November 2021 Medical Student Section (MSS) Meeting
Virtual
November 5-7

Policy Materials

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 01
(N-21)

Introduced by: Anna Heffron, MSS Section Delegate, on behalf of the MSS Governing Council

Sponsored by: n/a

Subject: Amending AMA Bylaw 2.12.2, Special Meetings of the House of Delegates

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, During the ongoing COVID-19 pandemic, our AMA has conducted three meetings of the House of Delegates as Special Meetings, and the November 2021 meeting is also a Special Meeting; and

Whereas, These Special Meetings have played a critical role in allowing for our House to adopt policy on key issues such as health equity, telemedicine, and health system reform even under the extenuating circumstances of the pandemic[1-3]; and

Whereas, Each of the four recent Special Meetings has involved the introduction of new procedures or alterations of procedures for that meeting; and

Whereas, Though tremendous efforts have been made at each Special Meeting to ensure the meetings are useful to our organization, many Delegates have concerns about the procedures employed, including but not limited to: (1) procedures used in the Special Meeting were not described fully prior to the meetings, (2) some procedures were kept confidential from Delegates, (3) the House was not made aware of any formally established mechanisms by which concerns could be relayed to leadership, (4) there was no independent oversight of these concerns; and

Whereas, New procedures regulating consideration of items of business has resulted in an unprecedented backlog of policies awaiting consideration by the House of Delegates; and

Whereas, Our AMA had never held a virtual House of Delegates prior to June 2020, and our Bylaws on Special Meetings were most recently amended at the Interim Meeting in 2009[4,5]; and

Whereas, The uncertain course of the COVID-19 pandemic and other natural disasters and national events raise the likelihood that Special Meetings may be imminently necessary in our AMA's future proceedings; and

Whereas, Our AMA supports individual member participation (G-625.011) and feedback to leadership by members (G-635.011) and Delegates (G-600.031); and

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Whereas, Our AMA has precedent for the creation and release of as-needed reports (G-635.125, G-605.051); therefore be it

RESOLVED, That our AMA update its Special Meeting procedures by amending Bylaw 2.12.2 as follows:

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.

2.12.2.1 Business. A complete description of the processes used to determine which items of business meet or do not meet the purpose for which the Special Meeting is called shall be published online and electronically sent to all members of the House of Delegates no later than 10 days after the announcement of the Special Meeting.

2.12.2.1.1 Procedures. Prior to deciding the procedures that will govern a Special Meeting, the Speakers shall send proposed procedures to and solicit input and concerns from the Chair of each Delegation and Section Governing Council. The Chairs shall have at least 5 days to return any concerns or comments regarding the proposed procedures.

2.12.2.1.2 Review. Formal feedback and review procedures shall be established and publicized for delegates to provide input on Special Meeting proceedings at the outset and conclusion of each Special Meeting.

2.12.2.2 Reports. Within 60 days of the adjournment of a Special Meeting, the Speakers, in collaboration with the Board of Trustees, shall release a report detailing the participation in the meeting, including the number of resolutions submitted and considered, a summary of the concerns and suggestions submitted via the formal feedback mechanism, and any other metrics or data deemed relevant, with comparisons to the most recent Interim and Annual Meetings, for the purpose of monitoring and continuously improving Special Meeting procedures.

2.12.2.3 Review. Within 60 days of the adjournment of a Special Meeting, a Committee whose composition reflects that of the House shall be convened for the purpose of (1) reviewing the Special Meeting and (2) proposing any improvements to the processes for future Special Meetings. This report shall be distributed to delegates prior to the next meeting of the House of Delegates.

; and be it further

RESOLVED, That our AMA-MSS immediately forward this resolution to the House of Delegates at the November 2021 meeting.

Fiscal Note: TBD

Date Received: 09/15/2021

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2. O'Reilly KB. Highlights from the June 2021 AMA Special Meeting. Published June 17, 2021. Accessed September 14, 2021. Online: https://www.ama-assn.org/house-delegates/special-meeting/highlights-june-2021-ama-special-meeting
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RELEVANT AMA AND AMA-MSS POLICY

Membership and Governance G-635.005
The House affirms that the AMA shall remain an association of voluntary, individual medical student and physician members and that the Association shall continue to be individually funded and organizationally governed through representation in the HOD.
Report of the Committee on Organization of Organizations, A-03Reaffirmed: CCB/CLRPD Rep. 3, A-12

Statement of Collaborative Intent G-620.030
(1) The AMA House of Delegates endorses the following preamble of a Statement of Collaborative Intent: The Federation of Medicine is a collaborative partnership in medicine. This partnership is comprised of the independent and autonomous medical associations in the AMA House of Delegates and their component and related societies. As the assemblage of the Federation of Medicine, the AMA House of Delegates is the framework for this partnership. The goals of the Federation of Medicine are to: (a) achieve a unified voice for organized medicine;
(b) work for the common good of all patients and physicians;
(c) promote trust and cooperation among members of the Federation; and
(d) advance the image of the medical profession; and (e) increase overall efficiency of organized medicine for the benefit of our member physicians.

(2) The AMA House of Delegates endorses the following principles of a Statement of Collaborative Intent: (a) Organizations in the Federation will collaborate in the development of joint programs and services that benefit patients and member physicians.
(b) Organizations in the Federation will be supportive of membership at all levels of the Federation.
(c) Organizations in the Federation will seek ways to enhance communications among physicians, between physicians and medical associations, and among organizations in the Federation.
(d) Each organization in the Federation of Medicine will actively participate in the policy development process of the House of Delegates.
(e) Organizations in the Federation have a right to express their policy positions.

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(f) Organizations in the Federation will support, whenever possible, the policies, advocacy positions, and strategies established by the Federation of Medicine.
(g) Organizations in the Federation will support an environment of mutual trust and respect.
(h) Organizations in the Federation will inform other organizations in the Federation in a timely manner whenever their major policies, positions, strategies, or public statements may be in conflict.
(i) Organizations in the Federation will support the development and use of a mechanism to resolve disputes among member organizations.
(j) Organizations in the Federation will actively work toward identification of ways in which participation in the Federation could benefit them.
CLRPD/CEJA/C&B Report, A-97Consolidated: CLRPD Rep. 3, I-01 Modified: BOT Rep. 23, A-02Modified: CCB/CLRPD Rep. 3, A-12

Function, Role and Procedures of the House of Delegates G-600.011
The function and role of the House of Delegates includes setting policy on health, medical, professional, and governance matters, as well as the broad principles within which AMA's business activities are conducted. The Board of Trustees is vested with the responsibility for the AMA's business strategy and the conduct of AMA affairs. Our AMA adopts the *AMA House of Delegates Reference Manual: Procedures, Policies and Practices* as the official method of procedure in handling and conducting the business before the AMA House of Delegates.
CCB/CLRPD Rep. 3, A-12

Participation of Individual Members in our AMA G-635.011
Our AMA supports individual member, two-way electronic communications that promote active grassroots discussion of timely issues; regular feedback for AMA leadership; and a needed voice for diverse ideas and initiatives from throughout the Federation. AMA members are encouraged to participate in the activities of the AMA, particularly in the following ways: (1) Though the AMA website or other communications conduits, provide comments and suggestions to the AMA Board and the AMA Councils on their policy development projects and on other AMA products and services; (2) Participate in the on-line discussion groups on the items of business included in the Handbook of the House of Delegates; (3) Communicate their views on the items of business in the House's Handbook to their AMA delegates and alternate delegates; (4) Inform the AMA, directly or through their AMA delegates, of situations that may represent opportunities to implement the Association's policy positions; (5) Help the AMA promote its policy positions; (6) When opportunities present themselves, explain the value of the AMA and the importance of belonging to the AMA to physicians; and (7) Work to help the AMA increase its membership level.
CCB/CLRPD Rep. 3, A-12

AMA Goals, Roles, and Obligations G-625.011
Our AMA: (1) reaffirms its goal to be the unified voice of the medical profession speaking for all physicians, and, (2) above all, affirms its role and obligations as a steward of our professional values, as well as the right and obligation of individual physicians to participate in the process.
Consolidated: CLRPD Rep. 3, I-01 Reaffirmed: BOT Rep. 35, A-08 Reaffirmed: CCB/CLRPD Rep. 3, A-12

Roles and Responsibilities of AMA Delegates and Alternate Delegates G-600.031
(1) 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

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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 email addresses so that the AMA can make the information accessible to individual members through the AMA Web site and through other communication mechanisms. (2) The roles and responsibilities of delegates and alternate delegates are as follows: (a) regularly communicate AMA policy, information, activities, and programs to constituents so he/she will be recognized as the representative of the AMA; (b) relate constituent views and suggestions, particularly those related to implementation of AMA policy positions, to the appropriate AMA leadership, governing body, or executive staff; (c) advocate constituent views within the House of Delegates or other governance unit, including the executive staff; (d) attend and report highlights of House of Delegates meetings to constituents, for example, at hospital medical staff, county, state, and specialty society meetings; (e) serve as an advocate for patients to improve the health of the public and the health care system; (f) cultivate promising leaders for all levels of organized medicine and help them gain leadership positions; and (g) actively recruit new AMA members and help retain current members.
Special Advisory Committee to the Speaker of the House of Delegates, I-99 Consolidated: CLRPD Rep. 3, I-01 Modified: Jt. Rep. of the BOT and CLRPD, A-02 Reaffirmed: CCB/CLRPD Rep. 3, A-12 Modified: Speakers Rep., I-18

Ancillary Meetings and Conferences of the House G-600.090
The Speakers of our AMA House must be notified prior to any planning for ancillary meetings and conferences to be scheduled in conjunction with the Annual or Interim Meetings of the House of Delegates in sufficient time to assess the impact of the timing and purpose on the deliberations of the House of Delegates. Prior approval of the Speaker and Vice Speaker is required before any meeting other than regular meetings of AMA Councils, Committees, Sections, and other groups that are part of the formal structure of our AMA can be scheduled in conjunction with Meetings of the House of Delegates.
Rep. on Rules and Credentials, A-93Consolidated: CLRPD Rep. 3, I-01Reaffirmed: CC&B Rep. 2, A-11Reaffirmed: Joint CCB/CLRPD Rep. 1, A-21

AMA Membership Demographics G-635.125
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.
BOT Rep. 26, A-10Reaffirmed: CCB/CLRPD Rep. 3, A-12Appended: Res. 603, A-17

Greater Involvement of Medical Students in Federation Organizations G-620.050

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Our AMA encourages medical societies to provide mechanisms for more direct involvement of students at the state and local levels, and to implement membership options for their state's medical students who are enrolled in medical school for longer than four years. Our AMA will work with the Association of American Medical Colleges to promote medical student engagement in professional medical societies, including attendance at local, state, and national professional organization meetings, during the pre-clinical and clinical years.
CCB/CLRPD Rep. 3, A-12

Data Used to Apportion Delegates G-600.016
1. Our AMA shall issue an annual, mid-year report on or around June 30 to inform each state medical society and each national medical specialty society that is in the process of its 5-year review of its current AMA membership count.

2. "Pending members" (defined as individuals who at the time they apply for membership are not current in their dues and who pay dues for the following calendar year) will be added to the number of active AMA members in the December 31 count for the purposes of AMA delegate allocations to state medical societies for the following year and this total will be used to determine the number of national medical specialty delegates to maintain parity.

3. Our AMA will track “pending members” from a given year who are counted towards delegate allocation for the following year and these members will not be counted again for delegate allocation unless they renew their membership before the end of the following year.

4. Our AMA Board of Trustees will issue a report to the House of Delegates at the 2022 Annual Meeting on the impact of Policy G-600.016 and recommendations regarding continuation of this policy.
BOT Rep. 01, I-18 Modified: BOT Rep. 12, A-19Modified: CCB Rep. 3, I-19

Situational Reporting Responsibilities of the AMA Board of Trustees G-605.051
The Board of Trustees provides reports to the House when the following situations occur:

(1) the Board submits a report to the House when the Board takes actions that differ from current AMA policy;

(2) consistent with AMA Bylaws, the Board submits a report to the House when the Board determines that the expenditures associated with recommendations and resolves that were adopted by the House would be inadvisable;

(3) consistent with AMA Bylaws, the Board transmits reports of the SSS to the House and informs the House of important developments with regard to Federation organizations; and

(4) consistent with Policy G-630.040, the Board reports to the House when the Board's review of the AMA's Principles on Corporate Relationships results in recommendations for changes in the Principles.

In fulfilling its responsibilities to report to the House when certain specified situations develop, the Board should provide succinct reports to the House and, if additional detail is needed, use the AMA web site to provide the additional information to interested members of the House.
CLRPD Rep. 1, A-03 Modified: CCB/CLRPD Rep. 3, A-12

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Improving Medical Student, Resident/Fellow and Academic Physician Engagement in Organized Medicine and Legislative Advocacy G-615.103
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

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 02
(N-21)

Introduced by: Leah Azab, Leelakrishna Channa, Rodolfo Valenti, Colline Wong, University of Connecticut; Fathima Haseefa, University of Arizona; Anjali Kalra UT Southwestern Medical School; Shandis Fancher, McGovern Medical School; Sanjana Satish, University of Miami Miller Medical School

Sponsored by: Region 3, PsychSIGN

Subject: A Response to Human Trafficking Amid a Public Health Emergency

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, Human trafficking is widely regarded as a public health crisis[1–5]; and

Whereas, It is estimated that between 57,000 and 403,000 people are currently being trafficked across the United States, and around 300,000 are at risk for sexual exploitation[6]; and

Whereas, In 2019, 11,500 trafficking situations were reported affecting over 20,000 victims[7], and from 2019 to 2020, the number of crisis trafficking situations increased by more than 40%[8]; and

Whereas, Disease outbreaks are associated with more individuals, especially women and children with low socioeconomic status[9–12], being at risk of trafficking as a result of disrupted families, and increased trafficking outflow at sites of disease outbreak[13–15]; and

Whereas, Other public health emergencies, such as floods and earthquakes, are also associated with an uptick in the number of individuals being trafficked[16,17]; and

Whereas, Stay-at-home orders during the COVID-19 pandemic are associated with increased risk of individuals being trafficked due to a lack of employment opportunities, increased debts, barriers in travel, difficulties accessing social services, and higher rates of intimate partner violence, child abuse, and childhood sexual explotation[1,3,18]; and

Whereas, The current pandemic has negatively impacted trafficked individuals, as they are more likely to live in areas with high COVID-19 rates, and are increasingly at risk of being put in situations with abusers where they can contract COVID-19[18,19]; and

Whereas, Trafficking victims experience numerous health consequences requiring medical attention, including depression, anxiety, memory loss, urinary tract infections, malnutrition, HIV, and substance dependence[20–24]; and

Whereas, Human trafficking victims seek healthcare at least once while being trafficked, with more than half of those visits at the emergency department[20,25–28]; and

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Whereas, In a survey of 500 residents, less than 10% thought that they had come in contact with a trafficking victim[29]; and

Whereas, Medical professionals are in a privileged position to identify red flags and health presentations of human trafficking victims, and trafficking victims may be more likely to talk to medical staff than police[20,27,30]; and

Whereas, The COVID-19 pandemic has made it even more challenging for healthcare providers to identify trafficked individuals due to overcrowded emergency rooms, and safety protocols such as PPE and telehealth visits make it difficult to build strong relationships with patients and identify body language indicative of abuse[1,18]; and

Whereas, Vulnerable populations who are trafficked, including youth and those experiencing homelessness, are less likely to disclose, without prompting, their exploitation due to fear of authorities and stigma associated with human trafficking[18]; and

Whereas, There are brief screening tools available for specific subsets of the population, but the tools are not widely implemented, validated, or applicable to the general population[31–36]; and

Whereas, The single screening question "Were you [or anyone you work with] ever beaten, hit, yelled at, raped, threatened or made to feel physical pain for working slowly or for trying to leave?", presented in the emergency department, was successful at identifying victims of human trafficking and was shown to be more successful than physician concern alone[31]; and

Whereas, A confidentially administered, six-item screening tool has been used to accurately identify sex trafficking among minors with a sensitivity of 84.6% and specificity of 53.2% in the pediatric emergency department setting[32]; and

Whereas, The Quick Youth Indicators for Trafficking 5 question screening tool for homeless youth has been shown to have 87% sensitivity and 76% specificity in identifying trafficking victims when one or more questions are positive, even when administered by an individual not trained in identifying human trafficking[33]; and

Whereas, The first comprehensive and validated human trafficking screening tool, Vera Institute's Trafficking Victim Identification Tool, is difficult to administer due to it's length of 45 minutes and requirement of admnistration by a trained social worker, and a validated tool for identifying trafficking in the healthcare setting, the Greenbaum Tool, is only applicable to 10-18 year olds with specific clinical presentations[34-36]; and

Whereas, The United States Department of State reported comprehensive funding cuts towards victim-support services due to COVID-19, and global access to resources commonly provided by anti-sex trafficking organizations such as shelter, food, water and legal representation decreased significantly, along with a 73% and 64% decrease in access to medical and psychological services respectively[1,37]; and

Whereas, Relevant stakeholders have recently emphasized the need for increased resources at the federal and state level for medical treatment, behavioral treatment, and medications for trafficked individuals[8,38,39]; and

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Whereas, AMA policy D-170.992 addresses studying the effectiveness of physician education on identifying and reporting human trafficking victims, but has not addressed the ability, or lack thereof, of physicians to treat trafficking victims during a public health emergency; and

Whereas, AMA policies D-170.992 and H-65.966 support education and training of physicians and medical students on how to identify and treat human trafficking victims but are currently lacking on the best method and frequency with which to screen individuals, despite the numerous screening tools and protocols available; therefore be it

RESOLVED, Our AMA will collaborate with relevant stakeholders to encourage the development and implementation of a brief standardized screening measure to identify trafficking victims in the healthcare setting; and be it further

RESOLVED, Our AMA urges that funding for medical and behavioral treatment for trafficking victims be expanded during the COVID-19 pandemic and during any future public health emergencies.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

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

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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.
(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)

Distribution and Display of Human Trafficking Aid Information in Public Places H-440.814
1. Our AMA policy is that readily visible signs, notices, posters, placards, and other readily available educational materials providing information about reporting human trafficking activities or providing assistance to victims and survivors be permitted in local clinics, emergency departments, or other medical settings.

2. Our AMA, through its website or internet presence, will provide downloadable materials displaying the National Human Trafficking Hotline number to aid in displaying such information in local clinics, emergency departments, or other medical settings and advocate that other recognized medical professional organizations do the same.

3. Our AMA urges the federal government to make changes in laws to advocate for the broad posting of the National Human Trafficking Hotline number in areas such as local clinics, emergency departments, and other medical settings.
(Res. 023, A-19)

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)

The Identification and Protection of Human Trafficking Victims 515.008MSS
AMA-MSS
(1) supports the development of educational initiatives to train medical students, residents and physicians to understand their role in treating and screening for human trafficking in suspected patients;
(2) supports AMA encouragement of editors and publishers of medical training literature to include indications that a patient might be a victim of human trafficking and suggested screening questions as created by Department of Health and Human Services;
(3) Supports the AMA working with the Department of Health and Human Services, and law enforcement agencies to develop guidelines for use in hospital and office settings in order to better identify victims of human trafficking and to provide a conduit to resources that can better address all of the victim's medical, legal and social needs; and
(4) encourages physicians to act as first responders in addressing human trafficking.

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MSS Res 19, A-12; Reaffirmed: MSS GC Report A, I-17

Improving the Health and Safety of Consensual Sex Workers 440.071MSS
AMA-MSS will ask the AMA to
(1) recognize the adverse health outcomes of criminalizing consensual sex work;
(2) support legislation that decriminalizes individuals who exchange sex for money or goods;
(3) oppose legislation that decriminalizes sex buying and brothel keeping;
(4) support the expungement of criminal records of those previously convicted of sex work, including trafficking survivors; and
(5) support research on the long-term health, including mental health, impacts of decriminalization of the sex trade.

MSS Res 05, A-19; Appended: MSS CGPH Report A, I-19

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 03
(N-21)

Introduced by: Kevin Lam, Sarah Marks, Virginia Commonwealth University School of Medicine; Katie O'Connell, Eastern Virginia Medical School; Garrett Smith, University of South Carolina School of Medicine Greenville

Sponsored by: Region 2, Region 6, Region 7

Subject: Elimination of sobriety requirements in evaluation for liver transplant for alcohol-associated liver dysfunction

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, In 2017, liver cirrhosis was the 11th leading cause of death in the United States (over 44,000 deaths), and among all cirrhosis deaths, 50% were alcohol associated[1]; and

Whereas, From 2010 to 2016, alcohol-associated liver disease was the primary cause of nearly 1 in 3 liver transplants in the United States, replacing hepatitis C virus infection as the leading cause of liver transplantation due to chronic liver disease[2-3]; and

Whereas, Liver transplants in patients presenting with life-threatening severe alcoholic hepatitis due to alcohol-associated liver dysfunction without 6-month sobriety have major improvements in mortality (1 year survival of 94% compared with a 6-month predicted survival of less than 20%) with low post-transplant alcohol relapse rates[4]; and

Whereas, Patients suffering from either severe acute alcoholic hepatitis or acute-on-chronic liver failure and not responding to medical therapy have high 3-month mortality rates ranging from 60%-70%, even reaching as high as 90% within the first year[6]; and

Whereas, The justification for the 6-month rule in 1997 at the conference of the American Association for the Study of Liver Diseases and American Society of Transplantation cited three studies that were confounded by small sample sizes and methodological flaws[7]; and

Whereas, Subsequent studies have failed to show the 6-month rule affects patient survival after liver transplant and instead can be lethal[8]; and

Whereas, Studies have shown that alcohol relapse rates among liver transplant recipients are identical whether or not there is a 6-month wait before transplant if there is careful selection of patients with factors such as a strong social support, awareness of the role of alcohol in their condition, free of severe comorbid psychiatric or comorbid disease[9]; and

Whereas, Transplant centers such as Johns Hopkins University[10] regularly transplant livers into patients with alcohol-related liver disease whose sobriety does not reach the six-month threshold[10] and transplant centers such as the University of California, Los Angeles[11], University

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of Chicago[12], and others consider listing patients without 6-month sobriety after careful selection[13]; and

Whereas, Reluctance to perform liver transplantation in patients with alcohol use disorder is based on the fact that alcoholism is frequently considered to be self-inflicted and due to fears of harmful post-transplant alcoholism recurrence[14]; and

Whereas, Alcohol use disorder is a recognized disease and not a mental failure, diagnosed based on the Diagnostic and Statistical Manual of Mental Disorders, fifth edition, and is due to complex interactions between environmental factors, genetics, psychiatric conditions[15]; and

Whereas, The utilization of abstinence periods unfairly discriminates against a patient population with a specific medical condition[16]; and

Whereas, Despite the widespread adoption of a 6-month rule requiring abstinence prior to liver transplant, this has never been a formal recommendation from the International Liver Transplantation Society[17], the Organ Transplant Procurement Network or European consensus groups[9] likely due the fact that it is an indefensible position from a legal standpoint[18]; and

Whereas, Failure to create national policy on abstinence periods may exacerbate existing inequities and disparities in access to liver transplantation[2]; and

Whereas, The American Academy of Addiction Psychiatry has a policy (Re: Organ Transplantation) in support of the evaluation of a patient's candidacy for organ transplantation based on clinical grounds alone, without an arbitrary length of time for a sobriety period, and substance use and the possibility of future substance use being just one clinical factor in evaluation[19]; and

Whereas, The AMA-MSS has a policy (370.014MSS) in support of removing cannabis as a contraindication for potential organ transplant; and

Whereas, The AMA-MSS has a policy transmittal (440.101MSS) in support of opposing sobriety requirements for hepatitis C treatment; and

Whereas, The AMA has a policy (H- 370.973) in support of the removal of transplant center policy excluding patients maintained on methadone from liver transplant waiting lists and encouraging transplant centers to assess patients maintained on methadone on a case-by-case basis; and

Whereas, The AMA has a policy (H-370.982) in support of ethical considerations in the allocation of organs among patients, stating allocation decisions should respect the individuality of patients and the particulars of individual cases as much as possible; therefore be it

RESOLVED, That our AMA-MSS amend the title of our existing policy 370.019MSS Support for the Use of Evidence-Based Guidelines for Determining Liver Transplant Waiting Periods in Alcohol-Related Liver Disease to be "Use of Evidence-Based Guidelines for Determining Liver Transplant Listing Requirements and Waiting Periods in Alcohol-Associated Liver Dysfunction"; and be it further

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RESOLVED, That our AMA-MSS amend our existing policy 370.019MSS Support for the Use of Evidence-Based Guidelines for Determining Liver Transplant Waiting Periods in Alcohol-Related Liver Disease by addition as follows:

Support for the Use of Evidence-Based Guidelines for Determining Liver Transplant Waiting Periods in Alcohol-Related Liver Disease, 370.019MSS

Our AMA-MSS: (1) supports the use of evidence-based guidelines for determining liver transplant waiting periods in alcohol-associated ~~related~~ liver disease; and (2) supports the elimination of sobriety requirements in the evaluation of patients for liver transplant for alcohol-associated liver dysfunction; and (3) supports the Centers for Medicare and Medicaid Services and Veterans Administration adding to their regulations for transplant hospitals that hospitals cannot exclude alcoholic liver disease-related patients from transplant based on sobriety duration; and (4) works with the American Society of Transplantation, American Society of Transplant Surgeons, and other appropriate stakeholders to add a rule that Organ Procurement and Transplantation Network hospitals cannot discriminate against patients based on the 6-month sobriety requirement.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

Methadone Maintenance and Transplantation H-370.973
Our AMA: (1) urges transplant centers across the nation to abrogate any policies that automatically exclude patients maintained on methadone from liver transplant recipient waiting lists; and (2) encourages transplant centers to assess patients maintained on methadone on a case-by-case basis using medically appropriate criteria supportable by peer-reviewed and published research.
(Res. 405, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20)

Medical, Surgical, and Psychiatric Service Integration and Reimbursement H-345.983
Our AMA advocates for: (1) health care policies that insure access to and reimbursement for integrated and concurrent medical, surgical, and psychiatric care regardless of the clinical

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setting; and (2) standards that encourage medically appropriate treatment of medical and surgical disorders in psychiatric patients and of psychiatric disorders in medical and surgical patients.
(Res. 135, A-99; Reaffirmation: A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: CMS Rep. 6, A-15; Reaffirmation: I-18)

Ethical Considerations in the Allocation of Organs and Other Scarce Medical Resources Among Patients H-370.982
Our AMA has adopted the following guidelines as policy: (1) Decisions regarding the allocation of scarce medical resources among patients should consider only ethically appropriate criteria relating to medical need. (a) These criteria include likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in some cases, the amount of resources required for successful treatment. In general, only very substantial differences among patients are ethically relevant; the greater the disparities, the more justified the use of these criteria becomes. In making quality of life judgments, patients should first be prioritized so that death or extremely poor outcomes are avoided; then, patients should be prioritized according to change in quality of life, but only when there are very substantial differences among patients. (b) Research should be pursued to increase knowledge of outcomes and thereby improve the accuracy of these criteria. (c) Non-medical criteria, such as ability to pay, social worth, perceived obstacles to treatment, patient contribution to illness, or past use of resources should not be considered.

(2) Allocation decisions should respect the individuality of patients and the particulars of individual cases as much as possible. (a) All candidates for treatment must be fully considered according to ethically appropriate criteria relating to medical need, as defined in Guideline 1. (b) When very substantial differences do not exist among potential recipients of treatment on the basis of these criteria, a "first-come-first-served" approach or some other equal opportunity mechanism should be employed to make final allocation decisions. (c) Though there are several ethically acceptable strategies for implementing these criteria, no single strategy is ethically mandated. Acceptable approaches include a three-tiered system, a minimal threshold approach, and a weighted formula.

(3) Decision making mechanisms should be objective, flexible, and consistent to ensure that all patients are treated equally. The nature of the physician-patient relationship entails that physicians of patients competing for a scarce resource must remain advocates for their patients, and therefore should not make the actual allocation decisions.

(4) Patients must be informed by their physicians of allocation criteria and procedures, as well as their chances of receiving access to scarce resources. This information should be in addition to all the customary information regarding the risks, benefits, and alternatives to any medical procedure. Patients denied access to resources have the right to be informed of the reasoning behind the decision.

(5) The allocation procedures of institutions controlling scarce resources should be disclosed to the public as well as subject to regular peer review from the medical profession.

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(6) Physicians should continue to look for innovative ways to increase the availability of and access to scarce medical resources so that, as much as possible, beneficial treatments can be provided to all who need them.

(7) Physicians should accept their responsibility to promote awareness of the importance of an increase in the organ donor pool using all available means.
(CEJA Rep. K, A-93; Reaffirmed: CSA Rep. 12, I-99; Reaffirmed: CSA Rep. 6, A-00; Appended: Res. 512, A-02; Reaffirmed: CEJA Rep. 3, A-12)

Organ Donors and Transplants 370.003MSS
AMA-MSS will ask the AMA to: (1) use public service announcements to enhance the general public's understanding of the procedures surrounding organ donation and transplant and increase the number of people who consent to be organ donors; and (2) research other ways of increasing the organ donor pool. (AMA Res 141, I-87 Referred) (BOT Rep ZZ, A-88 Adopted) (Reaffirmed: MSS Rep D, I-97) (Reaffirmed: MSS Rep B, I-02) (Amended: MSS Rep C, I-07) (Reaffirmed: MSS GC Rep B, I-12) (Reaffirmed: MSS GC Report A, I-17)

Removal of Cannabis as a Relative Contraindication for Potential Organ Transplant 370.014MSS
AMA-MSS opposes utilization of 1) reported marijuana use; and 2) positive cannabis toxicology tests as a relative contraindication for potential organ transplant recipients. (MSS Late Res 3, I-14) (Reaffirmed: MSS GC Rep A, I-19)

Support for the Use of Evidence-Based Guidelines for Determining Liver Transplant Waiting Periods in Alcohol-Related Liver Disease 370.019MSS
AMA-MSS supports the use of evidence-based guidelines for determining liver transplant waiting periods in alcohol-related liver disease. (MSS Res 08, A-18)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 04
(N-21)

Introduced by: Ryan Englander, Brent Heineman, University of Connecticut School of Medicine; Justin Magrath, Tulane University School of Medicine; Sarah Mae Smith, University of California-Irvine School of Medicine.

Sponsored by: Region 1, Region 2, Region 3, Region 7, PsychSIGN

Subject: Movement Away from Employer-Sponsored Health Insurance

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, More than 50% of Americans rely on employer-sponsored health insurance (ESHI), which was first offered as a benefit to attract workers during the wage freeze of WWII[1,2],

Whereas, With health insurance linked to employment, job loss can decrease access to healthcare, including important preventative services and chronic disease management[3,4]; and

Whereas, Economic downturns due to global recessions or pandemics can result in millions of people losing their employer-sponsored health insurance, including an estimated 7 million individuals who have lost ESHI due to the COVID-19 pandemic and associated recession[5-11]; and

Whereas, Due to variation in insurer networks, patients who switch jobs and as a result change their health insurance may have to change doctors, creating a barrier to continuity of care[12,13]; and

Whereas, In 2019, 36% of employers offered only a single health insurance plan and an additional 40% of employers offered only two plans, decreasing patient choice and preventing the functioning of a free market[14-16]; and

Whereas, By linking health insurance to employment, employer-sponsored health insurance creates job lock and decreases entrepreneurship[17,18]; and

Whereas, A 2016 study in the Journal of Economic Perspectives found that people in the bottom fifth of family income receive annual benefits of less than $500, while those in the top fifth receive benefits averaging $4,500, demonstrating that employer-sponsored health insurance tax deduction disproportionately benefits the wealthy[19]; and

Whereas, self-insurance refers to the practice wherein employers collect premiums from employees and pay for healthcare benefits for plan beneficiaries directly, with or without the assistance of third party administrators who may negotiate networks, process claims, and provide other services[20,21]; and

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Whereas, Because of financial and legal incentives that favor the practice, between 75-80% of employers self-insure, meaning that many firms become de facto health insurance companies in addition to the main business activities they are engaged in[22,23]; and

Whereas, Self-insured plans have proven incapable of controlling healthcare costs, with one RAND study focusing on predominantly self-insured employer plans showing that hospital costs increased from 236% of Medicare rates to 241% of Medicare rates in the two year period from 2015-2017[23,24]; and

Whereas, The administrative costs of private, employer-based plans far exceed the administrative costs of public plans in the United States and insurance systems in other industrialized peer nations[25-29]; and

Whereas, The excessively fragmented nature of the employer-sponsored health insurance market in the United States is a significant contributor to the higher costs of medical goods and services in the United States relative to other countries[29-31]; and

Whereas, Multiple different models exist for the provision of health insurance coverage, including systems based wholly on individually owned private insurance plans, the Bismarckian model wherein payroll taxes are used to fund competing nonprofit insurance providers, and the national health insurance model wherein government insurance plans funded by taxes contract with privately owned healthcare providers[32,33]; and

Whereas, All of the assorted health insurance systems employed in other industrialized countries outperform the ESHI-based American insurance system on key metrics such as health outcomes, cost, and administrative efficiency[29,30,34-36]; and

Whereas, Under the Affordable Care Act, patients who are offered an “affordable” ESHI plan that meets the minimum value standard are ineligible to receive premium tax credits and cost sharing reductions (a requirement known as the “ESHI firewall”), thus significantly impairing their ability to buy a plan on the ACA’s Health Insurance Marketplaces at an affordable rate[37]; and

Whereas, An ESHI plans needs to cover only 60% of the total cost of expected healthcare expenses to meet the minimum value standard, leaving up to 40% of these costs to be covered by the patient[37]; and

Whereas, A survey of employer-sponsored health insurance beneficiaries conducted by the Kaiser Family Foundation in 2019 found that over 40% of beneficiaries had difficulty paying for some aspect of their coverage, including the premium, deductibles, or other expenditures[38]; and

Whereas, Under current law, the cost of individual ESHI coverage is exclusively used to calculate plan affordability even if the employee wants to or needs to purchase a family plan, meaning that millions of Americans are ineligible for premium tax credits but may also be unable to afford a plan through their employer[39-42]; and

Whereas, Eliminating the ESHI firewall would allow individuals who are offered ESHI to still be eligible for premium tax credits and cost sharing reductions, thus enabling them to choose a plan that is the most affordable and best meets their needs from either their employer-sponsored plans or other plans offered on their state’s Health Insurance Marketplace[43,44]; and

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Whereas, Roughly 10-20 million Americans with ESHI could choose a plan on the ACA Exchanges with lower premiums than their current employer-based plan if the ESHI firewall were eliminated[44,45]; and

Whereas, In 2017, 2.7 million uninsured Americans who otherwise would be eligible for premium tax credits to lower the cost of insurance coverage were ineligible for those tax credits because of an offer of ESHI[46]; and

Whereas, Removing the ESHI firewall could contribute to substantial insurance coverage gains by making insurance options on the ACA Exchanges significantly more affordable for individuals who may not be able to afford insurance offered through their employer[47-50]; therefore be it

RESOLVED, That our AMA recognize the inefficiencies and complexity of the employer-sponsored health insurance system and the existence of alternative models that better align incentives to facilitate access to high quality healthcare; and be it further

RESOLVED, That our AMA support movement toward a healthcare system that does not rely on employer-sponsored health insurance and enables universal access to high quality healthcare; and be it further

RESOLVED, That our AMA amend Policy H-165.828, “Health Insurance Affordability”, by addition and deletion to read as follows:

HEALTH INSURANCE AFFORDABILITY, H-165.828

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).~~Our AMA advocates for the elimination of the employer-sponsored insurance firewall such that no individual would be ineligible for premium tax credits and cost-sharing assistance for marketplace coverage solely on the basis of having access to employer-sponsored health insurance.
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

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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.

; and be it further

RESOLVED, That our AMA amend Policy H-165.823, "Options to Maximize Coverage under the AMA Proposal for Reform", by deletion to read as follows:

OPTIONS TO MAXIMIZE COVERAGE UNDER THE AMA PROPOSAL FOR REFORM, H-165.823

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.~~

b~~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.

c~~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.

d~~e~~. The public option is financially self-sustaining and has uniform solvency requirements.

e~~f~~. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.

f~~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

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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.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

Universal Health Coverage H-165.904
Our AMA: (1) seeks to ensure that federal health system reform include payment for the urgent and emergent treatment of illnesses and injuries of indigent, non-U.S. citizens in the U.S. or its territories; (2) seeks federal legislation that would require the federal government to provide financial support to any individuals, organizations, and institutions providing legally-mandated health care services to foreign nationals and other persons not covered under health system reform; and (3) continues to assign a high priority to the problem of the medically uninsured and underinsured and continues to work toward national consensus on providing access to adequate health care coverage for all Americans
Sub. Res. 138, A-94; Appended: Sub. Res. 109, I-98; Reaffirmation A-02; Reaffirmation A-07; Reaffirmation I-07; Reaffirmed: Res. 239, A-12

State Efforts to Expand Coverage to the Uninsured H-165.845
Our AMA supports the following principles to guide in the evaluation of state health system reform proposals:
1. Health insurance coverage for state residents should be universal, continuous, and portable. Coverage should be mandatory only if health insurance subsidies are available for those living below a defined poverty level.
2. The health care system should emphasize patient choice of plans and health benefits, including mental health, which should be value-based. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as references when considering if a given plan would provide meaningful coverage.
3. The delivery system should ensure choice of health insurance and physician for patients, choice of participation and payment method for physicians, and preserve the patient/physician relationship. The delivery system should focus on providing care that is safe, timely, efficient, effective, patient-centered, and equitable.
4. The administration and governance system should be simple, transparent, accountable, and efficient and effective in order to reduce administrative costs and maximize funding for patient care.

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5. Health insurance coverage should be equitable, affordable, and sustainable. The financing strategy should strive for simplicity, transparency, and efficiency. It should emphasize personal responsibility as well as societal obligations.
CMS Rep. 3, I-07; Reaffirmed: Res. 239, A-12

Evaluating Health System Reform Proposals H-165.888
1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles:

A. Physicians maintain primary ethical responsibility to advocate for their patients' interests and needs.
B. Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed.
C. All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be.
D. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan.
E. Any national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care.
F. Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce an adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system.
G. All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President.
H. True health reform is impossible without true tort reform.
2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be specifically included in national health care reform legislation.
3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use / addiction disorders and will advocate for the inclusion of full parity for the treatment of mental illness and substance use / addiction disorders in all national health care reform legislation.
4. Our AMA supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients.
Res. 118, I-91;Res. 102, I-92; BOT Rep. NN, I-92; BOT Rep. S, A-93; Reaffirmed: Res. 135, A-93; Reaffirmed: BOT Reps. 25 and 40, I-93; Reaffirmed in lieu of Res. 714, I-93; Res. 130, I-93; Res. 316, I-93Sub. Res. 718, I-93; Reaffirmed: CMS Rep. 5, I-93; Res. 124, A-94; Reaffirmed

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by BOT Rep.1- I-94; CEJA Rep. 3, A-95; Reaffirmed: BOT Rep. 34, I-95; Reaffirmation A-00; Reaffirmation A-01; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CME Rep. 2, A-03; Reaffirmed and Modified: CMS Rep. 5, A-04; Reaffirmed with change in title: CEJA Rep. 2, A-05; Consolidated: CMS Rep. 7, I-05; Reaffirmation I-07; Reaffirmed in lieu of Res. 113, A-08; Reaffirmation A-09; Res. 101, A-09; Sub. Res. 110, A-09; Res. 123, A-09; Reaffirmed in lieu of Res. 120, A-12; Reaffirmation: A-17

Health System Reform Legislation H-165.838

1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy:

a. Health insurance coverage for all Americans

b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps

c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials

d. Investments and incentives for quality improvement and prevention and wellness initiatives

e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care

f. Implementation of medical liability reforms to reduce the cost of defensive medicine

g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens

2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.

3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.

4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.

5. AMA policy is that insurance coverage options offered in a health insurance exchange 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.

6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician.

7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals.

8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation:

a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services

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b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system
c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted
d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate
e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another
f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest
9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA's position based on AMA policy.
10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.
11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal.
12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.
13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform.
Sub. Res. 203, I-09; Reaffirmation A-10; Reaffirmed in lieu of Res. 102, A-10; Reaffirmed in lieu of Res. 228, A-10; Reaffirmed: CMS Rep. 2, I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: CMS Rep. 6, I-11; Reaffirmed in lieu of Res. 817, I-11; Reaffirmation I-11; Reaffirmation A-12; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 239, A-12; Reaffirmed: Sub. Res. 813, I-13; Reaffirmed: CMS Rep. 9, A-14; Reaffirmation A-15; Reaffirmed in lieu of Res. 215, A-15; Reaffirmation: A-17; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmed in lieu of: Res. 805, I-17; Reaffirmed: CMS Rep. 03, A-18; Reaffirmed: CMS Rep. 09, A-19

Evaluation of the Principles of the Health Care Access Resolution 165.009MSS
(1) AMA-MSS supports efforts to make health care more cost-effective by reducing administrative burdens, but only to such a degree that quality of care is not compromised; (2) AMA-MSS supports means of including both long-term care and prescription drug benefits into the guidelines for seeking affordable universal health care access and coverage; (3) AMA-MSS encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality of health care; and that our AMA-MSS supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons; (4) AMA-MSS will adopt policy to promote outcomes research as an effective mechanism to improve the quality of medical care for all persons and urge that the results of such research be used only for educational purposes and for improving practice parameters; (5) AMA MSS will adopt policy to address the need to increase numbers of qualified health care professionals, practitioners, and providers in underserved areas to increase timely access to quality care; (6) AMA-MSS supports the inclusion of adequate and timely payments to physicians and other providers into any plan calling for affordable universal health care access;

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(7) AMA-MSS supports the inclusion of the principles of continuity of health insurance coverage and continuity of medical care into any plan calling for affordable universal health care access; (8)AMA-MSS supports the inclusion of the principle of consumer choice of healthcare providers and practitioners into any plan calling for affordable universal health care access; (9) AMA-MSS supports the inclusion of reducing health care administrative cost and burden into any plan calling for affordable universal health care access.
MSS Rep C, A-04; Modified: MSS GC Rep B, I-09; Modified: GC Rep A, I-16

Covering the Uninsured as AMA's Top Priority 165.012MSS
AMA-MSS will ask the AMA to make the number one priority of the American Medical Association comprehensive health system reform that achieves reasonable health insurance for all Americans and that emphasizes prevention, quality, and safety while addressing the broken medical liability system, flaws in Medicare and Medicaid, and improving the physician practice environment.
MSS Res 10, I-05; AMA Amended Res 613, A-06 Adopted [H-165.847]; Reaffirmed: MSS GC Rep F, I-10; Reaffirmed: MSS GC Report D, I-15

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 05
(N-21)

Introduced by: Reilly Bealer, Elson S Floyd College of Medicine; Alec Calac; UC San Diego School of Medicine; Rohan Khazanchi, University of Nebraska Medical Center.

Sponsored by: Region 1, Region 2, Region 4, Region 6, Region 7, ANAMS

Subject: Advocating for Heat Exposure Protections for Outdoor Workers

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, Heat-related death is one of the leading cause 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 CDC (Center for Disease Control and Prevention), 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

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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].

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

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

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RESOLVED, That our AMA 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, and be it further

RESOLVED, That our AMA support legislation creating federal standard for protections against heat stress specific to the hazards of the workplace; 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; and be it finally

RESOLVED, That our AMA-MSS immediately forward this resolution to the AMA at the November 2021 Meeting.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA/AMA-MSS 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

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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)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 06
(N-21)

Introduced by: Lily Greene, Mariana Henry, Michael Koo, Margaret Sherin, Geisel School of Medicine at Dartmouth; Alexandra Piselli, Georgetown University School of Medicine; Winona Gbedey, UT Health San Antonio Long School of Medicine, Sarah Costello, University of Iowa Carver College of Medicine, Lora Nason, University of Mississippi School of Medicine; Christine Chin, Texas College of Osteopathic Medicine; Jara Crawford, Indiana University School of Medicine; Leelakrishna Channa, University of Connecticut; Sanjana Satish, University of Miami Miller Medical School

Sponsored by: Region 2, Region 3, Region 4, Region 5, Region 7

Subject: Opposition to Immediate Separation of Infants from Incarcerated Pregnant Persons

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, Since the 1980's females (those assigned female at birth) have been the fastest growing faction of the incarcerated population, and in 2019, there were 218,000 females incarcerated in prisons and jails within the United States comprising about 10% of incarcerated individuals[1-3]; and

Whereas, Three out of four incarcerated females in the United States are of childbearing age and already mothers, and up to 80% of incarcerated females report being heterosexually active without consistent contraceptive methods prior to being arrested, and this can lead to being pregnant before entering incarceration[2,4]; and

Whereas, In 2016 a survey of 22 state prisons found 3.8% of new admissions were pregnant people, and in a similar survey conducted at U.S. jails, 3% of admissions were pregnant people, which suggest a national jail admission rate of pregnant people to be around 55,000 a year[4,5]; and

Whereas, In the United States when a pregnant person gives birth while incarcerated the infant is often separated from the parent soon after birth to be placed in kinship care, foster care, or given up for adoption, which can lead to the termination of parental rights[6]; and

Whereas, The United States is one of only four nations which routinely separate infants from postpartum pregnant people, and many other nations including the United Kingdom and Canada offer Mother-Baby Units in prisons or jails to keep infants with their caregiver for a given period of time[7]; and

Whereas, In United Nations Children's Fund (UNICEF) report *Implementation Handbook for the Convention on the Rights of the Child* 3rd edition, UNICEF states that children should not be separated from their mother due to incarceration because of the child's wellbeing and right to

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family life and that if the mother is incarcerated the infant should be present in the prison or jail if possible[6]; and

Whereas, Separation of infants from pregnant persons post-partum can have negative effects for the baby, including altered heart rate, impaired infant-parent bonding, lower rates of successful breastfeeding, and impaired social and emotional development, as well as negatively affected parental well-being[8-12]; and

Whereas, The immediate separation of newborns from their parent during the postpartum period is associated with long-lasting deficits in maternal feelings of competency, infant self-regulation, and the mother-infant relationship, while interventions that enhance mother-infant contact are associated with short- and long-term improved neurodevelopmental and behavioral outcomes in newborns and children[11]; and

Whereas, The American College of Obstetricians and Gynecologists opposes the policy of immediate separation of infants from pregnant persons postpartum, stating that people who give birth while incarcerated should be allowed the maximum time for parent-infant bonding and further that immediately separating infants from incarcerated parents for non-medical reasons is unnecessary, punitive, and harmful[8]; and

Whereas, Eleven states offer alternatives to immediate separation such as prison nursery programs, which is a living arrangement located within a correctional facility in which an imprisoned parent and their infant can consistently co-reside with the parent as the primary caregiver during some or all of the mother's sentence[12,13]; and

Whereas, Alternatives to immediate separation like prison nursery programs have been shown to potentially increase infant-parent attachment and bonding, reduce recidivism, and improve parents self esteem and child rearing skills[12,13]; and

Whereas, In May 2021, Minnesota became the first state to oppose the immediate separation of infants from incarcerated pregnant people through passing the Healthy Start Act, which allowed incarcerated pregnant people to be placed in community-based programs such as halfway houses during the late term of their pregnancy and up to one year after[14]; and

Whereas, AMA policy H-60.903 supports initiatives that address specific healthcare needs of children with incarcerated parents and promote earlier interventions for children at risk; and

Whereas, AMA policy H-430.990 originally adopted in 1997 encourages further research into bonding programs for incarcerated pregnant people, however this policy fails to directly oppose the practice of immediate postpartum separation and recent research indicates that keeping infants and post-partum incarcerated pregnant individuals together during a crucial developmental time period is correlated with positive impacts for both infant and parent; therefore be it

RESOLVED, That our AMA-MSS oppose the immediate separation of infants from incarcerated pregnant individuals post-partum; and be it further

RESOLVED, That our AMA-MSS support solutions, such as community based programs, which allow infants and incarcerated postpartum individuals to remain together.

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Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

Children of Incarcerated Parents H-60.903

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Our AMA supports comprehensive evidence-based care, legislation, and initiatives that address the specific healthcare needs of children with incarcerated parents and promote earlier intervention for those children who are at risk.
Res. 503, A-19

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

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 advocates and requires a smooth transition including partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. Our AMA encourages 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 advocates for states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal legal system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA advocates for Congress to repeal the “inmate exclusion” of the 1965 Social Security Act that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons.
7. Our AMA advocates for Congress and the Centers for Medicare & Medicaid Services (CMS) to revise the Medicare statute and rescind related regulations that prevent payment for medical care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the services are delivered.
8. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of women and adolescent females who are incarcerated, including gynecological care and obstetrics care for individuals who are pregnant or postpartum.
9. Our AMA will collaborate with state medical societies, relevant medical specialty societies, and federal regulators to emphasize the importance of hygiene and health literacy information sessions, as well as information sessions on the science of addiction, evidence-based addiction

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treatment including medications, and related stigma reduction, for both individuals who are incarcerated and staff in correctional facilities.
10. 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 use disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; and (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community.
11. Our AMA advocates for the continuation of federal funding for health insurance benefits, including Medicaid, Medicare, and the Children's Health Insurance Program, for otherwise eligible individuals in pre-trial detention.
12. Our AMA advocates for the prohibition of the use of co-payments to access healthcare services in correctional facilities.
CMS Rep. 02, I-16; Appended: Res. 417, A-19; Appended: Res. 420, A-19; Modified: Res. 216, I-19; Modified: Res. 503, A-21; Reaffirmed: Res. 229, A-21

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

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-10Reaffirmed: BOT Rep. 04, A-20

Protections for Incarcerated Mothers to Breastfeed and/or Breast Pump 420.016MSS

Our AMA-MSS will ask the AMA to 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. However, since there are established benefits of breast milk for infants and breast milk expression for mothers, the AMA supports policy and legislation that extends the right to breastfeed and/or pump and store breast milk to include incarcerated mothers. The AMA recognizes the prevalence of mental health and substance use 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 and AMA-MSS Digest of Policy Actions/ 185 breastfeeding/breast pumping 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.
MSS Res. 043, Nov. 2020

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 07
(N-21)

Introduced by: Rasika Rao, Mayo Clinic Alix School of Medicine Arizona; Ian MacLeod, University of South Carolina School of Medicine Columbia; Mahima Goel, Carle Illinois College of Medicine; Radhika Patel, Sam Houston State University College of Osteopathic Medicine; Michelle Troup, University of South Carolina School of Medicine Greenville; Alyssa Reese, Jacobs School of Medicine; Alec Calac, University of California-San Diego School of Medicine.

