip all participating U.S. health care delivery systems with the knowledge and tools to address root causes of inequities by systematically incorporating equity into the operational DNA of healthcare delivery—by leveraging equity-informed high-performance quality and safety practices and technologies that will address structural and social drivers of health and advance equity for patients, staff, and local communities.

Health Care Professionals. Develop a pipeline of health care leaders equipped with anti-racist, structural justice praxis capable of redesigning health care for social health.

LESSONS LEARNED

Defining a single set of "best" practices to respond to the challenge of racism in health care is an illusory goal. Best practices can be effective tools for responding to problems that are (relatively) circumscribed in nature and scope, affect a limited set of readily definable stakeholders, and are amenable to reasonably straightforward solutions. Racism and its effects on patients, physicians and other health care personnel, and the institutions and communities within which they live and work, is of a different order. Racism is deeply rooted historically and pervasive across U.S. society, manifest in entangled policies, practices, institutions, and habits of mind among multiple stakeholders who bring diverging values and goals to the table and for whom different "solutions" can carry significantly different implications.

The responses to systemic racism discussed above don't delineate a set of "best practices." Rather, they suggest features that will be common to strong solutions across the board, however different those solutions may be in their details. These initiatives indicate that at minimum, effective efforts

to mitigate the impact of racism will explicitly name the problem for what it is, will engage both institutional and interpersonal racism, and will pair commitment with specific policies and concrete practices to create change.

Strong solutions will acknowledge and respond to the unique intersecting local histories of racism within the institution, the community, and their constituent populations. They will partner with the community to identify local values, needs, and assets and develop concrete, actionable plans to meet the full range of needs among the populations served. They will secure additional resources as needed to build local capacity. And they will adapt as the needs of the community change over time.

As essential partners in initiatives to mitigate racism, health care institutions will align institutional mission and strategic planning with the needs and values of the local community and populations served. They will promote and provide resources to support critical self-reflection and transformation on the part of the institution and its staff. Institutions will collaborate with the community and local populations served to design and implement meaningful measures of success and hold the institution accountable for meeting those measures. And they will ensure that at all levels of the institution polices are equity focused, actionable, and aligned with the institution's community-informed values and mission.

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 7-N-21

Subject: Improving Clinical Algorithms: Moving Beyond Race and Ethnicity

Presented by: Bobby Mukkamala, MD, Chair

At its November 2020 Special Meeting the House of Delegates of the American Medical Association (AMA) adopted three policies directed toward the ongoing impact of racism in medicine: D-350.981, "Racial Essentialism in Medicine," H-65.952, "Racism as a Public Health Threat," and H-65.953, "Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice."

These policies variously direct AMA to take action to address racism and racial essentialism as they manifest in medical education, clinical practice, and the development and use of new medical technologies, notably clinical algorithms. Staff from the AMA's Center for Health Equity and Health, Science & Ethics group tasked with co-implementing these directives realized that three key themes cut across individual policies: identifying best practices to respond to the effects of racism, addressing algorithmic bias and race-corrected algorithms, and collaborating with key stakeholders to address how medical education perpetuates mistaken beliefs about race as a biologic risk factor. Staff concluded that the most effective approach to accomplishing the goals of these policies would be to engage these crosscutting themes as organizing rubrics for three separate reports on best practices, clinical algorithms, and medical education, respectively.

The present report responds to directives to "promote antiracist strategies to mitigate algorithmic bias in medicine" [H-65.952(6)] and "innovative health technologies" [H-65.953(5)] and, importantly, to "collaborate with appropriate stakeholders and content experts to develop recommendations on how to interpret or improve clinical algorithms that currently include race-based correction factors" [D-350.981(4)].

BACKGROUND

With the advent of longitudinal clinical registries, electronic health record systems, and other large repositories of clinical data, many specialty societies, health systems, health plans, researchers, patient-facing organizations, government entities, and others have used the data to develop or support development of algorithms to inform the clinical care of individual patients and populations. As constructs based on real-world data and using mathematical and statistical methods such as multivariate analysis, these algorithms have been widely adopted, in part based on their implied or explicit promise to objectively synthesize and interpret data and offer clinical decision support that circumvents the potential biases of human decision makers.[1] Yet as is increasingly clear, much more remains to be done if clinical algorithms are to come closer to achieving that promise.