Sponsored by: Region 4, ANAMS, PsychSIGN

Subject: Addressing Longitudinal Health Care Needs of Children in Foster Care

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, The most recent estimation showed 424,000 children in foster care in the U.S. in 2019, which has stayed consistent since 2009[1,2]; and

Whereas, American Indian/Alaska Native (AI/AN) children were disproportionately overrepresented in the foster care system by double their share of the U.S. population in 2020, are twice as likely as their White counterparts to be removed from their family, and more likely to have special health care needs[3, 4, 5]; and

Whereas, Upon entering foster care, 30% to 80% of children have at least one physical health problem, 33% have a chronic health condition, 40% have significant dental issues, and up to 80% have a significant mental health need[6,7]; and

Whereas, During foster care, 50% of children have healthcare needs which remain chronic or unmet and 30% of children with potential mental health needs went 12 months without intervention[8,9]; and

Whereas, While in foster care, 50% of children are subject to at least one change of placement, and 20% move at least three times in one year[10]; and

Whereas, Poor communication between caregivers, Child welfare services, and medical personnel results in 50% of children having discrepancies in identifying data that prevents their electronic medical record from being matched with their child welfare files, and more than 40% of those children lack a basic social history in their health record such as why they entered foster care[6,11,12]; and

Whereas, Incomplete medical histories and frequent changes in physical custody lead to decreased continuity of care, causing the health needs of children in foster care to often go undiagnosed and untreated[1,6,8,13,14,15,16]; and

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Whereas, A “pediatric medical home” is a primary care model which provides a single home for medical records, maintains provider continuity throughout the childhood of a patient, and coordinates specialty care[17,18,19]; and

Whereas, In 2016, only 40% to 50% of all children in the U.S. were reported to have access to a medical home[18]; and

Whereas, Pediatric medical homes are associated with increased primary care utilization and improved health outcomes, making them ideal for children in foster care[19, 20, 21, 22]; and

Whereas, Computerized intersystem health information exchange platforms are associated with increased immunization and health record completeness, reduced care disparities, and increased overall quality of care[23]; and

Whereas, Interagency information exchange results in more than a threefold increase in the likelihood of receiving needed behavioral health services for a child managed by child welfare agencies[24]; and

Whereas, Several states have implemented computerized health systems to improve information exchange between child welfare agencies and health care services including The Texas Health Passport, Ohio IDENTITY, Pennsylvania UPMC for You, and California Foster Health Link[25]; and

Whereas, Health case management services and designation of accountability for the health services of a child in foster care are associated with positive health outcomes and more than a threefold increase in likelihood of a child receiving needed health services[24,26]; and

Whereas, Some states have implemented medical case management programs to longitudinally follow children in foster care including California and North Carolina[8,27,28]; and

Whereas, The variability in infrastructure to address health needs of children in foster care between and within states suggests a need for standardization of care quality through state-level supervision[6,25,27,28]; and

Whereas, The Indian Child Welfare Act (ICWA), enacted in 1978 to address the disparities in Native child foster placement, provides placements for AI/AN children that are conducive to longitudinal health care by requiring minimal Federal standards for their removal and placement of such children in long-lasting, culturally appropriate homes[5,29]; and

Whereas, The American Academy of Pediatrics (AAP) recognizes that the ICWA protects AI/AN children and adolescents from disproportionate rates of child removal and negative health outcomes, and supports increased engagement with the Indian Health Service which provides medical care to AI/AN children[5]; and

Whereas, The AAP recommends the use of pediatric medical homes, increased information exchange between child welfare and medical providers, and the appointment of a pediatrician to supervise state-level medical case management of children in foster care[6]; and

Whereas, AMA MSS policies support the health coverage of all children in foster care and the entire transferability of electronic health records data between independent healthcare systems (Enabling Contiguous, National Electronic Health Record Network 315.003MSS, Addressing

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Healthcare Accessibility for Current and Aged-Out Youth in the Foster Care System 60.037MSS); and

Whereas, Existing AMA policy encourages the use of medical homes, supports the use of health information technology in conjunction with medical homes, and advocates for comprehensive and evidence-based care that addresses the specific health care needs of children in foster care (The Patient-Centered Medical Home H-160.918, Principles of the Patient-Centered Medical Home H-160.919, Addressing Healthcare Needs of Children in Foster Care H-60.910); and

Whereas, No existing AMA policy addresses longitudinal continuity of care needs of children in foster care which remain unaddressed in spite of legal access to medical care for foster children[30,31]; therefore be it

RESOLVED, That our AMA support the construction of computerized health information systems to enhance information exchange between both tribal and non-tribal child welfare agencies and healthcare professionals; and be it further

RESOLVED, That our AMA promote existing pediatric medical homes which provide continuity of care to children in foster care; and be it further

RESOLVED, That our AMA advocate for the designation of medical providers, teams, and/or committees to longitudinally follow children in foster care; and be it further

RESOLVED, That our AMA support the appointment of a pediatrician in each state with experience in child welfare to the position of state medical director of foster care health case management in accordance with AAP guidelines to ensure standards of care are met; and be it further

RESOLVED, That the AMA support the longitudinal stability and care of American Indian and Alaska Native children in foster care by promoting the Indian Child Welfare Act.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

The Patient-Centered Medical Home H-160.918
Our AMA:
1. will urge the Centers for Medicare and Medicaid Services (CMS) to work with our AMA and national medical specialty societies to design incentives to enhance care coordination among providers who provide medical care for patients outside the medical home;
2. will urge CMS to assist physician practices seeking to qualify for and sustain medical home status with financial and other resources;
3. will advocate that Medicare incentive payments associated with the medical home model be paid for through system-wide savings – such as reductions in hospital admissions and readmissions (Part A), more effective use of pharmacologic therapies (Part D), and elimination of government subsidies for Medicare Advantage plans (Part C) – and not be subject to a budget neutrality offset in the Medicare physician payment schedule;

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4. will advocate that all payers support and assist PCMH transformation and maintenance efforts at levels that provide a stable platform for optimized patient-centered care recognizing that payer support is crucial to the long-term sustainability of delivery reform; and
5. encourages health agencies, health systems, and other stakeholders to support and assist patient-centered medical home transformation and maintenance efforts at levels that provide a stable platform for optimized patient-centered care.
(CMS Rep. 8, A-09; Modified: CMS Rep. 03, I-18)

Principles of the Patient-Centered Medical Home H-160.919
1. Our AMA adopts the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association "Joint Principles of the Patient-Centered Medical Home" as follows:

Principles

Personal Physician - Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician Directed Medical Practice - The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole Person Orientation - The personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home:

Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.

Evidence-based medicine and clinical decision-support tools guide decision making.

Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.

Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met.

Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.

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Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.

Patients and families participate in quality improvement activities at the practice level.

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.

It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.

It should support adoption and use of health information technology for quality improvement.

It should support provision of enhanced communication access such as secure e-mail and telephone consultation.

It should recognize the value of physician work associated with remote monitoring of clinical data using technology.

It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).

It should recognize case mix differences in the patient population being treated within the practice.

It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.

It should allow for additional payments for achieving measurable and continuous quality improvements.

2. Our AMA supports the patient-centered medical home (as defined in Policy H-160.919) as a way to provide care to patients without restricting access to specialty care.

3. It is the policy of our AMA that medical home participation criteria allow any physician practice to qualify as a medical home, provided it can fulfill the principles of a patient-centered medical home.

4. Our AMA will work with The Joint Commission (TJC) to examine the structures of TJC-accredited medical homes and determine whether differences exist in patient satisfaction, quality, value, and patient safety, as reflected by morbidity and mortality outcomes, between physician-led (MD/DO) and non-physician-led medical homes.

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5. Our AMA supports the physician-led patient-centered medical home and advocate for the public reporting/notification of the professional status (education, training, experience) of the primary care clinician who leads the primary care medical home.
(Res. 804, I-08; CMS Rep. 8, A-09; Reaffirmed: CME Rep. 15, A-10; Reaffirmed: Res. 723, A-11; Appended: Res. 723, A-11; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed in lieu of Res. 706, A-12; Reaffirmed: BOT Rep. 39, A-18; Reaffirmed: CMS Rep. 03, I-18)

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)

Medicaid Coverage for American Indian and Alaska Native Children D-350.992
Our AMA will advocate for immediate changes in Medicaid regulations to allow American Indian/Alaska Native (AI/AN) children who are eligible for Medicaid in their home state to be automatically eligible for Medicaid in the state in which the Bureau of Indian Affairs boarding school is located.
(Res. 424, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Reaffirmed in lieu of: Res. 001, I-16; Appended: CSAPH Rep. 3, A-21)

Addressing Healthcare Accessibility for Current and Aged-Out Youth in the Foster Care System 60.037MSS
Our AMA will amend policy H-60.910, by addition and deletion to read as follows:
ADDRESSING HEALTHCARE NEEDS OF YOUTH ~~CHILDREN~~ IN FOSTER CARE, H-60.910
1. Our AMA advocates for comprehensive and evidence-based care that addresses the specific health care needs of ~~children~~ youth 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. MSS Res. 097, Nov. 2020

Enabling Contiguous, National Electronic Health Record Network 315.003MSS
AMA- MSS (1) supports collaboration with appropriate federal government agencies and industry partners to develop and promote legislative and policy initiatives that require the interoperability of independent healthcare systems such that electronic health records data be entirely transferable; and (2) will ask the AMA to study private and public sector initiatives regarding efforts to establish a nationwide health information network and other relevant interoperability initiatives. MSS Res 12, A-13; Reaffirmed: MSS GC Rep A, I-19

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 08
(N-21)

Introduced by: Omer Ashruf, Warren Lee, Meghana Chanamolu, Krithika Sundaram, Zeel Vaghasia, Varun Aitharaju, Rommel Morales, Meghana Chalasani, Vardhan Avasarala, Northeast Ohio Medical University; Sarah Cole, Florida Atlantic University College of Medicine; Tsola Efejuku, University of Texas Medical Branch; Zehra Rizvi, NSU Dr. Kiran C. Patel College of Osteopathic Medicine; Preetha Ghosh, Wayne State University School of Medicine; Dilpreet Kaeley, University of Toledo College of Medicine; Colton Goebel, Indiana University School of Medicine; Stephanie Lin, Zucker School of Medicine at Hofstra/Northwell; Harinandan Sainath, University of Texas Health San Antonio Long School of Medicine; Haley Nadone, University of Nevada Reno School of Medicine; Krishna Channa, University of Connecticut School of Medicine; Christopher Prokosch, University of Minnesota - Twin Cities

Sponsored by: Region 2, Region 3, Region 5, Region 7

Subject: Reevaluating the Food and Drug Administration's Citizen Petition Process

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, Pharmaceutical drug prices in the United States are increasing at an alarming rate and more expensive than the rest of the industrialized world[1,2,3]; and

Whereas, Although brand name drugs account for about 15% of prescriptions dispensed by Medicaid and Medicare Part D, they account for about 75-80% spending on prescription drugs[1,4]; and

Whereas, In many situations, generic and brand name medications have the same clinical efficacy, risks and benefits because they have the same active ingredients and mechanism of action[5]; and

Whereas, Competition between generic drug companies and brand name manufacturers typically results in an 85% price reduction, and generic drugs saved the U.S. healthcare system $1.67 trillion from 2007 to 2016[5,6]; and

Whereas, The Food and Drug Administration’s (FDA) citizen petition process is intended as a method for average individuals, industry or consumer groups to formally request the FDA commissioner to invoke, amend, or revoke directives or pharmaceutical monographs as a democratic and transparent mode of regulation[7,8]; and

Whereas, Manufacturers of brand name drugs employ strategies including filing petitions to the FDA that delay and prevent the entry of generic drugs into the market and prevent this loss of profit[9,10,11]; and

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Whereas, An estimated 92% of citizen petitions filed against generic brands are filed by brand-name manufacturers[12]; and

Whereas, One of every five citizen petition filed by brand-name manufacturers (including but not limited to pharmaceutical drugs) has had the potential to delay generic entry into the market[13,14]; and

Whereas, An analysis of four frivolous citizen petitions filed by brand-name manufacturers in a 2-year span found a total market delay time of 521 days (against generic drugs) which cost approximately $782 million to government-provided insurance programs and $1.9 billion total[15]; and

Whereas, The Federal Trade Commission (FTC) has filed a formal complaint that these "repetitive, serial, and meritless filings lacked any supporting clinical data," and have "succeeded in delaying generic entry at a cost of hundreds of millions of dollars to patients and other purchasers"[16]; and

Whereas, Despite the overwhelming empirical data on the abuse of the FDA citizen petition process, there is minimal official data on the true cost to society[15]; and

Whereas, The FDA is not obligated to nor does it actively report to Congress which petitions have been filed fraudulently or the nature of generic entry market delay[17]; and

Whereas, Increasing transparency of the citizen petition process would facilitate more thorough research and analysis of petitions and lower unnecessary resource expenditure by the FDA[17]; therefore be it

RESOLVED, That our AMA support the research of anti-competitive practices on the Food and Drug Administration's (FDA) citizen petitions process; and be it further

RESOLVED, That our AMA advocate for further public transparency by the Food and Drug Administration (FDA) in the content of each petition, the relationship between citizen petitions and decisions to delay generic approval, and the time and resources expended on petition reviews.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

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.

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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 Re. 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)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 09
(N-21)

Introduced by: Jenna Gage, Migara Jayasekera, Roshaneh Ali, Kaci French, UTMB; Dilpreet Kaeley, Kristofer Jackson, University of Toledo

Sponsored by: Region 5, Region 6, Region 7

Subject: Microplastics

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, Microplastics (MPs) are plastic particles smaller than 5mm generated from the breakdown of plastic objects, clothing, car tires, and other everyday products[1]; and

Whereas, The breakdown of an estimated 5 billion tonnes of existing plastic and the production of 400 million tonnes of plastic each year, will cause the projected mass of plastics to more than double by 2050, accounting for the constantly rising levels of MPs[2]; and

Whereas, The COVID-19 pandemic has induced massive fossil fuel-derived plastic production, including a 340% increase in medical waste[3]; and

Whereas, There are significant MP concentrations contained in food, the water supply, and air (seafood = 1.48 MPs/g, sugar = 0.44 MPs/g, honey = 0.10 MPs/g, salt = 0.11 MPs/g, alcohol = 32.27 MPs/L, bottled water = 94.37 MPs/L, tap water = 4.23 MPs/L, and air = 9.80 MPs/m)[4]; and

Whereas, MPs can enter the human body by inhalation, ingestion, and dermal contact, and it is estimated humans could be ingesting 0.1 to 5 g of MPs per week, which may lead to an accumulation of several thousand MP particles in a lifetime[2,5,6]; and

Whereas, Existing AMA policy (H-135.996) supports efforts to alert the American people to health hazards of environmental pollution and the need for research and control measures in this area (environmental pollution); and

Whereas, Most of the existing literature regarding effects of MPs on human health is extrapolated from in vitro or animals studies, and as such, there is a drastic need for investigation into the long-term effects of MPs on the human body in vivo[7]; and

Whereas, Due to limited research, the World Health Organization has claimed that there is not enough evidence to confirm MPs as a threat to human health nor articulate their harmful effects[8]; and

Whereas, While the World Health Organization calls upon water suppliers, water regulators, researchers, politicians, and the public to address human health risks posed by MP exposure,

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there is little involvement of the medical community regarding potent and adverse effects of MPs on disease progression[8]; and

Whereas, MPs with a size of about 10 μm can cross cell membranes to organs including the liver, muscles, placenta, and even the blood-brain barrier[9]; and

Whereas, MPs can destabilize lipid membranes through mechanical stretching, leading to a strong reduction of membrane lifetime, and have been shown to induce damage to humans through inflammation, genotoxicity, and oxidative stress[10,11]; and

Whereas, Inhalation of MPs by susceptible individuals has been shown to incite airway and interstitial inflammation and induce cytotoxic effects on pulmonary epithelial cells and macrophages[12]; and

Whereas, MPs may contain chemicals such as phthalates, heavy metals, flame retardants, and bisphenol A that may disrupt endocrine function and have been linked to disorders including breast cancer, blood infection, early onset of puberty, genital defects, diminished sperm quality and more[1,6,9,13]; and

Whereas, The most substantial research regarding MPs lies within the digestive tract, emphasizing the toxic effects of sustained MPs on intestinal villi as well as studies reporting presence of MPs in stool[9]; and

Whereas, The cumulative and aggregative effects MPs in the human body additionally elicits a widespread, chronic inflammatory response[14]; and

Whereas, While there have been new advances regarding capturing MPs in an effort to reduce human and environmental harm, such as filtering systems coupled to washing machines and technology at wastewater treatment facilities, the most efficacious way at reducing human consumption of MPs would be reducing production of plastic[15,16]; and

Whereas, Studies emphasize the unsustainability of one-time plastic use and have predicted a 78% reduction in plastic pollution by 2040 if all feasible interventions were implemented, highlighting the need to create policy regarding mass plastic production[17]; therefore be it

RESOLVED, That our AMA acknowledges the impacts of microplastics on human disease and supports a greater presence of the medical community in recognizing the ubiquitous distribution of microplastics into the environment and therefore into the human body; and be it further

RESOLVED, That our AMA supports efforts on reducing plastic production as a way to reduce human exposure to microplastics; and be it further

RESOLVED, That our AMA supports further research on the effects of microplastics on human health and methods to remove microplastics from the environment to better inform policy.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

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 Preservation H-135.972
It is the policy of the AMA to support state society environmental activities by:
(1) identifying areas of concern and encouraging productive research designed to provide authoritative data regarding health risks of environmental pollutants;
(2) encouraging continued efforts by the CSAPH to prepare focused environmental studies, where these studies can be decisive in the public consideration of such problems;
(3) maintaining a global perspective on environmental problems;
(4) considering preparation of public service announcements or other materials appropriate for public/patient education; and
(5) encouraging state and component societies that have not already done so to create environmental committees.
Res. 52, A-90; Reaffirmed: Sunset Report, I-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

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-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

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)

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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

Banning Plastic Microbeads in Personal Care Products H-135.929
Our AMA supports local, state, and federal laws banning the sale and manufacture of personal care products containing plastic microbeads.
Res. 916, I-15

The Health Risks of Hydraulic Fracturing H-135.931
1. Our AMA encourages appropriate agencies and organizations to study the potential human and environmental health risks and impacts of hydraulic fracturing.
2. Our AMA: (A) supports the full disclosure of chemicals placed into the natural environment during the petroleum, oil and natural gas exploration and extraction process; and (B) supports the requirement that government agencies record and monitor the chemicals placed into the natural environment for petroleum oil and natural gas extraction and the chemicals found in flowback fluids, to monitor for human exposures in well water and surface water, and to share this information with physicians and the public.
3. Our AMA supports research on the implementation of buffer zones or well set-backs between oil and gas development sites and residences, schools, hospitals, and religious institutions, to determine the distance necessary to ensure public health and safety.
Res. 405, A-13; Appended: Sub. Res. 508, A-15; Appended: Res. 908, I-17

Per- and Polyfluoroalkyl Substances (PFAS) and Human Health H-135.916
Our AMA: (1) supports continued research on the impact of perfluoroalkyl and polyfluoroalkyl chemicals on human health; (2) supports legislation and regulation seeking to address contamination, exposure, classification, and clean-up of PFAS substances; and (3) will advocate for states, at minimum, to follow guidelines presented in the Environmental Protection Agency's Drinking Water Health Advisories for perfluorooctanoic acid (PFOA) and perfluorooctane sulfonic acid (PFOS), with consideration of the appropriate use of Minimal Risk Levels (MRLs) presented in the CDC/ATSDR Toxicological Profile for PFAS.
Res. 901, I-19

Manganese in Gasoline H-135.952
Our AMA: (1) urges the appropriate federal agencies and industries to support further research into health effects of manganese exposure from the use of methylcyclopentadienyl manganese tricarbonyl (MMT) in gasoline before it is introduced widely in the US gasoline supply. Research is especially needed to determine health effects of long-term low-dose exposures to MMT and its combustion products, particularly effects on vulnerable populations; (2) urges the appropriate government agencies to monitor the use of MMT by gasoline refiners and sellers and to make

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their findings available to the public; (3) urges appropriate federal agencies to fully inform physicians, other health care providers, and the public of any potential health effects of MMT; and (4) continues to monitor research and developments regarding potential health effects of MMT and its combustion products and that this report be updated as appropriate.
CSA Rep. 7, A-98; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: CSAPH Rep. 01, A-18

Light Pollution: Adverse Health Effects of Nighttime Lighting H-135.932
Our AMA:
1. Supports the need for developing and implementing technologies to reduce glare from vehicle headlamps and roadway lighting schemes, and developing lighting technologies at home and at work that minimize circadian disruption, while maintaining visual efficiency.
2. Recognizes that exposure to excessive light at night, including extended use of various electronic media, can disrupt sleep or exacerbate sleep disorders, especially in children and adolescents. This effect can be minimized by using dim red lighting in the nighttime bedroom environment.
3. Supports the need for further multidisciplinary research on the risks and benefits of occupational and environmental exposure to light-at-night.
4. That work environments operating in a 24/7 hour fashion have an employee fatigue risk management plan in place.
CSAPH Rep. 4, A-12

Health Impact of Per- and Polyfluoroalkyl Substances (PFAS) Contamination in Drinking Water 135.017MSS
AMA-MSS will ask the AMA to support legislation and regulation seeking to address contamination, exposure, classification, and clean-up of Per- and Polyfluoroalkyl substances.
MSS Res 02, A-19; AMA Res. 901, Adopt Alternate Resolution in Lieu of Res. 901and Res. 922 [H- 135.916], I-19

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 10
(N-21)

Introduced by: Alec Calac, Luis Gasca, UC San Diego School of Medicine; Reilly Bealer, Elson S Floyd College of Medicine; Rohan Khazanchi, University of Nebraska College of Medicine; William Swain, University of Wisconsin School of Medicine and Public Health; Christopher Prokosch, University of Minnesota Medical School; Canaan Hancock, University of Texas at Austin Dell Medical School; Stephanie Foster, Emory School of Medicine, Fatima Khan, University of Miami Leonard M. Miller School of Medicine; Anna Klunk, Philadelphia College of Osteopathic Medicine

Sponsored by: Region 1, Region 4, Region 6, Region 7, ANAMS, APAMSA, PsychSIGN, SOMA

Subject: Cultural Leave for American Indian Trainees

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, American Indian and Alaska Native students have disparately lower four-year medical school graduation rates compared to their non-Hispanic white peers (71% vs. 87%)[1]; and

Whereas, The Association of American Medical Colleges and Association of American Indian Physicians recognize that perception of one's school/workplace environment influences medical student retention and success and that a positive psychological climate can be fostered when student programming and student affairs offices are responsive to American Indian and Alaska Native culture and history[1]; and

Whereas, A 2021 survey conducted by the Association of Native American Medical Students found that 20% of respondents cited loss of culture and distance from family as significant challenges to their progression in medical training;[2] and

Whereas, The American Indian Religious Freedom Act of 1978 requires protection and preservation of American Indians' inherent right of freedom to believe, express, and exercise the traditional religions of the American Indian, Eskimo, Aleut, and Native Hawaiians, including but not limited to access to sites, use and possession of sacred objects, and the freedom to worship through ceremonial and traditional rites[3]; and

Whereas, Despite this law, American Indian and Alaska Native K-12 students are more likely to face disciplinary action in education systems, including suspension and expulsion, than their peers due to a lack of cultural responsiveness[4]; and

Whereas, Cultural responsiveness enables individuals and organizations to respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders, sexual orientations, and other diversity factors in a manner that recognizes, affirms, and values their worth[5]; and

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Whereas, Culturally-responsive practices involve recognizing and incorporating the assets and strengths all students bring into the classroom, and ensuring that learning experiences, from curriculum through assessment, are relevant to all students, and are grounded in evidence-based community practice[6]; and

Whereas, Existing AMA policy focused on equity, diversity and, inclusion (H-200.951, D-200.985) is not specific to or inclusive of cultural leave practices; and

Whereas, American Indian and Alaska Native cultural responsiveness must be an ongoing and deliberate effort, taking root across the school spectrum—curriculum, pedagogy, engagement with students and their families, and overall policies and practices;[7-8] and

Whereas, There is strong evidence that institutions must accommodate American Indian and Alaska Native cultural practices instead of relying on the student to navigate non-specific policies allowing for leave;[9] therefore be it

RESOLVED, That our AMA amend H-405.960, Policies for Parental, Family and Medical Necessity Leave, by addition and deletion as follows:

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

AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family, Cultural, 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, cultural, 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

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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, <u>cultural leave</u>, 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

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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. In support of and in compliance with the American Indian Religious Freedom Act of 1978, our AMA encourages all medical schools, residency programs, speciality boards, and medical group practices to allow American Indian and Alaska Native medical students, resident physicians and fellows, and attending physicians to take paid leave to attend and participate in ceremonies of significance in their respective culture(s). It is permissible to ask the individual to verify their leave request with supporting documentation from a tribal government, elder, or ceremonial figure.

~~14~~15. These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship.

; and be it further

RESOLVED, That our AMA amend H-310.923, Eliminating Religious Discrimination from Residency Programs, by addition as follows:

Eliminating Religious Discrimination from Residency Programs H-310.923

Our AMA encourages residency programs to: (1) make an effort to accommodate residents' religious and cultural 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 and cultural holidays and observances.

; and be it further

RESOLVED, That our AMA will work with the Association of American Indian Physicians, Association of Native American Medical Students, and other appropriate stakeholders to design model cultural leave policies for undergraduate and graduate medical education programs and healthcare employers.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

H-310.923 Eliminating Religious Discrimination from Residency Programs
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.

295.197MSS Support for the Study of the Timing and Causes for Leave of Absence and Withdrawal from United States Medical Schools
AMA-MSS will ask the AMA to (1) encourage medical schools to provide peer counseling groups for addicted students; (2) aid and support medical schools in the identification of alcohol and drug treatment programs; (3) urge medical schools to grant leaves of absence to addicted students to seek treatment; and (4) support the formation of a national or regional committee of addiction and rehabilitation experts who may evaluate and recommend desirability of readmission for expelled students. (AMA Amended Res 83, I-82 Adopted [H-30.961]) (Reaffirmed: MSS CORP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I10) (Reaffirmed: MSS GC Rep D, I-15) (Amended and Reaffirmed: MSS GC Rep B, A-21)

65.024MSS FMLA-Equivalent for LGBTQ+ Workers

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AMA-MSS will ask the AMA to support the expansion of policies regarding family and medical leave to include any individual related by blood or affinity whose close association with the employee is the equivalent of a family relationship. (MSS Res 03, I-17) (Amended: LGBTQ+ Affairs Report A, A-21)

270.003MSS Broadening Access to Paid Family Leave to Improve Health Outcomes and Health Disparities
AMA-MSS supports the preference of paid leave and job security, over unpaid, for persons who must forsake work responsibilities for family or medical reasons, including parental leave. (AMA Res 163, A-87 Referred) (BOT Rep A, A-88 Adopted [H-420.979]) (Amended MSS Rep F, A-97) (Reaffirmed: MSS Rep D, I-97) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12) (Amended: MSS Res 11, I-15) (Modified MSS Res 10, I-16)

270.032MSS Paid Parental Leave
Our AMA-MSS (1) supports policy that extends the length of universal paid parental leave, recommending especially a period of 14 weeks or longer; and (2) supports policies that equally encourage parents of all genders to take parental leave. (MSS Res 10, I-16)

295.140MSS Written Maternity Policies: A New LCME Accreditation Standard
AMA-MSS will urge the Liaison Committee on Medical Education to add maternity, paternity, and adoption leave policies as an accreditation standard or annotation. (MSS Res 8, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

295.197MSS Support for the Study of the Timing and Causes for Leave of Absence and Withdrawal from United States Medical Schools
AMA-MSS will ask the AMA to support the study of factors surrounding leaves of absence and withdrawal from allopathic and osteopathic medical undergraduate and graduate education programs, including the timing of and reasons for these actions, as well as the sociodemographic information of the students involved. (MSS Res 37 I-18) (AMA Res 322, A-19, Adopted as amended and with Title Change [H-295.856])

295.207MSS Family Planning for Medical Students
AMA-MSS (1) encourages medical schools to create informative resources that promote a culture that is supportive of their students who are parents and to provide openly accessible information to prospective and current students regarding family planning in the specific medical school including parental leave and relevant make up work, options to preserve fertility, breastfeeding policies, accommodations during pregnancy, and resources for childcare that span the institution and surrounding area; and (2) supports the development of comprehensive requirements for medical schools regarding guidelines and resources for family leave and parenthood; and (3) supports medical schools providing six weeks of parental leave for medical students of all genders, medical school or broader licensure-related policies that allow for students to take a full six week leave without delaying graduation, and (4) encourages medical schools to make these formal policies easily accessible for both current and prospective students. (MSS Res. 51, I-19) (Amended MSS WIM Report A, A-21)

295.233MSS Support for Family Planning for Medical Students
AMA-MSS continues to support family leave related policies brought forth by other delegations so as not to diminish incremental advancement in advocacy related to the topic. (MSS WIM Report A, A-21)

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310.002MSS Parental Leave Benefits for House Staff
AMA-MSS will ask the AMA to support greater flexibility in residency training programs for parental leave and alternative residency training schedules for pregnant house staff. (AMA Amended Res 89, I-79, Adopted [420.996]) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

310.049MSS Equal Paternal and Maternal Leave for Medical Residents
That our AMA amend policy H-405.960 by insertion and deletion as follows: H-405.960 Policies for Maternity, Family and Medical Necessity Leave

440.050MSS Measuring the Effect of Paid Sick Leave (PSL) on Health-Care Outcomes
AMA-MSS will ask the AMA to: (1) recognize the positive impact of paid sick leave on health and support legislation that offers paid sick leave; and (2) work with appropriate entities to build on the current body of evidence by studying the health and economic impacts of newly enacted legislation. (MSS Res 28, I-14) (AMA Res 202, A-15 Referred) (Reaffirmed: MSS GC Rep A, I19)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 11
(N-21)

Introduced by: Grayson Jackson, Jenna Gage, University of Texas Medical Branch; Shivani Bhatnagar, Texas College of Osteopathic Medicine

Sponsored by: Region 3

Subject: Supporting research and development of vaccines against neglected tropical diseases

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, Neglected tropical diseases (NTDs) are a group of debilitating but preventable parasitic, viral, and bacterial diseases that primarily impact poor and marginalized communities[1–2]; and

Whereas, The adverse health outcomes associated with NTDs include chronic physical and cognitive impairment as well as increased maternal and infant mortality[1–2]; and

Whereas, NTDs make it difficult to engage in productive work, thus leading to reduced individual and community-level economic output and contributing to cyclical poverty[1–2]; and

Whereas, According to the 2010 Global Burden of Disease Study, NTDs affect one billion people worldwide with an estimated global disease burden (measured in disability-adjusted life years, or DALYs) of over 25 million years of healthy life lost due to disease or disability[3]; and

Whereas, Fifty-six percent of the DALYs due to NTDs are comprised of years lost due to disability (YLD) and 44% are comprised of years of life lost (YLL), which experts suggest leads to less global health funding and attention toward NTDs compared to infectious diseases with disproportionately higher mortality[4]; and

Whereas, NTDs also impact communities of low socioeconomic status within wealthy countries, such as the United States, in which an estimated 12 million Americans live with at least one neglected tropical disease[5]; and

Whereas, Rising NTD transmission in the United States is aggravated by social and environmental factors such as poverty, human migration, and climate change, which alters the geographic distribution of endemic disease vectors and exacerbates the prevalence of NTDs in the southern United States[6–7]; and

Whereas, Mass drug administration (MDA) is the only strategy currently implemented to alleviate the NTD burden because no licensed vaccines exist to address NTDs[8]; and

Whereas, A significant component of MDA for NTDs is supplied by donations from major international pharmaceutical companies, which, while inexpensive, is an unsustainable disease

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management strategy in the long term because MDA does not prevent reinfection and relies too heavily on private-sector philanthropy[9]; and

Whereas, Combating NTDs through more sustainable and permanent interventions, such as vaccines, is needed in order to protect vulnerable areas of the United States and reduce the global disease burden; and

Whereas, Vaccines are considered by infectious disease experts and health economists as cost-effective and cost-saving solutions for treating and eliminating NTDs[10]; and

Whereas, Vaccine candidates are currently in clinical trials for schistosomiasis and hookworm infections, but vaccine research for these parasitic infections and other NTDs lacks funding and attention relative to other infectious diseases, particularly because of the predominance of NTDs among impoverished communities[6,11–12]; and

Whereas, Enhancing our understanding of the genetics and genomics of NTD transmission through scientific research will expand the possibilities and effectiveness of vaccines and other NTD control methods[13]; and

Whereas, Although the AMA supports research and development for vaccines against vector-borne diseases in general (H-440.820), current policy does not specifically prioritize the development of vaccines against NTDs, which are susceptible to being diluted by broader disease control efforts; therefore be it

RESOLVED, That our AMA support research and development of vaccines against neglected tropical diseases (NTDs) and advocate for the World Health Organization and Centers for Disease Control and Prevention to increase funding of NTD vaccine development commensurate with the domestic and international burden of NTDs.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

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.

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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

a. 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

a. 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.

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(CSAPH Rep. 4, I-08; Reaffirmation I-10; Reaffirmation I-12; Reaffirmation I-14; Reaffirmed: CMS Rep. 3, I-20)

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)

Promoting Equitable Resource Distribution Globally in Response to the COVID-19 Pandemic, D-440.917

1. Our AMA will, in an effort to improve public health and national stability, explore possible assistance through the COVID-19 Vaccines Global Access (COVAX) initiative co-led by the World Health Organization, Gavi, and the Coalition for Epidemic Preparedness Innovations, as well as all other relevant organizations, for residents of countries with limited financial or technological resources.
2. Our AMA will work with governmental and appropriate regulatory bodies to encourage prioritization of equity when providing COVID-19 pandemic-related resources, such as diagnostics, low cost or free medications, therapeutics, vaccines, raw materials for vaccine production, personal protective equipment, and/or financial support.
3. Our AMA recognizes the extraordinary efforts of many dedicated physicians, physician and ethnic organizations assisting in this humanitarian COVID-19 pandemic crisis.
4. Our AMA will support World Health Organization (WHO) efforts and initiatives to increase production and distribution of therapeutics and vaccines necessary to combat COVID-19 and future pandemics in order to provide vaccine doses to low- and middle-income countries with limited access, including: (a) a temporary waiver of the Trade Related Aspects of Intellectual Property (TRIPS) agreement and other relevant intellectual property protections; (b) technological transfers relevant for vaccine production; (c) other support, financial and otherwise, necessary to scale up global vaccine manufacturing; and (d) measures that ensure the safety and efficacy of products manufactured by such means.

(Res. 608, A-21)

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Education and Public Awareness on Vaccine Safety and Efficacy, H-440.830

1. Our AMA (a) encourages the development and dissemination of evidence-based public awareness campaigns aimed at increasing vaccination rates; (b) encourages the development of educational materials that can be distributed to patients and their families clearly articulating the benefits of immunizations and highlighting the exemplary safety record of vaccines; (c) supports the development and evaluation, in collaboration with healthcare providers, of evidence-based educational resources to assist parents in educating and encouraging other parents who may be reluctant to vaccinate their children; (d) encourages physicians and state and local medical associations to work with public health officials to inform those who object to immunizations about the benefits of vaccinations and the risks to their own health and that of the general public if they refuse to accept them; (e) will promote the safety and efficacy of vaccines while rejecting claims that have no foundation in science; (f) supports state policies allowing minors to override their parent's refusal for vaccinations; and encourages state legislatures to establish comprehensive vaccine and minor consent policies; and (g) will continue its ongoing efforts with other immunization advocacy organizations to assist physicians and other healthcare professionals in effectively communicating to patients, parents, policy makers, and the media that vaccines do not cause autism and that decreasing immunization rates have resulted in a resurgence of vaccine-preventable diseases and deaths.
2. Our AMA: (a) supports the rigorous scientific process of the Advisory Committee on Immunization Practices as well as its development of recommended immunization schedules for the nation; (b) recognizes the substantial body of scientific evidence that has disproven a link between vaccines and autism; and (c) opposes the creation of a new federal commission on vaccine safety whose task is to study an association between autism and vaccines.

(Res. 9, A-15; Modified: CSAPH Rep. 1, I-15; Appended: Res. 411, A-17; Modified: Res. 011, A-19)

Vector-Borne Diseases, H-440.820

Due to the increasing threat and limited capacity to respond to vector-borne diseases, our AMA supports and will advocate for:
(1) Improved surveillance for vector-borne diseases to better understand the geographic distribution of infectious vectors and where people are at risk;
(2) The development and funding of comprehensive and coordinated vector-borne disease prevention and control programs at the federal, state and local level;
(3) Investments that strengthen our nation's public health infrastructure and the public health workforce;
(4) Education and training for health care professionals and the public about the risk of vector-borne diseases and prevention efforts as well as the dissemination of available information;
(5) Research to develop new vaccines, diagnostics, and treatments for existing and emerging vector-borne diseases, including Lyme disease;
(6) Research to identify novel methods for controlling vectors and vector-borne diseases; and
(7) Increased and sustained funding to address the growing burden of vector-borne diseases in the United States.
(Res. 430, A-18; Modified: CSAPH Rep. 04, A-19)

Promoting Equity in Global Vaccine Distribution, 250.032MSS

AMA-MSS will ask the AMA to amend Policy H-250.988, Low-Cost Drugs to Poor Countries during Times of Pandemic Health Crises, by addition and deletion as follows:

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Aid ~~Low-Cost Drugs~~ to ~~Poor~~ Low- and Middle-Income Countries during Epidemics and Pandemics ~~Times of Pandemic Health Crises~~, H-250.988
Our AMA will: (1) ~~encourages pharmaceutical companies to~~ work with governmental and appropriate regulatory authorities to encourage (a) the prioritization of equity when providing ~~provide~~ low cost or free medications, including therapeutics and vaccines, to countries; (b) the temporary waiver of intellectual property protections for necessary medications and other countermeasures; and (c) sharing of equipment, materials, scientific methods, and technological information, to facilitate production and distribution of necessary medications during epidemics and pandemics ~~times of pandemic health crises~~; and (2) shall work with the World Health Organization (WHO), UNAIDS, and other similar organizations that provide comprehensive assistance, including health care, to low- and middle-income countries in an effort to improve public health and national stability.
(MSS Res. 009/037, A-21) (Immediately Forwarded to HOD as Res. 609, Combined with Res. 608, 610, 611 and Adopted, A-21)

Immunization Programs for Children, 440.002MSS
AMA-MSS will ask the AMA to: (1) support domestic and international immunization programs; (2) develop legislation to ensure the priority of these programs; and (3) urge more intensive research to develop improved vaccines and immunization technology.
(AMA Amended Res 63, I-82 Adopted [H-440.991]) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

Childhood Immunization, 440.003MSS
AMA-MSS will ask the AMA to: (1) support legislation to assure a safe and adequate supply of childhood vaccines; and (2) impress upon Congress the urgency of the effects of decreasing numbers of vaccine manufacturers on the public health of the nation's children.
(AMA Res 130, A-86 Adopted [H-60.969]) (Reaffirmed: MSS Rep E, I-96) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

Increasing Accessibility to Meningitis Protection, 440.027MSS
(1) AMA-MSS will encourage all universities to offer the meningococcal vaccine preferably at reduced cost and to educate students about the benefits of vaccination.
(2) AMA-MSS supports the incorporation of the cost of the meningococcal vaccine into the estimated cost of attendance.
(MSS Res 17, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

HPV Vaccine in Cervical Cancer Prevention Worldwide, 440.028MSS
AMA-MSS will ask the AMA to: (a) urge physicians to educate themselves and their patients about HPV vaccination; (b) encourage the development and funding of programs targeted at reducing HPV transmission and screening for infection and precancerous cervical changes in developing countries; (c) intensify efforts to improve awareness and understanding about the availability and efficacy of HPV vaccinations in the general public; (d) encourage the integration of HPV vaccination into reproductive health care settings, including but not limited to routine reproductive health care visits for adults and adolescents; and (e) support the availability of the HPV vaccine to patient groups that benefit most from preventative measures, including but not limited to low-income and presexually active populations.
(MSS Res 5, A-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

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Increasing Advocacy for and Public Awareness of the Lack of a Vaccine Autism Link, 440.035MSS
AMA-MSS will ask the AMA to ask the Office of the Surgeon General for a definitive repudiation of the link between developmental disorders, such as autism, and either thimerosal-containing vaccines or the MMR vaccine.
(MSS Res 24, I-09) (AMA Res 413, A-10 Adopted [H-440.853]) (Reaffirmed: MSS GC Rep A, I-14) (Reaffirmed: MSS GC Rep A, I-19)

A Comprehensive Education Strategy to Improve Vaccination Rates, 440.051MSS
AMA-MSS (1) supports national, evidence-based education of parents by clinicians and reputable public health organizations about the risks and benefits of immunization to both children and the community at large to combat the public health threat that under-immunization poses; (2) supports the development of resources for physicians aimed at improving patient education regarding the safety of vaccines, their effectiveness at preventing communicable diseases, and the importance of maintaining herd immunity; and (3) will ask the AMA to partner with appropriate stakeholders to sponsor a national, evidence-based public service announcement campaign aimed at increasing the vaccination rate.
(MSS Res 4, A-15) (Recommendations in CSAPH Rep 1 Adopted as Amended in Lieu of AMA Res 904, I-15) (Reaffirmed: MSS GC Rep B, A-21)

Medical Misinformation in the Age of Social Media, 440.106MSS
AMA-MSS will ask the AMA to: (1) encourage social media organizations to further strengthen their content moderation policies related to medical misinformation, including, but not limited to enhanced content monitoring, augmentation of recommendation engines focused on false information, and stronger integration of verified health information; (2) encourage social media organizations to recognize the spread of medical misinformation over dissemination networks and collaborate with relevant stakeholders to address this problem as appropriate, including but not limited to altering underlying network dynamics or redesigning platform algorithms; (3) continue to support the dissemination of accurate medical information by public health organizations and health policy experts; (4) work with public health agencies in an effort to establish relationships with journalists and news agencies to enhance the public reach in disseminating accurate medical information; (5) amend existing policy concerning COVID-19 vaccine information to increase its scope and impact regarding medical misinformation as follows:

> **An Urgent Initiative to Support COVID-19 ~~Vaccination~~ Information Programs, D-440.921**
> Our AMA will institute a program to promote the integrity of a COVID-19 ~~vaccination~~ information programs by: (1) education physicians on speaking with patients about AMA-MSS Digest of Policy Actions/ 207 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 COVID19 and associated infections as well as the safety and efficacy of COVID-19 vaccines, 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 vaccinations; (4) supporting ongoing monitoring of COVID-19 vaccines to ensure that the evidence continues to support safe and effective use of vaccines among recommended populations~~.~~; (5)

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educating physicians and other healthcare professionals on means to disseminate accurate information and methods to combat medical misinformation online.;

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

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

(MSS Late Res. 02, A-21, Immediate Forward) (HOD Res. 421, A-21, Adopt as amended, clause 6 Referred for Decision [X-XXX])

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 12
(N-21)

Introduced by: Rohan Khazanchi, University of Nebraska Medical Center; Alec Calac, University of California-San Diego School of Medicine; Haritha Pavuluri, University of South Carolina School of Medicine Greenville; Kylie Rostad, University of Toledo College of Medicine and Life Sciences

Sponsored by: Region 1, Region 2, Region 4, Region 5, Region 6, Region 7, ANAMS, GLMA, APAMSA, PsychSIGN

Subject: Advocating for the Elimination of Hepatitis C Treatment Restrictions

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, An estimated 2.4 million Americans are living with Hepatitis C Virus (HCV) infection,[1] and acute HCV infection rates doubled from 2012 to 2019[2]; and

Whereas, Even with improvements in HCV treatment, projections for the next 35 years estimate that 157,000 U.S. patients will develop hepatocellular carcinoma, 203,000 will develop decompensated cirrhosis, and 320,000 will die due to HCV[3]; and

Whereas, The prevalence of HCV among Medicaid enrollees is 7.5 times higher than prevalence among the commercially insured population, demonstrating the disproportionate impact of HCV on marginalized populations[4]; and

Whereas, Structural barriers to accessing HCV therapy persist, as many state Medicaid programs, prisons and jails, and private insurers implement non-medically indicated restrictions, including *fibrosis restrictions* (requirement that patients have severe liver damage before receiving HCV treatment coverage), *sobriety restrictions* (requirement of abstinence from drugs and/or alcohol before HCV treatment), and *prescriber restrictions* (limitations on the type of clinician that can prescribe HCV treatment, such as requiring primary care doctors to consult with or request direct prescription from a hepatologist)[5,6]; and

Whereas, Consensus guidelines from the American Association for the Study of Liver Diseases (AASLD)and the Infectious Diseases Society of America (IDSA) recommend with Level 1A evidence that nearly all people with acute or chronic HCV should receive treatment with direct-acting antivirals (DAAs), which can cure over 95% of individuals with HCV[7]; and

Whereas, The AASLD/IDSA guidelines emphasize with Level 1A evidence that “there are no data to support the utility of pretreatment screening for illicit drug or alcohol use in identifying a population more likely to successfully complete HCV therapy”[7]; and

Whereas, The AASLD/IDSA guidelines emphasize with Level 1A evidence that initiating therapy in patients with lower-stage fibrosis augments the clinical and public health benefits of virologic cure, and treatment delay may decrease the benefit of virologic cure[7]; and

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Whereas, While treatment restrictions were primarily created to help payors mitigate the high cost of HCV treatment regimens, numerous studies have demonstrated that these restrictive policies are more costly and less effective than unrestricted strategies[8–13]; and

Whereas, In spite of expert consensus that HCV treatment restrictions are neither medically indicated nor effective, as of April 2021, four states still have fibrosis restrictions, 28 states have sobriety restrictions, and 18 states have prescriber restrictions[5,6]; and

Whereas, A 2018 study found that 35.5% of patients across 45 states (including 52.4% of commercial enrollees, 34.5% of Medicaid enrollees, and 14.7% of Medicare enrollees) who received prescriptions for DAAs were denied DAA coverage due to fibrosis, sobriety, or prescriber restrictions[14]; and

Whereas, The wholesale cost of a DAA treatment course has dropped over the last decade from $80,000+ to as low as $20,000[15]; and

Whereas, The Centers for Medicare and Medicaid Services issued a letter to states in 2015 that HCV treatment access restrictions may violate Medicaid statutory requirements[16]; and

Whereas, The U.S. Department of Health and Human Services' Viral Hepatitis National Strategic Plan for 2021-2025 includes a disparities goal of reducing the proportion of states with fibrosis, sobriety, and prescriber restrictions[17]; and

Whereas, Restricted access to HCV treatment disproportionately exacerbates health and financial inequities for American Indian/Alaska Native (AIAN) populations, who face double the acute HCV incidence rates of non-Hispanic whites and the highest rates of HCV-related mortality of any racial/ethnic group, as well as other structurally vulnerable immigrant and minoritized communities[18–20]; and

Whereas, While there is a legal responsibility to provide healthcare to AIAN patients served by the Indian Health Service (IHS), the agency serves as a payor of last resort, meaning federal and state-level coverage restrictions (i.e., via Medicare and Medicaid) can adversely impact IHS and AIAN populations[20–23]; and

Whereas, Our AMA supports increased funding and negotiation for affordable pricing of HCV treatment "so that all Americans for whom HCV treatment would have a substantial proven benefit will be able to receive this treatment" (H-440.845), which should include nearly all people with HCV in accordance with expert guidelines[7]; and

Whereas, Our AMA-MSS has a pending policy transmittal (440.101MSS) adopted at the June AMA-MSS Assembly which asks that our AMA "support removal of sobriety requirements as a barrier to HCV treatment" and asks our AMA to "work with state medical societies to remove sobriety requirements to HCV treatment", but neither this transmittal nor existing policy call for active AMA advocacy or address fibrosis and prescriber restrictions; therefore be it

RESOLVED, That our AMA-MSS amend the title of our existing policy and pending transmittal 440.101MSS Opposition to Sobriety Requirements for Hepatitis C Treatment to be "Advocating for the Elimination of Hepatitis C Treatment Restrictions"; and be it further

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RESOLVED, That our AMA-MSS amend our existing policy and pending transmittal 440.101MSS Opposition to Sobriety Requirements for Hepatitis C Treatment by substitution as follows:

440.101MSS Opposition to Sobriety Requirements for Hepatitis C Treatment: AMA-MSS will ask the AMA to amend Policy H-440.845, Advocacy for Hepatitis C Virus Education, Prevention, Screening, and Treatment, by addition and deletion as follows:

Advocacy for Hepatitis C Virus Education, Prevention, Screening, and Treatment, H-440.845

Our AMA will: (1) encourage the adoption of birth year-based screening practices for hepatitis C, in alignment with the Centers for Disease Control and Prevention (CDC) recommendations; (2) encourage the CDC, Indian Health Service, and state Departments of Public Health to develop and coordinate Hepatitis C Virus infection educational and prevention efforts; (3) support hepatitis C virus (HCV) prevention, screening, and treatment programs that are targeted toward maximum public health benefit; (4) recognize sobriety requirements, fibrosis restrictions, and prescriber restrictions as structural barriers to equitable and non-stigmatizing HCV treatment access; (5) advocate, in collaboration with state and specialty medical societies as well as patient advocacy groups, for the elimination of sobriety requirements, fibrosis restrictions, and prescriber restrictions for coverage of HCV treatment by public and private payors; (~~4~~6) support programs aimed at training providers in the treatment and management of patients infected with HCV; (~~5~~7) support adequate funding by, and negotiation for affordable pricing for HCV antiviral treatments between the government, insurance companies, and other third party payers, so that all Americans for whom HCV treatment would have a substantial proven benefit will be able to receive this treatment; (~~6~~8) recognize correctional physicians, and physicians in other public health settings, as key stakeholders in the development of HCV treatment guidelines; (~~7~~9) encourage equitable reimbursement for those providing treatment; (10) encourage the allocation of targeted funding to increase HCV treatment access at Indian Health Service facilities.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

Advocacy for Hepatitis C Virus Education, Prevention, Screening and Treatment H-440.845
Our AMA will: (1) encourage the adoption of birth year-based screening practices for hepatitis C, in alignment with Centers for Disease Control and Prevention (CDC) recommendations; (2) encourage the CDC and state Departments of Public Health to develop and coordinate Hepatitis C Virus infection educational and prevention efforts; (3) support hepatitis C virus (HCV) prevention, screening, and treatment programs that are targeted toward maximum public health benefit; (4) support programs aimed at training providers in the treatment and management of patients infected with HCV; (5) support adequate funding by, and negotiation for affordable pricing for HCV antiviral treatments between the government, insurance companies, and other third party payers, so that all Americans for whom HCV treatment would have a substantial proven benefit will be able to receive this treatment; (6) recognize correctional physicians, and physicians in other public health settings, as key stakeholders in the development of HCV treatment guidelines; and (7) encourage equitable reimbursement for those providing treatment. (Res. 906, I-12; Modified: Res. 511, A-15; Modified: Res. 410, A-17)

Support for Standardized Diagnosis and Treatment of Hepatitis C Virus in the Population of Incarcerated Persons H-430.985
Our AMA: (1) supports the implementation of routine screening for Hepatitis C virus (HCV) in prisons; (2) will advocate for the initiation of treatment for HCV when determined to be appropriate by the treating physician in incarcerated patients with the infection who are seeking treatment; and (3) supports negotiation for affordable pricing for therapies to treat and cure HCV among correctional facility health care providers, correctional facility healthcare payors, and drug companies to maximize access to these disease-altering medications.
(Res. 404, A-17)

Incorporating Value into Pharmaceutical Pricing H-110.986
1. Our AMA supports value-based pricing programs, initiatives and mechanisms for pharmaceuticals that are guided by the following principles: (a) value-based prices of pharmaceuticals should be determined by objective, independent entities; (b) value-based prices of pharmaceuticals should be evidence-based and be the result of valid and reliable inputs and data that incorporate rigorous scientific methods, including clinical trials, clinical data registries, comparative effectiveness research, and robust outcome measures that capture short- and long-term clinical outcomes; (c) processes to determine value-based prices of pharmaceuticals must be transparent, easily accessible to physicians and patients, and provide practicing physicians and researchers a central and significant role; (d) processes to determine

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value-based prices of pharmaceuticals should limit administrative burdens on physicians and patients; (e) processes to determine value-based prices of pharmaceuticals should incorporate affordability criteria to help assure patient affordability as well as limit system-wide budgetary impact; and (f) value-based pricing of pharmaceuticals should allow for patient variation and physician discretion.
2. Our AMA supports the inclusion of the cost of alternatives and cost-effectiveness analysis in comparative effectiveness research.
3. Our AMA supports direct purchasing of pharmaceuticals used to treat or cure diseases that pose unique public health threats, including hepatitis C, in which lower drug prices are assured in exchange for a guaranteed market size.
(CMS Rep. 05, I-16; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: CMS-CSAPH Rep. 01, A-17; Reaffirmed: CMS Rep. 07, A-18; Reaffirmed: CSAPH Rep. 2, I-19; Reaffirmed: CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 6, I-20)

Disease Prevention and Health Promotion in Correctional Institutions H-430.989
Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public health systems toward the prevention and control of HIV/AIDS, substance abuse, tuberculosis, hepatitis, and other infectious diseases. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers and drug treatment center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase in direct referral by correctional systems of parolees with a recent, active history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs as a sentence or in connection with sentencing.
(CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13; Modified: Alt. Res. 404, I-20)

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;

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(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.
(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)

440.101MSS Opposition to Sobriety Requirements for Hepatitis C Treatment
AMA-MSS will ask the AMA to amend Policy H-440.845, Advocacy for Hepatitis C Virus Education, Prevention, Screening, and Treatment, by addition and deletion as follows:

> Advocacy for Hepatitis C Virus Education, Prevention, Screening, and Treatment, H440.845
> Our AMA will: (1) encourage the adoption of birth year-based screening practices for hepatitis C, in alignment with the Centers for Disease Control and Prevention (CDC) recommendations; (2) encourage the CDC and state Departments of Public Health to develop and coordinate Hepatitis C Virus infection educational and prevention efforts; (3) support hepatitis C virus (HCV) prevention, screening, and treatment programs that are targeted toward maximum public health benefit; (4) support removal of sobriety requirements as a barrier to HCV treatment; (5) work with state medical societies to remove sobriety requirements for HCV treatment; (~~4~~6) support programs aimed at training providers in the treatment and management of patients infected with HCV; (~~5~~7) support adequate funding by, and negotiation for affordable pricing for HCV antiviral treatments between the government, insurance companies, and other third party payers, so that all Americans for whom HCV treatment would have a substantial proven benefit will be able to receive this treatment; (~~6~~8) recognize correctional physicians, and physicians in other public health settings, as key stakeholders in the development of HCV treatment guidelines; (~~7~~9) encourage equitable reimbursement for those providing treatment.

(MSS Res. 005, A-21)

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440.040MSS Increased Advocacy for Hepatitis C Virus Education, Prevention, Screening, and Treatment

AMA-MSS will ask the AMA to (1) encourage the adoption of age-based screening practices for hepatitis C, in alignment with recent Centers for Disease Control recommendations; and (2) to encourage increased resources for Centers for Disease Control and state Departments of Public Health for the development and coordination of Hepatitis C Virus infection educational and prevention efforts.

(Sub MSS Res 45, A-12) (Reaffirmed: MSS GC Rep A, I-19)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 13
(N-21)

Introduced by: Anthony Gallo, Theja Channapragada, Revati Gummaluri, Rowan University School of Osteopathic Medicine; Vineeth Amba, Rutgers Robert Wood Johnson Medical School

Sponsored by: Region 4

Subject: Providing Reduced or Waived Parking Fees for Medical Students

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, 47% of medical schools do not cover cost of transportation/parking for medical students and 61% of schools do not have a formal written policy for parking costs[1]; and

Whereas, The process for assigning clerkship sites to students is usually based on a lottery system leaving students incurring costs unequally[1]; and

Whereas, Clinical sites change locations at times on short notice and are at multiple sites in the short course of a few weeks making it difficult for students to obtain accessible parking spots[2-11]; and

Whereas, Rotation sites in certain areas, including non-urban communities, may not be accessible by public transportation[12]; and

Whereas, Each medical system's distinct geographic and infrastructure differences contribute to challenges in large scale study and require equally broad solution strategies[13]; and

Whereas, Medical students, especially students of color, take out significant student loans and face challenges, including unexpected administrative and time delays, when requesting additional funds in financial aid packages during the semester to access changing clinical sites[14,15]; and

Whereas, Medical students from disadvantaged socioeconomic backgrounds have an increased burden of debt compared to peers[16,17]; and

Whereas, Medical student indebtedness is found to be negatively correlated with worse academic outcomes and mental-wellbeing, causing significant anxiety and decreased study time[18]; and

Whereas, Medical students are not listed as hospital employees or staff in parking studies which development plans are often based on and are subsequently more likely to be classified as visitors[19]; and

Whereas, Inconsistent practices among hospitals may lead to medical students being charged the less favorable price, namely as either being charged as visitors in systems where hospital

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employees (i.e., physicians, residents, nurses, staff, etc.) receive more discounted parking or as hospital employees in systems where being classified as a visitor would provide greater benefit[20-24]; and

Whereas, The American Medical Association and American Medical Association-Medical Student Section both have existing policies that support the spirit of this resolution, yet have an underlying gap addressing medical student parking costs and fees[25]; therefore be it

RESOLVED, That our AMA work with relevant stakeholders to recognize parking fees at clinical sites as an additional expense for medical students and encourage medical students receive the lowest overall price available, including no cost, for parking.

Fiscal Note: TBD

Date Received: 09/15/2021

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25. Relevant AMA and AMA-MSS Policy (below).

RELEVANT AMA AND AMA-MSS 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

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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.

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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

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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

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 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

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Proposed Revisions to AMA Policy on the Financing of Medical Education Programs H-305.929

1. It is AMA policy that:

A. Since quality medical education directly benefits the American people, there should be public support for medical schools and graduate medical education programs and for the teaching institutions in which medical education occurs. Such support is required to ensure that there is a continuing supply of well-educated, competent physicians to care for the American public.

B. Planning to modify health system organization or financing should include consideration of the effects on medical education, with the goal of preserving and enhancing the quality of medical education and the quality of and access to care in teaching institutions are preserved.

C. Adequate and stable funding should be available to support quality undergraduate and graduate medical education programs. Our AMA and the federation should advocate for medical education funding.

D. Diversified sources of funding should be available to support medical schools' multiple missions, including education, research, and clinical service. Reliance on any particular revenue source should not jeopardize the balance among a medical school's missions.

E. All payers for health care, including the federal government, the states, and private payers, benefit from graduate medical education and should directly contribute to its funding.

F. Full Medicare direct medical education funding should be available for the number of years required for initial board certification. For combined residency programs, funding should be available for the longest of the individual programs plus one additional year. There should be opportunities to extend the period of full funding for specialties or subspecialties where there is a documented need, including a physician shortage.

G. Medical schools should develop systems to explicitly document and reimburse faculty teaching activity, so as to facilitate faculty participation in medical student and resident physician education and training.

H. Funding for graduate medical education should support the training of resident physicians in both hospital and non-hospital (ambulatory) settings. Federal and state funding formulas must take into account the resources, including volunteer faculty time and practice expenses, needed for training residents in all specialties in non-hospital, ambulatory settings. Funding for GME should be allocated to the sites where teaching occurs.

I. New funding should be available to support increases in the number of medical school and residency training positions, preferably in or adjacent to physician shortage/underserved areas and in undersupplied specialties.

2. Our AMA endorses the following principles of social accountability and promotes their application to GME funding: (a) Adequate and diverse workforce development; (b) Primary care and specialty practice workforce distribution; (c) Geographic workforce distribution; and (d) Service to the local community and the public at large.

3. Our AMA encourages transparency of GME funding through models that are both feasible and fair for training sites, affiliated medical schools and trainees.

4. Our AMA believes that financial transparency is essential to the sustainable future of GME funding and therefore, regardless of the method or source of payment for GME or the number of funding streams, institutions should publicly report the aggregate value of GME payments received as well as what these payments are used for, including: (a) Resident salary and benefits; (b) Administrative support for graduate medical education; (c) Salary reimbursement for teaching staff; (d) Direct educational costs for residents and fellows; and (e) Institutional overhead.

5. Our AMA supports specialty-specific enhancements to GME funding that neither directly nor indirectly reduce funding levels for any other specialty.

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CME Rep. 7, A-05; Reaffirmation I-06; Reaffirmed: 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; Reaffirmed: CME Rep. 15, A-10; Reaffirmation A-11; Reaffirmation A-13; Reaffirmed: CME Rep. 5, A-13; Appended: CME 05, A-16; Appended: Res. 319, A-16; Reaffirmation A-16

Providing Reduced Parking Fees for Patients 155.008MSS
Our AMA-MSS will ask the AMA to work with relevant stakeholders to recognize parking fees as a burden of care for patients and encourage mechanisms for reducing parking costs. (MSS Res. 089, Nov. 2020)

Commendation of the AMA for Support of Medical Education Funding 295.034MSS AMA-MSS commends the AMA for its continued support of medical education funding through AMA investigations, endorsements, legislative activity, and monetary contributions. (MSS Res 26, A-92) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

Equal Fees for Osteopathic and Allopathic Medical Students 295.131MSS
AMA-MSS will ask the AMA to: (1) reaffirm AMA Policies H-405.989 and G-635.053; (2) discourage discrimination by institutions and programs based on Osteopathic or Allopathic training; (3) support equal fees for clinical rotation externships by Osteopathic and Allopathic medical students; and (4) encourage that LCME/ACGME accredited institutions maintain fair practice standards for equal access to all US medical students, Osteopathic and Allopathic (MSS Amended Res 3, A-05) (AMA Res 809, I05 R1 Adopted, R2 Adopted as Amended, R3 and R4 Referred [H-295.876]) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

Solutions to Tackling the Increasing Cost of Medical Education 305.060MSS
AMA-MSS will ask the AMA to (a) support policies that ensure that funding gained by medical schools from all future increases to medical school tuition and fees be allocated directly to improve the education of medical students; and (b) support policies that ensure that all information related to the allocation of funds from tuition and fees increases be disclosed to all prospective and current medical students for each respective medical school campus; (2) AMA-MSS will work to develop print and electronic resources for our local chapters to utilize on their campuses to encourage their medical school deans to adopt policies that ensure transparency in medical school tuition and fees increases; (3) The AMA-MSS Governing Council will (a) continue to work with our AMA Council on Medical Education, the Association of American Medical Colleges (AAMC), and the AAMC Organization of Student Representatives (OSR) to encourage medical schools to adopt policies that ensure that all increases to medical school tuition and fees go towards direct improvements to medical student education. (MSS Amended Report G, A-07) (AMA Sub Res 310, A-08 Adopted) (Modified: MSS GC Rep C, I-12) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Report A, I-17)

Increasing Availability and Access to Financial Aid 305.088MSS
The AMA-MSS supports the following principles regarding access to student loans and availability of financial aid and scholarship monies: 1. That the AMA-MSS will ask the AMA to ask state medical societies to develop and implement interest-subsidized guaranteed student loan programs via the private sector in order to maintain a choice of funding to students. 2. That the AMA-MSS will ask the AMA to recommend that state medical societies raise funds for such programs by physician contributions over a short, but definite, term. 3. That the AMA-MSS will ask the AMA to work with state medical societies, associated foundations and medical schools to ensure that information about all offered scholarships is readily available online. 4. That the

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AMA-MSS will ask the AMA to encourage societies to support further expansion of state loan repayment programs, and expansion of those programs to cover physicians in non-primary care specialties. 5. That the AMA-MSS will ask the AMA to urge each state medical society strongly to add a voting medical student representative to its foundation Board of Directors or other appropriate governing body in addition to collecting and propagating bylaw changes from state societies that have added a medical student vote to their Board of Directors. 6. That the AMA-MSS will ask the AMA to urge, via its component state medical societies, all state foundations to consider converting any loan programs they may have into scholarship programs and provide AMA-MSS Digest of Policy Actions/ 152 information to said foundations on how other states have achieved this conversion. 7. That the AMA-MSS will ask the AMA to request that the state foundations and the AMA Foundation encourage donors to pool their funds with others to endow large scholarships. 8. That the AMA-MSS will ask the AMA to request that the AMA Foundation work with state medical societies and their foundations to (1) make scholarship programs direct-application at the medical school level, (2) ensure that scholarship funds are disbursed directly to the student, not to the medical school. 9. That the AMA-MSS will ask the AMA to request that the AMA Foundation compile and distribute to the state foundations a list of fundraising “best practices” that have been shown to be effective in raising funds for medical scholarships. (MSS GC Rep A, I-17)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 14
(N-21)

Introduced by: Samantha Rea, Mirna Kaafarani, Riya Shah, Aarti Patel, Tabitha Moses, Wayne State SOM; Dilpreet Kaeley, University of Toledo; Melanie Schroeder, University of Arizona

Sponsored by: Region 4, Region 5, Region 7, APAMSA, PsychSIGN

Subject: Ensuring Quality of Medical Interpretation for Patients with Limited English Proficiency

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, The US Census Bureau states that over 25 million people, or about 8.2% of the current population have Limited-English-Proficiency (LEP), with this value continuing to rise with more diverse populations[1]; and

Whereas, Patients with LEP have a higher risk of adverse events in healthcare processes, including but not limited to misinterpretation of diagnoses, incorrect handling of medications, and lack of complete informed consent, leading to a poorer overall healthcare experience[2-8]; and

Whereas, Patients with LEP also experience worse health outcomes than native English speakers, including poorly controlled hypertension, higher rates of obstetrical trauma, more return emergency department visits, and disparities in diagnostic testing for pediatric bronchiolitis[4,9-10]; and

Whereas, After adjusting for other social determinants and comorbidities, native English speakers had a lower likelihood of testing positive for COVID-19, being intubated, or dying from COVID-19 as compared to patients with LEP, further highlighting health disparities exacerbated during the COVID-19 pandemic[11-14]; and

Whereas, Patients with LEP experience more adverse events, on average, than proficient English speakers; and 1 of every 40 malpractice claims were linked to the lack of proper medical interpretation[15-16]; and

Whereas, Section 1557 of the Affordable Care Act (ACA) and its interpretation under the Health and Human Services Final Rule in 2016 requires that patients with LEP have access to qualified interpreters, defined as an interpreter who protects patient confidentiality, has proficiency in speaking and understanding the language, and can “interpret effectively, accurately, and impartially...using any necessary specialized vocabulary and phraseology”[17-18]; and

Whereas, Although Section 1557 of the ACA allows bilingual providers, family members, or friends to serve as ad-hoc interpreters, a systematic review found drawbacks of this informal interpretation including lack of confidentiality, difficulty having sensitive conversations, problems with translation accuracy, and reliance on inadequate language skills[7,17,19-20]; and

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Whereas, The Agency for Healthcare Research and Quality describes that utilizing professional medical interpreters rather than ad hoc interpretation by bilingual staff, family, or friends reduces medical errors and improves safety for patients with LEP[21]; and

Whereas, The Civil Rights Act of 1964 states that healthcare providers who receive federal funds shall not discriminate on the basis of national origin, inspiring Health and Human Service Executive Order 13166 that requires meaningful access to services for people with LEP within reason, while also respecting patient preferences for family or health care providers to provide informal interpretation[22-23]; and

Whereas, Despite existing regulations, many healthcare providers do not receive proper education or training on providing adequate language access to their patients and may therefore be unaware of federal and state laws[24-26]; and

Whereas, Certification of a professional interpreter involves 40 hours of approved medical interpreter training, post-secondary medical interpreting coursework, a bachelor's degree, demonstrated English proficiency, demonstrated proficiency in the language of interpretation, registration for a Certified Medical Interpreter Program, and successful completion of a written and oral exam[27]; and

Whereas, According to the US Bureau of Labor Statistics there are currently around 11,100 interpreters employed in healthcare, only 6,000 of whom are certified through The Certification Commission for Healthcare Interpreters (CCHI) or The National Board for Certification of Medical Interpreters (NBCMI), resulting in a shortage of certified interpreters[27-31]; and

Whereas, A 2018 survey by the American Hospital Association found that only 56% of US hospitals offered any spoken language interpreter services, regardless of certification status from CCHI or NBCMI, further highlighting the need for interpreter services for the 25 million people in the US with LEP[4,10,32]; and

Whereas, Patients with LEP have expressed similar levels of satisfaction with spoken language interpretation whether it is delivered via telephone, video, or in-person, which increases the accessibility of certified medical interpreters[33-35]; and

Whereas, The use of properly trained medical interpreters and language concordant care has led to fewer errors in communication, higher quality of care and satisfaction with care, lower malpractice risk, improved comprehension, better care, reduced hospital stays, lower readmission rates, and increased patient satisfaction[16,36-37,]; and

Whereas, California, New York, New Jersey, North Dakota, and Vermont require all medical interpreters to be certified through CCHI or NBCMI, increasing the quality of interpretation in these states from use of qualified interpreters to certified interpreters[38-39]; and

Whereas, At the November 2020 meeting, as a result of CME MIC Report A, the AMA-MSS passed policy in support of standardized medical education surrounding the use of interpreters; however, this policy did not address the differences in interpreter training and skill level and how these impact patient care[40]; and

Whereas, AMA Policy D-385.957 addresses reimbursement for medical interpreters, but it does not specify that the interpreters be certified by CCHI or NBCMI, nor does it include reimbursement by Medicare or private insurers; and

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Whereas, Medical interpretation by certified medical interpreters has the potential to improve health outcomes and health equity in a cost-efficient way for a population that has been historically marginalized, by increasing and standardizing the quality of medical care that patients with LEP receive[41-42]; therefore be it

RESOLVED, That our AMA recognize that the ideal qualified medical interpreter is one who has been certified by a nationally recognized organization such as The Certification Commission for Healthcare Interpreters (CCHI) or The National Board for Certification of Medical Interpreters (NBCMI); and

RESOLVED, That our AMA support the utilization of certified medical interpreters by healthcare providers for patients with limited English proficiency to provide optimal patient care; and

RESOLVED, That our AMA advocate for reimbursement structures that incentivize the use of certified medical interpreters through Medicaid, Medicare, and all private insurers.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

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: MS Rep. 5, A-11; Reaffirmed in lieu of Re. 110, A-13; Reaffirmation: A-17)

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)

Interpreter Services and Payment Responsibilities H-385.917
Our AMA supports efforts that encourage hospitals to provide and pay for interpreter services for the follow-up care of patients that physicians are required to accept as a result of that patient's emergency room visit and Emergency Medical Treatment and Active Labor Act (EMTALA)-related services.
(CMS Rep. 5, A-11; Reaffirmed: CMS Rep. 1, A-21)

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;

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(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)

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)

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;

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(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.
(CAS 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)

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.
(CME Rep. 5, A-98; Reaffirmed: Res. 221, A-07; Reaffirmation: A-11; Appended: 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-385.928: Patient Interpreters
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)

Discrimination Against Physicians by Health Care Plans H-285.985
Our AMA: (1) will develop draft federal and model state legislation requiring managed care plans and third party payers to disclose to physicians and the public, the selection criteria used to select, retain, or exclude a physician from a managed care or other provider plans;

(2) will request an advisory opinion from the Department of Justice on the application of the Americans with Disabilities Act of 1990 to selective contracting decisions made by managed

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care plans or other provider plans;

(3) will support passage of federal legislation to clarify the Americans With Disabilities Act to assure that coverage for interpreters for the hearing impaired be provided for by all health benefit plans. Such legislation should also clarify that physicians practicing in an office setting should not incur the costs for qualified interpreters or auxiliary aids for patients with hearing loss unless the medical judgment of the treating physician reasonably supports such a need;

(4) encourages state medical associations and national medical specialty societies to provide appropriate assistance to physicians at the local level who believe they may be treated unfairly by managed care plans, particularly with respect to selective contracting and credentialing decisions that may be due, in part, to a physician's history of substance abuse; and

(5) urges managed care plans and third party payers to refer questions of physician substance abuse to state medical associations and/or county medical societies for review and recommendation as appropriate.
(BOT Rep. 18, I-93; Appended by BOT Rep. 28, A-98; Reaffirmation: A-99; Reaffirmation: A-00; Reaffirmed: BOT Rep. 6, A-10; Reaffirmed in lieu of Res. 110, A-13)

D-160.992: Appropriate Reimbursement for Language Interpretive Services
1. Our AMA will seek legislation to eliminate the financial burden to physicians, hospitals and health care providers for the cost of interpretive services for patients who are hearing impaired or do not speak English.
2. Our AMA will seek legislation and/or regulation to require health insurers to fully reimburse physicians and other health care providers for the cost of providing sign language interpreters for hearing impaired patients in their care.
(Res 209, A-03; Reaffirmation: A-09; Reaffirmation: A-10; Appended: Res. 114, A-12; Reaffirmed: Res. 702, A-12; Reaffirmation: A-14; Reaffirmation: A-17)

D-90.999: Interpreters For Physician Visits
Our AMA continues to monitor enforcement of those provisions of the ADA to assure that physician offices are not subjected to undue burdens in their efforts to assure effective communication with hearing disabled patients. (BOT Rep 15, I-98; Reaffirmation: I-03; Modified: BOT Rep. 28, A-13; Reaffirmation, A-14)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 15
(N-21)

Introduced by: Tabitha Moses, May Chammaa, Wayne State University School of Medicine; Nikita Sood, Washington University School of Medicine in Saint Louis; Alyssa Greenwood Francis, Nikita Changlani, Texas Tech University Health Sciences Center El Paso Foster School of Medicine; Jenna Gage, University of Texas Medical Branch at Galveston; Christopher Prokosch, University of Minnesota Medical School; Richard Easterling; University of Mississippi School of Medicine; Shivania Reddy, Virginia Commonwealth University School of Medicine; Arianne Felicitas, University of North Texas Health Science Center Texas College of Osteopathic Medicine; Shad Yasin, Rutgers New Jersey Medical School; Danielle Rivera, University of New Mexico School of Medicine; Samantha Pavlock, Florida State University College of Medicine; Swetha Maddipudi, University of Texas Health Sciences Center San Antonio Long School of Medicine; Rajadhar Reddy, Baylor College of Medicine

Sponsored by: Region 1, Region 2, Region 3, Region 4, Region 6, Region 7, PsychSIGN

Subject: Drug Policy Reform

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Drug Use in the US

Whereas, In 2019, 197.5 million Americans (71.8%) aged 12 and over used a substance in the past year, with 179 million using alcohol, 72 million using tobacco, and 57.2 million using an illicit drug, including 9.7 million using prescription opioids, 6 million using hallucinogens, 5.9 million using prescription tranquilizers or stimulants, 5.5 million using cocaine, 2 million using methamphetamine, and 745,000 using heroin[1]; and

Whereas, In 2019, 20.4 million Americans (9.7% of those who used a substance in the past year) aged 12 and over met substance use disorder (SUD) criteria, including 14.5 million Americans with alcohol use disorder and 8.3 million with an SUD involving an illicit drug[1]; and

Incarceration for Drug Possession in the US

Whereas, The US classifies controlled substances into five schedules, but significant controversy exists over the schedules of certain drugs deemed to have “no medical use,” despite research showing that these drugs may have therapeutic potential[2-5]; and

Whereas, Sentences and penalties for federal and state drug offenses vary depending on the drug’s schedule, amount of drug, circumstances of arrest, and previous drug convictions and criminal record[6-8]; and

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Whereas, Drug possession is defined as being found with an amount of a drug small enough for personal use (as determined by the government) without legal justification[6-8]; and

Whereas, Under federal statute, drug possession is classified as a criminal misdemeanor and can be punishable by up to 1 year imprisonment and/or at least $1,000 in fines for a first-time offense and up to 3 years imprisonment and/or $5,000 in fines for repeat offenses, with greater sentences and penalties depending on amount of drug, previous drug convictions, and criminal record[7-8]; and

Whereas, State statutes are most commonly used to charge people with drug possession and these statutes vary significantly, with many states (including Indiana, Kentucky, and Oklahoma) reclassifying possession from felonies to misdemeanors over the last decade, lowering mandatory minimums, and using savings from reduced incarceration to fund social services, while many other states (such as Idaho, Missouri, and Nebraska) continue to charge possession as felonies often punished with multiple years of imprisonment[9-13]; and

Whereas, In some states, multiple drug felony convictions can result in being charged with a "violent offense," despite no physical violence being committed against any person, which can further increase sentences and penalties and limit eligibility for parole[14]; and

Whereas, Drug possession arrests comprise 10% of all arrests in the US and make up over 80% of all drug offense arrests, and possession arrests drastically increased alongside changing policies of the War on Drugs from 538,100 in 1982 to over 1.4 million in 2018, even as arrests for drug distribution and manufacture remained relatively stable since 1990[15-16]; and

Whereas, Of the 2.3 million people incarcerated in the US, 450,000 (20%) are incarcerated for "nonviolent drug offenses," including 120,000 unconvicted awaiting trial[16]; and

Whereas, Defelonization refers to the reclassification of an offense from a felony to a misdemeanor, reduces the probability and potential length of imprisonment and decreasing the long-term harms associated with incarceration[17-19]; and

Whereas, "Decriminalization" is distinct from legalization and only refers to the removal of criminal charges associated with drug possession and its reclassification as a civil infraction, which is a prohibited action that results in civil penalties and sanctions against a person[17-20]; and

Whereas, "Legalization" would move beyond decriminalization by eliminating civil infractions for drug possession and creating a regulatory system to control legal production and sale of drugs to adults without a prescription, as with alcohol and tobacco[17-20]; and

Whereas, AMA Policy H-95.924, "Cannabis Legalization for Adult Use," states that our AMA "supports public health based strategies, rather than incarceration," and the AMA Council on Science & Public Health's Interim 2020 report on cannabis states that "AMA policy supports decriminalization of cannabis (i.e., reduction in the penalty associated with possession of a small amount of cannabis from a criminal offense subject to arrest to a civil infraction)"[21]; and

Whereas, Various states are considering policies to expunge (destroy) certain offenses (such as drug offenses, especially those due to cannabis) from a person's criminal record after completion of sentences and penalties, but expungement processes can still be costly and complicated, hindering eligible people from applying (for example, expungement in Missouri costs $250)[22-26]; and

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Whereas, The Marijuana Opportunity Reinvestment & Expungement Act, which was passed by the US House of Representatives in December 2020 but has not yet been considered in the Senate, contains language to "create an automatic process, at no cost to the individual, for the expungement, destruction, or sealing of criminal records for cannabis offenses; and...eliminate violations or other penalties for persons under parole, probation, pre-trial, or other State or local criminal supervision for a cannabis offense"[27-28]; and

Detrimental Health Impacts of Drug Criminalization

Whereas, The US Department of Health & Human Services' Healthy People 2020 initiative considers incarceration a key issue within the broad category of social determinants of health, due to poor physical and mental health outcomes and cross-generational effects on the children of those incarcerated, with evidence demonstrating the disproportionate impact of the "War on Drugs" on minoritized communities[29-31]; and

Whereas, While only 5% of people who use drugs are Black, arrests of Black people comprise nearly 30% of all drug arrests, and Black people are nearly six times more likely to be arrested for a drug offense than a white person, even when controlling for differences in drug use, exacerbating racial injustice[32-33]; and

Whereas, Research shows that incarceration is ineffective and does not significantly reduce recidivism, drug use, drug overdose deaths, or drug arrests, with a 2013 Washington state study finding that overdose was the leading cause of death for people previously incarcerated[34-36]; and

Whereas, Drug criminalization is associated with increased stigma and discrimination against people who use drugs, impairing their mental and physical health and hindering treatment efforts; has fueled the growth of illegal markets, organized crime, and violent injuries; and detrimentally affected public health by increasing overdose deaths due to drug contamination and spreading HIV and hepatitis C[37-41]; and

Whereas, Previous incarceration of people who use drugs is associated with lack of access to health insurance, even after the implementation of the Affordable Care Act, while possession arrests, regardless of conviction, can negatively impact employment, housing, and student loan eligibility, leading to widespread and multifactorial health consequences[42-44]; and

Whereas, Drug felony convictions can lead to lifelong bans from receiving government assistance (such as SNAP and TANF), employment and housing discrimination, and loss of the right to vote or serve on a jury[7,45-48]; and

Whereas, People who are incarcerated are at higher risk of chronic conditions such as cardiovascular disease, hypertension, and cancer compared to the general population, with an important 2013 New York state study finding that each year spent in prison corresponded with a two-year decline in life expectancy[49-50]; and

Outcomes of Drug Decriminalization

Whereas, Drug criminalization is costly, ineffective, and stigmatizing, exposing people to incarceration, encouraging more dangerous drug consumption methods, and discouraging people from receiving health services[51-53]; and

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Whereas, 83% of Americans believe that the "War on Drugs" has failed, 66% support "eliminating criminal penalties for drug possession," and 61% of voters support reducing sentences of people currently incarcerated for drug offenses, with similar findings replicated across multiple states[54-58]; and

Whereas, California reclassified drug possession from a felony to misdemeanor in 2014 by passing ballot initiative Proposition 47, "The Safe Neighborhoods and Schools Act," leading to the release or resentencing of 3,000 people and saving the state $156 million, with a later study finding no associated increase in crime[59-63]; and

Whereas, A 2018 study on cannabis decriminalization in five U.S. states did not find an increase in the prevalence of youth cannabis use as a result of decriminalization[64]; and

Whereas, In 2010 the Czech Republic decriminalized personal drug possession after a comprehensive policy review determined that criminal penalties did not reduce use or harm and were instead costly and unjustifiable, with later studies demonstrating net societal benefits without increased rates of drug use[65-66]; and

Whereas, Drug decriminalization in Portugal resulted in a decrease in heroin- and cocaine-related seizures, HIV and drug-related deaths, and decreased societal costs related to drug use[67-68]; and

Whereas, In 2019 the United Nations Chief Executives Board for Coordination issued a statement calling for the "promot[ion of] alternatives to conviction and punishment in appropriate cases, including the decriminalization of drug possession for personal use"[18,69]; and

Whereas, Decriminalization of personal use and possession of drugs is supported by the World Health Organization, American Public Health Association, Human Rights Watch, Global Commission on Drug Policy, International Federation of Red Cross and Red Crescent Societies, NAACP, and National Latino Congreso[70-76]; therefore be it

RESOLVED, That our AMA advocate for federal and state reclassification of drug possession offenses as civil infractions and the corresponding reduction of sentences and penalties for individuals currently incarcerated, monitored, or penalized for previous drug-related felonies; and be it further

RESOLVED, That our AMA support federal and state efforts to expunge criminal records for drug possession upon completion of a sentence or penalty at no cost to the individual; and be it further

RESOLVED, That our AMA support federal and state efforts to eliminate incarceration-based penalties for persons under parole, probation, pre-trial, or other criminal supervision for drug possession.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY:

Federal Drug Policy in the United States H-95.981
The AMA, in an effort to reduce personal and public health risks of drug abuse, urges the formulation of a comprehensive national policy on drug abuse, specifically advising that the federal government and the nation should: (1) acknowledge that federal efforts to address illicit drug use via supply reduction and enforcement have been ineffective (2) expand the availability and reduce the cost of treatment programs for substance use disorders, including addiction; (3) lead a coordinated approach to adolescent drug education; (4) develop community-based prevention programs for youth at risk; (5) continue to fund the Office of National Drug Control Policy to coordinate federal drug policy; (6) extend greater protection against discrimination in the employment and provision of services to drug abusers; (7) make a long-term commitment to expanded research and data collection; (8) broaden the focus of national and local policy from drug abuse to substance abuse; and (9) recognize the complexity of the problem of substance abuse and oppose drug legalization.
BOT Rep. NNN, A-88Reaffirmed: CLRPD 1, I-98Reaffirmed: CSAPH Rep. 2, A-08Modified: CSAPH Rep. 2, I-13Reaffirmed: BOT Rep. 14, I-20

Cannabis Legalization for Adult 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

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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.
CSAPH Rep. 05, I-17, Appended: Res. 913, I-19, Modified: CSAPH Rep. 4, I-20

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

Public Health Impacts of Cannabis Legalization D-95.960
Our AMA will study the expungement, destruction, and sealing of criminal records for legal offenses related to cannabis use or possession. CSAPH Rep. 4, I-20

Youth Incarceration in Adult Facilities H-60.916
1. Our AMA supports, with respect to juveniles (under 18 years of age) detained or incarcerated in any criminal justice facility: (a) early intervention and rehabilitation services, (b) appropriate guidelines for parole, and (c) fairness in the expungement and sealing of records**.** 2. Our AMA opposes the detention and incarceration of juveniles (under 18 years of age) in adult criminal justice facilities. Alt. Res. 917, I-16

Ending Money Bail to Decrease Burden on Lower Income Communities H-80.993
Our AMA: (1) recognizes the adverse health effects of pretrial detention; and (2) will support legislation that promotes the use of non-financial release options for individuals charged with nonviolent crimes.
Res. 408, A-18

Reduction of Medical and Public Health Consequences of Drug Abuse D-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

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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; Modified: CSAPH Rep. 2, I-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; Modified: Res. 914, I-16

Pilot Implementation of Supervised Injection Facilities H-95.925
Our AMA supports the development and implementation of pilot supervised injection facilities (SIFs) in the United States that are designed, monitored, and evaluated to generate data to inform policymakers on the feasibility, effectiveness, and legal aspects of SIFs in reducing harms and health care costs related to injection drug use. Res. 513, A-17

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

Advocate for the Legalization of Recreational Cannabis to End Mass Incarceration 100.027MSS
Our AMA-MSS supports the legalization of recreational cannabis at the federal level. MSS Res. 044, Nov. 2020

Opposing the Classification of Cannabidiol as a Schedule 1 Drug 100.021MSS
AMA-MSS will ask the AMA to support the reclassification of Cannabidiol (CBD) as a non-scheduled drug. MSS Res 64, I-17

Cannabis and the Regulatory Void 95.008MSS
AMA-MSS believes that although cannabis is a mind-altering drug whose use may have unforeseen consequences; (1) federal and state governments should abolish all criminal penalties relating to consumption or possession of cannabis; (2) the sale of cannabis for medicinal use should be regulated according to evidence-based research; and (3) additional research should be encouraged.
MSS Res 27, I-12; Modified: MSS Res 18, A-17

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 16
(N-21)

Introduced by: Sarah Mae Smith, University of California - Irvine School of Medicine; Rajadhar Reddy, Baylor College of Medicine; Jenna Gage, University of Texas Medical Branch at Galveston; Alyssa Greenwood Francis, Texas Tech University Health Sciences Center El Paso Paul L. Foster School of Medicine; Anand Singh, Texas Christian University & University of North Texas Health Science Center School of Medicine; Ryan Englander, University of Connecticut School of Medicine; Krithika Sundaram, Northeast Ohio Medical University; Meghana Chanamolu, Northeast Ohio Medical University; Sean O'Leary, University of Texas Medical Branch at Galveston; Richard Easterling, University of Mississippi School of Medicine; Rohan Khazanchi, University of Nebraska Medical Center

Sponsored by: Region 1, Region 2, Region 3, Region 4, Region 5, Region 6, Region 7, PsychSIGN, SOMA

Subject: Medicare Coverage of Dental, Vision, and Hearing Services

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, The Social Security Act expressly prohibits coverage for most dental services, specifically "services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth," by Original Medicare for its beneficiaries[1]; and

Whereas, Though Medicare covers "medically necessary" dental care, the Centers for Medicare & Medicaid Services presently interprets this to cover a very limited scope of services and coverage determinations are often inconsistent--for example, Medicare Part A will cover an oral examination as part of a comprehensive workup in preparation for a kidney transplant, but not for transplantation of non-kidney organs[2,3]; and

Whereas, Almost 24 million Medicare beneficiaries have no dental coverage, comprising nearly half of Medicare beneficiaries[4]; and

Whereas, In 2021, 16.6 million Medicare Advantage enrollees have some dental benefits through their plans, but 78% of those with coverage are enrolled in plans with annual dollar limits on dental coverage (average annual limit of $1,300), 10% are required to pay an additional premium for dental coverage, and plans with coverage for extensive dental services often necessitate significant coinsurance cost-sharing (most common cost-sharing of 50%)[4]; and

Whereas, Lack of dental coverage and dental underinsurance leads to Medicare beneficiaries forgoing recommended care, with 47% of those enrolled in Medicare not visiting the dentist in 2018[4]; and

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Whereas, Racial inequities are perpetuated in access to dental services, with Black and Hispanic Medicare enrollees most likely to have not seen a dentist in the past year (68% and 61%, respectively)[4]; and

Whereas, Only 7.27% of Medigap (Medicare Supplement) plans offer additional benefits such as dental, hearing, and vision coverage[5]; and

Whereas, A 2016 analysis of over 1,200 older adult respondents in the Health and Retirement Study found that only 68% used dental services, and two-thirds of those who wanted to use dental services but did not do so reported cost as a reason they did not receive dental care[6]; and

Whereas, The 2016 analysis of the Health and Retirement Study found that 42% of those using dental services received a filling, bonding, or inlay; 34% received a crown, implant, or prosthetic; 26% received a gum treatment, tooth extraction, or surgery; and 10% received dentures[6]; and

Whereas, Poor dental health has myriad negative repercussions for patients' health, including nutritional deficiencies secondary to tooth loss, exacerbation of diabetes and cardiovascular disease by untreated caries and periodontal disease, infections, and delayed diagnoses resulting in preventable complications and adverse outcomes, including for cancer[7,8]; and

Whereas, Original Medicare does not cover routine eye examinations or refractions for eyeglasses or contact lenses, nor does it cover eyeglasses or contact lenses themselves other than eyeglasses following cataract surgery[2,9]; and

Whereas, Untreated vision loss is correlated with increased risk of falls, depression, cognitive impairment, hospitalization, and mobility limitations among older adults[10]; and

Whereas, Thirty-nine percent of Medicare beneficiaries reported having trouble seeing even with their glasses, and low-income beneficiaries were most likely to have vision trouble[10]; and

Whereas, Among Medicare beneficiaries, forty-three percent who have difficulty seeing have not had an eye exam within the last year[11]; and

Whereas, Only thirty-seven percent of Medicare beneficiaries over the age of 65 had an eye exam at least once every 15 months in one recent study[12]; and

Whereas, Medicare beneficiaries with supplemental vision plans spent an average of $415 for vision care, while those with Medicare Advantage spent an average of $331, with 61% and 65% of spending being comprised of out-of-pocket costs to the patient, indicating that even those who have some vision care have significant out-of-pocket expenses for vision care[10]; and

Whereas, Medicare beneficiaries hospitalized for common illnesses were shown to have longer mean lengths of stay, higher readmission rates, and higher costs both during hospitalization and ninety days post-discharge if they had partial or severe vision loss compared to matched hospitalized Medicare beneficiaries with no vision loss, resulting in an estimated $500 million in excess healthcare costs annually[13]; and

Whereas, Among Medicare beneficiaries, low vision is associated with an increased risk of hip fractures, depression, anxiety, and dementia, and more prevalent among Black and Hispanic patients[14]; and

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Whereas, Medicare beneficiaries with vision impairment reported lower well-being, which was found to be mediated by limitations on mobility and household activities/ instrumental activities of daily living relative to Medicare patients without visual impairment[15]; and

Whereas, A 2018 study published in *JAMA Ophthalmology* found that Hispanic and Black Medicare beneficiaries were significantly less likely to report using low-vision devices than white patients, but there were no similar disparities for low-vision rehabilitation (which is covered by Medicare), leading the study authors to conclude that "policy makers could consider expanding Medicare coverage to include low-vision devices in an effort to address significant disparities in the use of this evidence-based intervention"[16]; and

Whereas, Among adults over the age of 65, the prevalence of falls in the past year for patients with vision impairment was over double that for patients without vision impairment (27.6% versus 13.2%), and the prevalence of activity restriction due to fear of falling was much higher in patients with vision impairment as well (50.8% versus 33.9% for patients without vision impairment)[17]; and

Whereas, A 2017 *JAMA Ophthalmology* study indicated that visual impairment was associated with a 1.9- to 2.8-fold increase in cognitive dysfunction or dementia among adults 60 years and older[18]; and

Whereas, A study of over 22,000 nationwide respondents to the Medicare Current Beneficiary Study found that beneficiaries with vision impairment were significantly more likely to be hospitalized over a three-year period[19]; and

Whereas, Nearly 25% of people aged 65-74 and 50% persons of people over 75 suffer from disabling hearing loss, which is associated with decreased quality of life, increased risk of cognitive decline and hospitalization, and higher healthcare costs by thousands of dollars, outweighing the relative cost of providing hearing services[20-24]; and

Whereas, Fewer than 30% of those aged 70 and older who could benefit from hearing aids have ever used them, with many reporting cost as prohibitive, with an average cost of $2,500 for a pair of digital hearing aids and some ranging up to $6,000[25-26]; and

Whereas, Original Medicare does not cover hearing exams, hearing aids, or aural rehabilitative services, while Medicare Advantage charges additional premiums for hearing coverage, with out-of-pocket costs and annual limits varying significantly across Advantage plans[27-28]; and

Whereas, The *Lancet* Commission has recognized hearing impairment as one of the most important modifiable risk factors for dementia, and observed that "hearing aid use was the largest factor protecting from decline" and "the long follow-up times in these prospective studies suggest hearing aid use is protective, rather than the possibility that those developing dementia are less likely to use hearing aids"[29]; and

Whereas, Medicare beneficiaries with functional hearing difficulty (which reflects perceived hearing under daily circumstances and takes the use of hearing aids into account for patients that have them) experience more unmet healthcare needs, such that study investigators concluded that "rethinking service delivery models to provide better access to hearing care could lead to increased hearing aid use and improved interactions between providers and patients with hearing loss"[30]; and

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Whereas, AMA Policy H-185.929, "Hearing Aid Coverage," supports Medicare covering hearing tests, but does not indicate support for hearing aids or aural rehabilitative services (which includes fittings and adjustments); and

Whereas, Numerous recent proposals from the legislative and executive branches have proposed the creation of new dental benefits for preventive and restorative services and additional vision and hearing benefits for routine exams and aids under Medicare Part B, including President Biden's 2022 budget request, legislation (H.R. 3) passed by the House of Representatives in 2019, and most recently, the Senate Democrats' budget resolution[5,31,32]; therefore be it

RESOLVED, That our AMA support Medicare coverage of preventive dental care, including dental cleanings and x-rays, and restorative services, including fillings, extractions, and dentures; and be it further

RESOLVED, That our AMA support Medicare coverage of routine eye examinations and visual aids, including eyeglasses and contact lenses; and be it further

RESOLVED, That our AMA amend Hearing Aid Coverage H-185.929 by addition as follows:

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, aural rehabilitative services, and hearing aids 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.; and be it further

RESOLVED, That this resolution be immediately forwarded to our AMA House of Delegates at the November 2021 Special Meeting.

Fiscal Note: TBD

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Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

Eye Exams for the Elderly H-25.990
Our AMA (1) encourages the development of programs and/or outreach efforts to support periodic eye examinations for elderly patients; and (2) encourages physicians to work with their state medical associations and appropriate specialty societies to create statutes that uphold the interests of patients and communities and that safeguard physicians from liability when reporting in good faith the results of vision screenings.
Res. 813, I-05; Reaffirmed: CSAPH Rep. 1, A-15

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.
CMS Rep. 6, I-15; Appended: Res. 124, A-19

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.
CMS Rep. 03, A-19

Importance of Oral Health in Patient Care D-160.925

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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.
Res. 911, I-16; Reaffirmed: CMS Rep. 03, A-19

Increased Affordability and Access to Hearing Aids and Related Care 25.003MSS
AMA-MSS will ask the AMA to 1) support policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences to the elderly; 2) encourage increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids; and 3) support the availability of over-the-counter hearing aids for the treatment of age-related mild-to-moderate hearing loss.
MSS CEQM Rep I-18, Adopted; AMA Res 124, A-19, Adopted [H-185.929]

Establishing Comprehensive Dental Benefits Under State Medicaid Programs 290.009MSS
AMA-MSS will ask the AMA to amend Policy H-330.872, "Medicare Coverage for Dental Services" by addition and deletion as follows:
Medicare, Medicaid, and Other Public Health Insurance Coverage for Dental Service 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, ~~and~~ Medicaid, and other public health insurance program beneficiaries; and (2) initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease among ~~in both~~ Medicare, ~~and~~ Medicaid, and other public health insurance program beneficiaries ~~populations~~, the optimal dental benefit plan designs to cost-effectively improve health and prevent disease ~~in both~~ among Medicare, ~~and~~ Medicaid, and other public health insurance programs beneficiaries ~~populations~~, and the impact of expanded dental coverage on health care costs and utilization.
MSS Res. 026, A-21

Importance of Oral Health in Medical Practice 440.058MSS
AMA-MSS (1) recognizes the importance of managing oral health as a part of overall patient care; (2) supports efforts to educate physicians on oral condition screening and management, as well as the consequences of poor oral hygiene on mental and physical health; (3) supports closer collaboration of physicians with dental providers to provide comprehensive medical care; and (4) support efforts to increase access to oral health services.
MSS Res 22, I-16

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 17
(N-21)

Introduced by: Lavanya Easwaran, Christopher Garcia-Wilde, Rhiya Mittal, Pooja Dave, University of Miami Miller School of Medicine

Sponsored by: Region 2, Region 4, PsychSIGN

Subject: Supporting and Funding Sobering Centers

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, Public intoxication related charges were among the top ten reasons for arrest in the United States (US) in 2019, with over 450,000 arrests[1]; and

Whereas, Black, American Indian and Alaska Native people are arrested at greater rates per capita annually for public intoxication charges in the US than those who are White[1]; and

Whereas, Several sobering centers are led by Alaska Native tribal organizations and have reduced incarceration rates per capita for public intoxication among Alaska Natives[2]; and

Whereas, Specialty and hospital-based treatments for acute alcohol intoxication account for $24.6 billion of healthcare costs, with most patients seeking care in emergency departments[3]; and

Whereas, The number of acute alcohol-related emergency department visits increased from 1,801,006 in 2006 to 2,728,313 in 2014, indicating a growing need for substance use disorder resources and interventions[4]; and

Whereas, The US has the highest incarceration rate in the world and incarceration can result in a series of social sequelae affecting a person's ability to maintain housing, personal health, employment, and other necessities[5]; and

Whereas, A growing number of local jurisdictions within the US and nations around the globe are shifting towards a health-based response to public intoxication, as opposed to criminalization[6]; and

Whereas, At least 35 sobering centers across 14 US states currently function to safely lead those acutely intoxicated by various substances to recover under medical observation and to connect them with substance use disorder recovery programs[7, 8,]; and

Whereas, Sobering centers are able to treat patients with substance use disorders and are well positioned to provide services to those disadvantaged by other social barriers, including experiencing homelessness[9]; and

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Whereas, Houston Recovery Center in Houston, Texas is a nationally recognized sobering center model, serving the largest metropolitan population among all sobering centers in the United States[8]; and

Whereas, Jail admissions for public intoxication in Harris County, Texas decreased by 95 percent (from 15,357 to 835) from 2012 to 2017 following the opening of the Houston Recovery Center [10]; and

Whereas, A jail admission in Harris County was reported to be $286 per day while the sobering center at full capacity would cost $127 per admission, allowing Harris County to view the program as a cost-offset [10]; and

Whereas, The primary workforce of the Houston Recovery Center consists of Texas state-certified peer recovery support specialists who work alongside nurses, licensed chemical dependency counselors, emergency medical technicians, social workers, and civilians with institution-specific training who provide comprehensive services [11]; and

Whereas, Sobering centers accept clients through multiple referral sources including ambulatory and vehicular outreach teams, walk-ins, police, emergency medical services, and emergency departments [11]; and

Whereas, Forty-eight percent of the 25,282 clients admitted to the Houston Recovery Center over 5 years accepted referral to additional services, requested housing assistance, or enrolled in treatment upon discharge [10]; and

Whereas, In 2014 the Houston Recovery Center launched the Partners in Recovery (PIR) program designed to address substance use among low-income, uninsured clients with complex needs and more than two admissions to the sobering center[12]; and

Whereas, The PIR Houston Recovery Center is able to practice a proactive intervention strategy by working with individuals with active substance use disorders in criminal justice and street outreach settings[12]; and

Whereas, A modeling study with a sobering center diversion rate of 50 percent resulted in an estimated annual national savings ranging from $230 million to $1.0 billion[13]; and

Whereas, The City of Houston reported a $2.9 million positive fiscal impact in the first 20 months after sobering center operation[14]; and

Whereas, Estimated national savings range from $230 million to $1.0 billion annually based on Monte Carlo modeling with sobering center diversion rate of 50%[15] ; and

Whereas, Cost analysis of the San Francisco Sobering Center comparing direct costs of emergency department to per-encounter costs at the Sobering Center found significantly less cost for care of acute intoxication than emergency department by savings of $243[16]; and

Whereas, A review done by Santa Cruz Recovery Center in 2018 reported a 86% decline in time spent by law enforcement processing public inebriates, with a 53% decline from 2014 to 2017 in average monthly jail bookings translating into $83,290 savings in officer costs[17]; therefore be it

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RESOLVED, That our American Medical Association recognize the utility, cost effectiveness, and racial justice impact of sobering centers; and be it further

RESOLVED, That our American Medical Association support the maintenance and expansion of sobering centers; and be it further

RESOLVED, That our American Medical Association support ongoing research of the sobering center public health model; and be it further

RESOLVED, That our American Medical Association support the use of state and national funding for the development and maintenance of sobering centers.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

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. CSAPH Rep. 01, A-18Reaffirmed: BOT Rep. 14, I-20

Harmful Substance Use H-95.96

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Our AMA encourages every physician to make a commitment to join his/her community in attempting to reduce harmful substance use and that said commitment encourage involvement in at least one of the following roles: (1) donation of time to talk to local civic groups, schools, religious institutions, and other appropriate groups about harmful substance use; (2) join or organize local groups dedicated to the prevention of harmful substance use; (3) talk to youth groups about brain damage and other deleterious effects of harmful substance use; and (4) educate and support legislators, office holders and local leaders about ways to end harmful substance use and providing adequate treatment to patients with substance use disorder. Sub. Res. 36, I-90Modified: Sunset Report, I-00Reaffirmed: CSAPH Rep. 1, A-10Modified: CSAPH Rep. 01, A-20

Increased Funding for Substance Use Disorder Treatment H-95.973
Our AMA (1) urges Congress to substantially increase its funding for substance use disorder treatment programs; (2) urges Congress to increase funding for the expansion and creation of new staff training programs; and (3) urges state medical societies to press for greater commitment of funds by state and local government to expand the quantity and improve the quality of the substance use disorder treatment system. Res. 116, I-89Reaffirmed: Sunset Report, A-00Reaffirmed: CSAPH Rep. 1, A-10Modified: CSAPH Rep. 01, A-20

Involuntary Civic Commitment for Substance Use Disorder H-95.912
Our AMA opposes civil commitment proceedings for patients with a substance use disorder unless: a) a physician or mental health professional determines that civil commitment is in the patient's best interest consistent with the AMA Code of Medical Ethics; b) judicial oversight is present to ensure that the patient can exercise his or her right to oppose the civil commitment; c) the patient will be treated in a medical or other health care facility that is staffed with medical professionals with training in mental illness and addiction, including medications to help with withdrawal and other symptoms as prescribed by his or her physician; and d) the facility is separate and distinct from a correctional facility. BOT Rep. 7, I-20

Addiction and Unhealthy Substance Use H-95.976
Our AMA is committed to efforts that can help the national problem of addiction and unhealthy substance use from becoming a chronic burden. The AMA pledges its continuing involvement in programs to alert physicians and the public to the dimensions of the problem and the most promising solutions. The AMA, therefore: (1) supports cooperation in activities of organizations in fostering education, research, prevention, and treatment of addiction; (2) encourages the development of addiction treatment programs, complete with an evaluation component that is designed to meet the special needs of pregnant women and women with infant children through a comprehensive array of essential services; (3) urges physicians to routinely provide, at a minimum, a historical screen for all pregnant women, and those of childbearing age for substance abuse and to follow up positive screens with appropriate counseling, interventions and referrals; (4) supports pursuing the development of educational materials for physicians, physicians in training, other health care providers, and the public on prevention, diagnosis, and treatment of perinatal addiction. In this regard, the AMA encourages further collaboration in delivering appropriate messages to health professionals and the public on the risks and ramifications of perinatal drug and alcohol use; (5) urges the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, and the Substance Abuse and Mental Health Services Administration to **continue to support research and demonstration projects around effective prevention and intervention strategies**; (6) urges that public policy be predicated on the understanding that alcoholism and drug dependence, including tobacco use

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disorder as indicated by the Surgeon General's report, are diseases characterized by compulsive use in the face of adverse consequences;
(7) affirms the concept that addiction is a disease and supports developing model legislation to appropriately address perinatal addiction as a disease, bearing in mind physicians' concern for the health of the mother, the fetus and resultant offspring; and (8) calls for better coordination of research, prevention, and intervention services for women and infants at risk for both HIV infection and perinatal addiction. BOT Rep. Y, I-89Reaffirmed: Sunset Report, A-00Reaffirmation A-09Modified: CSAPH Rep. 01, A-19

Federal Drug Policy in the United States H-95.981:
The AMA, in an effort to reduce personal and public health risks of drug abuse, urges the formulation of a comprehensive national policy on drug abuse, specifically advising that the federal government and the nation should: (1) acknowledge that federal efforts to address illicit drug use via supply reduction and enforcement have been ineffective (2) expand the availability and reduce the cost of treatment programs for substance use disorders, including addiction; (3) lead a coordinated approach to adolescent drug education; (4) develop community-based prevention programs for youth at risk; (5) continue to fund the Office of National Drug Control Policy to coordinate federal drug policy; (6) extend greater protection against discrimination in the employment and provision of services to drug abusers; (7) make a long-term commitment to expanded research and data collection; (8) broaden the focus of national and local policy from drug abuse to substance abuse; and (9) recognize the complexity of the problem of substance abuse and oppose drug legalization. BOT Rep. NNN, A-88Reaffirmed: CLRPD 1, I-98Reaffirmed: CSAPH Rep. 2, A-08Modified: CSAPH Rep. 2, I-13Reaffirmed: BOT Rep. 14, I-20

Community-Based Treatment Centers H-160.963:
Our AMA supports the use of community-based treatment centers for substance use disorders, mental health disorders and developmental disabilities. BOT Rep. F, I-91Reaffirmed: Sunset Report, I-01 Modified: CSAPH Rep. 1, A-11Modified: CSAPH Rep. 1, A-21

Involuntary Civic Commitment for Substance Use Disorder D-95.963:
Our AMA will continue its work to advance policy and programmatic efforts to address gaps in voluntary substance use treatment services. BOT Rep. 7, I-20