Clinical algorithms are only as good as the data on which they are trained and operate and can be subject to bias arising from several directions and due to many causes: limitations in the geographic origins and ancestral representativeness of data collection; missing data; small sample sizes; the implicit biases and inaccurate or inexperienced judgments of clinicians; or differential care

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delivered in different clinical settings to different populations of patients.[1] As a result, technical solutions to mitigate bias before, during, or after an algorithm processes data may not be sufficient to ensure that an algorithm benefits patients as intended.[2,3,4]

Collection of data to identify and describe individuals is ubiquitous, and often required, in clinical health care settings and research. In addition to name, address, and date of birth, health care organizations, clinicians, and researchers often collect information on gender, co-morbidities, race, ethnicity, and other characteristics that they believe contribute or may contribute significantly to the predictive accuracy of estimates of the risks and benefits of the various preventive, diagnostic and therapeutic options considered and discussed, recommended or advised against, and offered or not offered in clinical care settings. With race and ethnicity now understood as social, not biological constructs, and as proxies for nonbiological factors such as social determinants of health and structural racism, considerable scholarship has been focused on what "race" and "ethnicity" mean as descriptive or explanatory categories in clinical care and research, and what role, if any, data on race and ethnicity should play in clinical algorithms.[5]

CONGRESSIONAL INTEREST

AMA is not alone in recognizing and responding to the imperative to come to terms with racism endemic in American society, which manifests in stark health inequities among members of marginalized and minoritized communities compared to white patients. Understanding and redressing how clinical algorithms create, perpetuate, or exacerbate those inequities is essential. A growing body of literature reveals the way in which race corrections, intended to enhance the accuracy of predictive models, can in fact systematically disadvantage patients of color and contribute to differential outcomes.[6]

In September 2020, Congressman Richard E. Neal, chairman of the Committee on Ways and Means of the U.S. House of Representatives, directed a request to a number of medical professional societies and other entities, asking them to describe how they are addressing the challenges that can be associated with use of clinical algorithms that incorporate race and ethnicity data, among other factors.[7] The organizations' responses indicate that there is considerable variation within the professional community with respect to what ways and how far along different organizations are in their journey to address these issues.

Although respondents differed in the scope of their efforts to address the challenges associated with the use of race and ethnicity data in clinical algorithms, several shared concerns emerged:

- The need for guidelines on the *appropriate* use of race/ethnicity in research and clinical care.
- The need to identify and pay for, race-neutral well-validated biomarkers, if available, to improve estimates of risk of particular outcomes (e.g., use of cystatin to estimate a race-neutral creatinine clearance).
- The need for transparency on the part of algorithm developers, in particular:
  - information about the population(s) studied and the extent to which algorithms have been tested in different populations,
  - the extent to which algorithmic estimates predict outcomes and differences in outcomes that are important to people, and
  - the confidence intervals, or degree of uncertainty, associated with algorithmic estimates of outcomes of an intervention or no intervention, and
  - How algorithmic estimates change with inclusion or exclusion of race and ethnicity.
- The need to encourage and pay for collection and reporting of granular population data to identify and address inequities.

- The need to develop guidelines and opportunities for medical education about:
  - race and racism,
  - implicit bias, and
  - AI technologies.
- The need to establish and apply antiracist practices and policies throughout the total lifecycle of a clinical algorithm from conceptualization to implementation in practice.
- The need for federal support of research to advance the science of algorithm development, and identify and advance solutions that recognize racism, rather than race, as the driver of racial health inequities.
- The need for clear accountability and metrics of equitable access to care.

AMA ENGAGEMENT

The need for collaboration emerged as a dominant theme among respondents to the Committee on Ways and Means, one that AMA, with its power to convene, is well-positioned to address. As part of its larger mission to improve health equity nationwide, AMA is exploring opportunities to engage stakeholders across multiple domains.

Initiatives under development by the AMA Center for Health Equity provide an overarching framework for AMA engagement. Notably, collaboration with the Institute for Healthcare Improvement (IHI) will address issues at the level of health care institutions and health systems. The AMA-IHI Equity Campaign is designed to help institutions build equity and racial justice into their operations in all domains, from quality, safety, data, and education to place-based equity-focused anchor mission strategies that center community and marginalized voices.

Going forward, clinical algorithms must address the fact that in health datasets, race and ethnicity are proxies, not for ancestry or genetics, but for nonbiological causal factors such as social determinants of health and the effects of systemic racism. This has led to calls, such as those that surfaced in responses to the Committee on Ways and Means, to replace race/ethnicity with more appropriate data elements in EHRs, registries, and research datasets.

Further, race/ethnicity data currently available are problematic in that they are in some instances self-reported by patients and in others ascribed to patients by researchers and clinicians, with the latter approach more subject to error than the former. Furthermore, the options offered to reporters have varied as societal perspectives on race and ethnicity have changed over time. Some early data systems and evidence reports have limited choices or analyses to White and non-White, where systems today may offer 90 or more options, including giving individuals the opportunity to self-identify as multi-racial and to decline to report.[8] Arriving at a meaningful consensus on how race and ethnicity should be defined and reported in clinical care and research is fundamental.

AMA's Integrated Health Model Initiative (IHMI) is in a position to address these data issues, in particular, to introduce and advocate for appropriate data elements to replace race/ethnicity where they have served as proxies for biological risk factors. IHMI is a founding member of The Gravity Project, a consensus-building community that "seeks to identify coded data elements and associated value sets to represent social determinants of health data documented in EHRs" for screening, diagnosis, planning, and intervention.

Input from the medical specialty societies and other organizations that have expertise and direct experience in developing and using clinical algorithms will be key to understanding the range of algorithms currently in use and to identifying if and where bias and racism exist in these tools as a

first step to ensuring that they do not adversely affect health and access to care among marginalized and minoritized communities.

Following the publication of "Hidden in Plain Sight: Reconsidering the Use of Race Correction in Clinical Algorithms" in the *New England Journal of Medicine* more than a year ago,[2] the AMA communicated with the American College of Cardiology and the leadership of its National Cardiovascular Data Registry and the American College of Obstetricians and Gynecologists, as well as the Society of Thoracic Surgery (STS) and leadership of the STS Database and, subsequently, other stakeholder organizations, to gauge interest in convening a work group to address issues surfaced in the article.

AMA looks to engage specialty societies within the Federation, as well as clinical registry stewards and subject matter experts within and outside AMA, more broadly in 2022 to map more completely existing clinical algorithms and stakeholders' understandings of the challenges and opportunities they pose. We intend to provide a collaborative space in which stakeholders can share expertise and insights, regardless of their current or previous level of engagement with clinical algorithms, toward identifying key principles for antiracist design and implementation of clinical algorithms.

To be clear, it is not the intent of the AMA to eliminate the collection of race and ethnicity data. AMA recognizes that there is value in that data as it strives to overcome U.S. medicine's history of bias based on race and ethnicity. Absent such collection, it may be impossible to know if progress is being made and to what approaches such progress can be attributed. The AMA intends to convene organizations that are committed to making such progress and to sharing their expertise and experience and best practices, to make recommendations in support of equitable health outcomes.

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OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 1-N-21

Subject: Amendment to Opinion 9.3.2, "Physician Responsibilities to Impaired Colleagues"

Presented by: Alexander M. Rosenau, DO, Chair

INTRODUCTION

At the June 2021 Special Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 3, "Amendment to Opinion 9.3.2, 'Physician Responsibilities to Impaired Colleagues.'" The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the next print edition of the *Code of Medical Ethics*.

E-9.3.2 – Physician Responsibilities to Colleagues with Illness, Disability or Impairment

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

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

As individuals, physicians should:

(a) Maintain their own physical and mental health, strive for self-awareness, and promote recognition of and resources to address conditions that may cause impairment.

(b) Seek assistance as needed when continuing to practice is unsafe for patients, in keeping with ethics guidance on physician health and competence.

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* Opinions of the Council on Ethical and Judicial Affairs will be placed on the Consent Calendar for informational reports, but may be withdrawn from the Consent Calendar on motion of any member of the House of Delegates and referred to a Reference Committee. The members of the House may discuss an Opinion fully in Reference Committee and on the floor of the House. After concluding its discussion, the House shall file the Opinion. The House may adopt a resolution requesting the Council on Ethical and Judicial Affairs to reconsider or withdraw the Opinion.

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(c) Intervene with respect and compassion when a colleague is not able to practice safely. Such intervention should strive to ensure that the colleague is no longer endangering patients and that the individual receive appropriate evaluation and care to treat any impairing conditions.

(d) Protect the interests of patients by promoting appropriate interventions when a colleague continues to provide unsafe care despite efforts to dissuade them from practice.