Reduced Incarceration and Improved Treatment of Individuals with Mental Illness or Illicit Drug Dependence 345.006MSS
AMA-MSS will ask the AMA to amend policy H-430.989 by insertion and deletion as follows:
H-430.989 Disease Prevention and Health Promotion in Correctional Institutions
Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public health systems toward 1. the prevention and control of HIV/AIDS, substance abuse, tuberculosis and hepatitis, 2. the management and treatment of psychiatric disorders such as drug dependence, and 3. a reduction in reincarceration rates related to drug abuse and psychiatric disorders. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers, drug treatment center staff, and psychiatric care center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase in direct referral by correctional systems of parolees with a history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs, as well as inpatient or outpatient psychiatric treatment

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programs, as a sentence or in connection with sentencing." (MSS Res 30, I-11) (HOD Policy H-430.997 Amended in Lieu of AMA Res 502, A-12) (Reaffirmed: MSS GC Report A, I-16)

AMA 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

Substance Use Disorders as a Public Health Hazard H-95.975
Our AMA: (1) recognizes that substance use disorders are a major public health problem in the United States today and that its solution requires a multifaceted approach; (2) declares substance use disorders are a public health priority; (3) supports taking a positive stance as the leader in matters concerning substance use disorders, including addiction; (4) supports studying innovative approaches to the elimination of substance use disorders and their resultant street crime, including approaches which have been used in other nations; and (5) opposes the manufacture, distribution, and sale of substances created by chemical alteration of illicit substances, herbal remedies, and over-the-counter drugs with the intent of circumventing laws prohibiting possession or use of such substances. Res. 7, I-89Appended: Sub. Res. 401, Reaffirmed: Sunset Rep., I-99Reaffirmed: CSAPH Rep. 1, A-09Modified and Reaffirmed: CSAPH Rep. 1, A-09Reaffirmed: CSAPH Rep. 01, A-19
Enhanced Funding for and Access to Outpatient Addiction Rehabilitation D-95.962
Our AMA will advocate for: (1) the expansion of federal grants in support of treatment for a substance use disorder to states that are conditioned on that state's adoption of law and/or regulation that prohibit drug courts, recovery homes, sober houses, correctional settings, and other similar programs from denying entry or ongoing care if a patient is receiving medication for an opioid use disorder or other chronic medical condition; and (2) sustained funding to states in support of evidence-based treatment for patients with a substance use disorder and/or co-occurring mental disorder, such as that put forward by the American Society of Addiction Medicine, American Academy of Addiction Psychiatry, American Psychiatric Association, American Academy of Child and Adolescent Psychiatry and other professional medical organizations. BOT Rep.14, I-20
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

Improving Physician Mental Health and Reducing Stigma through Revision of Medical Licensure Applications 345.007MSS
AMA-MSS aims to reduce stigmatization mental health issues in the medical community by (a) opposing state medical boards' practice of issuing licensing applications that equate seeking help for mental health issues with the existence of problems sufficient to create professional

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impairment and (b) opposing the breach in a physician's private health record confidentiality by requiring access to these records when an applicant reports treatment. MSS Res 17, I-13

Implementation of an Annual Mental Health Awareness and Suicide Prevention Program at Medical Schools 345.009MSS
AMA-MSS supports medical schools to create a mental health awareness and suicide prevention screening program that would: 1) be available to all medical students on an opt-out basis, 2) ensure anonymity, confidentiality, and protection from administration, 3) provide proactive intervention for identified at-risk students by mental health professionals, and 4) educate students and faculty about personal mental health and factors that may contribute to suicidal ideation. MSS Res 15, I-15

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 18
(N-21)

Introduced by: Revati Gummaluri, Anthony Gallo, Theja Channapragada, Rowan University School of Osteopathic Medicine; Carly Polcyn, University of Toledo College of Medicine and Life Sciences; Danielle Rivera, University of New Mexico School of Medicine; Sarah Costello, University of Iowa Carver College of Medicine

Sponsored by: Region 1, Region 4, Region 5, Region 6, PsychSIGN

Subject: Increasing Access to Traumatic Brain Injury Resources in Primary Care Settings

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, There is a 43% increase in incidence of mild traumatic brain injuries in the United States in both non-athletic and athletic populations[1]; and

Whereas, The Centers for Disease Control and Prevention (CDC) acknowledges that non-athletic traumatic brain injuries affect diverse patient populations[2,3]; and

Whereas, 64.4% of traumatic brain injury are non-sports related, caused by activities of daily living, traffic or work-related accidents, falls, motor vehicle crashes, recreation, acts of interpersonal violence, and blast injuries [4,5,6]; and

Whereas, Studies show that adult patients with non-athletic traumatic brain injuries experience increased mortality rates and long-term consequences such as increased incidence of post concussion symptoms[7]; and

Whereas, A study by the Center for Disease Control suggests that rates of pediatric hospitalization and death are higher in non-athletes compared to that of athletic brain injuries due to a lack of early intervention[7,8,9,10]; and

Whereas, Approximately 48% of patients are lost to follow-up three months after hospitalization for traumatic brain injuries[11]; and

Whereas, Almost 88% victims of domestic violence suffer traumatic brain injuries, which can lead to devastating and permanent physical, behavioral, and cognitive consequences[12]; and

Whereas, Due to a lack of universally accepted diagnostic criteria, clinicians rely on likely mechanism of injury for diagnosis of TBI, which may delay care for victims of domestic violence who often do not report their injuries[12,13]; and

Whereas, Victims of domestic violence often face unstable social situations, homelessness, and impaired cognitive states as a result of years of repeated brain injury, thus when they do seek

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medical care for their injuries, they experience added barriers to follow-up care, such as transportation, communication, and education[12]; and

Whereas, 89% of women experiencing an intimate partner violence related TBI reported post-concussion syndrome, and early intervention for victims of domestic violence with mild traumatic brain injuries are correlated with a reduction in post-concussive and other residual symptoms[14,15]; and

Whereas, Due to longer time to admission for acute-injury admissions, ethnic minorities, including those with history of homelessness and incarceration, experience inequity in post-injury rehabilitation, and are less likely to obtain post-injury hospital admission compared to Non-Hispanic White patients[16,17]; and

Whereas, When the severity of injury may not differ significantly between patients of color and white patients, there are nonmedical factors including systemic and environmental barriers contributing to the delay in access to acute TBI-rehabilitation in patients of color[16]; and

Whereas, Victims of non-athletic traumatic brain injury are more likely to seek treatment via primary care providers[13]; and

Whereas, Over the past year, only 12 to 23% of adult female victims report to seeking treatment from their primary care physician for their injuries and subsequent morbidity after experiencing intimate partner violence[18]; and

Whereas, Patients who access primary care physicians for post-traumatic brain injury care may be less likely to receive equitable treatment compared to athletes who have access to athletic trainers, coaches, and specialty physicians with return-to-play models of treatment [19,20]; and

Whereas, Primary care providers who were trained by the CDC's Heads Up program on traumatic brain injuries were able to improve their patients' rate of treatment success and symptom recovery[13,21]; and

Whereas, Providing patients with information emphasizing the importance of post-injury care, encouraging interdisciplinary collaboration, and equipping primary physicians with the tools needed for appropriate treatment and referral services improves patients' functional recovery and treatment success[22]; and

Whereas, The treatment tools provided to primary care physicians include screening for neurosurgical emergencies or cervical spine injury and targeted treatment for specific symptoms of post-injury headaches, sleep disturbance, and psychological distress through medication and environmental and behavioral changes[13,23]; and

Whereas, The AMA recognizes the need for traumatic brain injury prevention and remediation of post-injury morbidities in H-470.954; and

Whereas, Current AMA policy does not emphasize ethnic minorities or victims of domestic violence in existing policy for traumatic brain injuries, nor does it address post-injury rehabilitation in non-athletic injuries; therefore be it

RESOLVED, That our AMA recognize disparities in the care for traumatic brain injuries, and acknowledge non-athletic traumatic brain injuries as a significant cause of morbidity and

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mortality, particularly for ethnic minorities and victims of domestic violence; and be it further

RESOLVED, That our AMA supports increased access to traumatic brain injury resources in primary care settings which advocate for early intervention, encourage follow-up retention of patients for post-injury rehabilitation, and demonstrate improved patient quality of life.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS 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.

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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-470.984 Brain Injury in Boxing
The AMA supports the following series of steps designed to protect amateur and professional boxers from injuries:

(1) Encourage the establishment of a "National Registry of Boxers" for all amateur and professional boxers, including "sparring mates," in the country. The proposed functions of a computer-based central registry would be to record the results of all licensed bouts, including technical knockouts, knockouts, and other boxing injuries, and to compile injury and win/loss records for individual boxers.

(2) Recommend to all boxing jurisdictions that the ring physician should be authorized to stop any bout in progress, at any time, to examine a contestant and, when indicated, to terminate a bout that might, in his opinion, result in serious injury for either contestant.

(3) Urge state and local commissions to conduct frequent medical training seminars for all ring personnel.

(4) Recommend to all boxing jurisdictions that no amateur or professional boxing bout should be permitted unless: (a) the contest is held in an area where adequate neurosurgical facilities are immediately available for skilled emergency treatment of an injured boxer; (b) a portable resuscitator with oxygen equipment and appropriate endotracheal tubes are available at ringside; and (c) a comprehensive evacuation plan for the removal of any seriously injured boxer to hospital facilities is ready.

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(5) Inform state legislatures that unsupervised boxing competition between unlicensed boxers in "tough man" contests is a most dangerous practice that may result in serious injury or death to contestants, and should be condemned.

(6) Urge state and local boxing commissions to mandate the use of safety equipment, such as plastic safety mats and padded cornerposts, and to encourage continued development of safety equipment.

(7) Urge state and local boxing commissions to extend all safety measures to sparring partners.

(8) Urge state and local boxing commissions to upgrade, standardize and strictly enforce medical evaluations for boxers.

AMA-MSS supports the research and development of helmet and/or concussion tracking technology in order to develop safer concussion management protocols to protect players from long term consequences of traumatic brain injuries and concussions in the sport of football at all levels.

(CSA Rep. F, A-82; Reaffirmed: A-83; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: Sub. Res. 408, I-93; Reaffirmed: CSA Rep. 3, A-99; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: CSAPH Rep. 3, A-15)

H-515.965 Family and Intimate Partner Violence
(1) Our AMA believes that all forms of family and intimate partner violence (IPV) are major public health issues and urges the profession, both individually and collectively, to work with other interested parties to prevent such violence and to address the needs of survivors. Physicians have a major role in lessening the prevalence, scope and severity of child maltreatment, intimate partner violence, and elder abuse, all of which fall under the rubric of family violence. To suppor physicians in practice, our AMA will continue to campaign against family violence and remains open to working with all interested parties to address violence in US society.

(2) Our AMA believes that all physicians should be trained in issues of family and intimate partner violence through undergraduate and graduate medical education as well as continuing professional development. The AMA, working with state, county and specialty medical societies as well as academic medical centers and other appropriate groups such as the Association of American Medical Colleges, should develop and disseminate model curricula on violence for incorporation into undergraduate and graduate medical education, and all parties should work for the rapid distribution and adoption of such curricula. These curricula should include coverage of the diagnosis, treatment, and reporting of child maltreatment, intimate partner violence, and elder abuse and provide training on interviewing techniques, risk assessment, safety planning, and procedures for linking with resources to assist survivors. Our AMA supports the inclusion of questions on family violence issues on licensure and certification tests.

(3) The prevalence of family violence is sufficiently high and its ongoing character is such that physicians, particularly physicians providing primary care, will encounter survivors on a regular basis. Persons in clinical settings are more likely to have experienced intimate partner and family violence than non-clinical populations. Thus, to improve clinical services as well as the public health, our AMA encourages physicians to: (a) Routinely inquire about the family violence histories of their patients as this knowledge is essential for effective diagnosis and care; (b) Upon identifying patients currently experiencing abuse or threats from intimates, assess and

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discuss safety issues with the patient before he or she leaves the office, working with the patient to develop a safety or exit plan for use in an emergency situation and making appropriate referrals to address intervention and safety needs as a matter of course; (c) After diagnosing a violence-related problem, refer patients to appropriate medical or health care professionals and/or community-based trauma-specific resources as soon as possible; (d) Have written lists of resources available for survivors of violence, providing information on such matters as emergency shelter, medical assistance, mental health services, protective services and legal aid; (e) Screen patients for psychiatric sequelae of violence and make appropriate referrals for these conditions upon identifying a history of family or other interpersonal violence; (f) Become aware of local resources and referral sources that have expertise in dealing with trauma from IPV; (g) Be alert to men presenting with injuries suffered as a result of intimate violence because these men may require intervention as either survivors or abusers themselves; (h) Give due validation to the experience of IPV and of observed symptomatology as possible sequelae; (i) Record a patient's IPV history, observed traumata potentially linked to IPV, and referrals made; (j) Become involved in appropriate local programs designed to prevent violence and its effects at the community level.

(4) Within the larger community, our AMA:

(a) Urges hospitals, community mental health agencies, and other helping professions to develop appropriate interventions for all survivors of intimate violence. Such interventions might include individual and group counseling efforts, support groups, and shelters.

(b) Believes it is critically important that programs be available for survivors and perpetrators of intimate violence.

(c) Believes that state and county medical societies should convene or join state and local health departments, criminal justice and social service agencies, and local school boards to collaborate in the development and support of violence control and prevention activities.

(5) With respect to issues of reporting, our AMA strongly supports mandatory reporting of suspected or actual child maltreatment and urges state societies to support legislation mandating physician reporting of elderly abuse in states where such legislation does not currently exist. At the same time, our AMA oppose the adoption of mandatory reporting laws for physicians treating competent, non-elderly adult survivors of intimate partner violence if the required reports identify survivors. Such laws violate basic tenets of medical ethics. If and where mandatory reporting statutes dealing with competent adults are adopted, the AMA believes the laws must incorporate provisions that: (a) do not require the inclusion of survivors' identities; (b) allow competent adult survivors to opt out of the reporting system if identifiers are required; (c) provide that reports be made to public health agencies for surveillance purposes only; (d) contain a sunset mechanism; and (e) evaluate the efficacy of those laws. State societies are encouraged to ensure that all mandatory reporting laws contain adequate protections for the reporting physician and to educate physicians on the particulars of the laws in their states.

(6) Substance abuse and family violence are clearly connected. For this reason, our AMA believes that:

(a) Given the association between alcohol and family violence, physicians should be alert for the presence of one behavior given a diagnosis of the other. Thus, a physician with patients with alcohol problems should screen for family violence, while physicians with patients presenting with problems of physical or sexual abuse should screen for alcohol use.

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(b) Physicians should avoid the assumption that if they treat the problem of alcohol or substance use and abuse they also will be treating and possibly preventing family violence.

(c) Physicians should be alert to the association, especially among female patients, between current alcohol or drug problems and a history of physical, emotional, or sexual abuse. The association is strong enough to warrant complete screening for past or present physical, emotional, or sexual abuse among patients who present with alcohol or drug problems.

(d) Physicians should be informed about the possible pharmacological link between amphetamine use and human violent behavior. The suggestive evidence about barbiturates and amphetamines and violence should be followed up with more research on the possible causal connection between these drugs and violent behavior.

(e) The notion that alcohol and controlled drugs cause violent behavior is pervasive among physicians and other health care providers. Training programs for physicians should be developed that are based on empirical data and sound theoretical formulations about the relationships among alcohol, drug use, and violence.

(CSA Rep. 7, I-00; Reaffirmed: CSAPH Rep. 2, I-09; Modified: CSAPH Rep. 01, A-19)

Encouraging the Research and Development of Concussion Tracking Technology in the Sport of Football 470.008MSS
AMA-MSS supports the research and development of helmet and/or concussion tracking technology in order to develop safer concussion management protocols to protect players from longterm consequences of traumatic brain injuries and concussions in the sport of football at all levels. (MSS Res 46, A-15) (Reaffirmed: MSS GC Rep B, A-21)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 19
(N-21)

Introduced by: Dilpreet Kaeley, University of Toledo College of Medicine and Life Sciences; Shreya Tripathy, University of Texas Health Science Center at San Antonio Long School of Medicine; Sarah Mae Smith, University of California - Irvine School of Medicine; Nikita Sood, Washington University School of Medicine in St. Louis; Swetha Maddipudi, University of Texas Health Science Center at San Antonio Long School of Medicine; Chris Wong, Baylor College of Medicine; Rajadhar Reddy, Baylor College of Medicine

Sponsored by: Region 2, Region 3, Region 4, Region 5, Region 6, Region 7, ANAMS, APAMSA, PsychSIGN

Subject: Universal Childcare & Preschool

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, In the 2019-2020 school year, only 34% of 4-year-olds and 6% of 3-year-olds were enrolled in state pre-kindergarten[1]; and

Whereas, The COVID-19 pandemic caused a sharp decline in preschool enrollment, quality standards, teacher qualifications, and state funding[1,2]; and

Whereas, Research has demonstrated that participation in preschool improves access to pediatric preventive care and is linked to decreases in child mortality, increases in immunizations, reductions in hospitalizations for accidents or injuries, and additional avenues for screening, diagnosis, and care for pediatric patients with ADHD[3-5]; and

Whereas, Early care and education programs have been shown to lead to long-term improvements in cardiovascular and metabolic health through adolescence and adulthood, as well as reduced smoking and obesity[3,6-8]; and

Whereas, Universal child care and preschool are avenues for capturing child maltreatment cases because of the crucial role that school personnel play in recognizing, reporting, and preventing child abuse and neglect[9]; and

Whereas, Childcare attendance is associated with improved cognitive abilities and mitigates the increase in externalizing behaviors observed in children exposed to early adversity[10]; and

Whereas, Children who participate in early childhood education have higher kindergarten scores in reading, mathematics, cognitive flexibility, and approaches to learning[11]; and

Whereas, A 2021 JAMA Pediatrics study determined that, for children of mothers with a lower education level, childcare attendance was positively associated with academic achievement at age 16[12]; and

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Whereas, High-quality childcare and early education are shown to have positive effects on the mother-child relationship, maternal wellbeing, and physical and mental, short- and long-term health outcomes for children[3,13-15]; and

Whereas, Maternal mental health, including maternal depression, and life satisfaction improved after implementation of universal child care in Canada and maternal wellbeing improved after implementation of publicly funded childcare in Germany[16-17]; and

Whereas, In 2020, the Department of Labor estimated that there were 20.1 million employed Americans with children under the age of six[18]; and

Whereas, A 2020 study of childcare facility closures published in JAMA Health Forum indicated that "state-level childcare facility closures were associated with greater reductions in employment among women compared to men" for parents of children under the age of six[19]; and

Whereas, There are significant racial and ethnic inequities in access to federal childcare subsidies as compared to the national average of 12%, with only 7% of Native American and Alaska Native, 6% of Hispanic/Latino, and 3% of Asian eligible children being served by the Child Care Development Block Grant subsidies in 2016[20]; and

Whereas, 57.3% of Hispanic/Latino and 60.2% of American Indian and Alaska Native populations live in childcare deserts (defined as "areas with an insufficient supply of licensed childcare"), compared to the overall population at 50.5%[21]; and

Whereas, Children from families with high socioeconomic status (SES) are more likely to attend early childhood education programs, with 69% of kindergarteners from high SES families and only 44% from low SES families[11]; and

Whereas, The Child Care and Development Fund is the primary source of financial childcare assistance for low-income families, but, according to the U.S. Department of Health & Human Services, it served only 15% of the 13.3 million children meeting federal eligibility parameters in 2016[22]; and

Whereas, Only five states, District of Columbia, New Jersey, North Carolina, Oklahoma, and West Virginia, fully fund high-quality full-day pre-K, as determined by quality benchmarks set by the National Institute for Early Education Research[1]; and

Whereas, There is a growing recognition of the importance of universal child care and preschool that is reflected by nationwide initiatives like the Senate's Improving Child Care for Working Families Act of 2021 and the Administration's American Families Plan which will provide universal free preschool and limit childcare costs to less than 7% of household income[23,24]; and

Whereas, The American Academy of Pediatrics Council on Early Childhood published a 2016 position statement stating that "high-quality early education and child care for young children improves physical and cognitive outcomes for the children and can result in enhanced school readiness"[25]; and

Whereas, While our AMA has some existing policies (D-200.974, H-310.912, G-600.115, H-95.916, H-440.970, H-150.927, and H-245.979) supporting access to childcare for healthcare professionals and patients in substance use treatment facilities, funding for Head Start (a

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federal childcare and preschool program for low-income families), and public health protections in childcare settings, our AMA does not currently have policy on universal, affordable access to childcare; and

Whereas, While AMA Policy H-60.917 states that our AMA "will issue a call to action to...to propose strategies...to further the access of all children to...early childhood education," this does not ask our AMA to advocate for proposed strategies currently being debated in Congress and state governments, and "early childhood education" in that context appears to refer to existing public education from kindergarten to third grade and not specifically childcare or preschool, which are more limited in availability and require greater advocacy to expand; therefore be it

RESOLVED, That our AMA advocate for universal access to high-quality and affordable childcare and preschool.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

Supporting Child Care for Health Care Professionals D-200.974
Our AMA will work with interested stakeholders to investigate solutions for innovative childcare policies and flexible working environments for all health care professionals (in particular, medical students and physician trainees). Res. 309, A-21

Preserving Childcare at AMA Meetings G-600.115
Our AMA will arrange onsite supervised childcare at no cost to members attending AMA Annual and Interim meetings. Res. 602, I-19

Disparities in Public Education as a Crisis in Public Health and Civil Rights H-60.917
1. Our AMA: (a) considers continued educational disparities based on ethnicity, race and economic status a detriment to the health of the nation; (b) will issue a call to action to all educational private and public stakeholders to come together to organize and examine, and using any and all available scientific evidence, to propose strategies, regulation and/or legislation to further the access of all children to a quality public education, including early childhood education, as one of the great unmet health and civil rights challenges of the 21st century; and (c) acknowledges the role of early childhood brain development in persistent educational and health disparities and encourage public and private stakeholders to work to strengthen and expand programs to support optimal early childhood brain development and school readiness.
2. Our AMA will work with: (a) the Health and Human Services Department (HHS) and Department of Education (DOE) to raise awareness about the health benefits of education; and (b) the Centers for Disease Control and Prevention and other stakeholders to promote a meaningful health curriculum (including nutrition) for grades kindergarten through 12.
3. Our AMA will encourage the U.S. Department of Education and Department of Labor to develop policies and initiatives in support of students from marginalized backgrounds that: (a) decrease the educational opportunity gap; (b) increase participation in high school Advanced Placement courses; and (c) increase the high school graduation rate. Res. 910, I-16; Appended: Res. 410, A-19; Appended: CME Rep. 5, A-21

Childcare Availability for Persons Receiving Substance Use Disorder Treatment H-95.916
Our AMA supports the implementation of childcare resources in existing substance use treatment facilities and acknowledges childcare infrastructure and support as a major priority in the development of new substance use programs. Res. 519, A-19

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

Parental Leave H-405.954

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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.
Res. 215, I-16; Appended: BOT Rep. 11, A-19

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

Strategies to Reduce the Consumption of Beverages with Added Sweeteners H-150.927
Our AMA: (1) acknowledges the adverse health impacts of sugar-sweetened beverage (SSB) consumption, and support evidence-based strategies to reduce the consumption of SSBs, including but not limited to, excise taxes on SSBs, removing options to purchase SSBs in primary and secondary schools, the use of warning labels to inform consumers about the health consequences of SSB consumption, and the use of plain packaging; (2) encourages continued research into strategies that may be effective in limiting SSB consumption, such as controlling portion sizes; limiting options to purchase or access SSBs in early childcare settings, workplaces, and public venues; restrictions on marketing SSBs to children; and changes to the agricultural subsidies system; (3) encourages hospitals and medical facilities to offer healthier beverages, such as water, unflavored milk, coffee, and unsweetened tea, for purchase in place of SSBs and apply calorie counts for beverages in vending machines to be visible next to the price; and (4) encourages physicians to (a) counsel their patients about the health consequences of SSB consumption and replacing SSBs with healthier beverage choices, as

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recommended by professional society clinical guidelines; and (b) work with local school districts to promote healthy beverage choices for students. CSAPH Rep. 03, A-17

270.003MSS Broadening Access to Paid Family Leave to Improve Health Outcomes and Health Disparities

AMA-MSS supports the preference of paid leave and job security, over unpaid, for persons who must forsake work responsibilities for family or medical reasons, including parental leave

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 20
(N-21)

Introduced by: Ryan Englander, Brent Heineman, University of Connecticut School of Medicine; Sarah Mae Smith, University of California-Irvine School of Medicine; Justin Magrath, Tulane University School of Medicine.

Sponsored by: Region 3, Region 7, ANAMS, APAMSA, PsychSIGN

Subject: Amending Policy on a Public Option to Maximize AMA Advocacy

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, The Patient Protection and Affordable Care Act of 2010 (ACA) reduced the uninsurance rate in the United States but has not achieved universal coverage[1,2]; and

Whereas, Tens of millions of Americans are either uninsured or underinsured with insurance that is too expensive to actually be used, significantly limiting their access to affordable healthcare[3-5]; and

Whereas, Many individual insurance plans offered on the ACA's Health Insurance Marketplaces (hereafter referred to as "ACA Exchanges") have high premiums, deductibles, and other out-of-pocket costs that leave beneficiaries exposed to financial risk and limit their access to healthcare services[2,6-8]; and

Whereas, Some ACA Exchanges, particularly those covering rural areas, offer only a small number of plans that are limited by very few insurers participating, which has been shown to lead to higher costs and faster premium growth due to limited competition[9-13]; and

Whereas, Plans offered on the ACA Exchanges frequently have narrow provider networks, which reduces access to care and can lead to high out-of-pocket costs if patients go out-of-network[14-16]; and

Whereas, A federally-managed public insurance plan ("public option") has been proffered as a mechanism to improve competition, increase access to affordable healthcare, and lower costs, particularly in areas where there are few participating insurers and a commensurate lack of competition between plans[8,17-19]; and

Whereas, A recent analysis from the Urban Institute found that various public option proposals with different eligibility criteria and payment rates would all decrease the uninsured rate, significantly reduce premiums, and reduce the federal deficit[20]; and

Whereas, RAND modeled four different scenarios under which a public option could be implemented and found that under all scenarios, premium costs in the public option were lower than in private plans, leading to more people being covered[21]; and

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Whereas, A Commonwealth Fund analysis of various healthcare reform proposals found that a public option would reduce the uninsured rate and significantly reduce costs to the federal government, permitting the implementation of more generous premium tax credits that could further reduce the uninsurance rate[22]; and

Whereas, A public option would have significant leverage during price negotiations with hospitals, pharmaceutical companies, pharmacy benefit managers, and other healthcare providers due to its large size and would likely have lower administrative costs per beneficiary than smaller private plans, leading to lower premiums and cost-sharing for beneficiaries and lower costs to the federal government[9,21,23,24]; and

Whereas, A 2021 CBO report on key design considerations for a public option showed that the benchmark premium for insurance plans offered on the ACA Exchanges is closely correlated with the number of insurers participating in the market with more insurers leading to lower premiums, suggesting that the public option, as an additional insurer, would reduce premiums for public and private insurers alike[25]; and

Whereas, The COVID-19 pandemic highlights the need for an affordable health insurance option as an analysis of 30 billion private health insurance claims found that the average out-of-pocket cost for an uninsured patient's hospitalization resulting from the virus exceeds $70,000[26,27]; and

Whereas, Though there are concerns that a public option may reduce overall physician reimbursement through lower provider payment rates, CBO estimates of the impacts of Medicare-for-All proposals on physician reimbursement show that lower provider payment rates may be balanced by increased healthcare utilization after the expansion of public insurance programs, leading to small overall changes in physician reimbursement and a net increase in some scenarios[28,29]; and

Whereas, Recent studies published by the CBO, JAMA, and AAFP have discussed the inherent tradeoffs between lowering costs through reduced provider reimbursement and developing provider networks attractive enough to convince prospective beneficiaries to enroll in the public option, highlighting how careful design of a public option can maximize benefit to patients and physicians alike[30-32]; and

Whereas, The state of Washington created a public option-like program called Cascade Care in 2019 that designed overall reimbursement to exceed no more than 160% of Medicare rates with a minimum reimbursement of 135% of Medicare rates for primary care practices, showing how a public option can be designed to reduce costs and expand coverage in ways that do not unduly burden physicians[33,34]; and

Whereas, The AMA passed Policy H-165.823 in November 2020, which lays out a variety of criteria that a public option should meet, but does not go so far as to explicitly support a public option; and

Whereas, H-165.823 already contains provisions to protect physicians and their practices, including a requirement that the public option not tie participation to participation in other public insurance programs, a requirement that contracts with physicians must be subject to meaningful negotiation, and a requirement that reimbursement exceed prevailing Medicare rates and be at levels sufficient to sustain the costs of medical practice; and

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Whereas, Based in large part upon on this policy, the AMA recently sent a letter to Congress regarding a public option, which highlighted the standards codified in H-165.823 while failing to mention the potential benefits or explicitly endorse a public option[35]; and

Whereas, multiple physician groups, including the American College of Physicians, American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American Osteopathic Association, American Psychiatric Association, and the Society of General Internal Medicine, have endorsed a public option[36-38]; therefore be it

RESOLVED, That our AMA amend Policy H-165.823, "Options to Maximize Coverage under the AMA Proposal for Reform", by addition and deletion as follows:

OPTIONS TO MAXIMIZE COVERAGE UNDER THE AMA PROPOSAL FOR REFORM, H-165.823

1. Our AMA will advocate ~~that any~~ for a public option to expand health insurance coverage ~~must~~ that meets 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

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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.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

Options to Maximize Coverage under the AMA Proposal for Reform H-165.823
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.

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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

Universal Health Coverage H-165.904
Our AMA: (1) seeks to ensure that federal health system reform include payment for the urgent and emergent treatment of illnesses and injuries of indigent, non-U.S. citizens in the U.S. or its territories; (2) seeks federal legislation that would require the federal government to provide financial support to any individuals, organizations, and institutions providing legally-mandated health care services to foreign nationals and other persons not covered under health system reform; and (3) continues to assign a high priority to the problem of the medically uninsured and underinsured and continues to work toward national consensus on providing access to adequate health care coverage for all Americans
Sub. Res. 138, A-94; Appended: Sub. Res. 109, I-98; Reaffirmation A-02; Reaffirmation A-07; Reaffirmation I-07; Reaffirmed: Res. 239, A-12

State Efforts to Expand Coverage to the Uninsured H-165.845

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Our AMA supports the following principles to guide in the evaluation of state health system reform proposals:

1. Health insurance coverage for state residents should be universal, continuous, and portable. Coverage should be mandatory only if health insurance subsidies are available for those living below a defined poverty level.

2. The health care system should emphasize patient choice of plans and health benefits, including mental health, which should be value-based. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as references when considering if a given plan would provide meaningful coverage.

3. The delivery system should ensure choice of health insurance and physician for patients, choice of participation and payment method for physicians, and preserve the patient/physician relationship. The delivery system should focus on providing care that is safe, timely, efficient, effective, patient-centered, and equitable.

4. The administration and governance system should be simple, transparent, accountable, and efficient and effective in order to reduce administrative costs and maximize funding for patient care.

5. Health insurance coverage should be equitable, affordable, and sustainable. The financing strategy should strive for simplicity, transparency, and efficiency. It should emphasize personal responsibility as well as societal obligations.
CMS Rep. 3, I-07; Reaffirmed: Res. 239, A-12

Evaluating Health System Reform Proposals H-165.888
1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles:

A. Physicians maintain primary ethical responsibility to advocate for their patients' interests and needs.
B. Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed.
C. All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be.
D. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan.
E. Any national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special

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programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care.
F. Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce an adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system.
G. All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President.
H. True health reform is impossible without true tort reform.
2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be specifically included in national health care reform legislation.
3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use / addiction disorders and will advocate for the inclusion of full parity for the treatment of mental illness and substance use / addiction disorders in all national health care reform legislation.
4. Our AMA supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients.
Res. 118, I-91;Res. 102, I-92; BOT Rep. NN, I-92; BOT Rep. S, A-93; Reaffirmed: Res. 135, A-93; Reaffirmed: BOT Reps. 25 and 40, I-93; Reaffirmed in lieu of Res. 714, I-93; Res. 130, I-93; Res. 316, I-93Sub. Res. 718, I-93; Reaffirmed: CMS Rep. 5, I-93; Res. 124, A-94; Reaffirmed by BOT Rep.1- I-94; CEJA Rep. 3, A-95; Reaffirmed: BOT Rep. 34, I-95; Reaffirmation A-00; Reaffirmation A-01; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CME Rep. 2, A-03; Reaffirmed and Modified: CMS Rep. 5, A-04; Reaffirmed with change in title: CEJA Rep. 2, A-05; Consolidated: CMS Rep. 7, I-05; Reaffirmation I-07; Reaffirmed in lieu of Res. 113, A-08; Reaffirmation A-09; Res. 101, A-09; Sub. Res. 110, A-09; Res. 123, A-09; Reaffirmed in lieu of Res. 120, A-12; Reaffirmation: A-17

Health System Reform Legislation H-165.838
1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy:

a. Health insurance coverage for all Americans

b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps

c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials

d. Investments and incentives for quality improvement and prevention and wellness initiatives

e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care

f. Implementation of medical liability reforms to reduce the cost of defensive medicine

g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens

2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.

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3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.
4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.
5. AMA policy is that insurance coverage options offered in a health insurance exchange 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.
6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician.
7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals.
8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation:
a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services
b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system
c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted
d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate
e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another
f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest
9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA's position based on AMA policy.
10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.
11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal.
12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.
13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform.
Sub. Res. 203, I-09; Reaffirmation A-10; Reaffirmed in lieu of Res. 102, A-10; Reaffirmed in lieu of Res. 228, A-10; Reaffirmed: CMS Rep. 2, I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: CMS Rep. 6, I-11; Reaffirmed in lieu of Res.

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817, I-11; Reaffirmation I-11; Reaffirmation A-12; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 239, A-12; Reaffirmed: Sub. Res. 813, I-13; Reaffirmed: CMS Rep. 9, A-14; Reaffirmation A-15; Reaffirmed in lieu of Res. 215, A-15; Reaffirmation: A-17; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmed in lieu of: Res. 805, I-17; Reaffirmed: CMS Rep. 03, A-18; Reaffirmed: CMS Rep. 09, A-19

Developing a Comprehensive Plan for Health System Reform 165.024MSS
AMA-MSS supports the following vision for health systems reform as incremental steps toward a single payer system:
(a) further expansion of fully refundable tax credits for patients to purchase individual insurance, including those intended to reduce premiums and those intended to reduce cost-sharing requirements;
(b) elimination of the income cap for the determination of premium tax credit eligibility;
(c) elimination of the requirement that patients need to lack access to affordable insurance through their employer or public insurance programs in order to qualify for premium tax credits;
(d) encouraging expansion of options that allow employers to provide tax-exempt benefits for employees to enroll in an individual health plan of their choice;
(e) federal requirements that healthcare insurance exchanges include personalized plan cost estimates to enhance price transparency and choice;
(f) state and/or federal reinsurance programs to reduce the cost of insurance;
(g) auto-enrollment in healthcare plans with the highest actuarial value for which prospective enrollees are eligible for coverage at no cost after the application of all relevant subsidies;
(h) the establishment of an affordable public insurance option to be offered by the federal government without regard to income eligibility that achieves the following goals:
    (i) expands access to high-quality health insurance coverage;
    (ii) lowers costs for patients, including premiums and out-of-pocket costs;
    (iii) only receives the subsidies available to competing insurers;
    (iv) reimburses hospitals, physicians, and all other healthcare providers at rates sufficient to support their participation without imposing an undue financial burden on those providers; and
(i) all-payer rate negotiation as a means to reduce the cost of healthcare.
MSS Res. 058, A-21

Health Insurance Premium Subsidies for Affordable Universal Coverage 165.004MSS
AMA-MSS will ask the AMA to expand health system reform efforts to integrate other federal health insurance premium subsidies in addition to refundable health insurance tax credits for attaining affordable universal access to health care.
MSS Res 4, I-02; AMA Res 108, A-03 Referred; Reaffirmed: MSS Rep C, A-04; Reaffirmed: MSS GC Report B, I-09; Reaffirmed: MSS GC Report A, I-16

Evaluation of the Principles of the Health Care Access Resolution 165.009MSS
(1) AMA-MSS supports efforts to make health care more cost-effective by reducing administrative burdens, but only to such a degree that quality of care is not compromised; (2) AMA-MSS supports means of including both long-term care and prescription drug benefits into the guidelines for seeking affordable universal health care access and coverage; (3) AMA-MSS encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality of health care; and that our AMA-MSS supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons; (4) AMA-MSS will adopt policy to promote outcomes research as an effective mechanism to improve the quality of medical care for all persons and urge that the results of such research be used only for educational purposes and for improving practice parameters; (5)

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AMA MSS will adopt policy to address the need to increase numbers of qualified health care professionals, practitioners, and providers in underserved areas to increase timely access to quality care; (6) AMA-MSS supports the inclusion of adequate and timely payments to physicians and other providers into any plan calling for affordable universal health care access; (7) AMA-MSS supports the inclusion of the principles of continuity of health insurance coverage and continuity of medical care into any plan calling for affordable universal health care access; (8)AMA-MSS supports the inclusion of the principle of consumer choice of healthcare providers and practitioners into any plan calling for affordable universal health care access; (9) AMA-MSS supports the inclusion of reducing health care administrative cost and burden into any plan calling for affordable universal health care access.
MSS Rep C, A-04; Modified: MSS GC Rep B, I-09; Modified: GC Rep A, I-16

Covering the Uninsured as AMA's Top Priority 165.012MSS
AMA-MSS will ask the AMA to make the number one priority of the American Medical Association comprehensive health system reform that achieves reasonable health insurance for all Americans and that emphasizes prevention, quality, and safety while addressing the broken medical liability system, flaws in Medicare and Medicaid, and improving the physician practice environment.
MSS Res 10, I-05; AMA Amended Res 613, A-06 Adopted [H-165.847]; Reaffirmed: MSS GC Rep F, I-10; Reaffirmed: MSS GC Report D, I-15

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 21
(N-21)

Introduced by: Rommel Morales, Natalie Ganios, Northeast Ohio Medical University

Sponsored by: Region 5, Region 6, Region 7

Subject: Addressing Health Insurance Coverage Disparity Among Latinx Children

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, Out of the 4.4 million uninsured children in the United States as of 2019, Latinx children rank the second-highest demographic in health insurance deficiency, with the largest decrement from 7.9% to 9.2% from 2017-2019[1]; and

Whereas, Extensive variation in individual state policies pertaining to health care access, especially in the implementation of Medicaid expansion, have been key drivers in the 2.5-fold increase in uninsured rate for Latinx children compared to both other demographics and non-expansion states[2]; and

Whereas, The AMA observes and opposes the health care disparities caused by differential insurance status (H-185.943)[3]; and

Whereas, Citizen-based eligibility for insurance access is nonuniform across states and federally constrained - with variable terms such as minimum residency terms and lack of coverage for undocumented children, as well as the prohibition of federally-funded coverage for youths with Deferred Action for Childhood Arrivals (DACA) status[4]; and

Whereas, A 2018 public charge rule proposal deemed participation of immigrant adults in public benefit programs to disadvantage their permanent residency applications[5,6]; and

Whereas, Despite child benefits being eventually protected from the public charge rule and a full reversal in January 2021, a “chilling effect” has persisted wherein immigrant families have declined to enroll or reenroll themselves and their children in public programs, including Medicaid, for fear of changes to immigrant status[5,6]; and

Whereas, Recent studies have enumerated the reduction of utilization of public programs, with up to 13.6% adults in immigrant families reporting a direct avoidance due to residency application concerns and a decrease of 260,000 children in Medicaid enrollment since 2017[7,8]; and

Whereas, Latinx adolescents in Spanish-speaking households have a higher likelihood of being uninsured compared to their English-speaking counterparts, highlighting the barrier of language in obtaining health care insurance coverage[9,10]; and

Whereas, The Centers for Disease Control and Prevention (CDC) and US Department of Health and Human Services (HHS) recognizes the effective value of lay community health workers in

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providing health education, access, and prevention services to vulnerable and underserved Latinx populations through the AMIGAS program and Promotores de Salud Initiative, respectfully[11]; and

Whereas, The AMA calls for states to improve children's access to health care by streamlining state enrollment in Medicaid and State Children's Health Insurance Programs (CHIP), urging medical outreach programs for Medicaid- and CHIP-eligible children, and urging that these efforts be sensitive to cultural and language diversities (H-290.982)[12]; and

Whereas, As of 2021, 34 states allow lawful immigrant children to enroll in Medicaid and CHIP, while 6 states utilize state funding to explicitly cover undocumented children[2]; and

Whereas, Policies from the American Academy of Pediatrics call for the health insurance coverage of every individual and child living in the United States, diminishing barriers to insurance enrollment for eligible children, the supply of culturally effective care, and proper access to information of federal, state, and community programs that serve vulnerable children and their families[13]; therefore be it

RESOLVED, That our AMA acknowledge the existing disparity in health insurance among Latinx children; and be it further

RESOLVED, That our AMA amend policy H-350.957, Addressing Immigrant Health Disparities:

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, and publicizes the legality of accessing these resources.

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

; and be it further

RESOLVED, That our AMA recognize the importance of culturally- and linguistically-sensitive measures in improving and expanding access to health care insurance by supporting the use of lay community health workers (promotores de salud) in at-risk Latinx communities; and be it further

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

Fiscal Note: TBD

Date Received: 09/15/2021

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Access to Care for the Uninsured H-290.982?uri=%2FAMADoc%2FHOD.xml-0-2140.xml. Accessed August 23, 2021.
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RELEVANT AMA AND AMA-MSS POLICY

Health Insurance Differences Contribute to Health Care Disparities and Poorer Outcomes H-185.943
Our AMA affirms its support for elimination of health care disparities caused by differential treatment based on insurance status of Americans.
(Res. 119, A-11; Reaffirmed: CMS Rep. 1, A-21)

Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured H-290.982
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

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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;

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(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; 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)

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)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 22
(N-21)

Introduced by:	Grayson Jackson, University of Texas Medical Branch; Arianne Felicitas, Texas College of Osteopathic Medicine; Camelia Malkami and Ahana Gaurav, Medical College of Georgia; Mahima Goel, Carle Illinois College of Medicine
Sponsored by:	Region 3, Region 7, GLMA
Subject:	Supporting minimum content standards of LGBTQ+ health curriculum in undergraduate medical education
Referred to:	MSS Reference Committee (Zachary Dunton and Neha Siddiqui, Chair)

Whereas, The AMA is committed to the care of historically marginalized patient populations and addressing barriers to healthcare access[1]; and

Whereas, The LGBTQ+ community qualifies as one of these historically marginalized patient populations in which the physician-patient relationship is critical to the delivery of equitable health care[1–2]; and

Whereas, LGBTQ+ patients face particular health disparities and barriers to care, with as many as 8% and 23% of LGBQ and transgender individuals, respectively, reporting that they were refused care because of their sexual orientation or gender identity[3]; and

Whereas, Future physicians pursuing their undergraduate medical studies should be prepared to recognize and address these disparities so that they can provide more equitable and comprehensive care across all patient populations; and

Whereas, Medical school curricula offer inconsistent training on LGBTQ+ health—a review of relevant literature finds that the content, delivery, and duration of LGBTQ+ health curricula vary widely across medical schools[4]; and

Whereas, The median hours spent on LGBTQ+ training in medical schools was 5, while 6.8% and one-third of medical schools reported 0 hours of LGBTQ+ teaching in preclinical and clinical years, respectively[5]; and

Whereas, Primary care providers (PCPs) report feeling unprepared to respond to the health needs of LGBTQ+ patients, with a 2017 survey reporting that 51.1% of PCPs believed their training was inadequate[6]; and

Whereas, Gaps in medical education may contribute to “decreased utilization of healthcare by LGBTQ individuals and may worsen various health disparities that exist among this population”[7]; and

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Whereas, Filling these gaps in medical student education will increase competence in LGBTQ+ health issues and encourage LGBTQ+ patients' access to health care[8]; and

Whereas, Teaching LGBTQ+ health in academic and clinical settings will minimize negative healthcare outcomes among LGBTQ+ patients[7]; therefore be it

RESOLVED, That our AMA amend Policy H-160.991, "Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations," to clarify curricular components of LGBTQ+ health curricula, by addition and deletion to read as follows:

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations, H-160.991, Section 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 LCME-accredited institutions to develop minimum content requirements in LGBTQ health curricula, including relevant terminology, health disparities, taking a comprehensive sexual history, developing inclusive clinical environments, gender-affirming care for transgender and nonbinary patients, gender-affirming physical exam skills, sexual health safety and satisfaction, and intersectional experiences of LGBTQ people ~~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.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

Eliminating Health Disparities - Promoting Awareness and Education of Sexual Orientation and Gender Identity 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)

Promoting Awareness and Education of LGBTQ+ Health Issues on Medical School Campuses, 65.010MSS
AMA-MSS (1) supports medical student interest groups to organize and congregate under the auspices of furthering their medical education or enhancing patient care by improving their knowledge and understanding of various communities – without regard to their gender, sexual

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orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students who wish to conduct on-campus educational seminars and workshops on health issues in LGBTQ+ communities; (3) encourages the LCME to require all medical schools to incorporate LGBTQ+ health issues in their curricula; and (4) reaffirms its opposition to discrimination against any medical student on the basis of sexual orientation and/or gender identity or expression. (MSS Amended Res 28, A-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Amended: LGBTQ+ Affairs Report A, A-21)

LGBTQ+ Patient-Specific Training Programs for Healthcare Providers, 65.017MSS
AMA-MSS will ask the AMA to support the training of healthcare providers in cultural competency as well as in physical health needs for LGBTQ+ patient populations.
(MSS Res 13, I-11) (Reaffirmed Existing Policy in Lieu of AMA Res 304, A-12) (Reaffirmed: MSS GC Rep A, I-16) (Reaffirmed, MSS Res 40, A-19) (Amended: LGBTQ+ Affairs Report A, A-21)

Strengthening Standards for LGBTQ Medical Education, 295.199MSS
AMA-MSS will ask the AMA to amend policy H-295.878, Eliminating Health Disparities – Promoting Awareness and Education of Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) Health Issues in Medical Education by insertion and deletion to read as follows:

> **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 in Lesbian, Gay, Bisexual, Transgender and Queer communities; and (3) encourages the Liaison committee on Medical Education (LCME), the American Osteopathic Association (AOA), and the Accreditation Council for Graduate Medical Education (ACGME) to include Lesbian, Gay, Bisexual, Transgender and Queer health issues in the <u>basic science, clinical care, and</u> cultural competency ~~curriculum~~ <u>curricula</u> for both undergraduate and graduate medical education; and (4) encourages the Liaison Committee on Medical Education (LCME), American Osteopathic Association (AOA), and Accreditation Council for Graduate Medical Education (ACGME) to <u>periodically</u> reassess the current status of curricula for medical student and residency education addressing the needs of Lesbian, Gay, Bisexual, Transgender and Queer patients.

(MSS Res 16, A-19) (AMA Res. 302, Adopt as Amended [H-295.878], I-19)

Improving Primary Care Residency Training to Advance Health Care for LGBTQ+ Patients, 310.041MSS
AMA-MSS will ask the AMA to work with the Accreditation Council for Graduate Medical Education and the American Osteopathic Association to recommend to primary care residency

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programs that they assess the adequacy and effectiveness of their curricula in training residents on best practices for caring for LGBTQ+ pediatric patients.
(MSS Res 11, A-10) (AMA policy H-295.878 Amended in Lieu of AMA Res 906, I10)
(Reaffirmed, MSS GC Rep D, I-15) (Amended: LGBTQ+ Affairs Report A, A-21)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 23
(N-21)

Introduced by: Courtney Merlo, Michigan State University School of Osteopathic Medicine; Alana Castro-Gilliard, Edward Via College of Osteopathic Medicine-VA

Sponsored by: ANAMS, APAMSA, SOMA

Subject: Single Licensing Exam Series for Osteopathic and Allopathic Medical Students

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, The Comprehensive Osteopathic Medical Licensing Examination (COMLEX) USA is a licensing exam series that is currently required by the Commission on Osteopathic College Accreditation (COCA) to be taken by all osteopathic medical students in order to graduate from a COCA-accredited medical school[1]; and

Whereas, The United States Medical Licensing Examination (USMLE) is a licensing exam series that is currently taken by all allopathic medical students and osteopathic medical students[2]; and

Whereas, Of 2020 first-time test takers, the number of osteopathic medical students who took USMLE Step 1 was equal to 70% of those who took COMLEX Level 1[2,3]; and

Whereas, In 1997, 363 osteopathic medical student first-time test takers completed USMLE Step 1 and Step 2 Clinical Knowledge (CK) and by 2020, that number had increased more than 23-fold, significantly outpacing the 3-fold growth in osteopathic medical school enrollment[2,3,4]; and

Whereas, The growing trend of osteopathic students choosing to take the USMLE series in addition to the COMLEX USA series further exacerbates the osteopathic medical student debt burden, adding an approximate total of $6,131,840 in additional examination fees for osteopathic test takers during 2019-2020[2,5]; and

Whereas, An increasing number of osteopathic medical schools have mandated students to complete the USMLE and COMLEX USA series prior to graduation, despite evidence that a minimal number of licensing examinations already significantly increase rates of stress, anxiety, and depression amongst medical students[6]; and

Whereas, Two high-stakes licensing examinations create redundancy in medical education with establishing competency as evident by strong correlation between USMLE Step 1 and Step 2 and respective COMLEX Level 1 and 2 scores for residency applicants[7,8,9]; and

Whereas, Although USMLE Step 1 and the COMLEX USA Level 1 will change to a pass/fail scoring system by 2022, the USMLE Step 2 CK will remain a scored exam[10]; and

Whereas, In 2014, the American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and the Accreditation Council of Graduate Medical Education (ACGME) agreed to transition to a single accreditation system to increase

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collaboration among the medical education community, reduce costs and increase efficiency, and provide consistency[11]; and

Whereas, The AOA has recognized the importance of modernizing board certification exams, and are offering a new pathway of board certification that does not include and/or require Osteopathic Manipulative Treatment (OMT), emphasizing the similarities between the allopathic and osteopathic professions[12]; and

Whereas, Although the AMA has adopted policy H297.876, *Equal Fees for Osteopathic and Allopathic Medical Students,* which is currently being enacted by the AMA Council of Medical Education, there is evidence that ACGME programs have and continue to discriminate against osteopathic medical students who did not to take the USMLE series when selecting candidates for away rotations and residencies[13,15,16]; and

Whereas, Nearly 20% of ACGME program directors do not utilize the COMLEX USA series and require the USMLE series as part of the residency selection process, putting osteopathic medical students that elect not take USMLE series at a significant disadvantage[11,13]; and

Whereas, Many ACGME program directors, and a majority of program directors in certain specialties such as Emergency Medicine, consider it to be important for osteopathic students to apply with USMLE series scores, and that in these specialties, osteopathic students who take the USMLE series have a 20% better match rate[13,22]; and

Whereas, Despite previously enacted advocacy efforts regarding AMA resolution H-275.013, *The Grading Policy for Medical Licensure Examination*, calling for equal recognition of the COMLEX USA and USMLE series as licensing exams, recent data shows that 54% of VSAS participating institutions require USMLE Step 1 scores for away rotations[13]; and

Whereas, The National Student Osteopathic Medical Association (SOMA) has adopted resolution S-20-30, *Single Licensing Exam*, and has encouraged the National Board of Osteopathic Medical Examiners (NBOME), National Board of Medical Examiners (NBME), and Federation of State Medical Boards (FSMB) to develop a single licensing examination series for all medical students with an additional osteopathic specific subject test for osteopathic medical students; and

Whereas, The Undergraduate Medical Education to Graduate Medical Education Review Committee (UGRC) of the Physician Accountability Coalition (PAC) has offered the solutions of standardized score conversion between USMLE and the COMLEX-USA series, historically program directors have required USMLE scores despite the long standing availability of COMLEX percentile converters by the NBOME; and

Whereas, SOMA has advocated to the COCA to adjust their continuing accreditation standards such that Element 6.12 no longer requires the COMLEX USA series to be passed prior to graduation from an Osteopathic medical school, rather Osteopathic medical students must pass a new single licensing exam developed by the NBOME, FSMB, and NBME; therefore be it,

RESOLVED, That our AMA encourage the development of a single licensing examination series for all medical students attending a medical school accredited by the Liaison Committee on Medical Education (LCME) or the Commission on Osteopathic College Accreditation (COCA), with a separate, additional osteopathic-specific subject test for osteopathic medical students.