(e) Seek assistance when intervening, in keeping with institutional policies, regulatory requirements, or applicable law.

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

(f) Encouraging the development of practice environments that promote collegial mutual support in the interest of patient safety.

(g) Encouraging development of inclusive training standards that enable individuals with disabilities to enter the profession and have safe, successful careers.

(h) Eliminating stigma within the profession regarding illness and disability.

(i) Advocating for supportive services and accommodations to enable physicians who require assistance to provide safe, effective care.

(j) Advocating for respectful and supportive, evidence-based peer review policies and practices that will ensure patient safety and practice competency. (II)

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 1-N-21

Subject: Drug Shortages: 2021 Update

Presented by: Alexander Ding, MD, MS, MBA, Chair

INTRODUCTION

American Medical Association (AMA) Policy H-100.956, "National Drug Shortages," directs the Council on Science and Public Health (CSAPH) to continue to evaluate the drug shortage issue and report back at least annually to the House of Delegates (HOD) on progress made in addressing drug shortages in the United States. This report provides an update on continuing trends in national drug shortages and ongoing efforts to further evaluate and address this critical public health issue.

METHODS

English-language reports were selected from a PubMed and Google Scholar search from September 2018 to August 2021, using the text term "drug shortages." Additional articles were identified by manual review of the references cited in these publications. Further information was obtained from the Internet sites of the U.S. Food and Drug Administration (FDA), National Academies of Sciences, Engineering, and Medicine (NASEM), U.S. Department of Health and Human Services (HHS), American Society of Health-System Pharmacists (ASHP), Duke Margolis Center for Health Policy, and by direct contact with key FDA, ASHP, and University of Utah Drug Information Service (UUDIS) staff who monitor drug shortages and related issues daily.

BACKGROUND

CSAPH has issued eleven reports on drug shortages.[1-11] The findings and conclusions of the first five reports are summarized in CSAPH Report 2-I-15, "National Drug Shortages: Update."[4] The remainder of this informational report will provide an update on drug shortages since the 2020 report was developed, specifically commenting on issues associated with the drug supply chain that lead to drug shortages.

CURRENT TRENDS IN DRUG SHORTAGES

Drug shortages remain an ongoing public health concern in the United States and the AMA continues to monitor the situation and take action when appropriate. Overall, new drug shortages are decreasing; however, a large number of shortages are still ongoing and pose continued problems for patient care. Additionally, new shortages may occur as manufacturing capacity in the pharmaceutical industry is prioritized during the continuing COVID-19 public health emergency, specifically for the production of COVID-19 vaccines and treatments.

The two primary data sources for information on drug shortages in the United States continue to be the Drug Shortage Program at the FDA and the Drug Shortage Resource Center maintained by ASHP in cooperation with the UUDIS (see Box 1 for links to these resources).[12,13]

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ASHP and UUDIS

According to the most recent data compiled by ASHP and UUDIS, provided in Appendix 1 of this report, there were 129 new shortages reported in 2020 and 38 new shortages reported as of June 30, 2021; this is compared to the 166 new shortages reported for 2019. The number of active drug shortages has decreased to 236 in the second quarter of 2021 from 271 in quarter one of this year. In 2019, 39 percent of shortages were in injectable drugs; this increased to 50 percent in 2020 and is currently at 47 percent for 2021. The top five classes of drugs implicated in active drug shortages include CNS medications (43); cardiovascular medications (31); antimicrobials (26); chemotherapy agents (19); and hormonal agents (19).[14]

The reasons for drug shortages vary and unknown/unreported reasons account for 57 percent of drug shortages in 2020, down from 82 percent in 2019 (See Appendix for ASHP/UUDIS data).[14] In the past year, significantly more suppliers did provide a reason for shortages. Additionally, "business decision" is included as a reason in 2020, with 14 percent of manufacturers reporting this as the reason for a shortage.

The ASHP Shortage Resource Center provides a list of shortages, guidance on managing critical shortages, as well as shortage metrics (Box 1).[12]

FDA

The FDA continues to utilize a mobile app to provide up-to-date access to information about drugs in shortage as well as notifications about new and resolved drug shortages. This mobile app also gives physicians the ability to report a drug shortage. The FDA Drug Shortages webpage includes a current shortages list, a link to the mobile app, and additional information (Box 1).[13]

The eighth annual report on drug shortages from the FDA to Congress published in early 2021 summarizes the major actions the FDA took in calendar year 2020 related to drug shortages.[15] During the COVID-19 pandemic in 2020, FDA continued to closely monitor the medical product supply chain and, as expected, the supply chain was impacted by the pandemic, leading to supply disruptions or shortages of drug products in the United States. Appendix 2 includes a breakdown of the FDA's calendar year 2020 metrics, including the number of expedited reviews (471) and expedited inspections (19).[15]

The Coronavirus Aid, Relief, and Economic Security Act (CARES Act) was signed into law on March 27, 2020, to aid response efforts to the COVID-19 pandemic and to ease the economic impact of COVID-19.[16] In addition, the CARES Act amended the Federal Food, Drug, and Cosmetic Act (FD&C Act) to include authorities intended to enhance FDA's ability to identify, prevent, and mitigate possible drug shortages by, among other things, enhancing FDA's view into drug supply chains.[17] Specific authorities to enhance FDA's ability to identify, prevent, and mitigate drug shortages took effect on September 23, 2020 and include the following:[18]

- Amendments to expand the requirement for manufacturers of certain drugs to provide information on permanent discontinuances and interruptions in manufacturing that may lead to a meaningful disruption in supply to FDA.
- Amendments to require FDA to prioritize and expedite, as appropriate, the review of certain applications and inspections that could help mitigate or prevent a shortage of a drug covered by section 506C(a).
- The addition of a section of the code of federal regulations requiring manufacturers of drugs described in section 506C(a) of the FD&C Act or of any active pharmaceutical ingredient (API) or any associated medical device used for preparation or administration

included in the drug to develop, maintain, and implement, as appropriate, a redundancy risk management plan that identifies and evaluates the risks to the supply of the drug, as applicable, for each establishment in which the drug or API of the drug is manufactured.

- Amendments to require drug manufacturers registered under section 510 of the FD&C Act to annually report on the amount of each drug that they have "manufactured, prepared, propagated, compounded, or processed" for commercial distribution.

DRUG SHORTAGES AND COVID-19

The FDA reports that it has been closely monitoring the supply chain with the expectation that the COVID-19 pandemic would likely impact the medical product supply chain, including potential disruptions to supply or shortages of critical medical products in the United States. The COVID-19 pandemic has also increased the risks of shortages due to sudden increases in demand for drugs used in hospitalized patients, particularly the most critically ill. To respond to this risk, Drug Shortage Staff within the FDA's Center for Drug Evaluation and Research (CDER) has asked manufacturers to evaluate their entire supply chain, including key starting materials, APIs, finished dose forms, packaging components, and any other components that may be impacted in any area of the supply chain due to the COVID-19 outbreak.

FDA reports proactively reaching out to manufacturers as part of an approach to identify potential disruptions or shortages and notes that the Agency will use all available tools to react swiftly and mitigate the impact to U.S. patients and health care professionals when a potential disruption or shortage is identified.

Actemra/RoActemra (tocilizumab)

Recently, Roche reported that the demand for Actemra/RoActemra (tocilizumab), a drug widely used to treat hospitalized patients with severe or critical COVID-19 around the world, has increased to unprecedented levels globally.[19] Actemra/RoActemra is not approved for the treatment of COVID-19 in any country but was recently granted an Emergency Use Authorization in the United States for hospitalized adults and pediatric patients (2 years of age and older) who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO).[20] Additionally, tocilizumab has also now been included in the World Health Organization (WHO) Therapeutics and COVID-19 Living Guideline, based on the body of evidence that has been generated throughout the last 18 months. A statement from Roche acknowledges the increase in demand and the global shortage of the drug and also details the company's efforts to minimize the impact of global supply constraints.[19] ASHP has developed an information sheet regarding the tocilizumab shortage.[21]

DRUG SUPPLY CHAIN AND DRUG SHORTAGES

Over the last several years, natural disasters, quality problems, manufacturer consolidation, and other issues have disrupted pharmaceutical manufacturing and have left the U.S. healthcare system on the brink of a significant public health crisis multiple times. The COVID-19 public health emergency further underscored the vulnerability of our nation's healthcare supply chain and stress-tested supply chains, highlighting the fragilities and deficiencies.