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Fiscal Note: TBD

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RELEVANT AMA AND AMA-MSS POLICY

Proposed Single Examination for Licensure H-275.962
Our AMA: (1) endorses the concept of a single examination for medical licensure;
(2) urges the NBME and the FSMB to place responsibility for developing Steps I and II of the new single examination for licensure with the faculty of U.S. medical schools working through the NBME;
(3) continues its vigorous support of the LCME and its accreditation of medical schools and supports monitoring the impact of a single examination on the effectiveness of the LCME;
(4) urges the NBME and the FSMB to establish a high standard for passing the examination;
(5) strongly recommends and supports actively pursuing efforts to assure that the standard for passing be criterion-based; that is, that passing the examination indicate a degree of knowledge acceptable for practicing medicine; and
(6) will work with the appropriate stakeholders to study the advantages, disadvantages, and practicality of combining the USMLE Step 1 and Step 2 CK exams into a single licensure exam measuring both foundational science and clinical knowledge competencies.
(CME Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Modified: CME Rep. 2, A-10; Reaffirmed: BOT Rep. 3, I-14; Appended: Res. 309, A-17)

Equal Fees for Osteopathic and Allopathic Medical Students H-295.876
1. Our AMA, in collaboration with the American Osteopathic Association, discourages discrimination against medical students by institutions and programs based on osteopathic or allopathic training.
2. 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.
3. Our AMA will 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.
(Res. 809, I-05; Appended: CME Rep. 6, A-07; Modified: CCB/CLRPD Rep. 2, A-14; Appended: Res. 303, I-19)

National Resident Matching Program Reform D-310.977
Our AMA:
(1) will work with the National Resident Matching Program to develop and distribute educational programs to better inform applicants about the NRMP matching process;
(2) will actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match;
(3) will request that the NRMP explore the possibility of including the Osteopathic Match in the NRMP Match;

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(4) will continue to review the NRMP's policies and procedures and make recommendations for improvements as the need arises;
(5) will work with the Accreditation Council for Graduate Medical Education and other appropriate agencies to assure that the terms of employment for resident physicians are fair and equitable and reflect the unique and extensive amount of education and experience acquired by physicians;
(6) does not support the current the "All-In" policy for the Main Residency Match to the extent that it eliminates flexibility within the match process;
(7) will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including application timelines and requirements;
(8) will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicant;
(9) encourages the National Resident Matching Program to study and publish the effects of implementation of the Supplemental Offer and Acceptance Program on the number of residency spots not filled through the Main Residency Match and include stratified analysis by specialty and other relevant areas;
(10) will work with the National Resident Matching Program (NRMP) and Accreditation Council for Graduate Medical Education (ACGME) to evaluate the challenges in moving from a time-based education framework toward a competency-based system, including: a) analysis of time-based implications of the ACGME milestones for residency programs; b) the impact on the NRMP and entry into residency programs if medical education programs offer variable time lengths based on acquisition of competencies; c) the impact on financial aid for medical students with variable time lengths of medical education programs; d) the implications for interprofessional education and rewarding teamwork; and e) the implications for residents and students who achieve milestones earlier or later than their peers;
(11) will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs;
(12) will work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs;
(13) will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program;
(14) will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions;
(15) encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match;

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(16) supports the movement toward a unified and standardized residency application and match system for all non-military residencies; and
(17) encourages the Educational Commission for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Resident Matching Program and are therefore unable to get a residency or practice medicine.
(CME Rep. 4, A-05; Appended: Res. 330, A-11; Appended: Res. 920, I-11; Appended: Res. 311, A-14; Appended: Res. 312, A-14; Appended: Res. 304, A-15; Appended: CME Rep. 03, A-16; Reaffirmation: A-16; Appended: CME Rep. 06, A-17; Appended: Res. 306, A-17; Modified: Speakers Rep. 01, A-17; Appended: CME Rep. 3, A-21)

Alternatives to the Federation of State Medical Boards Recommendations on Licensure H-275.934
Our AMA adopts the following principles:(1) Ideally, all medical students should successfully complete Steps 1 and 2 of the United States Medical Licensing Examination (USMLE) or Levels 1 and 2 of the Comprehensive Osteopathic Medical Licensing Examination (COMLEX USA) prior to entry into residency training. At a minimum, individuals entering residency training must have successfully completed Step 1 of the USMLE or Level 1 of COMLEX USA. There should be provision made for students who have not completed Step 2 of the USMLE or Level 2 of the COMLEX USA to do so during the first year of residency training. (2) All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all licensing examinations (USMLE or COMLEX USA), and must be certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine. The candidate for licensure should have had education that provided exposure to general medical content. (3) There should be a training permit/educational license for all resident physicians who do not yet have a full and unrestricted license to practice medicine. To be eligible for an initial training permit/educational license, the resident must have completed Step 1 of the USMLE or Level 1 of COMLEX USA. (4) Residency program directors shall report only those actions to state medical licensing boards that are reported for all licensed physicians. (5) Residency program directors should receive training to ensure that they understand the process for taking disciplinary action against resident physicians, and are aware of procedures for dismissal of residents and for due process. This requirement for residency program directors should be enforced through Accreditation Council for Graduate Medical Education accreditation requirements. (6) There should be no reporting of actions against medical students to state medical licensing boards. (7) Medical schools are responsible for identifying and remediating and/or disciplining medical student unprofessional behavior, problems with substance abuse, and other behavioral problems. as well as gaps in student knowledge and skills. (8) The Dean's Letter of Evaluation should be strengthened and standardized, to serve as a better source of information to residency programs about applicants.
(CME Rep. 8, A-99; Reaffirmed: CME Rep. 4, I-01; Reaffirmed: CME Rep. 2, A-11; Modified: CME Rep. 2, A-12; Modified: CME Rep. 2, A-21)

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

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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 credentialing 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.
(Res. 306, I-20)

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, I-90; 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)

Equality for COMLEX and USMLE 275.013MSS
AMA-MSS will ask the AMA to (1) promote equal acceptance of the USMLE and COMLEX at all United States residency programs; (2) 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

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how to interpret and use COMLEX scores; and (3) work with Residency Program Directors to promote higher COMLEX utilization with residency program matches in light of the new single accreditation system. (MSS Res 38, A-18)

Expanding the Visiting Students Application Service for Visiting Student Electives in the Fourth Year 295.147MSS
AMA-MSS will ask the AMA to (1) strongly encourage 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) support and encourage 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) encourage 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; and (4) explore the feasibility of collaborating with other stakeholder organizations and funding agencies to convene leaders in allopathic and osteopathic medicine responsible for undergraduate and graduate medical education, accreditation and certification, to explore opportunities to align education policies and practices, including visiting student elective opportunities. (MSS Amended Res 2, A-09) (AMA Res 910, I-09 [H-295.867]) (Reaffirmed: MSS GC Rep A, I-14) (Reaffirmed: MSS GC Rep A, I-19)

Unified Medical Education 295.176MSS
AMA-MSS supports a Unified Accreditation System for allopathic and osteopathic graduate medical education programs. (MSS Res 5, I-13) (Reaffirmed: MSS GC Rep A, I-19)

Future of the United States Medical Licensing Examination (USMLE): Examining Multi-Step Structure and Score Usage 295.188MSS
AMA-MSS will ask that our AMA (1) work with the appropriate stakeholders to investigate the advantages, disadvantages, and practicality of combining the United States Medical Licensing Examination (USMLE) Step 1 and Step 2 Clinical Knowledge (CK) exams into a single licensure exam measuring both foundational science and clinical knowledge competencies, and (2) work with the appropriate stakeholders to study alternate means of scoring United States Medical Licensing Examination (USMLE) exams. (MSS Res 21, I-16) (AMA Res 309, A-17 Adopted as Amended [appended to H-275.962 and H-275.953])

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 24
(N-21)

Introduced by: Shreya Tripathy, University of Texas Health Science Center at San Antonio Long School of Medicine; Dilpreet Kaeley, University of Toledo College of Medicine and Life Sciences; Nikita Sood, Washington University School of Medicine in St. Louis; Swetha Maddipudi, University of Texas Health Science Center at San Antonio Long School of Medicine; Chris Wong, Baylor College of Medicine; Rajadhar Reddy, Baylor College of Medicine

Sponsored by: Region 2, Region 3, Region 4, Region 5, Region 6

Subject: Amending Policy H-155.955: Increasing Accessibility to Incontinence Products to include Diaper Tax Exemption

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, Diapers are used by different population groups, including but not limited to young children and those with a variety of medical conditions[1]; and

Whereas, The populations that utilize diapers often overlap with vulnerable patient groups, such as infants/toddlers, the elderly, adults with physical disabilities, and adults with intellectual disabilities, who are unable to perform activities of daily living including toilet use on their own[1]; and

Whereas, Diapers that are not changed in a timely manner increase the risk of urinary tract infections and diaper dermatitis, especially for extended hours spent in a diaper overnight; this also creates an environment for the formation of pressure ulcers[2-3]; and

Whereas, 29-36% of families struggle to afford child diapers, and diaper need (defined as the lack of an adequate supply of clean diapers) can limit parents' ability to work, given that many child care centers require parents to supply diapers as a condition of enrollment[3-6]; and

Whereas, An AAP study found that the average cost of diapers is $936 per year, per child, which is over 6% of a federal minimum wage salary of $7.25 per hour[3,7,]; and

Whereas, An adult can expect to spend $80-240 per month on diapers, depending on the degree of incontinence and extent of need[8,9]; and

Whereas, According to the National Diaper Bank Network, some families pay more in taxes for diapers over a year than the cost of a one month supply of diapers and, in 2014, the lowest income quintile (with an average after-tax income of $11,000) spent an estimated 14% of its income on diapers[10,11]; and

Whereas, Mothers reporting mental health need were more likely to also report diaper need and, in a population of low-income families in an urban setting, 30% of mothers that reported diaper need were more likely to be Hispanic and older[3,6]; and

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Whereas, A study of Vermont WIC, a low-income based nutrition program, showed that 32.5% of families reported diaper need[12]; and

Whereas, Although the National Diaper Bank Network diaper distribution program assisted 280,000 children, it reached only 4% of the 7 million children living in families with incomes at or below 200% of the federal poverty level[13]; and

Whereas, Medicaid coverage of child diapers deemed medically necessary for incontinence varies among states, with Utah, New Hampshire, and the District of Columbia having no age limit for beginning diaper coverage, while Maine, Kansas, and California begin coverage at 5 years[14]; and

Whereas, Thirty-six states charge sales tax on diapers; California, Connecticut, Massachusetts, Minnesota, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont exempt diapers from taxation; and Maryland and North Dakota exempt adult incontinence products alone[13,15]; and

Whereas, In a study of 50,000 households in low-income areas with sales tax exemptions on diapers, there was a 5.4% increase in diaper spending and a 6.2% decrease in spending on children's' pain medication, suggesting health benefits as a result of tax exemptions[16]; and

Whereas, As of 2021, thirteen states have adopted specific tax exemptions on menstrual products, illustrating the legislative and economic feasibility of exempting necessary hygiene products from taxable goods[17]; and

Whereas, Cost savings from the repeal of sales tax on menstrual products have been shown to directly benefit consumers, particularly those of lower-income backgrounds, by shifting the tax break mostly to consumers and away from manufacturers[18]; and

Whereas, Congress is currently considering multiple bills to both remove sales tax on diapers as well as make child diapers qualified medical expenses eligible for spending from pre-tax HSAs, HRAs, and FSAs[19-21]; and

Whereas, AMA-MSS Policy 245.021MSS asks our AMA to support increased access to affordable diapers and AMA-MSS Policy 525.016MSS asks our AMA to support the inclusion of hygiene products under Supplemental Nutrition Programs; and

Whereas, AMA Policy H-270.953 recognizes access to feminine hygiene products used for menstruation and other genital tract secretions as a public health issue and supports the removal of sales tax on all feminine hygiene products; and

Whereas, AMA Policy H-155.955 supports increased access to affordable incontinence products, but does not contain specific measures for implementation; therefore be it

RESOLVED, That our AMA amend Policy H-155.955, "Increasing Accessibility to Incontinence Products," by addition and deletion as follows:

Increasing Accessibility to Incontinence Products H-155.955
Our AMA supports increased access to affordable incontinence products~~.~~, the removal of sales tax on child and adult diapers,

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including single-use and reusable diapers, and the inclusion of child diapers as qualified medical expenses for HSAs, HRAs, and FSAs.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

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

Infant Mortality in the United States H-245.986
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

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

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.

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Res. 246, I-94; Reaffirmed: BOT Rep. 29, A-04; Reaffirmed: BOT Rep. 19, A-14

Increasing Accessibility to Incontinence Products H-155.955
Our AMA supports increased access to affordable incontinence products.
Res. 908, I-18

The Diaper Gap 245.021MSS
AMA-MSS will ask that our AMA support increased access to affordable diapers. MSS Res 05, A-17

Increasing Accessibility to Adult Incontinence Products 155.007MSS
AMA-MSS will ask the AMA to support increased access to medically-recognized adult incontinence products through means including, but not limited to Medicare coverage. MSS Res 24, A-18; AMA Res 908, I-18, Adopted [H-155.955]

Inclusion of Hygiene Products in Supplemental Nutrition Programs 525.016MSS
AMA-MSS will ask the AMA to: (1) 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; (2) advocate for federal legislation that increases access to menstrual hygiene products, especially for recipients of public assistance; and (3) work with state medical societies to advocate for state legislation that increases access to menstrual hygiene products, especially for recipients of public assistance.
MSS Res. 044, A-21

Health Savings Accounts H-165.852

It is the policy of the AMA that: (1) high-deductible health insurance plans issued to families in conjunction with Health Savings Accounts (HSAs) be allowed to apply lower, per-person deductibles to individual family members with the permitted levels for per-person deductibles being the same as permitted levels for individual deductibles, and with the annual HSA account contribution limit being determined by the full family deductible or the dollar-limit for family policies; (2) contributions to HSAs should be allowed to continue to be tax deductible until legislation is enacted to replace the present exclusion from employees' taxable income of employer-provided health expense coverage with tax credits for individuals and families; (3) advocacy of HSAs continues to be incorporated prominently in its campaign for health insurance market reform; (4) activities to educate patients about the advantages and opportunities of HSAs be enhanced; (5) efforts by companies to develop, package, and market innovative products built around HSAs continue to be monitored and encouraged; (6) HSAs continue to be promoted and offered to AMA physicians through its own medical insurance programs; and (7) legislation promoting the establishment and use of HSAs and allowing the tax-free use of such accounts for health care expenses, including health and long-term care insurance premiums and other costs of long-term care, be strongly supported as an integral component of AMA efforts to achieve universal access and coverage and freedom of choice in health insurance. CMS Rep. 11 - I-94; Reaffirmed by Sub. Res. 125 and Sub. Res. 109, A-95; Reaffirmed by CMS Rep. 7, A-97; Reaffirmation A-97; Reaffirmed: CMS Rep. 5, I-97; Reaffirmation I-98; Reaffirmed: CMS Rep. 5 and 7, I-99; CMS Rep. 10, I-99; Appended by Res. 220, A-00; Reaffirmation I-00; Reaffirmed Res. 109 & Reaffirmation A-01; Reaffirmed: CMS Rep. 2, I-01; Reaffirmation A-02; CMS Rep. 3, I-02; Reaffirmed: CMS Rep. 3, A-03; Reaffirmation I-03; CMS Rep. 6, A-04; Reaffirmation A-04; Consolidated: CMS Rep. 7, I-05; Reaffirmation A-07; Reaffirmation A-10; Reaffirmed:

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CMS Rep. 2, A-11; Reaffirmed: CMS Rep. 9, A-11; Reaffirmed: Res. 239, A-12; Reaffirmed: CMS Rep. 5, I-12; Reaffirmed: CMS Rep. 9, A-14; Reaffirmed: CMS Rep. 05, A-18

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 25
(N-21)

Introduced by: Camelia Malkami, Rishab Chawla, Medical College of Georgia

Sponsored by: Region 2, Region 7, PsychSIGN

Subject: Supporting Sensitive Language Around Suicide

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, Suicide was the 10th leading cause of death with 47,511 documented reports of deaths by suicide in 2019[1]; and

Whereas, Suicide is highly stigmatized, and a 2016 systematic review found that loved ones of those who die by suicide experience higher levels of stigma than loved ones of those who have a natural death[2]: and

Whereas, There are a variety of phrases used to discuss suicide[3]; and

Whereas, The language used to talk about illnesses including mental health conditions and suicidality often reflects underlying assumptions and often impart value judgments on certain populations[4]; and

Whereas, The Substance Abuse and Mental Health Services Administration recommend that news media reporting on suicides use language such as “died by suicide,” “completed,” or “killed [themselves], yet there are no such clinical guidelines[5]; and

Whereas, The Canadian Journalism Forum on Violence and Trauma warns against reporting that a person “committed suicide,” linking suicide to illegality or moral failing, making it harder for others to seek help, or for families to recover and supports using plain language, such as saying the person “died by suicide” or “took their own life”[6]; and

Whereas, The Canadian Psychiatric Association recommends avoiding the use of inappropriate language, including “committed suicide” and “successful/unsuccessful” or “failed” attempts[7]; and

Whereas, The word “committed” evokes criminality, as suicide was historically criminalized, but this terminology is not consistent with the modern understanding of suicide as a treatable disorder[7]; and

Whereas, Phrases such as "chose to" or "decided to" in the context of suicide can erroneously connote selfishness and ignore the various biopsychosocial factors that can result in suicide"[8]; and

Whereas, A 2019 cross-sectional survey aimed at people who have been affected by suicide found that among phrases used to describe suicidal behavior, “took their own life” and “died by suicide” had the highest median acceptability scores[8]; and

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Whereas, a 2019 systematic comparison of recommendations for safe messaging about suicide in public communications found that only “died by suicide” was recommended by the majority, and that “successful suicide,” “committed suicide,” “failed suicide/attempt,” and “unsuccessful suicide/attempt” should be avoided[3]; therefore be it

RESOLVED, That our AMA work with the American Psychiatric Association and other relevant stakeholders to promote best practices on the use of sensitive, destigmatizing language regarding suicide, such as “died by suicide,” and avoiding language that implies criminality, culpability, or other problematic notions, such as “committed,” “successful/unsuccessful” or “failed” suicide/attempts.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

Teen and Young Adult Suicide in the United States 60.012MSS
AMA-MSS will ask the AMA to recognize teen and young-adult suicide as a serious health concern in the United States and compile resources to reduce teen and young adult suicide, including but not limited to CME classes, patient education programs and other appropriate educational and interventional programs for health care providers, and Rep Back at A-05. (MSS Res 18, A-04) (AMA Amended Res 424, A-05 Adopted [H-60.937]) (Reaffirmed: MSS GC Report B, I-09) (Reaffirmed: MSS GC Report A, I-16)

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Implementation of an Annual Mental Health Awareness and Suicide Prevention Program at Medical Schools 345.009MSS
AMA-MSS supports medical schools to create a mental health awareness and suicide prevention screening program that would: 1) be available to all medical students on an opt-out basis, 2) ensure anonymity, confidentiality, and protection from administration, 3) provide proactive intervention for identified at-risk students by mental health professionals, and 4) educate students and faculty about personal mental health and factors that may contribute to suicidal ideation. MSS Res 15, I-15

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 26
(N-21)

Introduced by: Shreya Tripathy, University of Texas Health Science Center at San Antonio Long School of Medicine; Theodora Winter, University of Texas Health Science Center at San Antonio Long School of Medicine; Dilpreet Kaeley, University of Toledo College of Medicine and Life Sciences; Richard Bui, Baylor College of Medicine; Rajadhar Reddy, Baylor College of Medicine

Sponsored by: Region 3, Region 4, Region 5, Region 6

Subject: Opposition to Debt Litigation against Patients

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, In 2020, medical debt was $429 million across the United States, exceeding nonmedical debt by $39 million[1]; and

Whereas, Medical debt affects a significant portion of the population, with 19% of U.S. families unable to afford paying up-front for medical care in 2017[2]; and

Whereas, 26.7% of households with a Black family member had medical debt compared to 17.2% of households with a white family member and 9.7% of households with an Asian family member[2]; and

Whereas, 31% of households with a family member in poor health had medical debt compared to 14.4% of those with family members in adequate health[2]; and

Whereas, 64% of Americans in 2018 delayed or avoided treatment due to cost of medical care[3]; and

Whereas, Medical debt is a risk factor for prolonging a period of homelessness, and in a study of 1,600 low income individuals, 27% stated they had housing problems including difficulty qualifying for a mortgage and inability to pay rent or mortgage as a result of their medical debt[4-5]; and

Whereas, Individual medical debt is often an insignificant portion of hospital's overall revenue, despite the devastating impacts it has on individuals and families[6]; According to ProPublica this portion can be as little as 0.03%, and the Healthcare Financial Management Association found that in 2018, bad debt (debt unlikely to be paid) consisted of 1-3% of total hospital revenue[7]; and

Whereas, There is a growing national recognition of the problems associated with medical billing, reflected in the introduced Medical Debt Relief Act of 2021, which primarily aims for increased forgiveness regarding the reporting of medical debt on patient credit, but does not address hospital billing practices[8]; and

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Whereas, An August 2021 study published in JAMA Network Open found that after media coverage of debt litigation against patients in Virginia, Virginia hospitals filed 59% fewer medical debt lawsuits compared to the previous year and 11 hospitals banned the practice altogether, demonstrating that public accountability can reduce this predatory practice[9]; and

Whereas, The American Hospital Association (AHA) Patient Billing Guidelines state that health care organizations have a responsibility to communicate effectively with patients and provide resources for patients wishing to discuss their payments; In the event of a nonpayment, the AHA guidelines recommend giving patients 30 days prior notice of any actions a hospital will take as a result[10]; and

Whereas, The AHA Patient Billing Guidelines state that health care organizations working with third-party debt collectors should ensure that the collectors adhere to the Fair Debt Collection Practices Act (FDCPA), which establishes guidelines meant to prevent abusive debt practice against consumers[10]; therefore be it

Whereas, AMA Policy H-385.963 encourages physicians to ensure no debt collection is sent to a patient without the physician's knowledge and to practice compassion and discretion when sending collection; and

Whereas, Our AMA currently lacks policy addressing the practice of debt litigation directly conducted by health care organizations; therefore be it

RESOLVED, That our AMA oppose the practice of health care organizations pursuing litigation against patients due to medical debt, and encourages health care organizations to consider the relative financial benefit of collecting medical debt to their revenue, against the detrimental cost to a patient's well-being; and be it further

RESOLVED, That our AMA encourage health care organizations to manage medical debt with patients directly and consider several options, including discounts, payment plans with flexibility and extensions as needed, or forgiveness of debt altogether, before resorting to third-party debt collectors or any punitive actions; and be it further

RESOLVED, That our AMA encourage health care organizations to consider the American Hospital Association Patient Billing Guidelines when faced with patients struggling to finance their medical bills.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

Offsetting the Costs of Providing Uncompensated Care: H-160.923

Our AMA: (1) supports the transitional redistribution of disproportionate share hospital (DSH) payments for use in subsidizing private health insurance coverage for the uninsured;(2) supports the use of innovative federal- or state-based projects that are not budget neutral for the purpose of supporting physicians that treat large numbers of uninsured patients, as well as EMTALA-directed care; and (3) encourages public and private sector researchers to utilize data collection methodologies that accurately reflect the amount of uncompensated care (including both bad debt and charity care) provided by physicians. CMS Rep. 8, A-05; Reaffirmed A-07; Modified: CMS Rep. 01, A-17.

Exclusion of Medical Debt That Has Been Fully Paid or Settled: H-373.996

Our AMA supports the principles contained in The Medical Debt Relief Act as drafted and passed by the US House of Representatives to provide relief to the American consumer from a complicated collections process and supports medical debt resolution being portrayed in a positive and productive manner. Res. 226, I-10; Reaffirmed: BOT Rep. 04, A-20.

Health Plan Payment of Patient Cost-Sharing D-180.979

Our AMA will: (1) support the development of sophisticated information technology systems to help enable physicians and patients to better understand financial obligations; (2) encourage states and other stakeholders to monitor the growth of high deductible health plans and other forms of cost-sharing in health plans to assess the impact of such plans on access to care, health outcomes, medical debt, and provider practice sustainability; (3) advocate for the inclusion of health insurance contract provisions that permit network physicians to collect patient

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cost-sharing financial obligations (eg, deductibles, co-payments, and co-insurance) at the time of service; and (4) monitor programs wherein health plans and insurers bear the responsibility of collecting patient co-payments and deductibles. CMS Rep. 09, A-19.

Physician Review of Accounts Sent for Collection and Policy: H-385.963
1. The AMA encourages all physicians and employers of physicians who treat patients to review their accounting/collection policies to ensure that no patient's account is sent to collection without the physician's knowledge.
2. The AMA urges physicians to use compassion and discretion **in** sending accounts of their patients to collection, especially accounts of patients who are terminally ill, homeless, disabled, impoverished, or have marginal access to medical care. Res. 127, I-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CMS Rep. 4, A-13.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 27
(N-21)

Introduced by: Sarah Mae Smith, University of California – Irvine School of Medicine; Shivani Bhatnagar, Texas College of Osteopathic Medicine; Miles Rothstein, University of South Carolina School of Medicine – Greenville

Sponsored by: Region 1, Region 3, Region 6, Region 7, ANAMS, PsychSIGN

Subject: Longitudinal Capacity-Building to Address Climate Action and Justice

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, The most recent report of the Intergovernmental Panel on Climate Change (IPCC) found that "human-induced climate change is already affecting many weather and climate extremes in every region across the globe,"[1]; and

Whereas, The first installment of the IPCC's Sixth Assessment Report observed that "global surface temperature will continue to increase until at least the mid-century under all emissions scenarios considered," and "global warming of 1.5°C and 2°C will be exceeded during the 21st century unless deep reductions in CO2 and other greenhouse gas emissions occur in the coming decades"[1]; and

Whereas, Limiting global warming to 1.5°C is dependent upon reaching net zero carbon dioxide emissions globally by around year 2050, as well as a significant reduction in non-carbon dioxide drivers[1]; and

Whereas, The deleterious health implications of climate change are well-characterized and range from heat-related illness and death to vector-borne diseases to food- and water-borne illnesses[2,3]; and

Whereas, Between 2000 and 2017, there were 158 hospital evacuations in the United States, 55.2% of which required the evacuation of more than 100 patients, and 72.2% of these evacuations were due to natural, climate-sensitive events such as hurricanes (sixty-five evacuations), wildfires (twenty-one evacuations), floods (ten evacuations), and storms (eight evacuations)[4,5]; and

Whereas, Extreme weather events precipitated and exacerbated by climate change have myriad negative repercussions for the healthcare system, such causing health facility damage and closures, transportation disruptions, power outages, displacement of health professionals, supply chain disruptions, and overcrowding of hospitals[5,6]; and

Whereas, The detrimental effects caused by climate change are inequitably distributed and disproportionately borne by marginalized and minoritized populations due to more substantial exposures and less capacity to mitigate the dangers of global warming[7,8]; and

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Whereas, Inequities in access to healthcare, transportation infrastructure, energy production resources, and spending on climate mitigation and resilience measures drive the disparate impacts of climate change on vulnerable communities, resulting in reduced capacity to respond to its dangerous effects[7-12]; and

Whereas, Older adults, Black and Indigenous populations, people with chronic illnesses or mobility challenges, geographically isolated communities, socioeconomically disadvantaged populations including low-income countries, and children are particularly vulnerable to poorer health outcomes due to the harmful impacts of climate change, and children will suffer the longest exposures to these effects[3,7,10,12,13]; and

Whereas, Climate justice has been defined as "a local, national, and global movement to protect at-risk populations who are disproportionately affected by climate change," recognizing that there are grave disparities between the communities most responsible for generating its destructive repercussions and those most burdened by its adverse effects[10,12,13]; and

Whereas, Heat-related mortality, including deaths from heat stress, heatstroke, and heat-related exacerbations of cardiovascular and respiratory disease, in people older than 65 years has increased by 53.7% in the past twenty years (resulting in 296,000 deaths in 2018), and people with disabilities and pre-existing medical conditions are most likely to be impacted[8]; and

Whereas, Rising temperatures endanger the global food supply, with the global yield potential for major crops such as maize, winter wheat, soybean, and rice decreasing from 1981 to 2019 by 1.8-5.6%, intensifying under-nourishment and malnutrition with the most significant impacts on low- and middle-income countries already suffering from high rates of food insecurity[8]; and

Whereas, The United States healthcare system is a major contributor to greenhouse gas emissions and its injurious impact on the climate is escalating, with emissions derived from the United States health sector increasing by six percent from 2010 to 2018, when the greenhouse gas and toxic air pollutant emissions from the health system caused the loss of 388,000 disability-adjusted life-years[14]; and

Whereas, The healthcare sector is responsible for 4.4% of global greenhouse gas emissions, emitting 2 billion metric tons of carbon dioxide equivalent annually as of 2014, and the United States produces both the highest rate of emissions from its healthcare system (7.6% of its total climate footprint) and the highest total contribution to emissions (546 million metric tons of carbon dioxide equivalent)[15]; and

Whereas, In 2018, greenhouse gas emissions from the healthcare supply chain comprised over 80% of the emissions from the United States healthcare sector, representing 453 million metric tons of carbon dioxide equivalent, and electric power generation, transmission, and distribution produced 29.4% of greenhouse gas emissions from the United States healthcare system[14]; and

Whereas, The United States healthcare sector has the highest per capita greenhouse gas emissions of any country worldwide, at 1,693 kilograms of carbon dioxide equivalent per capita[14]; and

Whereas, Because of the significant contributions of the healthcare sector to global greenhouse gas emissions, the decarbonization of the healthcare system constitutes an imperative to reach net zero emissions by 2050 and improve global health equity[14,15]; and

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Whereas, As noted in the 2020 report of the Lancet countdown on health and climate change, "Doctors, nurses, and the broader profession have a central role in health system adaptation and mitigation, in understanding and maximising the health benefits of any intervention, and in communicating the need for an accelerated response"[8]; and

Whereas, Extant AMA policy "concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant" (H-135.938), "urges Congress to adopt a comprehensive, integrated natural resource and energy utilization policy that will promote more efficient fuel use and energy production" (H-135.977), and "supports initiatives to promote environmental sustainability and other efforts to halt global climate change" (H-135.923); and

Whereas, The AMA has committed to exploring environmentally sustainable practices for the distribution of the Journal of the American Medical Association (D-135.968) and moving "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" (D-135.969); and

Whereas, The AMA currently lacks the organizational capacity to engage in health-oriented climate advocacy that meets the scale of the global climate crisis; therefore be it

RESOLVED, That our AMA develop a comprehensive and sustainable plan to address the emerging climate health crisis and further climate justice, including the development of new policy around climate change adaptation and mitigation with a focus on the decarbonization of the healthcare system, with report back to the House of Delegates; and be it further

RESOLVED, That our AMA consider the establishment of a longitudinal body or center within the AMA to coordinate and strengthen efforts toward advocacy for an equitable and inclusive transition to a net-zero carbon society by 2050, with report back to the House of Delegates.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS 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.

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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

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.
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.
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.

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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

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

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.

Support the Health Based Provisions of the Clean Air Act H-135.950
Our AMA opposes legislation to weaken the existing provisions of the Clean Air Act.
Res. 417, A-03; Reaffirmation A-05; Reaffirmation I-11; Modified: CSAPH Rep. 1, A-21

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Environmental Protection and Safety in Federal Facilities H-135.985
The AMA urges physicians to contribute to the solution of environmental problems by serving as knowledgeable and concerned consultants to environmental, radiation, and public health protection agencies of state and local governments.
BOT Rep. T, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17

Clean Air H-135.991
(1) The AMA supports setting the national primary and secondary ambient air quality standards at the level necessary to protect the public health. Establishing such standards at the level necessary to protect the public health. Establishing such standards at a level "allowing an adequate margin of safety," as provided in current law, should be maintained, but more scientific research should be conducted on the health effects of the standards currently set by the EPA.
(2) The AMA supports continued protection of certain geographic areas (i.e., those with air quality better than the national standards) from significant quality deterioration by requiring strict, but reasonable, emission limitations for new sources.
(3) The AMA endorses a more effective hazardous pollutant program to allow for efficient control of serious health hazards posed by airborne toxic pollutants.
(4) The AMA believes that more research is needed on the causes and effects of acid rain, and that the procedures to control pollution from another state need to be improved.
(5) The AMA believes that attaining the national ambient air quality standards for nitrogen oxides and carbon monoxide is necessary for the long-term benefit of the public health. Emission limitations for motor vehicles should be supported as a long-term goal until appropriate peer-reviewed scientific data demonstrate that the limitations are not required to protect the public health.
BOT Rep. R, A-82; Reaffirmed: CLRPD Rep. A, I-92; Amended: CSA Rep. 8, A-03; Reaffirmation I-06; Reaffirmed in lieu of Res. 509, A-09; Reaffirmation I-09; Reaffirmation A-14

Reducing Sources of Diesel Exhaust D-135.996
Our AMA will: (1) encourage the US Environmental Protection Agency (EPA) to set and enforce the most stringent feasible standards to control pollutant emissions from both large and small non-road engines including construction equipment, farm equipment, boats and trains; (2) encourage all states to continue to pursue opportunities to reduce diesel exhaust pollution, including reducing harmful emissions from glider trucks and existing diesel engines; (3) call for all trucks traveling within the United States, regardless of country of origin, to be in compliance with the most stringent and current diesel emissions standards promulgated by US EPA; and (4) send a letter to US EPA Administrator opposing the EPA's proposal to roll back the "glider Kit Rule" which would effectively allow the unlimited sale of re-conditioned diesel truck engines that do not meet current EPA new diesel engine emission standards.
Res. 428, A-04; Reaffirmed in lieu of Res. 507, A-09; Reaffirmation A-11; Reaffirmation A-14; Modified: Res. 521, A-18

Human and Environmental Health Impacts of Chlorinated Chemicals H-135.956
The AMA: (1) encourages the Environmental Protection Agency to base its evaluations of the potential public health and environmental risks posed by exposure to an individual chlorinated organic compound, other industrial compound, or manufacturing process on reliable data specific to that compound or process; (2) encourages the chemical industry to increase knowledge of the environmental behavior, bioaccumulation potential, and toxicology of their products and by-products; and (3) supports the implementation of risk reduction practices by the chemical and manufacturing industries.

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Sub. Res. 503, A-94; Reaffirmation I-98; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmation I-16

Assurance and Accountability for EPA's State Level Agencies H-135.924
Our AMA supports requiring that the United States Environmental Protection Agency (EPA) conduct regular quality assurance reviews of state agencies that are delegated to enforce EPA regulations.
Res. 221, A-16

Environmental Preservation H-135.972
It is the policy of the AMA to support state society environmental activities by:
(1) identifying areas of concern and encouraging productive research designed to provide authoritative data regarding health risks of environmental pollutants;
(2) encouraging continued efforts by the CSAPH to prepare focused environmental studies, where these studies can be decisive in the public consideration of such problems;
(3) maintaining a global perspective on environmental problems;
(4) considering preparation of public service announcements or other materials appropriate for public/patient education; and
(5) encouraging state and component societies that have not already done so to create environmental committees.
Res. 52, A-90; Reaffirmed: Sunset Report, I-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Green Initiatives and the Health Care Community H-135.939
Our AMA supports: (1) responsible waste management and clean energy production policies that minimize health risks, including the promotion of appropriate recycling and waste reduction; (2) the use of ecologically sustainable products, foods, and materials when possible; (3) the development of products that are non-toxic, sustainable, and ecologically sound; (4) building practices that help reduce resource utilization and contribute to a healthy environment; (5) the establishment, expansion, and continued maintenance of affordable, accessible, barrier-free, reliable, and clean-energy public transportation; and (6) community-wide adoption of 'green' initiatives and activities by organizations, businesses, homes, schools, and government and health care entities.
CSAPH Rep. 1, I-08; Reaffirmation A-09; Reaffirmed in lieu of Res. 402, A-10; Reaffirmed in lieu of: Res. 504, A-16; Modified: Res. 516, A-18; Modified: Res. 923, I-19

Synthetic Gasification D-135.977
Our AMA will encourage the study the health effects of clean coal technologies including synthetic gasification plants.
Res. 514, A-12

Air Pollution and Public Health D-135.985
Our AMA: (1) promotes education among its members and the general public and will support efforts that lead to significant reduction in fuel emissions in all states; and (2) will declare the need for authorities in all states to expeditiously adopt, and implement effective air pollution control strategies to reduce emissions, and this position will be disseminated to state and specialty societies.
Res. 408, A-08; Reaffirmation A-14

Support of Clean Air and Reduction in Power Plant Emissions H-135.949

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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

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

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-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

AMA Position on Air Pollution H-135.998
Our AMA urges that: (1) Maximum feasible reduction of all forms of air pollution, including particulates, gases, toxicants, irritants, smog formers, and other biologically and chemically active pollutants, should be sought by all responsible parties.
(2) Community control programs should be implemented wherever air pollution produces widespread environmental effects or physiological responses, particularly if these are accompanied by a significant incidence of chronic respiratory diseases in the affected community.
(3) Prevention programs should be implemented in areas where the above conditions can be predicted from population and industrial trends.
(4) Governmental control programs should be implemented primarily at those local, regional, or state levels which have jurisdiction over the respective sources of air pollution and the population and areas immediately affected, and which possess the resources to bring about equitable and effective control.
BOT Rep. L, A-65; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation I-06; Reaffirmed in lieu of Res. 509, A-09; Reaffirmation A-11; Reaffirmation A-12; Reaffirmation A-14; Reaffirmation A-16; Reaffirmed: BOT Rep. 29, A-19

Protecting Public Health from Natural Gas Infrastructure H-135.930
Our AMA recognizes the potential impact on human health associated with natural gas infrastructure and supports legislation that would require a comprehensive Health Impact Assessment regarding the health risks that may be associated with natural gas pipelines.
Res. 519, A-15

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Support Reduction of Carbon Dioxide Emissions D-135.972
Our AMA will (1) inform the President of the United States, the Administrator of the Environmental Protection Agency (EPA), and Congress that our American Medical Association supports the Administration's efforts to limit carbon dioxide emissions from power plants to protect public health; and (2) working with state medical societies, encourage state governors to support and comply with EPA regulations designed to limit carbon dioxide emissions from coal fired power plants.
Res. 421, A-14; Modified: Res. 506, A-15

EPA and Green House Gas Regulation H-135.934
1. Our AMA supports the Environmental Protection Agency's authority to promulgate rules to regulate and control green house 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

Clean Air H-135.979
Our AMA supports cooperative efforts with the Administration, Congress, national, state and local medical societies, and other organizations to achieve a comprehensive national policy and program to address the adverse health effects from environmental pollution factors, including air and water pollution, toxic substances, the "greenhouse effect," stratospheric ozone depletion and other contaminants.
Sub. Res. 43, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmation I-06; Reaffirmation I-07; Reaffirmed in lieu of Res. 507, A-09; Reaffirmed in lieu of Res. 509, A-09; Reaffirmed: CSAPH Rep. 01, A-19

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 28
(N-21)

Introduced by: Shivani Bhatnagar, Texas College of Osteopathic Medicine; Joel Mintz, Dr. Kiran C. Patel College of Allopathic Medicine; Skyler Burke, Washington State University Elson S. Floyd College of Medicine; Kristofer Jackson University of Toledo College of Medicine; Leelakrishna Channa, University of Connecticut School of Medicine; Madeline Drake, Melissa Yang, McGovern Medical School at UTHealth Houston; Matthew Swanson, Frank H. Netter MD School of Medicine at Quinnipiac University; Andrew Alexander, Texas A&M College of Medicine; David J. Horovitz, University of South Carolina School of Medicine; Adrian Falco, Texas Tech School of Medicine; Sarah Mukhtar, Sidney Kimmel Medical College at Thomas Jefferson University-Philadelphia; Raag Agrawal, David Geffen School of Medicine at UCLA-Los Angeles; Ayesha Firdous, University of Pittsburgh School of Medicine-Pittsburgh

Subject: The Importance of Keeping Health Information Technology (HIT) Advancements Age-Friendly

Sponsored by: Region 3

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, Globally and domestically the elderly make up a large and continually increasing proportion of the population[1]; and

Whereas, Age is a significant risk factor for comorbidities and increasing utilization of healthcare[2,3]; and

Whereas, In recent years, there have been a wide range of advancements within healthcare and health monitoring, including wearable devices, smartphone applications, telehealth appointments, and patient portals[4]; and

Whereas, Digital health literacy (DHL) is defined as “the ability to seek, find, understand, and appraise health information from electronic sources and apply the knowledge gained to addressing or solving a health problem”[5]; and

Whereas, There are known disparities in DHL based on various social determinants of health, including level of education, age, health status, digital literacy skills, and motivation for seeking information[5-7]; and

Whereas, Older adults often suffer from fears of loss of independence, which can be exacerbated by increasing reliance on younger caregivers to navigate technological advancements[8-9]; and

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Whereas, Research shows that sub-populations of older adults, like those with dementia, want to use and do benefit from health information technology (HIT) advancements in terms of increased independence, security, and quality of life, yet these groups may struggle more with utilizing HIT as well as with seeking and receiving assistance when issues arise while using HIT[10-12]; and

Whereas, The AARP reports that nearly 90% of Americans aged 65 years and older want to live at home as long as possible, but this goal can be marred by health complications that require costly emergency care visits, constant monitoring, or transitions to nursing homes[13]; and

Whereas, Advancements in HIT, such as remote glucose sensors, medication management devices, daily activity monitors, and telemedicine, may provide an opportunity for older adults to monitor their health in a way that allows sustained independence, safety, and quality of life at home while providing accurate, timely data to care providers and minimizing overutilization of medical visits[2,3,13]; and

Whereas, Safety measures during the COVID-19 Pandemic, especially to protect disproportionately susceptible older adults, brought on a massive shift towards telemedicine, but it is estimated that thirteen million older adults across America had risk factors, such as poverty or poor DHL, that made it difficult to access or utilize telemedicine platforms despite desire to engage with digital HIT[14-15]; and

Whereas, “Age-friendliness” in HIT has no standardized definition, successful examples of HIT targeted towards older adults include simplistic design components that have larger font sizes, improved visual contrast, fewer multitasking features, predictable and non-startling sounds, closed-captioning, reassurance of data safety, and less reliance on manual dexterity[13,16-18]; and

Whereas, Given that healthcare utilization increases with age and that there is a desire among older adults to utilize technology and retain autonomy, it would be ideal to ensure “age-friendliness” and usability across HIT developments that manage illnesses associated with advanced age[3,15,18]; therefore be it

RESOLVED, That our AMA work with the appropriate stakeholders to develop a standardized definition for “age-friendliness” in health information technology (HIT) advancements; and be it further

RESOLVED, That our AMA identify current best practices to set expectations of HIT developers to ensure that they create devices and technology applicable to older adults that are age-friendly by default.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

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H-315.967 Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation
Our AMA: (1) supports the voluntary inclusion of a patient's biological sex, current gender identity, sexual orientation, preferred gender pronoun(s), preferred name, and clinically relevant, sex specific anatomy in medical documentation, and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner; (2) will advocate for collection of patient data in medical documentation and in medical research studies, according to current best practices, that is inclusive of sexual orientation, gender identity, and other sexual and gender minority traits for the purposes of research into patient and population health; (3) will research the problems related to the handling of sex and gender within health information technology (HIT) products and how to best work with vendors so their HIT products treat patients equally and appropriately, regardless of sexual or gender identity; (4) will investigate the use of personal health records to reduce physician burden in maintaining accurate patient information instead of having to query each patient regarding sexual orientation and gender identity at each encounter; and (5) will advocate for the incorporation of recommended best practices into electronic health records and other HIT products at no additional cost to physicians.
(Res. 212, I-16; Reaffirmed in lieu of: Res. 008, A-17; Modified: Res. 16, A-19; Appended: Res. 242, A-19; Modified: Res. 04, I-19)

H-180.944 Plan for Continued Progress Toward Health Equity
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)

H-480.937 Addressing Equity in Telehealth
Our AMA:
(1) recognizes access to broadband internet as a social determinant of health;
(2) encourages initiatives to measure and strengthen digital literacy, with an emphasis on programs designed with and for historically marginalized and minoritized populations;
(3) encourages telehealth solution and service providers to implement design functionality, content, user interface, and service access best practices with and for historically minoritized and marginalized communities, including addressing culture, language, technology accessibility, and digital literacy within these populations;
(4) supports efforts to design telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology, such as older adults, individuals with vision impairment and individuals with disabilities;
(5) encourages hospitals, health systems and health plans to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and non-physician provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth;
(6) supports expanding physician practice eligibility for programs that assist qualifying health care entities, including physician practices, in purchasing necessary services and equipment in order to provide telehealth services to augment the broadband infrastructure for, and increase connected device use among historically marginalized, minoritized and underserved populations;
(7) supports efforts to ensure payers allow all contracted physicians to provide care via telehealth;
(8) opposes efforts by health plans to use cost-sharing as a means to incentivize or require the use of telehealth or in-person care or incentivize care from a separate or preferred telehealth network over the patient’s current physicians; and
(9) will advocate that physician payments should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person. (CMS Rep. 7, A-21)

165.009MSS Evaluation of the Principles of the Health Care Access Resolution
(1) AMA-MSS supports efforts to make health care more cost-effective by reducing administrative burdens, but only to such a degree that quality of care is not compromised; (2) AMAMSS supports means

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of including both long-term care and prescription drug benefits into the guidelines for seeking affordable universal health care access and coverage; (3) AMA-MSS encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality of health care; and that our AMA-MSS supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons; (4) AMA-MSS will adopt policy to promote outcomes research as an effective mechanism to improve the quality of medical care for all persons and urge that the results of such research be used only for educational purposes and for improving practice parameters; (5) AMA-MSS will adopt policy to address the need to increase numbers of qualified health care professionals, practitioners, and providers in underserved areas to increase timely access to quality care; (6) AMA-MSS supports the inclusion of adequate and timely payments to physicians and other providers into any plan calling for affordable universal health care access; (7) AMA-MSS supports the inclusion of the principles of continuity of health insurance coverage and continuity of medical care into any plan calling for affordable universal health care access; (8)AMA-MSS supports the inclusion of the principle of consumer choice of healthcare providers and practitioners into any plan calling for affordable universal health care access; (9) AMA-MSS supports the inclusion of reducing health care administrative cost and burden into any plan calling for affordable universal health care access. (MSS Rep C, A-04) (Modified: MSS GC Rep B, I-09) (Modified: GC Rep A, I-16)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 29
(N-21)

Introduced by: Alyssa Greenwood Francis, Texas Tech El Paso; Rajadhar Reddy, Baylor College of Medicine

Sponsored by: Region 2, Region 3, PsychSIGN

Subject: AMA Study of Chemical Castration in Incarceration

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, Chemical castration is defined as the use of pharmacologic agents, including anti-antagonists and gonadotropin-releasing hormone agonists, to reduce serum testosterone levels and quell libido in individuals diagnosed with a paraphilic disorder and other individuals who commit sexual offenses, in an effort to reduce the occurrence of sexual offenses[1,2]; and

Whereas, 4,984 people are currently incarcerated for sexual offenses in federal prisons[3,4]; and

Whereas, Several states have passed or debated statutes requiring chemical castration for individuals who commit sexual offenses as a sentence and/or as a requirement for parole, most recently Alabama in 2019, where offenders are required to pay for their own treatment, and in Tennessee in 2020[1,5-8]; and

Whereas, DSM-V defines “paraphilic disorder” as “recurrent and intense sexual arousal over a period of at least 6 months with nonconsenting victims through voyeurism, exhibitionism, frotteurism, sexual sadism, and pedophilia” and estimated lifetime prevalences are 12% for males and 4% for females[9]; and

Whereas, Chemical castration can be traced to the 1900s eugenics movement where people with developmental delays and psychiatric diagnoses were forcibly sterilized, including up to 60,000 incarcerated women diagnosed with and intellectual disability[1]; and

Whereas, Chemical castration via injection with Depo-Provera (medroxyprogesterone acetate) and surgical sterilization have historically disproportionately targeted Black individuals in the United States, including the deceptive, experimental testing of Depo-Provera as a method of birth control on young Black females in the 1960s[10,11]; and

Whereas, The current method of chemical castration for incarcerated males who committed sex offenses in several states, including California and Florida, is via injection with Depo-Provera, although no medication, including Depo-Provera, is currently FDA-approved for chemical castration[12]; and

Whereas, Limited evidence exists for the effectiveness of chemical castration, with several studies noting that chemical castration does not address the core psychological impulses relating to sexually aberrant behavior[12,13]; and

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Whereas, When chemical castration is a requirement for parole, judges, not medical doctors, are charged with deciding whether or not a prisoner receives chemical castration therapy, suggesting that chemical castration constitutes punishment instead of rehabilitative therapy[12]; and

Whereas, The Association for the Treatment of Sexual Abusers (ATSA) published a 2012 statement on the use of chemical castration for individuals with paraphilic disorders and individuals who commit sexual offenses, concluding that chemical castration may be effective for certain patients when combined with other non-pharmacologic interventions such as psychotherapy[14]; and

Whereas, The issue of chemical castration is rife with ethical quandaries and valid arguments may exist both in support of and in opposition to this practice[15]; and

Whereas, In situations where chemical castration is a requirement for parole, some may argue that this requirement unjustly coerces an individual to agree to a medical procedure, while others may argue that if chemical castration was not required, an individual may never be allowed the possibility of parole at all and may remain incarcerated[15]; and

Whereas, Scientific research, medical information, and expert opinions from physicians on the issue of chemical castration for individuals who commit sexual offenses, especially in the last 5 years, are difficult to find most likely since the population affected by chemical castration have not been the subject of much retrospective research; and

Whereas, The American Psychiatric Association raised concerns in July 2021 about the use of chemical castration as a condition for parole, citing ethical concerns over the minimal to absent involvement of physicians and calling the "court-driven, one-size-fits-all approach to anti-androgen treatment inconsistent with contemporary medical practice"[16]; and

Whereas, Our AMA previously adopted Policy 140.955, "Court-Ordered Castration," which stated that "The AMA opposes physician participation in castration and other surgical or medical treatments initiated solely for criminal punishment," but this policy was later rescinded due to being considered duplicative of Code of Medical Ethics Opinion 9.7.2, "Court-Initiated Medical Treatment in Criminal Cases"[17-18]; and

Whereas, While the AMA Code of Medical Ethics Opinion 9.7.2 states that "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," the morality of chemical castration under this Code is unclear, including its use as efficacious treatment, as a mechanism for social control, as a tool for public safety, and as an alternative to incarceration[1,5-8,15,18]; and

RESOLVED, That our AMA study the use of chemical castration in the treatment of incarcerated individuals with paraphilic disorders and for other individuals who commit sexual offenses, including ethical concerns over coercion in its use as an alternative to incarceration and in probation and parole proceedings.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

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)

Informed Consent, E-2.1.1
Informed consent to medical treatment is fundamental in both ethics and law. Patients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care. Successful communication in the patient-physician relationship fosters trust and supports shared decision making.

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The process of informed consent occurs when communication between a patient and physician results in the patient's authorization or agreement to undergo a specific medical intervention. In seeking a patient's informed consent (or the consent of the patient's surrogate if the patient lacks decision-making capacity or declines to participate in making decisions), physicians should:
(a) Assess the patient's ability to understand relevant medical information and the implications of treatment alternatives and to make an independent, voluntary decision.
(b) Present relevant information accurately and sensitively, in keeping with the patient's preferences for receiving medical information. The physician should include information about:
(i) the diagnosis (when known);
(ii) the nature and purpose of recommended interventions;
(iii) the burdens, risks, and expected benefits of all options, including forgoing treatment.
(c) Document the informed consent conversation and the patient's (or surrogate's) decision in the medical record in some manner. When the patient/surrogate has provided specific written consent, the consent form should be included in the record.
In emergencies, when a decision must be made urgently, the patient is not able to participate in decision making, and the patient's surrogate is not available, physicians may initiate treatment without prior informed consent. In such situations, the physician should inform the patient/surrogate at the earliest opportunity and obtain consent for ongoing treatment in keeping with these guidelines.
AMA Principles of Medical Ethics: I,II,V,VIII (Code of Medical Ethics Opinion, Issued: 2016)

Patient-Physician Relationships, E-1.1.1
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.
AMA Principles of Medical Ethics: I,II,IV,VIII (Code of Medical Ethics Opinion, Issued: 2016)

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-84Reaffirmed by CLRPD Rep. 3 - I-94Amended: Res. 416, I-99, Reaffirmed: CEJA Rep. 8, A-09Reaffirmation I-09, Modified in lieu of Res. 502, A-12Reaffirmation: I-12)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 30
(N-21)

Introduced by: Samantha Rea, Wayne State University School of Medicine; Amanda Schoonover, Man Yee (Tiffie) Keung, Melanie Valentin, Michigan State University CHM; Bradley Fleming, University of Iowa

Sponsored by: Region 2, Region 5, ANAMS, PsychSIGN

Subject: Amend H-145.976 to Reimburse Physicians for Firearm Counseling

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, Firearm ownership is embedded within United States (US) culture with nearly 22% of individuals owning a firearm and 35% living in a household with firearms[1]; and

Whereas, Firearm-related hospitalizations (FRHs) contribute to substantial physical morbidity, psychological and societal costs, and higher risk of subsequent violent victimization and crime perpetration[2]; and

Whereas, More than 39,000 people die by firearms each year in the US, and firearm purchases, injuries, and deaths have increased during the COVID-19 pandemic[1,3-5]; and

Whereas, Firearm injuries create a disproportionate burden of morbidity and mortality on people of color, highlighting racial disparities in firearm access and health outcomes[6-10]; and

Whereas, Over 4 billion dollars were spent on firearm injuries in emergency departments from 2006-2016, which demonstrates the increasing and significant economic burden of gun violence in the US[11-14]; and

Whereas, Although organizations including the AMA and American Academy of Pediatrics agree that physicians should counsel patients on firearm safety, only 25% of family physicians, psychiatrists, and internists provide this counseling very often or often[15-16]; and

Whereas, One study reported that only 15% of physicians documented firearm counseling discussions with patients, due to lack of physician training, time constraints, and fear of offending patients and families[17-20]; and

Whereas, A study of pediatrics resident physicians demonstrated that after a workshop about firearm safety counseling, residents were 5 times more likely to counsel their patients on firearms and had greater comfort during the discussion, due to increased knowledge on recommendations and safe storage[20]; and

Whereas, Physician firearm counseling, when combined with firearm safety devices, has demonstrated improvements in firearm storage in patients' homes from increased availability of locks and safes and increased patient education[21]; and

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Whereas, Individuals at greater risk for firearm injury include those involved in intimate-partner violence and community violence, or those with mental illness, suicidal ideation, and cognitive decline[22-24]; and

Whereas, Efficient use of physician time and resources can be encouraged through implementation of screening of individuals who are at higher risk for firearm injury;[25-27] and

Whereas, Examples of reimbursement for other preventive education, including smoking cessation, have demonstrated increased counseling by physicians and improved patient health outcomes[28-29]; and

Whereas, For example, preventive smoking cessation counseling increased cessation rates by 30%, and since the Affordable Care Act included smoking cessation counseling coverage in 2014, more people have quit smoking[28-29]; and

Whereas, Smoking cessation counseling, which is reimbursed independently by insurance companies, can prevent over 50,000 smoking-attributable fatalities and reduce smoking prevalence by 5.5 percentage points, and firearm counseling would be expected to follow this same trend[30]; and

Whereas, Medicaid and Medicare value-based reimbursement of preventative services has been shown to improve health outcomes through rewarding quality care from primary care physicians[31]; and

Whereas, Physician decision-making has been linked to financial incentives, suggesting that value-based payments specifically for firearm safety counseling may drive increased rates of counseling and improved health outcomes, similar to other preventive care reimbursement strategies[32]; and

Whereas, Although the 2021 ICD-10-CM diagnosis code Z71.89 encompasses other specified counseling, this does not cover specific topics such as firearm storage and prevention of firearm-related injuries[33]; and

Whereas, Other preventive counseling efforts, including smoking cessation, alcohol misuse, dental health, diet, and sexually transmitted diseases, have their own designated ICD-10 codes[33-34]; and

Whereas, For the high-risk subpopulation of older adults, firearm counseling could be incorporated into a patient's Medicare Annual Wellness Visit (AWV) to be billed under the preventive services modifier and to provide remuneration for physicians providing counseling[35]; and

Whereas, AMA Policies H-145.990, H-145.975, and H-145.976 address the need for firearm injury prevention, safe firearm storage, and improved physician counseling and education, but do not specify how physicians should be reimbursed for such efforts; and

Whereas, Physicians should be incentivized to provide firearm safety counseling for patients through a combination of education and appropriate compensation for their time and efforts, contributing to reduced morbidity and mortality from firearms; therefore be it

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RESOLVED, That our AMA-MSS ask the AMA to amend Policy H-145.976, Firearm Safety Counseling in Physician-Led Health Care Teams by addition to read as follows:

Firearm Safety Counseling in Physician-Led Health Care Teams, H-145.976

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.

3. Our AMA will support the development of reimbursement structures that incentivize physicians to counsel patients on firearm-related injury risk and prevention.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

Prevention of Firearm Accidents in Children H-145.990
Our AMA (1) supports increasing efforts to reduce pediatric firearm morbidity and mortality by encouraging its members to (a) inquire as to the presence of household firearms as a part of childproofing the home; (b) educate patients to the dangers of firearms to children; (c) encourage patients to educate their children and neighbors as to the dangers of firearms; and (d) routinely remind patients to obtain firearm safety locks, to store firearms under lock and key, and to store ammunition separately from firearms;(2) encourages state medical societies to work with other organizations to increase public education about firearm safety; (3) encourages organized medical staffs and other physician organizations, including state and local medical

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societies, to recommend programs for teaching firearm safety to children; and (4) supports enactment of Child Access Prevention laws that are consistent with AMA policy.
(Res. 165, I-89; Reaffirmed: Sunset Report and Appended: Sub. Res. 401, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmation: A-13; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmation: I-18; Modified: 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.
(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; Reaffirmed: CSAPH Rep. 3, A-21)

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.
(BOT Rep. 11, A-18)

Gun Violence as a Public Health Crisis D-145.995
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)

Physicians and the Public Health Issues of Gun Safety D-145.997
Our AMA will request that the US Surgeon General develop a report and campaign aimed at reducing **gun**-related injuries and deaths.

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(Res. 410, A-13)

Firearm Safety Counseling in Physician-Led Health Care Teams H-145.976
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)

Data on Firearm Deaths and Injuries H-145.984
The AMA supports legislation or regulatory action that: (1) requires questions in the National Health Interview Survey about firearm related injury as was done prior to 1972; (2) mandates that the Centers for Disease Control and Prevention develop a national firearm fatality reporting system; and (3) expands activities to begin tracking by the National Electronic Injury Surveillance System.
(Res. 811, I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmation: A-13)

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

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(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.
(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)

Strategies to Address Rising Health Care Costs H-155.960
Our AMA:
(1) recognizes that successful cost-containment and quality-improvement initiatives must involve physician leadership, as well as collaboration among physicians, patients, insurers, employers, unions, and government;
(2) supports the following broad strategies for addressing rising health care costs: (a) reduce the burden of preventable disease;
(b) make health care delivery more efficient; (c) reduce non-clinical health system costs that do not contribute value to patient care; and
(d) promote "value-based decision-making" at all levels;
(3) will continue to advocate that physicians be supported in routinely providing lifestyle counseling to patients through: adequate third-party reimbursement; inclusion of lifestyle counseling in quality measurement and pay-for-performance incentives; and medical education and training;
(4) will continue to advocate that sources of medical research funding give priority to studies that collect both clinical and cost data; use evaluation criteria that take into account cost impacts as well as clinical outcomes; translate research findings into useable information on the relative cost-effectiveness of alternative diagnostic services and treatments; and widely disseminate cost-effectiveness information to physicians and other health care decision-makers;
(5) will continue to advocate that health information systems be designed to provide physicians and other health care decision-makers with relevant, timely, actionable information, automatically at the point of care and without imposing undue administrative burden, including: clinical guidelines and protocols; relative cost-effectiveness of alternative diagnostic services and treatments; quality measurement and pay-for-performance criteria; patient-specific clinical and insurance information; prompts and other functionality to support lifestyle counseling, disease management, and case management; and alerts to flag and avert potential medical errors;
(6) encourages the development and adoption of clinical performance and quality measures aimed at reducing overuse of clinically unwarranted services and increasing the use of recommended services known to yield cost savings;
(7) encourages third-party payers to use targeted benefit design, whereby patient cost-sharing requirements are determined based on the clinical value of a health care service or treatment. Consideration should be given to further tailoring cost-sharing requirements to patient income and other factors known to impact compliance; and
(8) supports ongoing investigation and cost-effectiveness analysis of non-clinical health system spending, to reduce costs that do not add value to patient care.
(9) Our AMA will, in all reform efforts, continue to identify appropriate cost savings strategies for our patients and the health care system.

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(CMS Rep. 8, A-07; Reaffirmed; CMS Rep. 7, A-08; Reaffirmed in lieu of Res. 828, I-08; Reaffirmation: A-09; Reaffirmation: I-09; Reaffirmation: A-11; Reaffirmation: I-11; Appended: Res. 239, A-12; Reaffirmed in lieu of Res. 706, A-12; Reaffirmed; CMS Rep. 1, I-12; Modified: CMS Rep. 2, A-13; Reaffirmed in lieu of Res. 122, A-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmed: CMS Rep. 05, I-16; Reaffirmation: I-16; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmed: CMS Rep. 07, A-18; Reaffirmed: Joint CME CSAPH Rep. 01, I-18)

Stark Law and Physician Compensation H-385.914
Our AMA opposes and continues to advocate against the misuse of the Stark Law and regulations to cap or control physician compensation.
(BOT Rep. 6, I-15)

Physicians and Family Caregivers: Shared Responsibility H-210.980
Our AMA: (1) specifically encourages medical schools and residency programs to prepare physicians to assess and manage caregiver stress and burden;

(2) continues to support health policies that facilitate and encourage health care in the home;

(3) reaffirm support for reimbursement for physician time spent in educating and counseling caregivers and/or home care personnel involved in patient care;

(4) supports research that identifies the types of education, support services, and professional caregiver roles needed to enhance the activities and reduce the burdens of family caregivers, including caregivers of patients with dementia, addiction and other chronic mental disorders; and

(5) (a) encourages partner organizations to develop resources to better prepare and support lay caregivers; and (b) will identify and disseminate resources to promote physician understanding of lay caregiver burnout and develop strategies to support lay caregivers and their patients.
(Res. 308, I-98; Reaffirmation: A-02; Reaffirmed: CME Rep. 2, A-12; Appended: Res. 305, A-17)

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)

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;

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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

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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,

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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)

145.004MSS Prevention of Unintentional Firearm Accidents in Children
AMA-MSS will ask the AMA to increase efforts to reduce pediatric firearm morbidity and mortality by encouraging its members: (1) to inquire as to the presence of household firearms as a part of childproofing the home; (2) to educate patients to the dangers of firearms to children; (3) to encourage patients to educate their children and neighbors as to the dangers of firearms; and (4) to routinely remind patients to obtain firearm safety locks and store firearms under lock and key; and that the AMA encourage state medical societies to work with other organizations to increase public education about firearm safety. (AMA Amended Res 165, I-89 Adopted [H-145.990]) (Reaffirmed: MSS Rep D, I-99) (Reaffirmed: MSS GC Report A, I-16)

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145.009MSS Regulation of Handgun Safety and Quality
AMA-MSS will ask the AMA to support legislation that seeks to apply the same quality and safety standards to domestically manufactured handguns that are currently applied to imported handguns. (MSS Amended Sub Res 22, I-97) (AMA Res 235, I-97 Adopted [H-145.985]) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12)

145.011MSS Gun Safety Counseling in Undergraduate Medical Education
AMA-MSS will ask the AMA to (1) advocate for the inclusion of strategies for counseling patients on safe gun storage and use in undergraduate medical education; (2) add additional language to AMA Policy H-145.976 prohibiting limitations on the ability of medical students to discuss firearms with patients; and (3) advocate that the Association of American Medical Colleges, Agency for Health, Research and Quality, and other relevant professional medical societies develop gun safety counseling modules to be used in undergraduate medical education. (MSS Res 2, A-13) (AMA Res 903, I-13 Adopted with Change in Title [H-145.976])

145.014MSS Preventing Fire-Arm Related Injury and Morbidity in Youth
AMA-MSS will ask the AMA to collaborate with firearms owners and training organizations to develop and distribute firearm safety materials that are appropriate for the clinical setting. (MSS Res 30, I-14)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 31
(N-21)

Introduced by: Joel Mintz, Dr. Kiran C. Patel College of Allopathic Medicine; Shivani Bhatnagar, Texas College of Osteopathic Medicine; Dhruv Puri, UC San Diego School of Medicine; Sarah Mukhtar, Sidney Kimmel Medical College at Thomas Jefferson University-Philadelphia; Skyler Burke, Washington State University Elson S. Floyd College of Medicine; Kristofer Jackson University of Toledo College of Medicine; Krishna Channa, University of Connecticut School of Medicine; Madeline Drake, McGovern Medical School at UTHealth Houston; Matthew Swanson, Frank H. Netter MD School of Medicine at Quinnipiac University; Andrew Alexander, Texas A&M College of Medicine; David J. Horovitz, University of South Carolina School of Medicine; Adrian Falco, Texas Tech School of Medicine; Melissa Yang, McGovern Medical School at UTHealth Houston; Raag Agrawal, David Geffen School of Medicine at UCLA-Los Angeles; Ayesha Firdous, University of Pittsburgh School of Medicine-Pittsburg

Sponsored by: Region 7

Subject: Evaluating Clinical Outcomes of Mobile Health Technologies

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, Americans are more reliant on their mobile smartphones now than ever before, with over 80 percent currently owning one, an increase of over 40 percent since 2011[1]; and

Whereas, Global mobile health application had a market size of $40.05 billion in 2020, and saw a 13.4 percent increase in the development of healthcare applications from 2019 to 2020, with a total of over 318,000 health related apps available on app stores[2,3]; and

Whereas, The market for wearable devices, defined as smartwatches, wristbands, ear-worn, head-mounted displays, smart clothing, and smart patches, increased to $81.5 billion in 2021, an 18.1 percent increase from 2020[4]; and

Whereas, Both smartphones and wearable devices have the capacity to affect and monitor health through integrated sensors and applications which can measure, record, display, and/or transmit bio-data[5,6]; and

Whereas, Mobile health (mHealth) is defined by the World Health Organization as “medical and public health practice supported by mobile devices, such as mobile phones, patient monitoring devices, personal digital assistants (PDAs), and other wireless devices”, and includes both smartphone applications and wearable devices[7]; and

Whereas, mHealth apps and devices often claim to monitor a wide variety of health metrics and conditions, which includes but is not limited to healthy lifestyle tracking, sleep and heart rate monitoring, and the detection of underlying diseases, such as atrial fibrillation[8,9]; and

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Whereas, The ongoing COVID-19 pandemic has expanded in interest in remote patient monitoring, driving innovation, as demonstrated by a 25% increase in health app downloads during the pandemic[4,10]; and

Whereas, mHealth is rapidly revolutionizing the practice, delivery and training of healthcare through a variety of mechanisms, including but not limited too, enhanced patient engagement, biofeedback monitoring, and improved self-management of chronic diseases[11–15]; and

Whereas, Claims made by mHealth developers are often broad and unsubstantiated by clinical evidence, with an unclear impact on health-related behaviors and patient outcomes[16]; and

Whereas, Future innovations may claim to have additional advanced features attractive to general consumers or target specific populations of patients with chronic diseases[17–20]; and

Whereas, Our AMA has developed mHealth policy under D-480.972 "Guidelines for Mobile Medical Applications and Devices" and H-480.943 "Integration of Mobile Health Applications and Devices into Practice," which covers the protection of PHI, HIPAA, and clinical efficacy/utility and recommends the AMA educate providers on clinically useful mHealth interventions and create best practice guidelines alongside relevant stakeholders[21,22]; and

Whereas, Our AMA has a strong incentive to identify how mHealth interventions improve patient outcomes with the goal of educating providers on useful mHealth interventions and creating best practice guidelines[21]; and

Whereas, Our AMA's current mHealth policy does not mention the need to study how mHealth interventions impact patient outcomes; therefore be it

RESOLVED, That our AMA amend D-480.972 "Guidelines for Mobile Medical Applications and Devices", by addition as follows:

> **Guidelines for Mobile Medical Applications and Devices, D-480.972**
> (1) Our AMA will monitor market developments in mobile health (mHealth), including the development and uptake of mHealth apps, in order to identify developing consensus that provides opportunities for AMA involvement; (2) Our AMA will study how mHealth apps and devices impact patient outcomes, especially in patient populations at whom interventions may be targeted, such as those managing chronic diseases and consumers seeking healthier lifestyles; (3) Our AMA will continue to engage with stakeholders to identify relevant guiding principles to promote a vibrant, useful and trustworthy mHealth market; (4) Our AMA will make an effort to educate physicians on mHealth apps that can be used to facilitate patient communication, advice, and clinical decision support, as well as resources that can assist physicians in becoming familiar with mHealth apps that are clinically useful and evidence based; (5) Our AMA will develop and publicly disseminate a list of best practices guiding the development and use of mobile medical applications; (6) Our AMA encourages further research integrating

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mobile devices into clinical care, particularly to address challenges of reducing work burden while maintaining clinical autonomy for residents and fellows; (7) Our AMA will collaborate with the Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education to develop germane policies, especially with consideration of potential financial burden and personal privacy of trainees, to ensure more uniform regulation for use of mobile devices in medical education and clinical training; (8) Our AMA encourages medical schools and residency programs to educate all trainees on proper hygiene and professional guidelines for using personal mobile devices in clinical environments; (9) Our AMA encourages the development of mobile health applications that employ linguistically appropriate and culturally informed health content tailored to linguistically and/or culturally diverse backgrounds, with emphasis on underserved and low-income populations.

Fiscal Note: TBD

Date Received: 09/15/2021

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21. AMA Policy D-480.972: Res. 903, I-19
22. AMA Policy H-480.943: CMS Rep. 06, I-16

RELEVANT AMA AND AMA-MSS POLICY

Guidelines for Mobile Medical Applications and Devices D-480.972
1. Our AMA will monitor market developments in mobile health (mHealth), including the development and uptake of mHealth apps, in order to identify developing consensus that provides opportunities for AMA involvement.
2. Our AMA will continue to engage with stakeholders to identify relevant guiding principles to promote a vibrant, useful and trustworthy mHealth market.
3. Our AMA will make an effort to educate physicians on mHealth apps that can be used to facilitate patient communication, advice, and clinical decision support, as well as resources that can assist physicians in becoming familiar with mHealth apps that are clinically useful and evidence based.
4. Our AMA will develop and publicly disseminate a list of best practices guiding the development and use of mobile medical applications.

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5. Our AMA encourages further research integrating mobile devices into clinical care, particularly to address challenges of reducing work burden while maintaining clinical autonomy for residents and fellows.
6. Our AMA will collaborate with the Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education to develop germane policies, especially with consideration of potential financial burden and personal privacy of trainees, to ensure more uniform regulation for use of mobile devices in medical education and clinical training.
7. Our AMA encourages medical schools and residency programs to educate all trainees on proper hygiene and professional guidelines for using personal mobile devices in clinical environments.
8. Our AMA encourages the development of mobile health applications that employ linguistically appropriate and culturally informed health content tailored to linguistically and/or culturally diverse backgrounds, with emphasis on underserved and low-income populations.
(CSAPH Rep. 5, A-14; Appended: Res. 201, A-15; Appended: Res. 305, I-16; Modified: Res. 903, I-19)

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

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7. Our AMA supports further development of research and evidence regarding the impact that mHealth apps have on quality, costs, patient safety and patient privacy.
8. Our AMA encourages national medical specialty societies to develop guidelines for the integration of mHealth apps and associated devices into care delivery.
(CMS Rep. 06, I-16; Reaffirmation: A-17)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 32
(N-21)

Introduced by: Sabrina Hennecke, University of Miami Miller School of Medicine; Eshani Kishore, Paul L. Foster School of Medicine; Lora Nason, University of Mississippi School of Medicine; Shanon Quach, Texas College of Osteopathic Medicine; Zehra Rizvi, NSU Dr. Kiran C. Patel College of Osteopathic Medicine; Dilpreet Kaeley, University of Toledo College of Medicine; Francis Yang, Michigan State University College of Human Medicine; Melanie Schroeder, University of Arizona College of Medicine – Phoenix; Hannah Lyons, University of Florida College of Medicine; Region 4.

Sponsored by: Region 4, Region 5, PsychSIGN

Subject: Amending H-160.903 Eradicating Homelessness to Include Support for Street Medicine Programs.

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, “Street medicine” is the practice of providing medical care to unsheltered people experiencing homelessness in locations like encampments, parks, and under bridges[1]; and

Whereas, Street medicine is an evidence-based health provision model that effectively bridges the unique barriers and gaps in care seen in populations experiencing unsheltered homelessness, bringing medicine to the streets and connecting individuals to the existing resources they need and historically have difficulty accessing[2,3]; and

Whereas, Approximately one third of the estimated 580,466 persons experiencing homelessness in 2020 were unsheltered according to reports from the United States Department of Housing and Development and the Urban Institute[4]; and

Whereas, The National Healthcare for the Homeless Council reports up to 46,500 persons experiencing homelessness die each year in the United States, and this number is climbing[5]; and

Whereas, Life expectancy for people living on the streets is estimated to be twelve years shorter than the national average, and chronic diseases and disabilities are abundant and exacerbated by life on the street[5,6]; and

Whereas, The COVID-19 pandemic resulted in an increased rate of persons experiencing homelessness, increased criminalization of homelessness, and increased death rates amongst people experiencing homelessness[5,7,8]; and

Whereas, 1.4 million unsheltered people access emergency shelter or transitional housing each year, placing them in congregative settings which pose tremendous risk for the spread of communicable diseases like COVID-19, with the New York City Department of Emergency

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Services reporting that COVID-19 mortality rates are 49 percent higher for sheltered homeless individuals[9]; and

Whereas, Lack of access to health care services, limited autopsies, and the absence of housing status on death certificates and hospital records leads to a severe undercount of COVID-related cases and deaths among unsheltered individuals[10,11]; and

Whereas, Rent prices have risen dramatically in recent years with cities implementing rent control policies still placing undue burden upon lower income households[12]; and

Whereas, Communities criminalize homelessness and make it illegal for people to sit, sleep, or eat in public places, thus creating arrest records that further prevent unsheltered people from obtaining jobs or housing[13]; and

Whereas, A report from the American Hospital Association showed that those experiencing homelessness are five times more likely to be admitted as inpatients into a hospital with longer hospital stays and that investing in the care of these patients will reduce this cost burden[14]; and

Whereas, Unsheltered individuals have health care costs on average five times higher than the national average, largely due to their overreliance on Emergency Rooms; the majority do not have health insurance or a primary care doctor, and up to 80% of these Emergency Room visits are for ailments that could have been addressed preventatively[2,15-18]; and

Whereas, Individuals experiencing homelessness who were treated by a Street Medicine team were more likely to subsequently engage with a primary care provider as compared to individuals experiencing homelessness who were not seen by a Street Medicine team, and therefore did not receive referral to crucial healthcare services[19,20]; and

Whereas, Street Medicine has been shown to decrease hospital admissions, hospital length-of-stay, emergency department visits, and saved one health system 3.7 million dollars in Emergency Department visits[21,22]; and

Whereas, Institutions such as the Street Medicine Institute, a non-profit organization that aims to cultivate and improve Street Medicine programs both nationally and globally, have successfully maintained 85 programs along with their student coalition which contains 30 student-run programs across 17 states[23]; and

Whereas, There are multiple ways to implement a street medicine program based on the geographical regions of people experiencing homelessness or through follow up discharge visits after hospitalization[24]; and

Whereas, Street medicine program creation involves education, funding, partnering with local agencies, establishing supplies, implementing protocols, and formation of a medical team[25]; and

Whereas, There may be challenges to starting a Street medicine program such as maintaining connection in a population with a migratory culture, building interpersonal relationships, and establishing institutional partnerships that can be overcome through joint efforts such as partnerships between institutions knowledgeable in this area as well as recruiting professionals that are experienced with this population[26]; and

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Whereas, There is growing legislative awareness around the impact of such programs, with the California State legislature having recently passed AB 369, which will now require Medi-Cal, California's Medicaid program, to reimburse street medicine[19]; and

Whereas, There are several existing AMA policies (H-160.903, H-160.978, H-160.894, H-20.903, H-345.975, H-440.938) that advocate for and support measures that improve access to adequate health care for people experiencing homelessness through methods such as waiving co-pays, or providing care through free clinics; and

Whereas, H-160.903 specifically asks that the AMA "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", and as such has set precedence for feasibly supporting such measures; therefore be it

RESOLVED, That our AMA encourage medical schools to implement Street Medicine programs and/or promote student-led Street Medicine programs; and be it further

RESOLVED, That our AMA recognizes and supports the use of Street Medicine programs by amending policy H-160.903 Eradicating Homelessness via addition and deletion as follows.

Eradicating Homelessness, H-160.903

Our AMA:

(1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;

(2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless;

(3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;

(4) supports the use of street medicine programs, which travel to individuals who are unhoused or unsheltered and provide healthcare and social services, as well as funds, including Medicaid and other public insurance reimbursement, for their maintenance

(~~4~~5) recognizes the need for an effective, evidence-based national plan to eradicate homelessness;

(~~5~~6) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;

(~~6~~7) will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs;

(~~7~~8) encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;

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(~~8~~9) encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;

(~~9~~10) (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; and

(~~10~~11) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

The Mentally Ill Homeless H-160.978
Our AMA (1) believes that public policy initiatives directed to the homeless, including the homeless mentally ill population, should include the following components: (a) access to care (e.g., integrated, comprehensive services that permit flexible, individualized treatment; more humane commitment laws that ensure active inpatient treatment; and revisions in government funding laws to ensure eligibility for homeless persons); (b) clinical concerns (e.g., promoting diagnostic and treatment programs that address common health problems of the homeless population and promoting care that is sensitive to the overriding needs of this population for food, clothing, and residential facilities); (c) program development (e.g., advocating emergency shelters for the homeless; supporting a full range of supervised residential placements; developing specific programs for multiproblem patients, women, children, and adolescents; supporting the development of a clearinghouse; and promoting coalition development); (d) educational needs; (e) housing needs; and (f) research needs; (2.) encourages medical schools and residency training programs to develop model curricula and to incorporate in teaching programs content on health problems of the homeless population, including experiential community-based learning experiences; (3.) urges specialty societies to design interdisciplinary continuing medical education training programs that include the special treatment needs of the homeless population. (BOT Rep. LL, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: CMS Rep. 01, A-16; Reaffirmed: BOT Rep. 16, A-19)

Maintaining Mental Health Services by States H-345.975
Our AMA (a) 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; (b) 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; (c) supports increased funding for state Mobile Crisis Teams to locate and treat homeless individuals with mental illness; (d) supports enforcement of the Mental Health Parity Act at the federal and state level; and (e) will take these resolves into consideration when developing policy on essential benefit services. (Res. 116, A-12; Reaffirmation A-15)

11.1.4 Financial Barriers to Health Care Access
1. Individual physicians should (i) take steps to promote access to care for individual patients, such as providing pro bono care in their office or through freestanding facilities or government programs that provide health care for the poor, or, when permissible, waiving insurance copayments in individual cases of hardship. Physicians in the poorest communities should be

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able to turn for assistance to colleagues in more prosperous communities; (ii) help patients obtain needed care through public or charitable programs when patients cannot do so themselves.
2. Physicians, individually and collectively through their professional organizations and institutions, should participate in the political process as advocates for patients (or support those who do) so as to diminish financial obstacles to access health care.
3. The medical profession must work to ensure that societal decisions about the distribution of health resources safeguard the interests of all patients and promote access to health services.
4. All stakeholders in health care, including physicians, health facilities, health insurers, professional medical societies, and public policymakers must work together to ensure sufficient access to appropriate health care for all people.
Issued: 2016

AMA-MSS Policy
440.048MSS: Eradicating Homelessness
AMA-MSS will ask the AMA to: (1) support improving the health outcomes and decreasing the health care costs of treating the chronically homeless through housing first approaches; and (2) support the appropriate organizations in developing an effective national plan to eradicate homelessness. (MSS Res 33, A-14) (Reaffirmed: MSS GC Rep A, I-19)

440.060MSS: Housing Provision and Social Support to Immediately Alleviate Chronic Homelessness in the United States

AMA-MSS will ask that our AMA amend policy H-160.903 by addition and deletion to read as follows: Eradicating Homelessness H-160.903 Our American Medical Association: (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services; (2) will work with state medical societies to advocate for legislation implementing stable, affordable housing and appropriate voluntary social services as a first priority in the treatment of chronically-homeless individuals, without mandated therapy or services compliance and (3) supports the appropriate organizations in developing an effective national plan to eradicate homelessness. (MSS Res 38, I-16) (AMA Res 208, A-17 Referred)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 33
(N-21)

Introduced by: Madeline Holt, Bryan Knoedler, Haritha Pavuluri, Grant Gauthier, Michelle Troup, Miles Rothstein, University of South Carolina School of Medicine Greenville; Sritej Devineni, Zeel Vaghasia, Northeast Ohio Medical University; Anand Singh, Texas Christian University and University of North Texas Health Science Center School of Medicine; Miranda Westrick, University of Toledo College of Medicine; Anastasia Rubakovic, Midwestern University-Chicago College of Osteopathic Medicine

Sponsored by: Region 3, Region 4, Region 5

Subject: Increase Federal Funding Towards Nutrition Research

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, Inadequate nutrition has been linked to the high prevalence of chronic, preventable disease and diet-related illnesses remain the most frequent and preventable causes of death in the United States (U.S.)[1,2,3]; and

Whereas, Diet-related illnesses are estimated to cost the U.S. hundreds of billions of dollars each year[1,4,5];and

Whereas, The increased prevalence of chronic, preventable disease among African Americans, Hispanics, Asians, and other minority populations demonstrate the need for understanding the culturally sensitive associations between food and health[6]; and

Whereas, COVID-19 pandemic further exposed major diet-related comorbidities such as diabetes, hypertension, and obesity through poor outcomes from COVID-19[5]; and

Whereas, Diet-related illnesses may feed a harsh cycle of poverty by lower academic achievement in school, lower productivity at work, increased chronic disease risk, increased out-of-pocket health cost [5]; and

Whereas, Nutrition research can enhance the understanding of diet-related health disparities and uncover methods to address the social determinants that impact access to healthy foods and nutrition practices; and therefore, has the expected outcome of improving community health[5]; and

Whereas, Proper nutrition is one of the most cost-effective ways to decrease disease prevalence and, thus, change the trajectory of diet-related chronic illness in the U.S, but still lacks adequate governmental coordination and investment[5,7]; and

Whereas, More than 10 federal agencies invest in nutrition research; however, financial investments in nutrition research has remained flat or declined over several decades-despite a consistent rise in diet-related illnesses[5]; and

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Whereas, Spending across federal agencies, including the National Institutes of Health, U.S. Department of Agriculture (USDA), and Centers for Disease Control and Prevention, on nutrition research and promotion of healthy food habits to combat chronic disease has been inadequate for decades[5,8]; and

Whereas, Strategic planning at the National Institute of Health (NIH) and USDA for the coming decade emphasize radical enhancements in nutrition research and the need to connect agriculture to improved human health[1,9]; and

Whereas, The World Health Organization's three part General Work Programme includes increased focus on research in prevention of non-communicable diseases and improving human capital across the life course[10]; and

Whereas, AMA policies H-150.929 and H-150.953 emphasize the importance of healthy lifestyles for addressing obesity and reducing diseases[11,12]; and

Whereas, Our AMA encourages all preventative services to have evidence-based data to demonstrate improved outcomes of quality of life and supports research to improve evidence of disease prevention and health promotion[13,14,15,16] and

Whereas, Our AMA does not yet have policy on increasing federal funding towards nutrition research in light of the current federal emphasis on this topic; therefore be it

RESOLVED, That our AMA support increases in federal funding towards nutritional research in order to address the high prevalence of diet-related chronic disease; and be it further

RESOLVED, Our AMA recognizes the need for increased federal funding to conduct culturally responsive nutrition research through amending policy D-440.978 “Culturally Responsive Dietary and Nutritional Guidelines” by addition as follows:

> **Culturally Responsive Dietary and Nutritional Guidelines D-440.978**
> 1. Our AMA and its Minority Affairs Section will: (a) encourage the United States Department of Agriculture (USDA) to include culturally effective guidelines that include listing an array of ethnic staples and use of multicultural symbols to depict serving size in their Dietary Guidelines for Americans and Food Guide; (b) seek ways to assist physicians with applying the USDA Dietary Guidelines for Americans and MyPlate food guide in their practices as appropriate; (c) recognize that lactose intolerance is a common and normal condition among many Americans, especially African Americans, Asian Americans, and Native Americans, with a lower prevalence in whites, often manifesting in childhood; and (d) monitor and encourage increase federal funds for ~~existing~~ culturally responsive research and identify opportunities where organized medicine can impact issues related to obesity, nutritional and dietary guidelines, racial and ethnic health disparities as well as assist physicians with delivering culturally effective care.

Fiscal Note: TBD

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Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

Obesity as a Major Public Health Problem H-150.953
Our AMA will: (1) urge physicians as well as managed care organizations and other third party payers to recognize obesity as a complex disorder involving appetite regulation and energy metabolism that is associated with a variety of comorbid conditions;
(2) work with appropriate federal agencies, medical specialty societies, and public health organizations to educate physicians about the prevention and management of overweight and obesity in children and adults, including education in basic principles and practices of physical activity and nutrition counseling; such training should be included in undergraduate and graduate medical education and through accredited continuing medical education programs;
(3) urge federal support of research to determine: (a) the causes and mechanisms of overweight and obesity, including biological, social, and epidemiological influences on weight gain, weight loss, and weight maintenance; (b) the long-term safety and efficacy of voluntary weight maintenance and weight loss practices and therapies, including surgery; (c) effective interventions to prevent obesity in children and adults; and (d) the effectiveness of weight loss counseling by physicians;
(4) encourage national efforts to educate the public about the health risks of being overweight and obese and provide information about how to achieve and maintain a preferred healthy weight;
(5) urge physicians to assess their patients for overweight and obesity during routine medical examinations and discuss with at-risk patients the health consequences of further weight gain; if treatment is indicated, physicians should encourage and facilitate weight maintenance or reduction efforts in their patients or refer them to a physician with special interest and expertise in the clinical management of obesity;
(6) urge all physicians and patients to maintain a desired weight and prevent inappropriate weight gain;
(7) encourage physicians to become knowledgeable of community resources and referral services that can assist with the management of overweight and obese patients; and
(8) urge the appropriate federal agencies to work with organized medicine and the health insurance industry to develop coding and payment mechanisms for the evaluation and management of obesity.
(CSA Rep. 6, A-99; Reaffirmation: A-09; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmation: A-10; Reaffirmation: I-10; Reaffirmation: A-12; Reaffirmed in lieu of Res. 434, A-12; Reaffirmation: A-13; Reaffirmed: CSAPH Rep. 3, A-13; Reaffirmation: A-19)

Preventive Services H-425.997
1. Our AMA encourages the development of policies and mechanisms to assure the continuity, coordination and continuous availability of patient care, including professional preventive care and early-detection screening services, provided the services are cost effective.
2. It is the policy of the AMA that any preventive service that is being considered for inclusion in public or private sector insurance products have evidence-based data to demonstrate improved outcomes or quality of life and the cost effectiveness of the service.
3. Our AMA believes that preventive care should ideally be coordinated by a patient's physician.

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(BOT Rep. A, NCCMC Rec. 31, A-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report and Reaffirmed and Appended: CMS Rep. 7, A-00; Reaffirmed in lieu of Res. 104, A-06; Reaffirmation: A-07; Modified and Reaffirmed: Sub Res. 101, A-08; Reaffirmed: CMS Rep. 03, I-16; Reaffirmed: CMS Rep. 03, I-17; Reaffirmed: CMS Rep. 06, A-19)

Healthy Lifestyles H-425.972
1. Our AMA: (A) recognizes the 15 competencies of lifestyle medicine as defined by a blue ribbon panel of experts convened in 2009 whose consensus statement was published in the *Journal of the American Medical Association* in 2010; (B) will urge physicians to acquire and apply the 15 clinical competencies of lifestyle medicine, and offer evidence-based lifestyle interventions as the first and primary mode of preventing and, when appropriate, treating chronic disease within clinical medicine; and (C) will work with appropriate federal agencies, medical specialty societies, and public health organizations to educate and assist physicians to routinely address physical activity and nutrition, tobacco cessation and other lifestyle factors with their patients as the primary strategy for chronic disease prevention and management.
2. Our AMA supports policies and mechanisms that incentivize and/or provide funding for the inclusion of lifestyle medicine education and social determinants of health in undergraduate, graduate and continuing medical education.
(Res. 423, A-12; Appended: Res. 959, I-17)

Importance of Clinical Research H-460.930
(1) Given the profound importance of clinical research as the transition between basic science discoveries and standard medical practice of the future, the AMA will a) be an advocate for clinical research; and b) promote the importance of this science and of well-trained researchers to conduct it.
(2) Our AMA continues to advocate vigorously for a stable, continuing base of funding and support for all aspects of clinical research within the research programs of all relevant federal agencies, including the National Institutes of Health, the Agency for Healthcare Research and Quality, the Centers for Medicare & Medicaid Services, the Department of Veterans Affairs and the Department of Defense.
(3) The AMA believes it is an inherent obligation of capitation programs and managed care organizations to invest in broad-based clinical research (as well as in health care delivery and outcomes research) to assure continued transition of new developments from the research bench to medical practice. The AMA strongly encourages these groups to make significant financial contributions to support such research.
(4) Our AMA continues to encourage medical schools a) to support clinical research; b) to train and develop clinical researchers; c) to recognize the contribution of clinical researchers to academic medicine; d) to assure the highest quality of clinical research; and e) to explore innovative ways in which clinical researchers in academic health centers can actively involve practicing physicians in clinical research.
(5) Our AMA encourages and supports development of community and practice-based clinical research networks.
(CSA Rep. 2, I-96; Reaffirmed: CSA Rep. 13, I-99; Reaffirmation: A-00; Reaffirmed: CME Rep. 4, I-08; Modified: CSAPH Rep. 01, A-18)

Support for Uniform, Evidence-Based Nutritional Rating System H-150.936
1. Our AMA supports the adoption and implementation of a uniform, nutritional food rating system in the US that meets, at a minimum, the following criteria: is evidence-based; has been developed without conflict of interest or food industry influence and with the primary goal being the advancement of public health; is capable of being comprehensive in scope, and potentially applicable to nearly all foods; allows for relative comparisons of many different foods;

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demonstrates the potential to positively influence consumers' purchasing habits; provides a rating scale that is simple, highly visible, and easy-to-understand and used by consumers at point of purchase; and is adaptable to aid in overall nutritional decision making.
2. Our AMA will advocate to the federal government - including responding to the Food and Drug Administration call for comments on use of front-of-package nutrition labeling and on shelf tags in retail stores - and in other national forums for the adoption of a uniform, evidence-based nutrition rating system that meets the above-referenced criteria.
(Res. 424, A-10; Reaffirmed: CSAPH Rep. 01, A-20)

Defending Federal Child Nutrition Programs 150.032MSS
AMA-MSS will ask that our AMA (1) oppose legislation that reduces or eliminates access to federal child nutrition programs; and (2) reaffirm H-150.962 Quality of School Lunch Program. (MSS Res 09, A-17)

Support of the Supplemental Nutrition Assistance Program (SNAP) Education Programs and Research 150.036MSS
AMA-MSS (1) supports nutrition education programs for Supplemental Nutrition Assistance Program (SNAP) recipients and (2) opposes changes to SNAP that would increase food insecurity such as rigid work requirements or categorical exclusion of individuals who receive SNAP benefits based on their income level. (MSS Res 17, A-18)

Amending H-150.962, Quality of School Lunch Program, to Advocate for Expansion and Sustainability of Nutritional Assistance Programs during COVID-19 150.043MSS
Our AMA-MSS will ask the AMA to amend policy H-150.962, Quality of School Lunch Program by addition as follows: QUALITY OF SCHOOL LUNCH PROGRAM, H150.962 1. Our AMA recommends to the National School Lunch Program that school meals be congruent with current U.S. Department of Agriculture/Department of HHS Dietary Guidelines. 2. Our AMA opposes legislation and regulatory initiatives that reduce or eliminate access to federal child nutrition programs. AMA-MSS Digest of Policy Actions/ 68 3. Our AMA support adoption and funding of alternative nutrition and meal assistance programs during a national crisis, such as a pandemic. (MSS Res. 015, Nov. 2020)

8.11 Health Promotion and Preventive Care
Medicine and public health share an ethical foundation stemming from the essential and direct role that health plays in human flourishing. While a physician’s role tends to focus on diagnosing and treating illness once it occurs, physicians also have a professional commitment to prevent disease and promote health and well-being for their patients and the community.
The clinical encounter provides an opportunity for the physician to engage the patient in the process of health promotion. Effective elements of this process may include educating and motivating patients regarding healthy lifestyle, helping patients by assessing their needs, preferences, and readiness for change and recommending appropriate preventive care measures. Implementing effective health promotion practices is consistent with physicians’ duties to patients and also with their responsibilities as stewards of health care resources. While primary care physicians are typically the patient’s main source for health promotion and disease prevention, specialists can play an important role, particularly when the specialist has a close or long-standing relationship with the patient or when recommended action is particularly relevant for the condition that the specialist is treating. Additionally, while all physicians must balance a commitment to individual patients with the health of the public, physicians who work solely or primarily in a public health capacity should uphold accepted standards of medical professionalism by implementing policies that appropriately balance individual liberties with the social goals of public health policies.

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Health promotion should be a collaborative, patient-centered process that promotes trust and recognizes patients' self-directed roles and responsibilities in maintaining health. In keeping with their professional commitment to the health of patients and the public, physicians should:
(a) Keep current with preventive care guidelines that apply to their patients and ensure that the interventions they recommend are well supported by the best available evidence.
(b) Educate patients about relevant modifiable risk factors.
(c) Recommend and encourage patients to have appropriate vaccinations and screenings.
(d) Encourage an open dialogue regarding circumstances that may make it difficult to manage chronic conditions or maintain a healthy lifestyle, such as transportation, work and home environments, and social support systems.
(e) Collaborate with the patient to develop recommendations that are most likely to be effective.
(f) When appropriate, delegate health promotion activities to other professionals or other resources available in the community who can help counsel and educate patients.
(g) Consider the health of the community when treating their own patients and identify and notify public health authorities if and when they notice patterns in patient health that may indicate a health risk for others.
(h) Recognize that modeling health behaviors can help patients make changes in their own lives.
Collectively, physicians should:
(i) Promote training in health promotion and disease prevention during medical school, residency and in continuing medical education.
(j) Advocate for healthier schools, workplaces and communities.
(k) Create or promote healthier work and training environments for physicians.
(l) Advocate for community resources designed to promote health and provide access to preventive services.
(m) Support research to improve the evidence for disease prevention and health promotion.
(Issued: 2016)

Recognizing and Taking Action in Response to the Obesity Crisis D-440.980
Our AMA will: (1) collaborate with appropriate agencies and organizations to commission a multidisciplinary task force to review the public health impact of obesity and recommend measures to better recognize and treat obesity as a chronic disease; (2) actively pursue, in collaboration and coordination with programs and activities of appropriate agencies and organizations, the creation of a "National Obesity Awareness Month"; (3) strongly encourage through a media campaign the re-establishment of meaningful physical education programs in primary and secondary education as well as family-oriented education programs on obesity prevention; (4) promote the inclusion of education on obesity prevention and the medical complications of obesity in medical school and appropriate residency curricula; and (5) make Council on Medical Education Report 3, A-17, Obesity Education, available on the AMA website for use by medical students, residents, teaching faculty, and practicing physicians.
(Res. 405, A-03; Reaffirmation: A-04; Reaffirmation: A-07; Appended: Sub. Res. 315, A-15; Modified: CME Rep. 03, A-17)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 34
(N-21)

Introduced by: Laila Koduri, Tulane University School of Medicine; Colleen Leu, Florida State University College of Medicine; Tabitha Moses, Wayne State University School of Medicine;

Sponsored by: Region 3

Subject: Supporting Further Study of Kratom

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, Kratom (*Mirtragyna speciosa*) is a tropical tree used as a consumable herb in many parts of the world [1]; and

Whereas, Kratom interacts with opioid receptors, and large amounts of consumption can result in producing sedation, pleasure, and decreased pain[13] (source); and

Whereas, Kratom use has expanded in the United States in the past decade [2]; and

Whereas, Kratom has been increasingly used as a natural remedy and substitute for prescription and opioid withdrawal since the early 2000s in the United States [3]; and

Whereas, About 10-16 million people in the United States currently use Kratom (9); and

Whereas, In a recent survey for the DSM-5 symptom checklist for Kratom-related Substance Use Disorder fewer than 3% of responses met the criteria of moderate or severe substance use disorder, and only 8.8% met the criteria for mild substance use disorder [5]; and

Whereas, Under the Controlled Substances Act of of 1970, schedule 1 drugs, substances, or chemicals are defined as drugs with no currently accepted medical use and a high potential for misuse [6]; and

Whereas, In 2016, kratom was set-up to be banned and categorized as a schedule 1 drug by the U.S. Food and Drug Administration (FDA) which received major pushback, including more than 50 congress members [7] ; and

Whereas, The FDA states that Kratom's potential risk of addiction, contamination with other illicit drugs, and it's opioid-like characteristics as reasons for classifying it as a schedule 1 drug [8]; and
Whereas, There have been 44 possible kratom-related deaths in the last decade worldwide, most of which are known to have involved pre-existing conditions or contamination with other substances, suggesting regulation of the substance (5); and

Whereas, Some researchers concluded that Kratom has a lower rate of harm than similar opioids currently prescribed for treating pain, anxiety, and addiction [9]; and

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Whereas, Evaluation according to the 8 factors of the Controlled Substance Act (CSA) concluded that Kratom does not show any documented threat to public health and does not appear to warrant immediate scheduling [10]; and

Whereas, A 2016 study showed that only 1% of participants sought medical treatment related to Kratom consumption, whereas, in 2017, more than 16% of drug-overdose related deaths were due to prescription opioids[14] [15] [16](sources); and

Whereas, Kratom is a partial mu-opioid receptor agonist, and does not recruit beta-arrestin pathways like classical opioids, this conferring similar effects with low risk of respiratory depression compared to classic opioids (5); and

Whereas, Banning Kratom under schedule 1 risks instead of regulation would create public health risks such as higher contamination rates, and unregulated illicit marketing, contrary to the intention behind scheduling [10]; and

Whereas, Kratom shows potential for having medical applications that are yet to be explored including its role in treatment of anxiety, depression, PTSD, pain and opioid withdrawal [12], (5); and

Whereas, Further research on Kratom could provide valuable insight into its potential therapeutic benefits as well as any side-effects [12]; therefore be it

RESOLVED, That our AMA amend policy H-95.934 “Kratom and its Growing Use Within the United States,” by the addition and deletion as follows

Kratom and its Growing Use Within the United States H-95.934
Our AMA: ~~supports legislative or regulatory efforts to prohibit the sale or distribution of Kratom in the United States which do not inhibit proper scientific research~~.

1. Supports efforts to further study the clinical uses, benefits, and potential harms of Kratom,
2. Opposes the classification of Kratom as a schedule 1 drug,
3. Opposes efforts that will criminalize individuals for use of Kratom.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

Kratom and its Growing Use Within the United States H-95.934
Our AMA supports legislative or regulatory efforts to prohibit the sale or distribution of Kratom in the United States which do not inhibit proper scientific research.
(Res. 509, A-16)

Drugs of Choice H-100.997

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Our AMA opposes any proposal that would establish a classification of drugs of choice for any specific clinical entity through governmental regulation.
(Res. 117, 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)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 35
(N-21)

Introduced by: Kimberly Hernandez, CUNY School of Medicine; Sarah Costello and Bradley Fleming, University of Iowa Carver College of Medicine; Miranda Solly, University of Florida; Dilpreet Kaeley, University of Toledo College of Medicine; Christopher Prokosch, University of Minnesota; Jara Crawford, University of Indiana

Sponsored by: Region 4, Region 7

Subject: Amendment to Policy H-405.960: Policies for Parental, Family and Medical Necessity Leave

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, In 2020, 68% of students who began their medical training were 23 years of age or older[1], and;

Whereas, the age of matriculation into medical school has continued to rise from 46.9% of respondents being 23-25 years old in 2016 to 51.9% in 2019[1,2], and;

Whereas, the mean age of the mother at first birth was 27 years old[3] and 55.4% of medical students were female[1], and;

Whereas, 9.2% of medical students are parents by the time they graduate from medical school[4], and;

Whereas, the Liaison Committee on Medical Education does not specifically address parental leave policies[5], and;

Whereas, Only 32.66% of medical schools had parental leave policies available online or in the student handbook with the majority of these policies being difficult to access requiring interested parties to do a diligent search with specific keywords[6], and;

Whereas, Only 32.1% of medical school's policies included an option to retain original graduation date[6], and;

Whereas, Only 14.07% of medical schools have stand alone parental leave policies that are separate from their general leave of absence policies[6], and;

Whereas, a general leave of absence often leads to loss of any eligible financial aid that would normally cover expenses during school and these students are also ineligible for paid family leave or unemployment insurance[5], and;

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Whereas, delaying medical school education beyond 4 years comes with total tuition increase and assumption of more debt[5,8], and;

Whereas, adoption of online learning platforms and video-based educational tools have shown to produce equivalent learner outcomes[5], and;

Whereas, clinical electives exist within family medicine and pediatric residency programs that allow for telecommuting[5], and;

Whereas, adoption of online learning platforms and clinical electives within preclinical and clinical years allow for flexible scheduling and for timely completion of graduation requirements for students utilizing parental leave[5], and;

Whereas, Previous AMA policy endorsed family and parental leave accomodations and protections for medical residents and physicians superior to those provided for medical students[7]; and therefore be it,

RESOLVED, That our AMA will amend policy H-405.960 Policies for Parental, Family and Medical Necessity Leave, to read as follows:

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

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should be able to return to their practices or training programs after taking parental leave without the loss of status.

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

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

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

7. Residency programs and medical schools should develop clear and easily accessible written policies on parental leave, family leave, and medical leave for physicians and medical students. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) 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

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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 and medical school 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. Our AMA a) encourages medical schools to create informative resources that promote a culture that is supportive of their students who are parents and to provide openly accessible information to prospective and current students regarding family planning in the specific medical school including parental leave and relevant make up work, accommodations during pregnancy, and (b) supports the development of comprehensive requirements for medical schools regarding guidelines and resources for family leave and parenthood; and (c) supports medical school or broader licensure-related policies that allow for students to take a full six-week week leave without delaying graduation.

~~14.~~ 15. These policies as above should be freely available online and in writing to all current students and applicants to medical school, residency or fellowship.

Fiscal Note: TBD

Date Received: 09/15/2021

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7. Policies for Parental, Family and Medical Necessity Leave H-405.960. Adopted AMA-MSS Resolution 2013.