Considerable attention has been focused on supply chain resilience in the past several months. This year, the FDA has published several guidance documents related to supply chain security,[22] the White House released a report and fact sheet on policies to support the creation of resilient supply

chains,[23,24] and The Duke-Margolis Center for Health Policy and the COVID Collaborative released a new white paper on challenges and potential solutions for resilient drug supply chains that complements the White House reports.[25] All of these publications address aspects of AMA policy regarding drug shortage, including calls for increased transparency, global cooperation, resiliency and redundancy in manufacturing capability, and the creation of a quality rating system.

CURRENT AMA DRUG SHORTAGE ACTIVITIES

AMA staff continue to remain engaged in drug shortage activities. Staff are involved in a multi-stakeholder effort to remain current on policies, drug shortage and supply chain issues, and to develop group recommendations on the topics. The effort includes the AMA, the ASHP, the American Hospital Association (AHA), the United States Pharmacopeia (USP), the American Society of Anesthesiologists (ASA), and the American Society of Clinical Oncology (ASCO). Earlier this year, the group sent a letter to the Secretary of Health and Human Services and leaders in the office of the Assistant Secretary for Preparedness and Response (ASPR) offering to assist the administration in its efforts to improve our nation's healthcare supply chains and specifically noting that:

> For a number of years, we have worked collaboratively to address drug shortages. Recently, our organizations have begun developing consensus recommendations on a number of other supply chain issues, including Strategic National Stockpile (SNS) enhancement, visibility into supply chains, quality and manufacturing improvement (e.g., reducing contamination in finished pharmaceuticals), and medical supply and medical device supply chain reinforcement. We would welcome the opportunity to meet with you to share these recommendations, which are drawn from our members' expertise and their real-world experience with utilizing complex, and sometimes fragile, medical supply chains. We greatly appreciate the work ASPR and FDA are already undertaking on EO 14017, and we look forward to continuing to work closely with you.

SUMMARY

The rate of new medical product shortages is decreasing, but the current COVID-19 public health emergency requires continued diligence in monitoring any shortage or supply chain issues due to manufacturing capacity prioritization for COVID-19 vaccines and treatments.

The AMA's drug shortage policy is timely and already addresses a variety of issues that are under consideration by the White House, FDA, and other stakeholders including the improvement of quality assurance systems; expedited facility inspections and manufacturing changes/improvements; necessary resiliency and redundancy in manufacturing capability; evaluation of root causes of drug shortages; transparent analysis of economic drivers and reasonable and sustainable payment rates for prescription drugs; greater transparency of the manufacturing process; and including drug manufacturing sites as part of the nation's critical infrastructure plan. Therefore, the Council feels that an update to AMA policy is not warranted at this time.

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Box 1. Resources available to assist in mitigation of drug shortages.

1. ASHP Resource Center
2. ASHP list of current shortages
3. FDA Drug Shortages Page (includes current shortages list, mobile app, and additional information)

APPENDIX 1

ASHP/University of Utah Drug Information Service Drug Shortage Data

Figure 1.