RELEVANT AMA AND AMA-MSS POLICY

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

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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.
CCB/CLRPD Rep. 4, A-13Modified: Res. 305, A-14Modified: Res. 904, I-14

Family Planning for Medical Students 295.207MSS
AMA-MSS (1) encourages medical schools to create informative resources that promote a culture that is supportive of their students who are parents and to provide openly accessible information to prospective and current students regarding family planning in the specific medical school including parental leave and relevant make up work, options to preserve fertility, breastfeeding policies, accommodations during pregnancy, and resources for childcare that span the institution and surrounding area; and (2) supports the development of comprehensive requirements for medical schools regarding guidelines and resources for family leave and parenthood; and (3) supports medical schools providing six weeks of parental leave for medical students of all genders, medical school or broader licensure-related policies that allow for students to take a full six week leave without delaying graduation, and (4) encourages medical schools to make these formal policies easily accessible for both current and prospective students. (MSS Res. 51, I-19) (Amended MSS WIM Report A, A-21

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 36
(N-21)

Introduced by: Sarah Mae Smith, University of California — Irvine School of Medicine

Sponsored by: PsychSIGN

Subject: Pharmaceutical Drug Pricing: Parameters around Medicare Negotiation and Government Manufacturing of Generic Drugs

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, Among United States adults, 24% indicate that it is difficult to afford the cost of their prescription medication(s) and 29% state that they have been unable to take their medications as prescribed within the past year (either not filling a prescription, substituting an over-the-counter drug, cutting pills in half, skipping doses, or some combination thereof) due to inability to afford them[1]; and

Whereas, In 2019, 1.49 million Medicare Part D enrollees exceeded the out-of-pocket catastrophic coverage threshold of $6,550, such that they had to pay out of pocket for 5% of total drug costs with no hard cap on total spending by enrollees, resulting in $1.8 billion in out-of-pocket spending by these enrollees for drug costs over the threshold[2]; and

Whereas, Spending on prescription pharmaceuticals constitutes 10% of national health spending, 18% of large employer health benefit expenses, 19% of out-of-pocket spending for Medicare beneficiaries, and 17% of out-of-pocket spending for employees[3]; and

Whereas, One analysis of the economic impact of medication non-adherence among fourteen disease groups estimated the all-causes cost of non-adherence at between $5,271 and $52,341 per patient[4]; and

Whereas, A 2017 study published in *Cancer* determined that 23.8% of adolescent and young adult cancer survivors (aged 15 to 39 years) experience cost-related medication non-adherence, with Black survivors, uninsured survivors, and survivors with multiple comorbidities suffering the highest rates of medication non-adherence[5]; and

Whereas, Research on patients with hypertension demonstrated that patients with cost-related non-adherence are less likely to have self-reported normal blood pressure (59.5% versus 69.8% for patients without nonadherence)[6]; and

Whereas, An analysis by the Kaiser Family Foundation found that 50% of drugs covered by Medicare Part D had list price increases that were greater than the rate of inflation between July 2018 and 2019, with 14% of Part D-covered drugs having list price increases of 10% or more over that year-long timeframe[7]; and

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Whereas, Approximately 60% of total Medicare Part D spending ($87 billion) results from the purchase of the 250 top-selling drugs covered by Part D that have one manufacturer and no generic or biosimilar competition[8]; and

Whereas, Legislation currently under Congressional consideration, the Elijah E. Cummings Lower Drug Costs Now Act (H.R. 3), would require the Secretary of the Department of Health and Human Services to negotiate the price of up to 250 brand-name drugs without generic competitors based, in part, on an "average international market price" derived from the lowest average price of each drug in six countries (Australia, Canada, France, Germany, Japan, and the United Kingdom)[9-10]; and

Whereas, During the 116th Congress, the House of Representatives voted to pass H.R. 3 on December 19th, 2019, and the House Ways and Means Committee approved mirroring language as part of its mark-up of the budget reconciliation package on September 15th, 2021 during the 117th Congress[11-13]; and

Whereas, An issue brief released by the Kaiser Family Foundation in August 2021 projects that Medicare Part D premiums for beneficiaries would be reduced by an estimated 9% of the Part D base beneficiary premium beginning in 2023, increasing to 15% in 2029, if H.R. 3 were to be adopted[14]; and

Whereas, An analysis from the Centers for Medicare and Medicaid Services Office of the Actuary found that the negotiation provisions in legislation similar to H.R. 3 would reduce spending for Medicare Part D beneficiaries by an estimated $117 billion, including a reduction of $102.6 billion in cost sharing for patients using the drugs subject to negotiation under the schema outlined[15]; and

Whereas, Current AMA policy (H-110.980) surrounding the use of international price indices in determining pharmaceutical prices states that "Any international drug price index or average should exclude countries that have single-payer health systems and use price controls," approximating the Market-Based International Index proffered by health policy advisor Avik Roy[16]; and

Whereas, The Market-Based International Index (MBII) purports to base its benchmark primarily on drug prices in four countries (Denmark, the Netherlands, Singapore, and Switzerland) where it claims that "prescription drug prices are largely or entirely unregulated, and/or where a competitive private health insurance market provides the vast majority of coverage," and to a lesser extent on drug prices in nine countries "with a hybrid system of public and private health insurance and prescription drug price regulation"[16]; and

Whereas, An analysis by the Office of Health Economics observed that the Netherlands, Switzerland, and Denmark negotiate drug prices through a central monopsonistic payer which regulates prices, and Singapore undertakes central negotiation of pharmaceutical prices utilizing Group Procurement Offices and tender contracts, leading the Office to conclude that "if comparisons [to countries with similar drug pricing schema] are sought, then our analysis suggests that finding market-oriented health systems will be difficult"[17]; and

Whereas, A Galen Institute report found that "governments in [Denmark, the Netherlands, Singapore, and Switzerland] play an active role in setting drug prices and therefore in regulating access to prescription medicines," and thus "drug prices in the MBII countries are generally not market-based"[18]; and

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Whereas, The Netherlands and Switzerland employ international reference-based pricing frameworks that are themselves inclusive of single payer countries such as the United Kingdom, Finland, and Spain[16,19-20,]; and

Whereas, External reference pricing has been described as the "prevailing method" for setting prices for on-patent pharmaceuticals and among the major drivers for setting prices for off-patent pharmaceuticals in high-income countries[21]; and

Whereas, External reference pricing is utilized in Australia, Brazil, Canada, Jordan, and South Africa, as well as 23 of 27 countries in the European Union as of 2019, including serving as the primary systematic criterion for setting the price for new pharmaceutical products in the vast majority of European countries[20,22]; and

Whereas, The number of generic suppliers per market decreased over time from 2004 to 2016, due to both increased exit from markets and decreased market entry[23]; and

Whereas, The median number of drug manufacturers per market in 2016 was two, with 40% of pharmaceutical markets supplied by a sole manufacturer as of 2016[23]; and

Whereas, There is evidence that the price of generic drugs is undergoing a statistically significant increase over time, and the price increases are associated with decreasing numbers of manufacturers for each generic drug, as well as alternative measures of increased supplier concentration[23]; and

Whereas, According to a 2016 United States Government Accountability Office report, between 2010 and 2015, 315 of the 1,441 generic pharmaceuticals that were available for the duration of the study period (22%) underwent at least one "extraordinary" price increase in Medicare Part D, defined as a price increase of 100% or more[24]; and

Whereas, Generic drug shortages in the United States quadrupled between 2005 and 2011, increasing from 61 drugs to 250 drugs[25]; and

Whereas, The entry of additional generic manufacturers to a pharmaceutical market frequently results in rapidly decreasing prices, as generic drugs entering the market between 2002 and 2014 lowered drug prices by 51% in the first year[25]; and

Whereas, An antitrust investigation into generic manufacturers in 2018 uncovered evidence of a generic "cartel" implicating at least 16 companies, in which anti-competitive price-fixing agreements involving 300 pharmaceuticals resulted in price increases of up to 2,000 percent[26,27]; and

Whereas, A *National Bureau of Economic Research* paper noted that "for products targeting exceptionally small patient populations, the fixed costs of entry and the likelihood of intense post-entry price competition mean that a new entrant is unlikely to earn profits"- in other words, a generic manufacturer is highly unlikely to ever enter the market for some drugs targeted at small patient populations[28]; and

Whereas, In 2018, a group of major hospital systems, including the Mayo Clinic and HCA Healthcare, and philanthropies launched a non-profit generic drug manufacturer to produce generic drugs experiencing shortages or dramatic price increases[29,30]; and

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Whereas, A recent *New England Journal of Medicine* perspective proposed the creation of a non-profit generic pharmaceutical manufacturer to mitigate generic market failures and sell generic drugs directly to hospitals and other institutional partners, with predetermined contracts to ensure low prices and a minimum volume, which would protect the non-profit manufacturer from being forced out of the market because of price changes[31]; and

Whereas, There is federal legislation most recently re-introduced in January 2020 that seeks to establish an Office of Drug Manufacturing within the Department of Health and Human Services to facilitate public manufacturing of generic drugs[32-24]; and

Whereas, In recent testimony before the House of Representatives Subcommittee on Regulatory Reform, Commercial and Antitrust Law, economist Craig Garthwaite characterized the proposal to establish a government generic manufacturer for small market drugs as "a potentially viable policy option" to mitigate the market failure resulting from the dearth of competition in markets for generic drugs with insufficient market size to support more than one manufacturer, which creates a natural monopoly[35];

Whereas, A federal non-profit government manufacturer would be able to focus production of generic version of prescription drugs on circumstances in which market failures occur, as in scenarios where there are no generic manufacturers within a market or there are two or fewer manufacturers and a significant price increase or a drug shortage[32,36-37]; therefore be it

RESOLVED, That our AMA amend Policy H-110.980, "Additional Mechanisms to Address High and Escalating Pharmaceutical Prices," by deletion to read as follows:

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;

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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~~a. 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~~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 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.
; and be it further

RESOLVED, That our AMA support the formation of a non-profit government manufacturer of pharmaceuticals to produce small-market generic drugs.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS 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

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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

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

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.

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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

Pay for Delay Arrangements by Pharmaceutical Companies H-110.989
Our AMA supports: (1) the Federal Trade Commission in its efforts to stop "pay for delay" arrangements by pharmaceutical companies and (2) federal legislation that makes tactics delaying conversion of medications to generic status, also known as "pay for delay," illegal in the United States.
Res. 520, A-08; Appended: Res. 222, I-12; Reaffirmed: CMS 2, I-15; Reaffirmed in lieu of: Res. 817, I-16

Price of Medicine H-110.991
Our AMA: (1) advocates that pharmacies be required to list the full retail price of the prescription on the receipt along with the co-pay that is required in order to better inform our patients of the price of their medications; (2) will pursue legislation requiring pharmacies, pharmacy benefit managers and health plans to inform patients of the actual cash price as well as the formulary price of any medication prior to the purchase of the medication; (3) opposes provisions in pharmacies' contracts with pharmacy benefit managers that prohibit pharmacists from disclosing that a patient's co-pay is higher than the drug's cash price; (4) will disseminate model state legislation to promote drug price and cost transparency and to prohibit "clawbacks"; (5) supports physician education regarding drug price and cost transparency, manufacturers' pricing practices, and challenges patients may encounter at the pharmacy point-of-sale; and (6) work with relevant organizations to advocate for increased transparency through access to meaningful and relevant information about medication price and out-of-pocket costs for prescription medications sold at both retail and mail order/online pharmacies, including but not limited to Medicare's drug-pricing dashboard.
CMS Rep. 6, A-03; Appended: Res. 107, A-07; Reaffirmed in lieu of: Res. 207, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Reaffirmation: A-19; Appended: Res. 126, A-19

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Incorporating Value into Pharmaceutical Pricing H-110.986
1. Our AMA supports value-based pricing programs, initiatives and mechanisms for pharmaceuticals that are guided by the following principles: (a) value-based prices of pharmaceuticals should be determined by objective, independent entities; (b) value-based prices of pharmaceuticals should be evidence-based and be the result of valid and reliable inputs and data that incorporate rigorous scientific methods, including clinical trials, clinical data registries, comparative effectiveness research, and robust outcome measures that capture short- and long-term clinical outcomes; (c) processes to determine value-based prices of pharmaceuticals must be transparent, easily accessible to physicians and patients, and provide practicing physicians and researchers a central and significant role; (d) processes to determine value-based prices of pharmaceuticals should limit administrative burdens on physicians and patients; (e) processes to determine value-based prices of pharmaceuticals should incorporate affordability criteria to help assure patient affordability as well as limit system-wide budgetary impact; and (f) value-based pricing of pharmaceuticals should allow for patient variation and physician discretion.
2. Our AMA supports the inclusion of the cost of alternatives and cost-effectiveness analysis in comparative effectiveness research.
3. Our AMA supports direct purchasing of pharmaceuticals used to treat or cure diseases that pose unique public health threats, including hepatitis C, in which lower drug prices are assured in exchange for a guaranteed market size.
CMS Rep. 05, I-16; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: CMS-CSAPH Rep. 01, A-17; Reaffirmed: CMS Rep. 07, A-18; Reaffirmed: CSAPH Rep. 2, I-19; Reaffirmed: CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 6, I-20

Cost of Prescription Drugs H-110.997
Our AMA:
(1) supports programs whose purpose is to contain the rising costs of prescription drugs, provided that the following criteria are satisfied: (a) physicians must have significant input into the development and maintenance of such programs; (b) such programs must encourage optimum prescribing practices and quality of care; (c) all patients must have access to all prescription drugs necessary to treat their illnesses; (d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and (e) such programs should promote an environment that will give pharmaceutical manufacturers the incentive for research and development of new and innovative prescription drugs;
(2) reaffirms the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourages physicians to supplement medical judgments with cost considerations in making these choices;
(3) encourages physicians to stay informed about the availability and therapeutic efficacy of generic drugs and will assist physicians in this regard by regularly publishing a summary list of the patient expiration dates of widely used brand name (innovator) drugs and a list of the availability of generic drug products;
(4) encourages expanded third party coverage of prescription pharmaceuticals as cost effective and necessary medical therapies;
(5) will monitor the ongoing study by Tufts University of the cost of drug development and its relationship to drug pricing as well as other major research efforts in this area and keep the AMA House of Delegates informed about the findings of these studies;
(6) encourages physicians to consider prescribing the least expensive drug product (brand name or FDA A-rated generic); and
(7) encourages all physicians to become familiar with the price in their community of the medications they prescribe and to consider this along with the therapeutic benefits of the medications they select for their patients.

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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

Opposition to Medicare Part B to Part D Changes H-110.982
Our AMA will advocate against Medicare changes which would recategorize Medicare Part B drugs into Part D.
Res. 217, I-18

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

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

Co-Pay Accumulators D-110.986
Our AMA will develop model state legislation regarding Co-Pay Accumulators for all pharmaceuticals, biologics, medical devices, and medical equipment, and support federal and state legislation or regulation that would ban co-pay accumulator policies, including in federally regulated ERISA plans.
Res. 205, I-19; Appended: Res. 212, I-20

Addressing the Exploitation of Restricted Distribution Systems by Pharmaceutical Manufacturers H-100.950
1. Our AMA will advocate with interested parties for legislative or regulatory measures that require prescription drug manufacturers to seek Food and Drug Administration and Federal Trade Commission approval before establishing a restricted distribution system.
2. Our AMA supports requiring pharmaceutical companies to allow for reasonable access to and purchase of appropriate quantities of approved out-of-patent drugs upon request to generic manufacturers seeking to perform bioequivalence assays.
3. Our AMA will advocate with interested parties for legislative or regulatory measures that expedite the FDA approval process for generic drugs, including but not limited to application review deadlines and generic priority review voucher programs.
Res. 809, I-16

Prescription Drug Price and Cost Transparency D-110.988

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1. Our AMA will continue implementation of its TruthinRx grassroots campaign to expand drug pricing transparency among pharmaceutical manufacturers, pharmacy benefit managers and health plans, and to communicate the impact of each of these segments on drug prices and access to affordable treatment.
2. Our AMA will report back to the House of Delegates at the 2018 Interim Meeting on the progress and impact of the TruthinRx grassroots campaign.
Alt. Res. 806, I-17

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. 817, I-16; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: BOT Rep. 14, A-18

Cost Sharing Arrangements for Prescription Drugs H-110.990
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

Study of Actions to Control Pharmaceutical Costs H-110.992
Our AMA will monitor the relationships between pharmaceutical benefits managers and the pharmaceutical industry and will strongly discourage arrangements that could cause a negative impact on the cost or availability of essential drugs.
Sub. Res. 114, A-01; Reaffirmed: Res. 533, A-03; Reaffirmed: CMS Rep. 4, A-13; Reaffirmed in lieu of Res. 229, I-14; Reaffirmed: CMS 2, I-15; Reaffirmed: CMS Rep. 07, A-18; Reaffirmed: CMS Rep. 08, A-19

Cost of New Prescription Drugs H-110.998
Our AMA urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs.

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Res. 112, I-89; Reaffirmed: Res. 520, A-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed in lieu of Res. 229, I-14

Public Reporting of PBM Rebates H-110.981
Our AMA will advocate for: (1) Pharmacy Benefit Managers (PBMs) and state regulatory bodies to make rebate and discount reports and disclosures available to the public; and (2) the inclusion of required public reporting of rebates and discounts by PBMs in federal and state PBM legislation.
Res. 813, I-19

Drug Pricing Reform 100.014MSS
AMA-MSS (1) supports enabling Medicare and other federal health systems to negotiate drug prices with pharmaceutical companies, and support states who wish to negotiate with pharmaceutical companies, and support states who wish to negotiate with pharmaceutical companies for their state-run health programs; and (2) supports legislation that requires increased transparency and public accessibility to drug manufacturing costs from all players in the drug supply production chain, including but not limited to: drug manufacturers, pharmaceutical company marketing information, pharmaceutical research and development costs and distribution companies. (MSS Res 21, I-15) (Reaffirmed: MSS GC Rep B, A-21)

Towards a Comprehensive Plan to Lower Drug Prices while Preserving Innovation 100.029MSS
AMA-MSS: (1) supports a systematic plan to lower drug prices wherein a statutorily empowered authority would negotiate drug prices with manufacturers, prioritizing the most expensive medications;
(2) supports such an authority considering the following information during the course of a negotiation:
(a) the comparative efficacy of the drug relative to the standard of care,
(b) the unmet need of the disease(s) for which the drug is intended to treat,
(c) the costs of the drug's development and manufacturing,
(d) the amount of public investment used to develop the drug,
(e) the prices charged for the drug in other peer countries if available, considering rebates, discounts, and other price modifications;
(3) supports that these negotiated prices would be used by all public and private insurance providers unless those providers choose to opt-out;
(4) supports the imposition of reasonable penalties to enforce pharmaceutical manufacturer compliance with negotiated prices;
(5) supports a ban on rebates from pharmaceutical manufacturers to pharmacy benefit managers or a requirement that the savings derived from a rebate must be passed on to insurance plan beneficiaries in their entirety.

Ensuring Fair Pricing of Drugs Developed with the United States Government 100.023MSS
AMA-MSS will ask our AMA to amend policy H-110.987 by insertion to read as follows:
Pharmaceutical Costs H-110.987
(1) Our AMA encourages the 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.

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(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 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 drugs more affordable for all patients.
(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 not 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 will support trial programs using international reference pricing for pharmaceuticals as an alternative drug reimbursement model for Medicare, Medicaid, and/or any other federally-funded health insurance programs, either as an individual solution or in conjunction with other approaches.
(MSS Res 49, A-19) (AMA Res. 802, Amended CMS Report 4 Adopted in Lieu of Res. 802 [H-110.980], I-19)

Reforming the Orphan Drug Act 100.020MSS
AMA-MSS will ask the AMA to (1) support legislation and policy efforts to reform the Orphan Drug Act by closing loopholes identified by the FDA in order to protect the Act's original intent of promoting therapies targeting rare diseases; (2) support increased transparency in development costs, post-approval regulation, overall earnings, and off-label uses for pharmaceuticals designated as "Orphan Drugs"; and (3) support efforts to modify the exclusivity period of "Orphan Drugs" in order to increase access to these pharmaceutical drugs. (MSS Res 34-I-17)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 37
(N-21)

Introduced by: Sandra Carpenter, Maria Slater, Leelakrishna Channa, Lauren Benedetto, Madalyn Gibson-Williams, Anika Makol, Isabelle Moore, Megan Civitello, University of Connecticut School of Medicine; Madison Hoenle, University of Illinois College of Medicine Rockford; Julia Versel, Angelika Kwak, Loyola University Chicago Stritch School of Medicine; Melanie Schroeder, University of Arizona College of Medicine; Patrick Smith, University of South Carolina School of Medicine Greenville; Nora Newcomb, University of South Florida Morsani College of Medicine; Lydia Smeltz, Lucy Emery, Penn State College of Medicine; Maya Ramy, Texas A&M College of Medicine

Sponsored by: Region 3, Region 4, Region 7

Subject: H-90.968 “Medical Care of Persons with Developmental Disabilities” Amendment

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, According to the Americans with Disabilities Act of 1990 (ADA) and The ADA Amendments Act of 2008, disability is defined as “physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment”[1-3]; and

Whereas, The World Health Organization defines disability broadly as an “interaction between individuals with a health condition and personal and environmental factors”, which acknowledges the individualistic and contextual nature of disability[4]; and

Whereas, The disability justice movement recognizes disability (including but not limited to developmental, intellectual, physical, sensory, learning, and psychiatric disability) as a component of diversity and identity that intersects with other forms of diversity and identity (including but not limited to social class, race, age, gender identity, and geographic location)[5]; and

Whereas, Studies report approximately 12 to 30% of the United States’ population has a disability[4,6-8]; and

Whereas, Similar to other oppressed minority groups, people with disabilities have experienced a long shared history of marginalization and discrimination in society and medicine, and as a result, continue to experience health disparities and social determinants of poor health[6,8-11]; and

Whereas, Physicians of all specialties will treat patients with a range of disability, yet many physicians hold implicit and explicit biases, such that studies demonstrate that healthcare providers consistently assume a lesser quality of life for people with disabilities than what is self-reported[5,8-9]; and

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Whereas, In a 2019-2020 survey of United States' physicians, less than half (40.4%) were confident they could provide the same quality of care for those with a disability, around half (56.5%) strongly agreed that they welcome patients with disability into their practices, and less than one fifth (18.1%) strongly agreed that the healthcare system often treats these patients unfairly[8]; and

Whereas, Research demonstrates that physicians and medical students report a lack of comfort in interviewing and examining patients with disabilities, often translating to poor outcomes and negative attitudes toward working with this population[5-6,12-19]; and

Whereas, Disability curricula in undergraduate medical education is highly variable, such that a 2015 survey estimated that less than 23% of medical schools provide any disability-focused training[5,19-20]; and

Whereas, Even though disability core competencies and curriculum exist at some institutions, no standardized disability curriculum currently exists across undergraduate medical education or graduate medical education[5,21]; and

Whereas, The Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education do not require disability training curricula as an accreditation requirement for undergraduate medical education or graduate medical education programs respectively[22-23]; and

Whereas, Major reports, most notably the Surgeon General's 2005 "Call to Action", the Institute of Medicine's 2007 "The Future of Disability in America", and the National Council on Disability's 2015 "The Current State of Health Care for People with Disabilities", all call for improvements in the training of healthcare providers in order to address health disparities for people with disabilities[1,3-4,6,9,24-28]; and

Whereas, Section 5307 of the Patient Protection and Affordable Care Act specifically requires the development, evaluation, and dissemination of disability cultural competency curricula for training in health professions schools and continuing education programs[19,29]; and

Whereas, Disability studies scholars and activists advocate for disability-conscious medical education, training, and practice that includes critical disability studies, a multidisciplinary academic field which "explores the social, political, and cultural contexts of disability"[5,12,31], and

Whereas, Several medical schools have created and evaluated model disability curricula and the Alliance for Disability in Health Care Education has developed disability competencies that could provide a framework for implementing disability curricula at other institutions[22,32-34]; and

Whereas, Research demonstrates that disability curricula are well-received by students, reduce bias, and improve health professionals' confidence with working with patients with disabilities[35-36]; and

Whereas, Research demonstrates that incorporation of people with disabilities as patient-instructors, or standardized patients, is beneficial to student learning and addresses the harmful reduction of people to their disabilities that may result from a non-disabled actor playing a role[33,37-40]; and

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Whereas, These changes are even more urgent since the COVID-19 pandemic has further exposed ableism in medicine and continues to exacerbate the health disparities experienced by people with disabilities[5,8]; and

Whereas, While AMA policy "A Study to Evaluate Barriers to Medical Education for Trainees with Disabilities D-295.929" has the potential to revise technical standards and remove outdated standards rooted in bias, it only addresses the need to expand inclusion of people with disabilities within medical education, training, and practice, but does not go far enough to include care and treatment outlined in curricula and continuing education; and

Whereas, While AMA policy "Medical Care of Persons with Developmental Disabilities H-90.968" advocates for medical curricula involving the care and treatment of those with developmental disabilities, it is too narrow in its definition of disability to address the lack of training that contributes to salient health inequities for an extremely diverse demographic that shares experiences of stigma and discrimination in all arenas of public life; therefore be it

RESOLVED, In order to address the shared healthcare barriers of people with disabilities and the need for curricula in medical education on the care and treatment of people with a range of disabilities, our AMA amends by addition and/or deletion H-90.968 "Medical Care of Persons with Developmental Disabilities" to include those with a broad range of disabilities while retaining goals specific to the needs of those with developmental disabilities.

Medical Care of Persons with ~~Developmental~~ Disabilities, H-90.968

1. Our AMA encourages: (a) clinicians to learn and appreciate variable presentations of complex functioning profiles in all persons with ~~developmental disabilities~~ disabilities including but not limited to physical, sensory, developmental, intellectual, learning, and psychiatric disabilities and chronic illnesses; (b) medical schools and graduate medical education programs to acknowledge the benefits of education on how aspects in the social model of disability (e.g. ableism) can impact the physical and mental health of persons with ~~Developmental~~ ~~D~~disabilities; (c~~d~~) the education of physicians on how to provide and/or advocate for ~~quality, developmentally appropriate~~ accessible medical, social and living supports for patients with ~~developmental~~ disabilities so as to improve health outcomes; (d~~e~~) medical schools and residency programs to encourage faculty and trainees to appreciate the opportunities for exploring diagnostic and therapeutic challenges while also accruing significant personal rewards when delivering care with professionalism to persons with profound ~~developmental~~ disabilities and multiple co-morbid medical conditions in any setting.
2.Our AMA seeks: (a) legislation to increase the funds available for training physicians in the care of ~~intellectual disabilities/developmentally~~ disabled individuals, and to increase the reimbursement for the health care of these individuals; and (b) insurance industry and government reimbursement that reflects the true cost of health care of individuals with disabilities. ~~intellectual disabilities/developmentally disabled individuals~~.
3. Our AMA entreats health care professionals, parents and others participating in decision-making to be guided by the following

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principles: (a) All people with ~~developmental~~ disabilities, regardless of the degree of their disability, should have access to appropriate and affordable medical and dental care throughout their lives; and (b) An individual's medical condition and welfare must be the basis of any medical decision. Our AMA advocates for the highest quality medical care for persons with profound ~~developmental~~ disabilities; encourages support for health care facilities whose primary mission is to meet the health care needs of persons with profound ~~developmental~~ disabilities; and informs physicians that when they are presented with an opportunity to care for patients with profound ~~developmental~~ disabilities, that there are resources available to them.

4. Our AMA will continue to work with medical schools and their accrediting/licensing bodies to encourage schools to include disability related competencies/objectives in medical school curricula so that medical professionals are able to effectively communicate with patients and colleagues with disabilities, and are able to provide the most clinically competent and compassionate care for patients with disabilities.

5. Our AMA will collaborate with AAMC, EdHub, the MSS Committee on Disability Affairs, and other appropriate stakeholders to create a model general curriculum/objectives for medical schools to use for medical education that (a) incorporates critical disability studies; and (b) includes people with disabilities as patient-instructors in formal training sessions and preclinical and clinical instruction.

6~~7.~~ Our AMA encourages the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, and allopathic and osteopathic medical schools to develop and implement curriculum on the care and treatment of people with a range of ~~developmental~~ disabilities.

7~~8.~~ Our AMA encourages the Accreditation Council for Graduate Medical Education and graduate medical education programs to develop and implement curriculum on providing appropriate and comprehensive health care to people with a range of ~~developmental~~ disabilities.

8~~9.~~ Our AMA encourages the Accreditation Council for Continuing Medical Education, specialty boards, and other continuing medical education providers to develop and implement continuing education programs that focus on the care and treatment of people with a range of ~~developmental~~ disabilities.

9~~10.~~ Our AMA will advocate that the Health Resources and Services Administration include persons with ~~intellectual and developmental~~ disabilities ~~(IDD)~~ as a medically underserved population.

10~~2.~~ Specific to people with developmental and intellectual disabilities, a uniquely underserved population, our AMA encourages (a~~1c~~) medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental disabilities, to improve quality in

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clinical care; (b~~1f~~) medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for the developmentally disabled; and (c~~1g~~) cooperation among physicians, health & human services professionals, and a wide variety of adults with developmental disabilities to implement priorities and quality improvements for the care of persons with developmental disabilities.

11~~5.~~Our AMA recognizes the importance of managing the health of children and adults with developmental disabilities as a part of overall patient care for the entire community.

12~~6.~~ Our AMA supports efforts to educate physicians on health management of children and adults with developmental disabilities, as well as the consequences of poor health management on mental and physical health for people with developmental disabilities.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

Medical Care of Persons with Developmental Disabilities H-90.968
1. Our AMA encourages: (a) clinicians to learn and appreciate variable presentations of complex functioning profiles in all persons with developmental disabilities; (b) medical schools and graduate medical education programs to acknowledge the benefits of education on how aspects in the social model of disability (e.g. ableism) can impact the physical and mental health of persons with Developmental Disabilities; (c) medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental disabilities, to improve quality in clinical care; (d) the education of physicians on how to provide and/or advocate for quality, developmentally appropriate medical, social and living supports for patients with developmental disabilities so as to improve health outcomes; (e) medical schools and residency programs to encourage faculty and trainees to appreciate the opportunities for exploring diagnostic and therapeutic challenges while also accruing significant personal rewards when delivering care with professionalism to persons with profound developmental disabilities and multiple co-morbid medical conditions in any setting; (f) medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for the developmentally disabled; and (g) cooperation among physicians, health & human services professionals, and a wide variety of adults with developmental disabilities to implement priorities and quality improvements for the care of persons with developmental disabilities.
2. Our AMA seeks: (a) legislation to increase the funds available for training physicians in the care of individuals with intellectual disabilities/developmentally disabled individuals, and to increase the reimbursement for the health care of these individuals; and (b) insurance industry and government reimbursement that reflects the true cost of health care of individuals with intellectual disabilities/developmentally disabled individuals.

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3. Our AMA entreats health care professionals, parents and others participating in decision-making to be guided by the following principles: (a) All people with developmental disabilities, regardless of the degree of their disability, should have access to appropriate and affordable medical and dental care throughout their lives; and (b) An individual's medical condition and welfare must be the basis of any medical decision. Our AMA advocates for the highest quality medical care for persons with profound developmental disabilities; encourages support for health care facilities whose primary mission is to meet the health care needs of persons with profound developmental disabilities; and informs physicians that when they are presented with an opportunity to care for patients with profound developmental disabilities, that there are resources available to them.
4. Our AMA will continue to work with medical schools and their accrediting/licensing bodies to encourage disability related competencies/objectives in medical school curricula so that medical professionals are able to effectively communicate with patients and colleagues with disabilities, and are able to provide the most clinically competent and compassionate care for patients with disabilities.
5. Our AMA recognizes the importance of managing the health of children and adults with developmental disabilities as a part of overall patient care for the entire community.
6. Our AMA supports efforts to educate physicians on health management of children and adults with developmental disabilities, as well as the consequences of poor health management on mental and physical health for people with developmental disabilities.
7. Our AMA encourages the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, and allopathic and osteopathic medical schools to develop and implement curriculum on the care and treatment of people with developmental disabilities.
8. Our AMA encourages the Accreditation Council for Graduate Medical Education and graduate medical education programs to develop and implement curriculum on providing appropriate and comprehensive health care to people with developmental disabilities.
9. Our AMA encourages the Accreditation Council for Continuing Medical Education, specialty boards, and other continuing medical education providers to develop and implement continuing education programs that focus on the care and
treatment of people with developmental disabilities. Reaffirmed in lieu of the 1st Resolved: Res. 304, A-18.

Children and Youth with Disabilities H-60.974
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. Reaffirmed: CSAPH Rep. 1, A-2.

Preserving Protections of the Americans with Disabilities Act of 1990 D-90.992

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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

Enhancing Accommodations for People with Disabilities H-90.971
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

Support for Persons with Intellectual Disabilities H-90.967
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

Enhancing the Cultural Competence of Physicians H-295.897
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. Appended: Res. 315, A-18

Promoting Health Awareness of Preventative Screenings in Individuals with Disabilities H-425.970
Our AMA will work closely with relevant stakeholders to advocate for equitable access to health promotion and preventive screenings for individuals with disabilities. Res. 911, I-13

Underrepresented Student Access to US Medical Schools H-350.960
Our AMA: (1) recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population; (2) supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented

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students; (3) recognizes some people have been historically underrepresented, excluded from, and marginalized in medical education and medicine because of their race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality, due to racism and other systems of exclusion and discrimination; (4) is committed to promoting truth and reconciliation in medical education as it relates to improving equity; and (5) recognizes the harm caused by the Flexner Report to historically Black medical schools, the diversity of the physician workforce, and the outcomes of minoritized and marginalized patient populations. Appended: CME Rep. 5, A-21

Eliminating Use of the Term 'Mental Retardation' by Physicians in Clinical Settings H-70.912
Our AMA recommends that physicians adopt the term "intellectual disability" instead of "mental retardation" in clinical settings. Res. 024, A-19

Service Animals, Animal-Assisted Therapy, and Animals in Healthcare H-90.966
Our AMA: (1) encourages research into the use of animal-assisted therapy as a part of a therapeutic treatment plan; (2) supports public education efforts on legitimately trained service animals, as defined by the Americans with Disabilities Act (ADA); (3) supports a national certification program and registry for legitimately trained service animals, as defined by the ADA; and (4) encourages health care facilities to set evidence-based policy guidelines for animal visitation. BOT Rep. 29, A-18

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 38
(N-21)

Introduced by: Ana Untaroiu, Medical College of Wisconsin; Shefali Jain, Aparna Kanjhlia, Medical College of Georgia; Sritej Devineni, Northeast Ohio Medical University

Sponsored by: n/a

Subject: Supporting a Hybrid Residency and Fellowship Interview Process

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, The Association of American Medical Colleges released data suggesting residency interviews cost medical students between $1,000 to $11,580, with a median cost of $4,000 and an average cost of $200-499 per interview[1]; and

Whereas, Studies suggest 71% of medical students borrow money for residency interviews and four out of ten students decline interviews for financial reasons[2]; and

Whereas, Interviews costs residency programs a significant amount of money, with one plastic surgery program reporting a cost of $2763 per applicant interviewed, which includes applicant receptions, food and beverage costs, and losses of clinical productivity[3]; and

Whereas, It is estimated virtual interviews would allow residency programs to reduce the amount of time needed to conduct interviews by approximately 7 days, reducing faculty's time away from clinical and teaching responsibilities[4]; and

Whereas, The standard model of in-person residency interviews takes time away from medical student educational and clinical work, given that applicants devote an average of 20 days towards residency interviews[5,6]; and

Whereas, In a 2014 study of GI fellowship applicants with four in-person interviews and a single video interview, 87% of applicants thought that video interviews should continue and 81% reported that the video interview met or exceeded their expectations, which suggests web-based video interviews has the potential to either be an effective screening tool or an acceptable alternative to in-person interviews[7]; and

Whereas, In a survey of the 46 applicants and 36 program directors after the 2020 cardiothoracic fellowship match, the majority of the applicants and program directors thought virtual interviews should be continued in the future; however, most do not think that virtual interviews should completely replace in-person interviews[8]; and

Whereas, In the same 2020 cardiothoracic fellowship study, most applicants and program directors did not believe virtual interviews negatively impacted applicants' chances of matching into programs at the top of their rank list[8]; and

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Whereas, An observational study of an anesthesiology residency program with options for in-person or virtual interviews demonstrated a higher proportion of non-local applicants and the preference for virtual format was driven by travel concerns and interview date conflicts[7]; and

Whereas, A 2020 survey of 1711 medical students and 113 residents in Texas medical programs indicated majority of respondents believed virtual interviews were less stressful than in-person interviews, and residency programs should offer both options for interviewing[9]; and

Whereas, In May 2020, the American Association of Medical Colleges released resources and protocols for residency interviewees and program directors to use in preparing for virtual interviews[10,11]; and

Whereas, Several studies from August 2020-June 2021 showed that although residency interviewees expressed concerns about the limitations of virtual interviews such as ability to assess the program, ability to fully demonstrate their personality, and increased emphasis on exam scores and class rank, residency programs may be able to improve the virtual interview experience, by developing comprehensive marketing materials, hosting a resident panel for interviewees, and creating an informal virtual gathering for interviewees and residents[12–14]; and

Whereas, The 2020-2021 MATCH success rate for applicants was 94.9 percent and 99.6 percent at the conclusion of the Supplemental Offer and Acceptance Program (SOAP), which were comparable to that of years before the COVID-19 pandemic[15]; and

Whereas, The National Resident Matching Program reported that 60% of surveyed program directors from the 2021 MATCH intended to use virtual platforms for future recruitment seasons, including two-thirds of these respondents intending to use these platforms for the interview[16]; and

Whereas, Incorporating video conferencing into residency interviews as an adjunct to in-person interviews is proposed as a means to increase efficiency and lower costs, given its perceived feasibility from the 2021 MATCH[17]; and

Whereas, Most existing AMA policy supports studying methods to reduce residency interviewing cost (H-310.966, D-310.949), but does not take a stance to support the incorporation of technologies, such as videoconferencing, as a method to increase interview efficiency; therefore be it

RESOLVED, That our AMA supports incorporating virtual interviews as a component to the residency and fellowship interview process as a means to increase interviewing efficiency; and be it further

RESOLVED, That our AMA will work with appropriate stakeholders, such as the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education, to study interviewee and program perspectives on incorporating videoconferencing as an adjunct to residency and fellowship interviews, in order to guide the development of protocols for expansion of hybrid residency and fellowship interviews.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

Residency Interview Costs H-310.966

1. It is the policy of the AMA to pursue changes to federal legislation or regulation, specifically to the Higher Education Act, to include an allowance for residency interview costs for fourth-year medical students in the cost of attendance definition for medical education.
2. Our AMA will work with appropriate stakeholders, such as the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education, in consideration of the following strategies to address the high cost of interviewing for residency/fellowship: a) establish a method of collecting data on interviewing costs for medical students and resident physicians of all specialties for study, and b) support further study of residency/fellowship interview strategies aimed at mitigating costs associated with such interviews. (Res. 265, A-90; Reaffirmed: Sunset Report, I-00; Modified: CME Rep. 2, A-10; Appended: Res. 308, A-15)

Medical Student Involvement and Validation of the Standardized Video Interview Implementation D-310.949

Our AMA:

(1) will work with the Association of American Medical Colleges and its partners to advocate for medical students and residents to be recognized as equal stakeholders in any changes to the residency application process, including any future working groups related to the residency application process;
(2) will advocate for delaying expansion of the Standardized Video Interview until data demonstrates the Association of American Medical Colleges' stated goal of predicting resident performance, and make timely recommendations regarding the efficacy and implications of the Standardized Video Interview as a mandatory residency application requirement; and
(3) will, in collaboration with the Association of American Medical Colleges, study the potential implications and repercussions of expanding the Standardized Video Interview to all residency applicants. (Res. 960, I-17)

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Financial Burden of Application to Medical School and Residency 305.083MSS

The AMA-MSS recognizes the financial burden associated with applying to and attending medical school and applying to residency, and supports the following principles:

1. AMA MSS supports the incorporation of admissions practices that objectively evaluate applicants' behavioral competencies into future AMA medical education funding initiatives.
2. That the AMA-MSS will ask the AMA to (a) support medical school admission policies that do not discriminate against students who may AMA-MSS Digest of Policy Actions/ 149 require financial aid to pursue a medical education; (b) encourage all US medical schools to adopt an active policy of informing medical school applicants of estimated tuition and fees for each year of undergraduate medical education and the sources of financial aid available; and (c) continue to encourage the maintenance and development of resources, both public and private, to help meet the financial needs of students attending American medical schools.
3. That the AMA-MSS will ask our AMA to consider the following strategies to address the high cost of interviewing for residency: (a) establishing a method of collecting data on interviewing costs for medical students of all specialties (e.g., NRMP survey collaboration) for further study, (b) supporting further study of residency interview strategies aimed at mitigating costs associated with residency interviews, (c) producing and providing a toolkit of recommended resources for 4th year medical students who are interviewing on the AMA-MSS webpage, (d) creating and/or promoting specific websites related to med student travel, and (e) providing or recommending and online forum where students can accommodate other medical students who are interviewing in their area. (MSS GC Rep A, I-17)

Online Medical School Interview Option 295.230MSS

AMA-MSS will ask the AMA to work with relevant stakeholders to study the advantages and disadvantages of an online medical school interview option for future medical school applicants including but not limited to financial implications and potential solutions, long term success, and well-being of students/residents. (MSS Res. 056, A-21)

The Residency Match Process 310.001MSS

The AMA-MSS recognizes the significant time, energy, and resources that are allocated to the residency match process and hereby supports the following principles to help improve the residency match process:

1. That the AMA-MSS will continue to work with other student, resident, and physician organizations to research and promote changes in the structure and/or the rules governing the Match so as to maximize the advantage to medical students and residents.
2. That the AMA-MSS supports efforts to encourage residency and fellowship programs to incorporate in their interview dates increased flexibility, whenever possible, to accommodate applicants' schedules.
3. That the AMA-MSS supports efforts to encourage the ACGME, the AOA, 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.

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4. That the AMA-MSS supports a change in the NBME policy to report examination scores as “pass-fail” only.
5. That the AMA-MSS encourages individual chapters to maintain a roster of students willing to host residency applicants when they visit their institution.
6. That the AMA-MSS will ask the AMA to work with the NRMP to keep transaction costs of the Match to reasonable levels, and ensure that fees charged for each program a medical student applies to be capped at a reasonable level that takes into account medical students’ budgeting constraints.
7. That the AMA-MSS will ask the AMA to support students, residents, and all appropriate organizations who work to ensure that any suspected violation of NRMP policy is addressed, publicized, and proper redress achieved, including the active promotion of NRMP complaint forms and other existing channels.
8. That the AMA-MSS will ask the AMA to urge the NRMP to allow students to opt out of the Match without penalty when there are extenuating circumstances, including but not limited to: unforeseen family emergencies such as illness that would require the individual to care for a family member; unforeseen physical or mental health problems that would impede the individual’s ability to participate in residency training and required military or foreign service duty.
9. That the AMA-MSS will ask the AMA to support the concept that programs should retain the ability to extend applicants positions outside the Match.
10. That the AMA-MSS will ask the AMA to support improvements to the structure of the Match program for efficient placement of unmatched students, as long as such alterations do not result in postponement of the traditional “Match Day” date in mid-March. (MSS GC Rep A, I-16).

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 39
(N-21)

Introduced by: Sunil Sathappan, Kendahl Servino, Sam Genis, Natasha McGlaun, Katrina Marks, Benjamin Wagner, Haley Nadone, University of Nevada, Reno School of Medicine

Sponsored by: APAMSA

Subject: Redesigning the U.S. Immigration System

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, Immigrants contribute greatly to the nation's economy and social fabric in a number of ways, one of which is by directly boosting population growth and the population as a whole, elevating our standing in world affairs, growing the economy, and broadening our tax base for any number of infrastructure and other projects[1,2]; and

Whereas, Economic growth is positively associated with increasing levels of healthcare investment, which in turn positively affects health outcomes[3]; and

Whereas, The U.S. immigration system as it stands today is rife with issues: it is overly bureaucratic with a process that is both costly and delayed, entails backlogs of over 10 years for some countries, prioritizes individuals who can afford to navigate an expensive application process, emphasizes immigration from the more developed regions of the world, and often shuts the door to those fleeing violence and tyranny, to name a few[4,5,6]; and

Whereas, An influx of largely working-age adults would stabilize social welfare programs such as Medicare and Social Security, maintaining their solvency for decades to come[2,7]; and

Whereas, Current immigration policy coupled with demographic trends indicate the trust funds for Medicare and Social Security may be depleted as early as 2026 and 2034, respectively[8,9]; and

Whereas, Medicare and Medicaid (along with a collection of smaller public health insurance programs) comprised 43% of all national healthcare expenditures in 2018, which in turn made up a clear plurality of physician revenue, a percentage which is increasing over time[10]; and

Whereas, The United States has one of the lowest population densities of the world, ranking 185th in density out of 250 nations and dependencies[11]; and

Whereas, Our nation contains an abundance of not only natural resources, but the 2nd highest amount of arable land (relative only to India which has a population over 4x greater)[12]; and

Whereas, Many habitable areas of the country remain undeveloped and underdeveloped due to a lack of population[13]; and

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Whereas, The United States faces chronic and rampant shortages of physicians, nurses, caregivers, and other healthcare workers in many of its rural and urban areas[14]; and

Whereas, Our current system doesn't reflect our values as a nation that welcomes and incorporates the best aspects of every immigrant's culture regardless of their nation's development status or majority race[15]; and

Whereas, Immigration in the past and present has fueled economic and population growth, and contributes to a cosmopolitan mosaic of an American identity[16]; and

Whereas, In 2019, 3.1% of foreign-born adults were unemployed, while 3.8% of native-born adults were unemployed, demonstrating the considerable economic contributions immigrants offer[17]; and

Whereas, Immigrants are far more likely to contribute to the sciences and technology, bolstering a technological edge over foreign competitors [2,18]; and

Whereas, Immigrants are also far more likely to start successful businesses, from family-owned shops to megacorporations, contributing to an increase in both employment and per capita income (income per person)[18,19]; and

Whereas, The United States currently grants approximately 1 million permanent residency ("green card") approvals per year[20]; and

Whereas, Modestly increasing immigration levels from roughly 1 million to 2 million permanent residency approvals each year would mirror immigration levels from Canada (~250k/year) and Australia (~160k/year) adjusting for population, a number high enough to witness the evident benefits of increased immigration, while remaining constrained enough to avoid excessive "brain drain" on origin nation's economies from the departure of driven and skilled individuals[21,22]; and

Whereas, Selecting potential immigrants at a value proportionate to their origin nation's population in that year would ensure equal opportunity for every nation's citizens to immigrate, including immigrants from more populous countries who face a "per country limit" irrespective of population size [23,24]; and

Whereas, Placing higher priority on those immigrants who can meet a standard for English proficiency and a workforce demand in which the US experiences a shortage (such as farm work, construction work, nursing, and a myriad of others) would drastically improve health outcomes, income potential, and ease of integration for immigrant populations[2,25-29]; and

Whereas, Prioritizing entry of medical professionals to severely underserved areas of the country would likely improve health outcomes such as life expectancy, mortality, and morbidity in those locales[30,31]; and

Whereas, Reinforcing an emphasis on immediate family unification of one's spouse and/or children above any technical qualifications would improve both the health and happiness of the American immigrant population[32]; and

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Whereas, Expanding the Refugee Resettlement Program to welcome more individuals would save lives in cases where their origin nations make that far from certain, as well as contributing to local economies[33]; and

Whereas, Immigration of health personnel and other talented and motivated workers to developed nations such as the United States has contributed to a significant "brain drain", where many developing or underdeveloped countries face the loss of their motivated and talented individuals to locales with a higher standard of living, thereby both contributing to physician shortages in and impeding the economic development of those origin nations[34-37]; and

Whereas, Providing direct economic aid to origin nations for each accepted immigrant would help to stave off the effects of "brain drain" on origin nation's economies, as these nations could apply those funds toward education and infrastructure development for their citizens[34-37]; therefore be it

RESOLVED, That our AMA advocates for increasing overall immigration levels to grant more permanent residency ("green card") approvals; and be it further

RESOLVED, That our AMA support determining immigrant candidacy proportionate to their origin nation's population; and be it further

RESOLVED, That our AMA promote immigration reform that grants potential entries a higher priority if they meet a workforce demand and a standard for English proficiency. This screening process would become the responsibility of US embassies around the world to find the most appropriate individuals; and be it further

RESOLVED, That our AMA endorse a prioritized entry of medical professionals, particularly to the medically underserved areas of the country; and be it further

RESOLVED, That our AMA support prioritizing immediate family unification (spouse, children) above any technical qualifications; and be it further

RESOLVED, That our AMA favor an expansion of the Refugee Resettlement Program to welcome more individuals fleeing violence, political instability, or persecution; and be it further

RESOLVED, That our AMA support the provision of a direct financial contribution to origin nations for each formally-accepted immigrant.

Fiscal Note: TBD

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RELEVANT AMA AND AMA-MSS POLICY

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.

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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, A-15; 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

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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

Visa Complications for IMGs in GME D-255.991
1. Our AMA will: (A) work with the ECFMG to minimize delays in the visa process for International Medical Graduates applying for visas to enter the US for postgraduate medical training and/or medical practice; (B) promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related to the immigration and registration process required for International Medical Graduates; and (C) work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency applicants to reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position.

2. Our AMA International Medical Graduates Section will continue to monitor any H-1B visa denials as they relate to IMGs? inability to complete accredited GME programs.

3. Our AMA will study, in collaboration with the Educational Commission on Foreign Medical Graduates and the Accreditation Council for Graduate Medical Education, the frequency of such J-1 Visa reentry denials and its impact on patient care and residency training.

4. Our AMA will, in collaboration with other stakeholders, advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care.
Res. 844, I-03; Reaffirmation A-09; Reaffirmation I-10; Appended: CME Rep. 10, A-11; Appended: Res. 323, A-12; Reaffirmation: A-19

Conrad 30 - J-1 Visa Waivers D-255.985
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;

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(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.
Res. 233, A-06; Appended: CME Rep. 10, A-11; Appended: Res. 303, A-11; Reaffirmation I-11; Modified: BOT Rep. 5, I-12; Appended: BOT Rep. 27, A-13; Reaffirmation A-14

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.

Financial Impact of Immigration on American Health System D-160.988

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Our AMA will: (1) ask that when the US Department of Homeland Security officials have physical custody of undocumented foreign nationals, and they deliver those individuals to US hospitals and physicians for medical care, that the US Office of Customs and Border Protection, or other appropriate agency, be required to assume responsibility for the health care expenses incurred by those detainees, including detainees placed on "humanitarian parole" or otherwise released by Border Patrol or immigration officials and their agents; and (2) encourage that public policy solutions on illegal immigration to the United States take into consideration the financial impact of such solutions on hospitals, physicians serving on organized medical staffs, and on Medicare, and Medicaid.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 40
(N-21)

Introduced by: Haritha Pavuluri, University of South Carolina School of Medicine Greenville; Shreya Mandava, University of Virginia School of Medicine; Niamh Cahill, University of South Carolina School of Medicine Greenville; Jara Crawford, Indiana University School of Medicine; Lawson Traylor, University of South Carolina School of Medicine Greenville; Nikita Sood, Washington University School of Medicine in St Louis

Sponsored by: Region 2, Region 4, GLMA, PsychSIGN

Subject: Amending H-65.967 “Conforming Sex and Gender Designation on Government IDs and Other Documents” to Support Removal of Requirement of Proof of Surgery to Change Gender on Government Documentation

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, Approximately 1.4 million individuals in the United States identify as transgender and gender nonconforming and current identification guidelines pose serious risks to their health and wellbeing[1]; and

Whereas, The transgender identity spectrum refers to individuals who identify with or express a gender different than the sex they were assigned at birth, and includes identities such as genderqueer, non-binary, and gender nonconforming[2]; and

Whereas, Thirty-nine percent of transgender and gender nonconforming individuals reported experiencing serious psychological distress and 40% reported having attempted suicide in their lifetime, which is close to nine times higher than the attempted suicide rate in the U.S. population (4.6%)[2]; and

Whereas, Thirty-three percent of transgender individuals identified having at least one negative experience with their healthcare provider in the last year and 28% of transgender and gender nonconforming individuals reported postponing needed medical care due to fear of discrimination, which contributes to the significant health disparities they experience[2,3]; and

Whereas, Twenty-nine percent of transgender and gender nonconforming individuals live in poverty and 55% of transgender individuals seeking transition-related surgery reported being denied for health insurance coverage, which contributes to only 25% of transgender individuals reporting having a form of transition related surgery[2]; and

Whereas, Research shows that misgendering and misclassification are psychologically disruptive and are associated with negative affect, adverse mental health outcomes, and perceived stigma[4]; and

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Whereas, stress that members of marginalized communities experience due to gender identity contributes to the higher rates of mental health issues, disabilities, and chronic conditions experienced by transgender people compared to cisgender people[5]; and

Whereas, It has been shown that the number of gender affirmation experiences an individual experiences is inversely associated with depressive, anxiety, and stress symptoms[6]; and

Whereas, Birth certificates serve as the legal proof of identity in the United States and are crucial for obtaining a passport, accessing social services, and enrolling in school[7]; and

Whereas, It has been shown that those who had the ability to change their name and gender marker on birth certificates, driver's licenses or other forms of identification were 25% less likely to experience psychological distress or consider taking their own lives[81]; and

Whereas, Currently only 26 of 57 US states, territories, and districts explicitly allow for changes to birth certificate gender without medical and/or legal testimony such as proof of surgery or court order[8-78]; and

Whereas, Alabama, Arizona, Arkansas, Georgia, Iowa, Kentucky, Louisiana, Missouri, Montana, Nebraska, New Hampshire, North Carolina, North Dakota, and Wisconsin all explicitly require proof of surgery to change the gender marker on a birth certificate[16,18,20-23,32,41,43-44,50-51,53-57,76]; and

Whereas, Several states including Mississippi, Oklahoma, South Carolina, South Dakota, and Wyoming do not currently have a clear, standardized policy for how transgender individuals may update their gender marker on a birth certificate[79]; and

Whereas, Several states included Georgia, Iowa, Kentucky, Louisiana, Oklahoma, South Carolina, Tennessee, and Texas require proof of surgery, court order, or an amended birth certificate for transgender individuals to change their gender marker on driver's license;[82]; and

Whereas, In June 2021 the U.S. State Department announced it would allow for self-selection of gender markers on passport applications without requiring proof of gender, signaling a federal-level implementation of inclusive policies that is not yet reflected at the state-level [80]; and

Whereas, Our AMA believes that the physician's recognition of patients' sexual orientations, sexual behaviors, and gender identities without judgement or bias optimizes patient care in health as well as in illness, and that this recognition is especially important in addressing the specific health care needs of people who are or may be LGBTQ as indicated by H.160.991; and

Whereas, Our AMA recognizes the importance of updating gender and preferred pronouns in accordance with a patient's gender identity in medical records; therefore be it

RESOLVED, That our AMA amend policy H-65.967 "Conforming Sex and Gender Designation on Government IDs and Other Documents" by addition and deletion as follows

Conforming Sex and Gender Designation on Government IDs and Other Documents H-65.967

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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 will work with state medical societies and other relevant stakeholders to ensure that all states have clear policies that allow for change of gender designation on government identification that do not require proof of gender-affirming surgery, verification by a medical professional, or other such documentation, including establishing policies in states that currently do not have them.