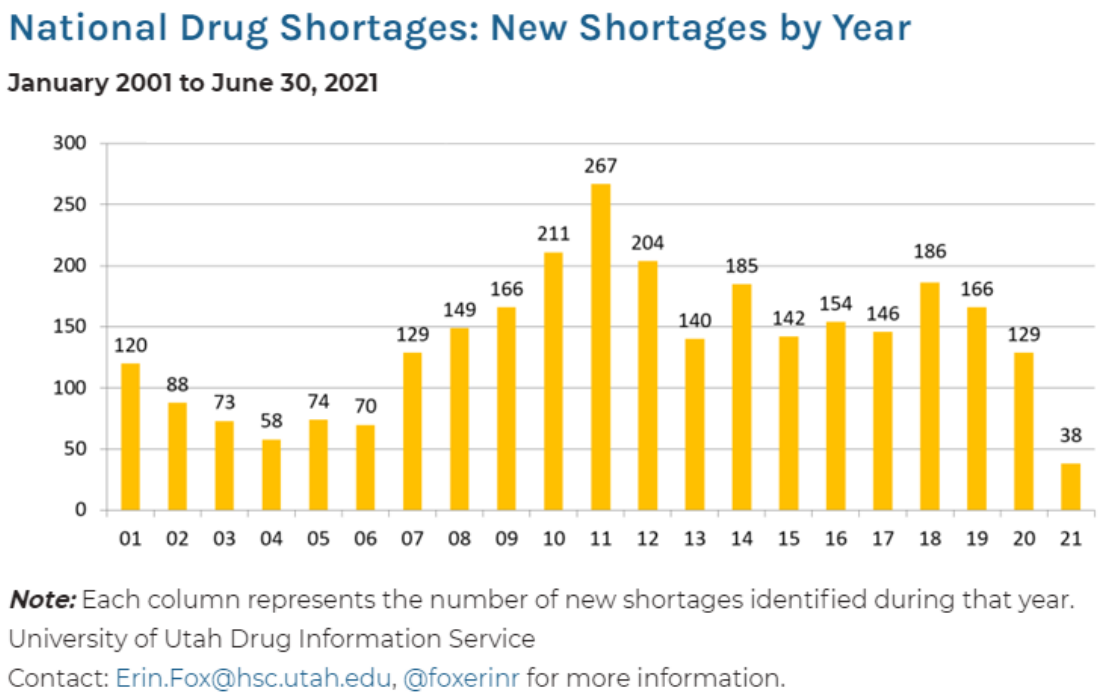


Figure 2.

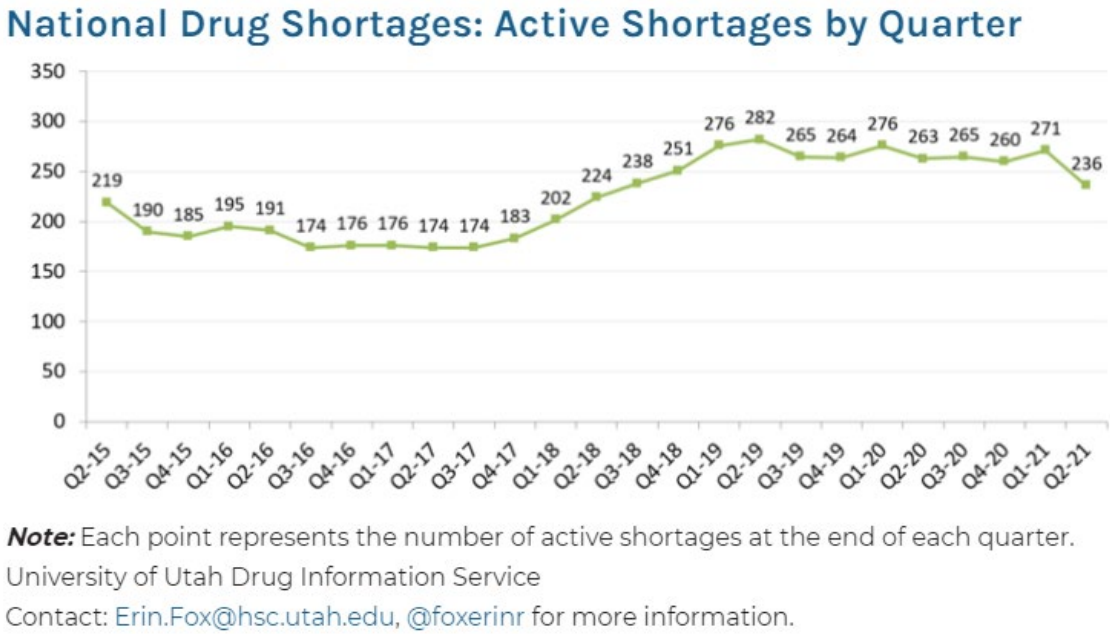


Figure 3.

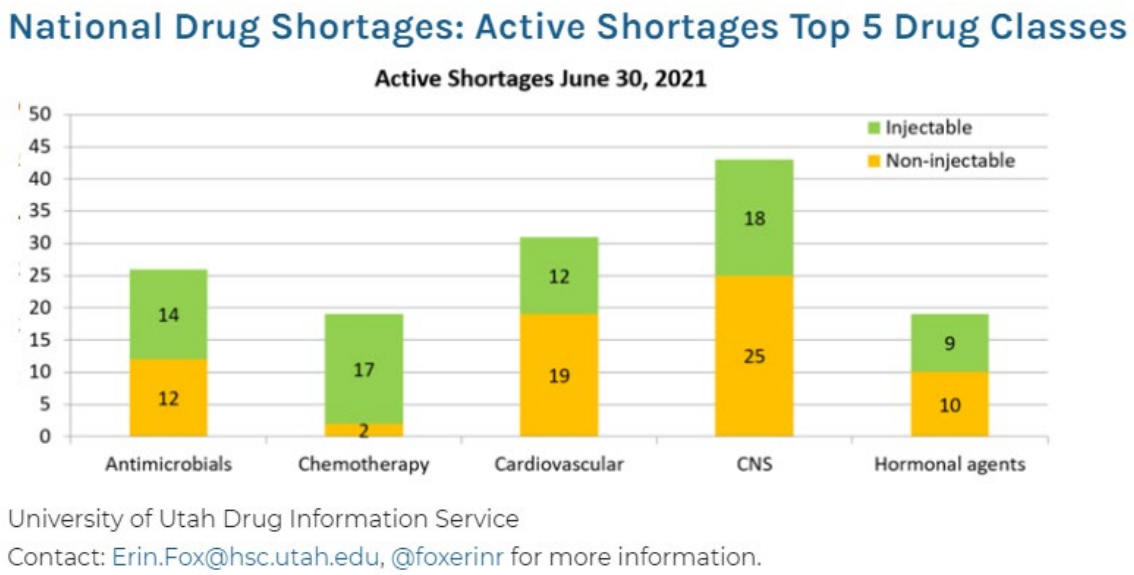
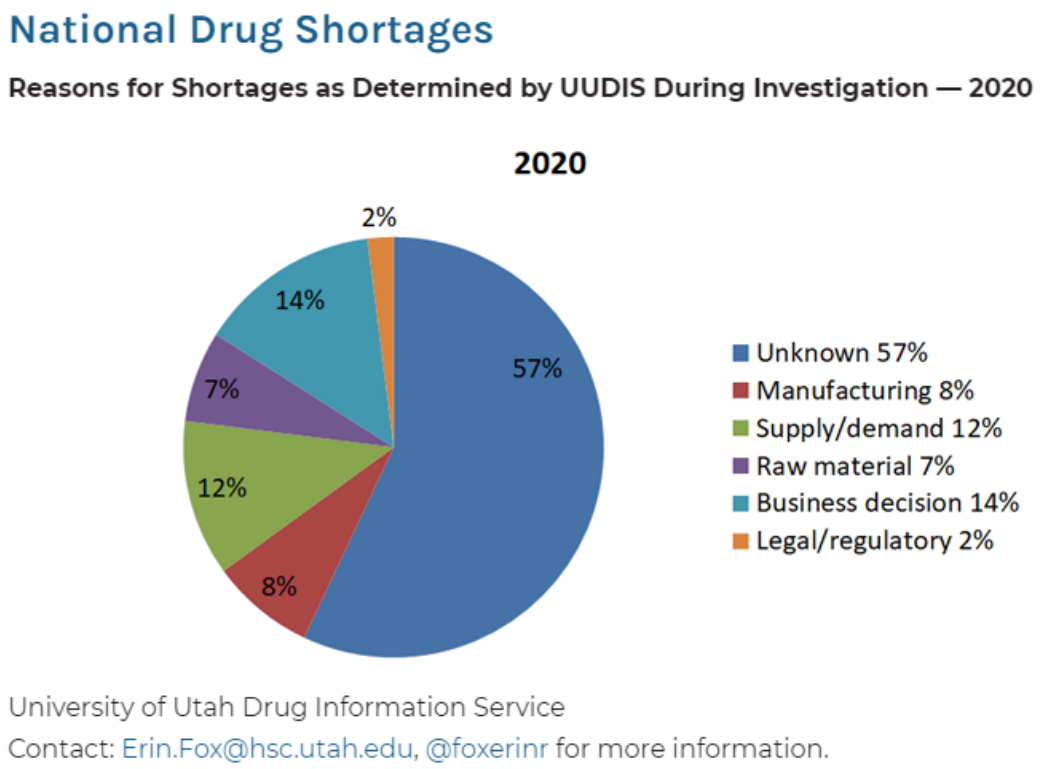


Figure 4.



APPENDIX 2

FDA Drug Shortage Data

Breakdown of CDER's and CBER's Shortage Numbers, CY 2020

	CDER	CBER
New Shortages	43	0
Prevented Shortages	179	20
Ongoing Shortages	78	8
Notifications	473	39
No. of Manufacturers Notifying	93	29
ACTIONS TAKEN TO MITIGATE SHORTAGES		
Regulatory Flexibility and Discretion	110	1
Expedited Reviews	471	18*
ExpeditedInspections	19	0

* This number includes expedited reviews for nine biologics license application (BLA)/BLA supplements and nine lot-release submissions for CBER-regulated products.