~~3~~4. 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~~5. Our AMA supports efforts to ensure that the sex designation assigned at birth 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.

Fiscal Note: TBD

Date Received: 09/15/2021

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63. R.I. Gen. Laws § 23-3-21 (2005)
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RELEVANT AMA AND AMA-MSS POLICY

Conforming Sex and Gender Designation on Government IDs and Other Documents H-65.967
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.
Res. 4, A-13; Appended: BOT Rep. 26, A-14; Modified: Res. 003, A-19

Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation H-315.967

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Our AMA: (1) supports the voluntary inclusion of a patient's biological sex, current gender identity, sexual orientation, preferred gender pronoun(s), preferred name, and clinically relevant, sex specific anatomy in medical documentation, and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner; (2) will advocate for collection of patient data in medical documentation and in medical research studies, according to current best practices, that is inclusive of sexual orientation, gender identity, and other sexual and gender minority traits for the purposes of research into patient and population health; (3) will research the problems related to the handling of sex and gender within health information technology (HIT) products and how to best work with vendors so their HIT products treat patients equally and appropriately, regardless of sexual or gender identity; (4) will investigate the use of personal health records to reduce physician burden in maintaining accurate patient information instead of having to query each patient regarding sexual orientation and gender identity at each encounter; and (5) will advocate for the incorporation of recommended best practices into electronic health records and other HIT products at no additional cost to physicians.
Res. 212, I-16Reaffirmed in lieu of: Res. 008, A-17Modified: Res. 16, A-19Appended: Res. 242, A-19Modified: Res. 04, I-19

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

Improving Physician Mental Health and Reducing Stigma through Revision of Medical Licensure Applications 345.007MSS
AMA-MSS aims to reduce stigmatization mental health issues in the medical community by (a) opposing state medical boards' practice of issuing licensing applications that equate seeking help for mental health issues with the existence of problems sufficient to create professional impairment and (b) opposing the breach in a physician's private health record confidentiality by requiring access to these records when an applicant reports treatment.
MSS Res 17, I-13

Implementation of an Annual Mental Health Awareness and Suicide Prevention Program at Medical Schools 345.009MSS
AMA-MSS supports medical schools to create a mental health awareness and suicide prevention screening program that would: 1) be available to all medical students on an opt-out basis, 2) ensure anonymity, confidentiality, and protection from administration, 3) provide proactive intervention for identified at-risk students by mental health professionals, and 4) educate students and faculty about personal mental health and factors that may contribute to suicidal ideation.
MSS Res 15, I-15

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991

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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

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 41
(N-21)

Introduced by: Bahareh Jabbari, Darby Keirns, Albert Dickan, Sydney Scheel, Abigail Jones, Monica Reeson, Lauren Townson, Creighton University School of Medicine; Nikita Sood, Washington University School of Medicine in St. Louis; Mary Grace Kenny, Creighton University School of Medicine Phoenix Regional Campus; Dilpreet Kaeley, University of Toledo College of Medicine; Rishab Chawla, Medical College of Georgia

Sponsored by: Region 5

Subject: Support the World Health Organization's Moratorium on COVID-19 Booster Shots

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, To end the COVID-19 pandemic, public health experts estimate that 67% of the world's population must be fully vaccinated[1] ; and

Whereas, Fully vaccinated is defined by the CDC as 2 weeks after receiving the second dose in a 2-dose series, such as Pfizer or Moderna vaccines, or 2 weeks after a single dose vaccine, such as the Janssen vaccine[2]; and

Whereas, Only 24.4% of the world population is fully vaccinated and 32.4% of the world population has received at least one dose of the 2-dose series as of August 22nd, 2021[3]; and

Whereas, Only 1.4% of people in low-income countries have received one dose of a COVID-19 vaccine as of August 22nd, 2021[3]; and

Whereas, A study by the Kaiser Family Foundation (KFF) in July found that at current vaccination rates, "many countries may not achieve substantial levels of vaccination until at least 2023[4];" and

Whereas, Fear of waning immunity from COVID-19 vaccines has led to vaccine nationalism with many high-income countries increasing orders for COVID-19 booster shots[5,6]; and

Whereas, Vaccine booster shots for COVID-19 are defined as an additional dose of either Pfizer-BioNTech or Moderna vaccine for individuals who have already received their second dose at least 8 months ago[7]; and

Whereas, An article recently published in The Lancet reviewed 93 studies that examined vaccine efficacy and concluded that current evidence does not demonstrate a need for booster shots among the general population where initial efficacy of COVID-19 vaccines remains high[8]; and

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Whereas, Even if waning vaccine efficacy is contributing to increased COVID-19 spread in countries that have received initial vaccinations, other factors such as increased rates of unmasked socializing and noncompliance to social distancing recommendations are adjustable factors that are likely contributing as well[9,10]; and

Whereas, In populations with high vaccinations rates, the unvaccinated are at the highest risk of serious disease and the main drivers of transmission in their communities[11]; and

Whereas, So long as there are unvaccinated people in the world, the SARS-CoV-2 can spread, cause infection, mutate, and create new variants that may be resistant to the immune response created by the current vaccine[12]; and

Whereas, KFF's July report on vaccine equity found that vaccine donations by countries like the U.S. and those in Europe who have purchased almost all of the vaccines doses to be produced by Pfizer and Moderna this year would still be insufficient to achieve goal vaccination rates by the end of this year--booster shot campaigns by these same countries who have already consumed much of the world's vaccine doses would further hamper this progress[13]; and

Whereas, A widespread booster shot campaign in the US may divert needed doses away from low income countries around the world and thus lead to the emergence of new variants, further prolonging the pandemic[14-17]; and

Whereas, Studies indicate individuals who are immunocompromised experience significant improvement in the immunogenicity of vaccines after receiving a third dose of the 2 dose series vaccines[18,19]; and

Whereas, The same evidence has not been found in healthy individuals and the appropriateness of widespread booster shots has not been adequately researched[8]; and

Whereas, Messaging encouraging booster shots when there is not yet evidence-based research demonstrating this need can threaten current vaccination campaigns and reduce already-suboptimal confidence in vaccines overall[8]; and

Whereas, Studies indicate equitable distribution of vaccines, including countries that have minimal access to them, decreases overall infections and helps mitigate antigenic evolution of the virus, limiting the development of new variants[5,20]; and

Whereas, The AMA is an organization that stands for the betterment of public health and supports equitable vaccine distribution[21]; and

Whereas, The World Health Organization (WHO) has called for a moratorium on the administration of vaccine boosters worldwide until the end of 2021[22, 23]; and

Whereas, There have been almost 4.6 million deaths from COVID-19 worldwide as of September 14th, 2021[24]; and

Whereas, There are more than 18 million active COVID-19 cases worldwide as of August 24th, 2021[24]; and

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Whereas, Without vaccines, medications, and other pertinent medical equipments and technology, COVID-19 will continue to overwhelm public health systems, especially in the least developed countries[25]; therefore be it

RESOLVED, That our AMA support providing greater consideration to internationally unvaccinated individuals; and be it further

RESOLVED, That our AMA supports the World Health Organization's call for a moratorium on COVID-19 booster shots for healthy individuals; and be it further

RESOLVED, That our AMA supports global vaccine distribution guidelines and suggestions set by the World Health Organization throughout the course of the COVID-19 pandemic and any future pandemic.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

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

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

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

Res. 408, I-20; Reaffirmed: Res. 228, A-21

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.

Res. 228, A-21

Promoting Equitable Resource Distribution Globally in Response to the COVID-19 Pandemic D-440.917

1. Our AMA will, in an effort to improve public health and national stability, explore possible assistance through the COVID-19 Vaccines Global Access (COVAX) initiative co-led by the World Health Organization, Gavi, and the Coalition for Epidemic Preparedness Innovations, as well as all other relevant organizations, for residents of countries with limited financial or technological resources.

2. Our AMA will work with governmental and appropriate regulatory bodies to encourage prioritization of equity when providing COVID-19 pandemic-related resources, such as diagnostics, low cost or free medications, therapeutics, vaccines, raw materials for vaccine production, personal protective equipment, and/or financial support.

3. Our AMA recognizes the extraordinary efforts of many dedicated physicians, physician and ethnic organizations assisting in this humanitarian COVID-19 pandemic crisis.

4. Our AMA will support World Health Organization (WHO) efforts and initiatives to increase production and distribution of therapeutics and vaccines necessary to combat COVID-19 and future pandemics in order to provide vaccine doses to low- and middle-income countries with limited access, including: (a) a temporary waiver of the Trade Related Aspects of Intellectual Property (TRIPS) agreement and other relevant intellectual property protections; (b) technological transfers relevant for vaccine production; (c) other support, financial and otherwise, necessary to scale up global vaccine manufacturing; and (d) measures that ensure the safety and efficacy of products manufactured by such means.

Res. 608, A-21

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 42
(N-21)

Introduced by: Sarah Kelly, Samantha Rea, Trisha Gupte, Aarti Patel, Wayne State University School of Medicine

Sponsored by: Region 5, PsychSIGN

Subject: Amending H-345.981 to Address Increased Utilization of Mobile Health Technology for the Management of Mental Health Conditions

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, The World Health Organization defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” and further supports that “there is no health without mental health”[1]; and

Whereas, Rates of psychological distress, anxiety, depression, and other mental health conditions increased significantly worldwide during the COVID-19 pandemic, including a 93% increase in anxiety screening and a 62% increases in anxiety and depression screening[2,3]; and

Whereas, Despite increasing prevalence of mental illness during the COVID-19 pandemic, 24% of adults with mental illness reported that they were unable to receive treatment[3]; and

Whereas, There is a large and growing body of evidence supporting the important role of psychotherapy in decreasing disabilities, morbidity, and mortality, improving work functioning, and reducing psychiatric hospitalizations[4]; and

Whereas, Telebehavioral health (or telemental health) describes the delivery of behavioral health services through telecommunication systems, while mobile health (mHealth) refers to the use of secure information and communication technologies in support of health and health-related fields, which can utilize communication via text, chat, or voice in addition to monitoring symptoms, tracking treatment progress, and collecting survey data for research[5-7]; and

Whereas, The American Psychiatric Association (APA) and American Telemedicine Association (ATA) have established formal guidelines for the delivery of telemental health through interactive videoconferencing, but these guidelines do not address telemental health delivered through mHealth applications and websites[7-8]; and

Whereas, The visibility and utilization of consumer mental health apps has increased dramatically during the COVID-19 pandemic, with up to 20,000 apps on the market targeting numerous psychiatric conditions and continued industry growth[9-10]; and

Whereas, mHealth has the potential to serve as a tool for reducing disparities and increasing affordability of mental health treatment, but the majority of these apps operate in isolation from

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the traditional care process, which contributes to fragmentation in mental health care while impeding care delivery[11-13]; and

Whereas, Many mHealth apps and websites avoid FDA regulation by including clauses in their user agreements claiming that services are not intended to "diagnose, treat, or mitigate disease," including Betterhelp and Talkspace, which are online counseling websites with over one million users each[14-18]; and

Whereas, Both Betterhelp and Talkspace advertise that their services are "as effective as face-to-face therapy" although the cited studies lacked control groups for comparison[19,20]; and

Whereas, A 2019 study examining claims made by 73 of the top-ranked mental health apps on app stores found that 64% claimed effectiveness at improving symptoms of mental health conditions, but only one included a citation to published literature, suggesting a lack of transparency[21]; and

Whereas, A systematic assessment of mHealth apps targeted towards depression and suicide prevention found that only five out of 69 apps provided all six evidence-based suicide prevention strategies[22]; and

Whereas, The development of comprehensive guidelines for mHealth in collaboration with app developers, healthcare providers, and regulatory bodies is necessary to ensure high-quality care, patient safety, and transparency as the mental health app industry continues to grow and evolve[13,22,23]; and

Whereas, The WPA-Lancet Commission on the Future of Psychiatry states that mHealth technology "will lead to reduced need for office visits, increased access to care, and facilitation of seamless integration of care," but notes that this will require "novel research methods, transparency standards, clinical evidence, and care delivery models created in collaboration with a wide range of stakeholders"[24]; and

Whereas, AMA Policy H-480.943 describes standards of care for mobile health applications; however, this policy does not incorporate telebehavioral health that is delivered through mHealth apps or websites, creating arbitrary guidelines for physicians who are practicing through highly unregulated apps and platforms; and

Whereas, AMA policies H-345.984 and H-345.981 highlight the important role of physicians as leaders in the field of mental health and advocates for high quality, accessible mental health care, but the emergence and rapid growth of mobile applications for mental health has not been addressed by previous policy; therefore be it

RESOLVED, That our AMA amend Access to Mental Health Services H-345.981 by addition as follows:

> 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;

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(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;
(7) working with appropriate stakeholders to establish guidelines defining the role and scope of mobile health applications for mental health such that regulation mirrors that of telebehavioral health guidelines.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

Guidelines for Mobile Medical Applications and Devices D-480.972

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1. Our AMA will monitor market developments in mobile health (mHealth), including the development and uptake of mHealth apps, in order to identify developing consensus that provides opportunities for AMA involvement.
2. Our AMA will continue to engage with stakeholders to identify relevant guiding principles to promote a vibrant, useful and trustworthy mHealth market.
3. Our AMA will make an effort to educate physicians on mHealth apps that can be used to facilitate patient communication, advice, and clinical decision support, as well as resources that can assist physicians in becoming familiar with mHealth apps that are clinically useful and evidence based.
4. Our AMA will develop and publicly disseminate a list of best practices guiding the development and use of mobile medical applications.
5. Our AMA encourages further research integrating mobile devices into clinical care, particularly to address challenges of reducing work burden while maintaining clinical autonomy for residents and fellows.
6. Our AMA will collaborate with the Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education to develop germane policies, especially with consideration of potential financial burden and personal privacy of trainees, to ensure more uniform regulation for use of mobile devices in medical education and clinical training.
7. Our AMA encourages medical schools and residency programs to educate all trainees on proper hygiene and professional guidelines for using personal mobile devices in clinical environments.
8. Our AMA encourages the development of mobile health applications that employ linguistically appropriate and culturally informed health content tailored to linguistically and/or culturally diverse backgrounds, with emphasis on underserved and low-income populations.
(CSAPH Rep. 5, A-14; Appended: Res. 201, A-15; Appended: Res. 305, I-16; Modified: Res. 903, I-19)

Health Information Technology Principles H-478.981
Our AMA will promote the development of effective electronic health records (EHRs) in accordance with the following health information technology (HIT) principles. Effective HIT should:

1. Enhance physicians ability to provide high quality patient care;
2. Support team-based care;
3. Promote care coordination;
4. Offer product modularity and configurability;
5. Reduce cognitive workload;
6. Promote data liquidity;
7. Facilitate digital and mobile patient engagement; and
8. Expedite user input into product design and post-implementation feedback.

Our AMA will AMA utilize HIT principles to:

1. Work with vendors to foster the development of usable EHRs;
2. Advocate to federal and state policymakers to develop effective HIT policy;
3. Collaborate with institutions and health care systems to develop effective institutional HIT policies;
4. Partner with researchers to advance our understanding of HIT usability;
5. Educate physicians about these priorities so they can lead in the development and use of future EHRs that can improve patient care; and
6. Promote the elimination of Information Blocking.

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Our AMA policy is that the cost of installing, maintaining, and upgrading information technology should be specifically acknowledged and addressed in reimbursement schedules.

(BOT Rep. 19, A-18; Reaffirmation: A-19)

Addressing Equity in Telehealth H-480.937
Our AMA:
(1) recognizes access to broadband internet as a social determinant of health;
(2) encourages initiatives to measure and strengthen digital literacy, with an emphasis on programs designed with and for historically marginalized and minoritized populations;
(3) encourages telehealth solution and service providers to implement design functionality, content, user interface, and service access best practices with and for historically minoritized and marginalized communities, including addressing culture, language, technology accessibility, and digital literacy within these populations;
(4) supports efforts to design telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology, such as older adults, individuals with vision impairment and individuals with disabilities;
(5) encourages hospitals, health systems and health plans to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and non-physician provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth;
(6) supports expanding physician practice eligibility for programs that assist qualifying health care entities, including physician practices, in purchasing necessary services and equipment in order to provide telehealth services to augment the broadband infrastructure for, and increase connected device use among historically marginalized, minoritized and underserved populations;
(7) supports efforts to ensure payers allow all contracted physicians to provide care via telehealth;
(8) opposes efforts by health plans to use cost-sharing as a means to incentivize or require the use of telehealth or in-person care or incentivize care from a separate or preferred telehealth network over the patient's current physicians; and
(9) will advocate that physician payments should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person.
(CMS Rep. 7, A-21)

Integration of Mobile Health Applications and Devices into Practice H-480.943
1. Our AMA supports the establishment of coverage, payment and financial incentive mechanisms to support the use of mobile health applications (mHealth apps) and associated devices, trackers and sensors by patients, physicians and other providers that: (a) support the establishment or continuation of a valid patient-physician relationship; (b) have a high-quality clinical evidence base to support their use in order to ensure mHealth app safety and effectiveness; (c) follow evidence-based practice guidelines, especially those developed and produced by national medical specialty societies and based on systematic reviews, to ensure patient safety, quality of care and positive health outcomes; (d) support care delivery that is patient-centered, promotes care coordination and facilitates team-based communication; (e) support data portability and interoperability in order to promote care coordination through medical home and accountable care models; (f) abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services facilitated by the app; (g) require that physicians and other health practitioners delivering services through the app be licensed in the state where the patient receives services, or be providing these services

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as otherwise authorized by that state's medical board; and (h) ensure that the delivery of any services via the app be consistent with state scope of practice laws.
2. Our AMA supports that mHealth apps and associated devices, trackers and sensors must abide by applicable laws addressing the privacy and security of patients' medical information.
3. Our AMA encourages the mobile app industry and other relevant stakeholders to conduct industry-wide outreach and provide necessary educational materials to patients to promote increased awareness of the varying levels of privacy and security of their information and data afforded by mHealth apps, and how their information and data can potentially be collected and used.
4. Our AMA encourages the mHealth app community to work with the AMA, national medical specialty societies, and other interested physician groups to develop app transparency principles, including the provision of a standard privacy notice to patients if apps collect, store and/or transmit protected health information.
5. Our AMA encourages physicians to consult with qualified legal counsel if unsure of whether an mHealth app meets Health Insurance Portability and Accountability Act standards and also inquire about any applicable state privacy and security laws.
6. Our AMA encourages physicians to alert patients to the potential privacy and security risks of any mHealth apps that he or she prescribes or recommends, and document the patient's understanding of such risks
7. Our AMA supports further development of research and evidence regarding the impact that mHealth apps have on quality, costs, patient safety and patient privacy.
8. Our AMA encourages national medical specialty societies to develop guidelines for the integration of mHealth apps and associated devices into care delivery.
(CMS Rep. 06, I-16; Reaffirmation: A-17)

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 physicians' fundamental 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.

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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 patient's 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 patient's 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.

(Issued: 2016)

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H-345.984 Awareness, Diagnosis and Treatment of Depression and other Mental Illnesses

1. Our AMA encourages: (a) medical schools, primary care residencies, and other training programs as appropriate to include the appropriate knowledge and skills to enable graduates to recognize, diagnose, and treat depression and other mental illnesses, either as the chief complaint or with another general medical condition; (b) all physicians providing clinical care to acquire the same knowledge and skills; and (c) additional research into the course and outcomes of patients with depression and other mental illnesses who are seen in general medical settings and into the development of clinical and systems approaches designed to improve patient outcomes. Furthermore, any approaches designed to manage care by reduction in the demand for services should be based on scientifically sound outcomes research findings.
2. Our AMA will work with the National Institute on Mental Health and appropriate medical specialty and mental health advocacy groups to increase public awareness about depression and other mental illnesses, to reduce the stigma associated with depression and other mental illnesses, and to increase patient access to quality care for depression and other mental illnesses.
3. Our AMA: (a) will advocate for the incorporation of integrated services for general medical care, mental health care, and substance use disorder care into existing psychiatry, addiction medicine and primary care training programs' clinical settings; (b) encourages graduate medical education programs in primary care, psychiatry, and addiction medicine to create and expand opportunities for residents and fellows to obtain clinical experience working in an integrated behavioral health and primary care model, such as the collaborative care model; and (c) will advocate for appropriate reimbursement to support the practice of integrated physical and mental health care in clinical care settings.
4. Our AMA recognizes the impact of violence and social determinants on women’s mental health.
(Res. 502, I-96; Reaffirm & Appended: CSA Rep. 7, I-97; Reaffirmation: A-00; Modified: CSAPH Rep. 1, A-10; Modified: Res. 301, A-12; Appended: Res. 303, I-16; Appended: Res. 503, A-17; Reaffirmation: A-19)

140.029MSS: Ethical Parameters for Recommending Mobile Medical Applications: AMA-MSS ask the AMA to examine the issues related to physicians recommending medical software and apps to patients, especially those in which the physician has a vested interest, and to make recommendations as to how to conduct these interactions ethically. (MSS Res 13, A-15) (AMA Res 002, I-15 Reaffirmation) (Reaffirmed: MSS GC Rep B, A-21)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 43
(N-21)

Introduced by: Kari Stauss, Creighton School of Medicine Phoenix Regional Campus; Morgan Hopp, Mary Grace Kenny, Emily Reeson Creighton School of Medicine Phoenix Regional Campus; Megan Gainer, Lauren Townson, Creighton School of Medicine Main Campus

Sponsored by: PsychSIGN

Subject: Support of Increased Formal Training of Correctional Medicine Physicians

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, Approximately 639 of every 100,000 US citizens are currently in correctional facilities[1]; and

Whereas, According to the Federal Bureau of Prisons, black prisoners make up 38.2% of inmates and white prisoners make up 57.9% of inmates[2]; and

Whereas, According to the United States Census Bureau, black individuals account for only 13.4% of the US population and white individuals account for 76.3% of the US population[3]; and

Whereas, In a comparison study from 2016 to 2018 of all-cause mortality rates between black and white populations in US cities, the mortality rate among black populations was 24% higher than among white populations[4]; and

Whereas, There is increased burden of human immunodeficiency virus (HIV), hepatitis B virus (HBV), hepatitis C virus (HCV), and tuberculosis in incarcerated populations[5]; and

Whereas, Incarcerated individuals are guaranteed a right to health care by the 1976 US Supreme Court decision Estelle v. Gamble that established failure to provide basic medical care to a prisoner violates the Eighth Amendment to the Constitution banning cruel and unusual punishment[6]; and

Whereas, Released inmates have higher rates of hospitalizations for up to one year following release and are two times more likely to die within 30-90 days of release compared with matched control groups[7]; and

Whereas, The National Commission on Correctional Health Care has provided minimum standards for prison and jail-based health systems to follow voluntary accreditation[8]; and

Whereas, A minority of the 4575 correctional institutions in the US have volunteered to become accredited using these standards[8]; and

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Whereas, The AMA supports 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 (H-430.986); and

Whereas, The AMA supports the provision of comprehensive medical care for all entrants (H-430.988), yet doesn't have any policy requiring training of physicians to take care of this population; and

Whereas, Only a small proportion of academic health centers (AHCs) have reached out to incarcerated populations to fulfill their mission of training the next generation of clinicians[9]; and

Whereas, in a self-reported study where 23 medical schools responded, Only one school had a rotation in a correctional facility in which students were required to participate (5%)[10]; and

Whereas, Only 14% of residency programs offered lectures or conferences on the care of incarcerated persons, and only 22% offered clinical experiences in a correctional facility[11]; and

Whereas, Only 33% of psychiatry residents rotate at some form of correctional facility during their training[12]; and

Whereas, Only the correctional facilities in the states of Texas, Connecticut, Georgia, New Hampshire, New Jersey, and Massachusetts have partnered with an AHC to provide healthcare to incarcerated persons, with New Jersey reducing overtime by 10% and operating expenses by $2 million[9,13]; and

Whereas, It has been shown that medical residents who establish a relationship with incarcerated individuals and schedule a visit following their release result in a 60% follow up rate in this hard to reach population[14]; and

Whereas, Programs that train in correctional medicine seek to improve public health, reduce stigma and recruit physicians to correctional health as well as review the impact of incarceration on families and communities[11]; and

Whereas, Patients treated at a major teaching hospital have up to 20% higher odds of survival compared to those treated at nonteaching hospitals[15]; and

Whereas, Partnerships between medical training centers and correction facilities provide training and exposure for residents that fosters social responsibility among the next generation of physicians[14]; and

Whereas, The AMA advocates for necessary programs and staff training to address the distinctive health care needs of women and adolescent females who are incarcerated, including gynecological care and obstetrics care for individuals who are pregnant or postpartum, but does not have specific policy addressing the general incarcerated population (H-430.986); therefore be it

RESOLVED, That our AMA-MSS supports implementing correctional medicine in more residency training programs in all fields; and be it further

RESOLVED, That our AMA-MSS supports expanding partnerships between academic health centers and correctional facilities; and be it further

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RESOLVED, That our AMA-MSS supports enforcing patient care standards in training programs that are affiliated with correctional facilities.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

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 advocates and requires a smooth transition including partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. Our AMA encourages 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 advocates for states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal legal system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA advocates for Congress to repeal the “inmate exclusion” of the 1965 Social Security Act that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons.
7. Our AMA advocates for Congress and the Centers for Medicare & Medicaid Services (CMS) to revise the Medicare statute and rescind related regulations that prevent payment for medical care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the services are delivered.
8. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of women and adolescent females who are incarcerated, including gynecological care and obstetrics care for individuals who are pregnant or postpartum.
9. Our AMA will collaborate with state medical societies, relevant medical specialty societies, and federal regulators to emphasize the importance of hygiene and health literacy information sessions, as well as information sessions on the science of addiction, evidence-based addiction treatment including medications, and related stigma reduction, for both individuals who are incarcerated and staff in correctional facilities.
10. 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 use disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; and (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community.
11. Our AMA advocates for the continuation of federal funding for health insurance benefits, including Medicaid, Medicare, and the Children’s Health Insurance Program, for otherwise eligible individuals in pre-trial detention.

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12. Our AMA advocates for the prohibition of the use of co-payments to access healthcare services in correctional facilities.
(CMS Rep. 02, I-16; Appended: Res. 417, A-19; Appended: Res. 420, A-19; Modified: Res. 216, I-19; Modified: Res. 503, A-21; Reaffirmed: Res. 229, A-21)

Disease Prevention and Health Promotion in Correctional Institutions, H-430.989
Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public health systems toward the prevention and control of HIV/AIDS, substance abuse, tuberculosis, hepatitis, and other infectious diseases. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers and drug treatment center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase in direct referral by correctional systems of parolees with a recent, active history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs as a sentence or in connection with sentencing.
(CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13; Modified: Alt. Res. 404, I-20)

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)

Prevention and Control of HIV/AIDS and Tuberculosis in Correctional Facilities H-430.988
(1) Medical Testing and Care of Prisoners a) Federal and state correctional systems should provide comprehensive medical management for all entrants, which includes voluntary testing for HIV infection and mandatory testing for tuberculosis followed by appropriate treatment for those infected; b) During incarceration, prisoners should be tested for HIV infection as medically indicated or on their request; c) All inmates and staff should be screened for tuberculosis infection and retested at least annually. If an increase in cases of tuberculosis or HIV infection is

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noted, more frequent retesting may be indicated; d) Correctional institutions should assure that informed consent, counseling, and confidentiality procedures are in place to protect the patient, when HIV testing is appropriate; e) During their post-test counseling procedures, HIV-infected inmates should be encouraged to confidentially notify their sexual or needle-sharing partners; and f) Correctional medical care must, as a minimum, meet the prevailing standards of care for HIV-infected persons in the outside community at large. Prisoners should have access to approved therapeutic drugs and generally employed treatment strategies. (2) HIV/AIDS Education and Prevention Our AMA: a) Encourages the inclusion of HIV-prevention information as a regular part of correctional staff and inmate education. AIDS education in state and federal prisons should stress abstinence from drug use and high-risk sexual practices, as well as the proper use of condoms as one way of decreasing the spread of HIV; b) Will pursue legislation that encourages state, local, and federal correctional institutions to make condoms available to inmates; and c) Urges medical personnel in correctional institutions to work closely with state and local health department personnel to control the spread of HIV/AIDS, tuberculosis, and other serious infectious diseases within and outside these facilities. (3) Prison-based HIV Partner Notification Program Our AMA: a) Urges state health departments to take steps to initiate with state departments of correctional services the development of prison-based HIV Partner Notification Programs for inmates convicted of drug-related crimes and their regular sexual partners; and b) Believes that all parties should recognize that maximum effectiveness in an HIV Partner Notification Program will depend on the truly voluntary participation of inmates and the strict observance of confidentiality at all levels.
(CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13)

Support Public Health Approaches for the Prevention and Management of Contagious Diseases in Correctional and Detention Facilities H-430.979

1. Our AMA, in collaboration with state and national medical specialty societies and other relevant stakeholders, will advocate for the improvement of conditions of incarceration in all correctional and immigrant detention facilities to allow for the implementation of evidence-based COVID-19 infection prevention and control guidance.
2. Our AMA will advocate for adequate access to personal protective equipment and SARS-CoV-2 testing kits, sanitizing and disinfecting equipment for correctional and detention facilities.
3. Our AMA will advocate for humane and safe quarantine protocols for individuals who are incarcerated or detained that test positive for or are exposed to SARS-CoV-2, or other contagious respiratory pathogens.
4. Our AMA supports expanded data reporting, to include testing rates and demographic breakdown for SARS-CoV-2 and other contagious infectious disease cases and deaths in correctional and detention facilities.
5. Our AMA recognizes that detention center and correctional workers, incarcerated persons, and detained immigrants are at high-risk for COVID-19 infection and therefore should be prioritized in receiving access to safe, effective COVID-19 vaccine in the initial phases of distribution, and that this policy will be shared with the Advisory Committee on Immunization Practices for consideration in making their final recommendations on COVID-19 vaccine allocation.
(Alt. Res. 404, I-20)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 44
(N-21)

Introduced by: Fathima Haseefa, University of Arizona College of Medicine-Phoenix; Michael J. Rigby, PhD, University of Wisconsin School of Medicine and Public Health; Radhika Patel, Sam Houston State University College of Osteopathic Medicine

Sponsored by: PsychSIGN

Subject: Access to Naloxone for Vulnerable and Underserved Populations

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

I. Naloxone availability for populations with limited access

Whereas, The opioid overdose epidemic continues to be a significant public health issue as 69,710 overdose deaths involving opioids were reported in the United States in 2020, a 29.4% increase from 2019 and the highest death toll to date[1]; and

Whereas, Naloxone has been shown to be a safe and effective method of reversing opioid overdose[2]; and

Whereas, Rural counties have lower rates of drug use than urban counties yet higher rates of overdose since 2006[3]; and

Whereas, Rural counties had the lowest naloxone dispensing rates in 2018 with only 1.5 naloxone prescriptions for every 100 high-dose opioid prescriptions[4]; and

Whereas, Individuals who are homeless have a six-fold increased risk of overdose compared to low-income housed individuals[5]; and

Whereas, Prior attempts at naloxone prescribing programs for rural communities and individuals who are homeless have been successful in providing useful education about overdose signs and life-saving interventions, achieving a naloxone prescription fill rate of 33% in one study[6-7]; and

Whereas, AMA policy H-95.932 supports increasing availability of naloxone through pharmacies, co-prescriptions, law enforcement agencies, and all public spaces but is inadequate in tailoring efforts to ensure naloxone availability for vulnerable and underserved populations; and

II. Naloxone use education in pregnancy

Whereas, Of the 7% of women in the United States who self-reported opioid use in pregnancy, 1 in 5 reported misuse of opioids[8], and 11 to 20% of pregnancy-associated deaths were reported to be as a result of opioid overdose[9]; and

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Whereas, Maternal opioid use disorder rates have more than doubled between 2000 and 2017, which makes addressing maternal opioid use disorder a pressing public health concern[10]; and

Whereas, Screening for opioid use disorder in reproductive-age women based on factors such as history of adverse pregnancy outcome, poor prenatal care adherence, racial/ethnic group, or socioeconomic status can result in stereotyping, stigma, and missed cases as opioid use disorder occurs in women of all backgrounds[11]; and

Whereas, Administering naloxone is essential for reversing opioid overdose during pregnancy, and the associated reversal of maternal hypoxia can be beneficial to the fetus[12]; and

Whereas, While naloxone crosses the placenta, significant teratogenic effects on the fetus have not been found[12]; and

Whereas, Pregnant women at risk for overdose, such as due to high doses or chronic use, and their family members can benefit from having access to a naloxone kit and receiving appropriate education for administration in case of overdose[13]; and

Whereas, Women with substance use disorder had a 57% higher emergency department visit frequency compared to women without substance use disorder, suggesting that emergency departments could serve as a critical access point for screening, diagnosis, and treatment of maternal opioid use disorder[14]; and

Whereas, AMA policy H-420.950 supports increasing access to treatment for pregnant women with substance use disorders, it does not specifically address early identification of opioid use disorder in pregnancy and naloxone use education; and

III. Naloxone distribution in emergency departments

Whereas, The frequency of opioid overdose-related emergency department visits increased four-fold between 1993 and 2010[15] and increased by 28.5% in the past year alone[16]; and

Whereas, Emergency departments serve as a critical access point for naloxone distribution, especially for vulnerable and underserved populations[17]; and

Whereas, Only 31% of patients presenting to an emergency department for an unintentional opioid overdose reported having access to naloxone[18]; and

Whereas, Naloxone distribution in emergency departments has been shown to be feasible, sustainable, and lead to higher attainment rates than prescription fill rates[19-20]; and

Whereas, An emergency department-based naloxone distribution program was shown to result in 80% of naloxone kits leaving the hospital campus as an indicator of community penetrance[20]; and

Whereas, A systematic review of available literature on naloxone distribution in emergency departments reported limited data on naloxone administration and opioid overdose rates in participants and low program uptake due to barriers such as burden on workflow and time required for staff training[19]; and

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Whereas, AMA policy D-95.987 urges the implementation of community-based programs for naloxone distribution and encourages the study of treatments and risk mitigation strategies for opioid overdose, further research is needed to identify barriers to implementation and the most effective methods for naloxone distribution in emergency departments; therefore be it

RESOLVED, That our AMA support universal opioid use screenings at prenatal care visits with early intervention, comprehensive naloxone use education and distribution for those who screen positive and following overdose-related emergency department visits; and be it further

RESOLVED, That our AMA amend policy H-95.932, Increasing Availability of Naloxone, by addition as follows,:

Increasing Availability of Naloxone, H-95.932

1. Our AMA supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community-based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery. <u>There should be a focus on populations with limited access to naloxone, including but not limited to rural areas and individuals experiencing homelessness.</u>
2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone.
3. Our AMA encourages physicians to co-prescribe naloxone to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients.
4. Our AMA encourages private and public payers to include all forms of naloxone on their preferred drug lists and formularies with minimal or no cost sharing.
5. Our AMA supports liability protections for physicians and other health care professionals and others who are authorized to prescribe, dispense and/or administer naloxone pursuant to state law.
6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone to receive appropriate education to enable them to do so effectively.
7. Our AMA encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone with the Food and Drug Administration.
8. Our AMA supports the widespread implementation of easily accessible Naloxone rescue stations (public availability of Naloxone through wall-mounted display/storage units that also include instructions) throughout the country following distribution and legislative edicts similar to those for Automated External Defibrillators.
9. Our AMA supports the legal access to and use of naloxone in all public spaces regardless of whether the individual holds a prescription.

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10. Our AMA supports additional research on the most effective methods of naloxone distribution in emergency departments and solutions to overcome barriers to implementation.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

Increasing Availability of Naloxone H-95.932
1. Our AMA supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community-based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery.

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

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

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

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

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

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

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

9. Our AMA supports the legal access to and use of naloxone in all public spaces regardless of whether the individual holds a prescription. BOT Rep. 22, A-16; Modified: Res. 231, A-17; Modified: Speakers Rep. 01, A-17; Appended: Res. 909, I-17; Reaffirmed: BOT Rep. 17, A-18; Modified: Res. 524, A-19; Reaffirmed: BOT 09, I-19; Reaffirmed: Res. 219, A-21

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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 Rep. 22, A-16; Modified: Res. 511, A-18; Reaffirmed: Res. 235, I-18

Substance Use Disorders During Pregnancy H-420.950
Our AMA will: (1) oppose any efforts to imply that the diagnosis of substance use disorder during pregnancy represents child abuse; (2) support legislative and other appropriate efforts for the expansion and improved access to evidence-based treatment for substance use disorders during pregnancy; (3) oppose the removal of infants from their mothers solely based on a single positive prenatal drug screen without appropriate evaluation; and (4) advocate for appropriate medical evaluation prior to the removal of a child, which takes into account (a) the desire to preserve the individual's family structure, (b) the patient's treatment status, and (c) current impairment status when substance use is suspected.

Promoting Prevention of Fatal Opioid Overdose 100.010MSS
AMA-MSS will ask the AMA to (1) encourage the establishment of new pilot programs directed towards heroin overdose treatment with naloxone; and (2) advocate for encourage the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities. MSS Res 36, I-11; HOD Policy D-95.987 Amended in lieu of AMA Res 503, A-12; Reaffirmed: MSS GC Report A, I-16

OTC Availability of Naloxone 100.013MSS
AMA-MSS will ask the AMA to support the study of over the counter availability of naloxone. MSS Res 33, A-15; AMA Res 909, I-15 Adopted as Amended [H-95.932]; Reaffirmed: MSS GC Rep B, A-21

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 45
(N-21)

Introduced by:	Brandon Poppe, Jennifer Concepcion, Ryan Andrade, A.T. Still University School of Osteopathic Medicine in Arizona
Sponsored by:	n/a
Subject:	Screening for Suicide Risk in Transgender Patients
Referred to:	MSS Reference Committee (Zachary Dunton and Neha Siddiqui, Chair)

Whereas, A transgender person is a person whose gender identity differs from the sex that was assigned at birth, and a non-transgender person may be referred to as cisgender[13]; and

Whereas, Suicide is the second leading cause of death among adolescents and young adults ages 10 to 34 years, and the 10th leading cause of death in the general population in the United States[1,2]; and

Whereas, In a study including 27,715 respondents who identified as transgender, nearly five out of ten individuals reported thinking about suicide in the past year, which is higher than previous research[2]; and

Whereas, In the largest National Transgender Survey to date (n = 6456), 41% of the respondents reported having attempted suicide (26 times higher than the general population)[3]; and

Whereas, A study using data from the Profiles of Student Life: Attitudes and Behavior survey (N = 120,617 adolescents aged 11-19 years) revealed a disparate burden of suicide-related behavior among gender-minority adolescents in the United States, particularly transgender adolescents[1]; and

Whereas, According to Perez-Brumer et al. (2017) and Day et al. (2017), when comparing transgender youth with cisgender and other sexual minority youth (i.e. gay, lesbian, etc.), the prevalence of suicidal ideation was almost twice as high for transgender youth with depressive symptoms[4]; and

Whereas, Stigma due to deviance from societal norms, sexual experiences at an early age, a history of physical or sexual abuse, and lack of important social support increase risk for suicidality in the transgender population[5]; and

Whereas, Lack of family and social supports, gender-based discrimination, transgender-based abuse and violence, gender dysphoria and body-related shame, difficulty while undergoing gender reassignment, and being a member of another or multiple minority groups contribute to the high rate of suicide in the transgender population[6]; and

Whereas, According to the Trans Needs Assessment Survey, the largest city-based, trans-specific needs assessment in US history with over 500 participants, among those who had

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attempted suicide, 61% had a history of physical assault and 54% had a history of sexual assault[12]; and

Whereas, Item 9 of the Patient Health Questionnaire evaluates passive thoughts of death or self-injury within the last two weeks, and is often used to screen depressed patients for suicide risk, however this is an insufficient assessment tool for suicide risk and suicide ideation with limited utility in certain demographic and clinical subgroups that requires further investigation[7]; and

Whereas, The ASK Suicide-Screening Questions tool, created by the National Institute of Mental Health and approved by the Joint Commission, is a brief, valid and useful tool for screening for elevated suicide risk in outpatient clinical settings[8], however it does not ask questions regarding factors that are associated with attempted suicide and suicidal ideation in the transgender population, including but not limited to history of physical assault and sexual assault; and

Whereas, The Suicidal Ideation Attributes Scale was validated based on a prospective study focusing on the general population rather than a clinical population, and it has been noted that the cutoff score indicating high risk of suicidal ideation needs validation in different populations[9]; and

Whereas, The application of the Columbia-Suicide Severity Rating Scale, used to measure the intensity of suicidal ideation, in different populations deserves further study, particularly in light of variable routes to suicidal behavior (e.g., which severity items predict which behaviors, and what other factors, such as substance abuse or family history, modify the risk associated with the severity or intensity of ideation)[10]; and

Whereas, While definitive predictors do not exist, there is strong evidence that asking people with risk factors (such as mental illness or substance use, recent loss, trauma histories) is effective in identifying suicidal individuals[11]; and

Whereas, Our American Medical Association (AMA) has approved (1) addressing effective screening tools in suicide prevention of youth and young adults and (2) encouraging continued research to better understand suicide risk and effective prevention efforts in the LGBTQ+ population, but current policy does not address the investigation of a screening tool with evidence-based risk factors for suicide prevention in transgender patients; and

Whereas, There is much that we do not yet know about predicting and preventing suicide, and while we should act on the knowledge that we have, more research is needed to help identify and assist those at risk and studies are needed to more thoroughly examine reasons why suicidal ideation is high among transgender individuals[2,11]; therefore be it

RESOLVED, That our AMA encourage the development of a screening tool for suicide prevention in transgender patients that includes but is not limited to screening questions regarding physical assault, sexual assault, recent loss, lack of social support, body-related shame, and substance abuse that can be easily accessed at no cost by health care providers; and be it further

RESOLVED, That our AMA urge health care providers to maintain adequate follow-up and to provide appropriate services and support for all transgender patients that are at risk for suicide.

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Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

Youth and Young Adult Suicide in the United States H-60.937
Our AMA:
(1) Recognizes youth and young adult suicide as a serious health concern in the US;

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(2) Encourages the development and dissemination of educational resources and tools for physicians, especially those more likely to encounter youth or young adult patients, addressing effective suicide prevention, including screening tools, methods to identify risk factors and acuity, safety planning, and appropriate follow-up care including treatment and linkages to appropriate counseling resources;
(3) Supports collaboration with federal agencies, relevant state and specialty medical societies, schools, public health agencies, community organizations, and other stakeholders to enhance awareness of the increase in youth and young adult suicide and to promote protective factors, raise awareness of risk factors, support evidence-based prevention strategies and interventions, encourage awareness of community mental health resources, and improve care for youth and young adults at risk of suicide;
(4) Encourages efforts to provide youth and young adults better and more equitable access to treatment and care for depression, substance use disorder, and other disorders that contribute to suicide risk;
(5) Encourages continued research to better understand suicide risk and effective prevention efforts in youth and young adults, especially in higher risk sub-populations such as Black, LGBTQ+, Hispanic/Latinx, Indigenous/Native Alaskan youth and young adult populations, and among youth and young adults with disabilities;
(6) Supports the development of novel technologies and therapeutics, along with improved utilization of existing medications to address acute suicidality and underlying risk factors in youth and young adults;
(7) Supports research to identify evidence-based universal and targeted suicide prevention programs for implementation in middle schools and high schools;
(8) Will publicly call attention to the escalating crisis in children and adolescent mental health in this country in the wake of the COVID-19 pandemic;
(9) Will advocate at the state and national level for policies to prioritize children's mental, emotional and behavioral health; and
(10) Will advocate for a comprehensive system of care including prevention, management and crisis care to address mental and behavioral health needs for infants, children and adolescents.
(Res. 424, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Reaffirmed in lieu of: Res. 001, I-16; Appended: CSAPH Rep. 3, A-21)

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.
(Res 903, I-17; Modified: CSAPH Rep. 01, I-18)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 46
(N-21)

Introduced by: Neha Siddiqui, University of Illinois Urbana-Champaign; Justin Magrath, David Long, Mahitha Koduri, Jonathan Paul, Tina Reddy, Tulane University; Arvinth Sethuraman, Rutgers University; Rohan Khazanchi, University of Nebraska Medical Center; Sarah Mae Smith, University of California — Irvine; Nikita Sood, Washington University in St Louis; Jenna Gage, University of Texas Medical Branch Galveston; Christopher Prokosch, University of Minnesota Medical School; Tabitha Moses, Wayne State University School of Medicine; Ida Vaziri, UT Health San Antonio Long School of Medicine; Raj Reddy, Baylor College of Medicine; Lavanya Easwaran, University of Florida; Sam Pavlock, FSU

Sponsored by: Region 3, Region 4

Subject: Reducing the Burden of Incarceration on Public Health

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Health Impact of Prisons:

Whereas, The United States is the most incarcerated nation in the world, with an incarceration rate of 655 per 100,000 and over 2.1 million people in prison in 2018[1]; and

Whereas, The number of people imprisoned for a violent crime increased by 300% between 1980 and 2009 despite the number of murders per capita staying relatively constant[2,3]; and

Whereas, The US criminal justice system results in significant adverse impacts on individual and community health during and after incarceration; and

Whereas, People who are incarcerated in the US have higher rates of nearly every infectious disease compared with the general population, including HIV, tuberculosis population, hepatitis C virus (HCV) I, and COVID-19 infection rates more than 5x higher than the general US population[4-6]; and

Whereas, Incarcerated individuals in the U.S. also show an increased presentation of symptoms or diagnosis of psychiatric illness nearly four times the rate of,the overall US adult population[7]; and

Whereas, Solitary confinement, being assaulted while incarcerated, lack of social interaction, crowded conditions, and reduced healthcare access all lead to poor physical and mental health outcomes while being incarcerated[8]; and

Whereas, Our AMA has already recognized the health vulnerability of incarcerated individuals in the US through H-430.979, H-430.985, H-430.986, H-430.987, H-430.988, H-430.989, and H-

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440.931 which outline specific necessary measures needed to address HIV/AIDS, hepatitis C, tuberculosis, COVID-19, substance use disorder, and mental health issues as well as overall poorer health outcomes among incarcerated individuals; and

Health Impacts After Incarceration:

Whereas, Previously incarcerated individuals face a 3.5 times greater risk of death within the first 2 years after release, and are 129 times more likely to die due to a drug overdose within the first 2 weeks than the average resident[9]; and

Whereas, Formerly incarcerated youth[27] as well as adults have increased rates of chronic medical conditions, sexually transmitted infections, substance abuse disorders, and mental health disorders[10,11]; and

Whereas, Previously incarcerated individuals are 5 times less likely to be employed, with 60% unemployed one year after release, as well as 3 times more likely to be uninsured, and face significant barriers in acquiring education, stable housing, and support for mental health[12]; and

Whereas, Because of the socioeconomic consequences of having been previously incarcerated or underlying social determinants that have not been addressed, and the dearth of societal re-entry programs that support healthy transitions back to everyday life, recidivism rates are high, demonstrating the US criminal justice system's failure to decrease prevalence of crimes or improve the public health of the communities that previously incarcerated individuals reside in[13]; and

Disproportionate Health Impacts on Disadvantaged Populations:

Whereas, Adverse health outcomes during and following incarceration extend to the family of the incarcerated individual, including:

- Children of incarcerated parents experiencing greater rates of mental and behavioral issues, including substance use in childhood and adulthood
- Families facing additional financial hardships due to lack of income, with men who are incarcerated contributing nearly $1300 less to their children per year compared to men who had never been incarcerated
- Incarceration during pregnancy being associated with a similar increase in risk of adverse child and maternal health outcomes as seen in pregnant women with "high levels of intersecting stressors" outside of prison[14-16]; and

Whereas, The burdens of mass incarceration have been disproportionately borne by black communities and other minorities due to racially-motivated policing, race-based discrimination in jury-selection, and other factors[17]; and

Whereas, As of September 2020, 46.2% of federal inmates were imprisoned due to drug offenses; and racial minorities are more likely to be arrested for drug- and alcohol-related crimes[23], even when adjusted for rates of drug and alcohol use, and were more likely to be arrested, convicted and imprisoned rather than cited and released at both the felony and misdemeanor levels, findings that hold true in every U.S. state[18-21]; and

Overburdening the Criminal Justice System:

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Whereas, Approximately one quarter of the prison population are held due to violation of parole or other technical violation rather than violent offense contributing to overcrowding issues, particularly at state prisons[22-24]; and

a. Mandatory Minimums:

Whereas, Mandatory minimums are defined as laws requiring judges to sentence offenders to a pre-specified minimum incarceration term for a particular crime; and

Whereas, Mandatory minimums have not shown to be effective in decreasing crime, with a 2018 analysis examining the use of cocaine base and powdered cocaine following the implementation of mandatory minimum policies found no decrease in cocaine base use after the implementation of such policies, despite the harshest penalties being imposed for cocaine base use[25]; and

Whereas, Mandatory minimum sentences fail to effectively deter crime and result in long periods of incarceration that are associated with increases in recidivism[26]; and

Whereas, Rhode Island experienced a decrease in its violent crime rate following the repeal of its mandatory minimum sentencing law for drug offenses[27]; and

Whereas, Racial inequities in the application of mandatory minimum sentences are driven in part by disparities in the types of offenses to which mandatory sentences are applied (including drug-related charges and particularly repeat offenses), but also are due to inequities in the application and enforcement of the mandatory sentences via prosecution, with Black defendants being more likely than White defendants to be subjected to the mandatory minimum sentence even among those convicted of the exact same charges[28,29]; and

Whereas, Because under mandatory minimums, conviction is required and standardized once an individual is found guilty, the enforcement of minimums is dependent on prosecutors' willingness to prosecute individuals, thus shifting discretionary power from judges (judicial discretion) to prosecutors (prosecutorial discretion), who can be perceived as “less neutral court actors”, thus contributing to the demographic and racial inequities exacerbated by mandatory minimum sentencing[30,31]; and

b. Three Strikes Rules

Whereas, Sentencing policies known as “three-strikes” policies, which are termed habitual offender laws were first implemented in the 1990’s as part of the US Anti-Violence Strategy, refer to laws that significantly increase the sentence of a felony if a person has been convicted of 2 or more felonies previously[31]; and

Whereas, In some states, one incident can result in an individual being charged for multiple felonies, and receive all three strikes all at once; and

Whereas, Three-strikes policies consistently fail to reduce recidivism, generate massive economic burden, and further derelictions of duty to rehabilitate and reintroduce offenders to society after long sentences[32]; and

c. Effect of Removing Mandatory Minimums and Three Strikes Rules

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Whereas, Three-strikes policies and mandatory minimum sentencing deprive judges of the ability to tailor sentencing based on mitigating factors[33,34]; and

Whereas, In 2018, the First Step Act was passed as federal law, lowering mandatory minimums, easing the three-strike rule, and increasing good time credits and earned time credits, but oes not impact state-level criminal justice reform, and thus only accounts for 155,741 federal prisoners (as of September 2020) of the total 2.1 million US prisoners in 2020 (only 7.4%)[35]; and

d. Fair Navigability of the Criminal Justice System

Whereas, Indigent defense systems allow for the defendant to obtain counsel when they are unable to afford one, allowing for fairer access to navigate the criminal justice system; and

Whereas, Funding for indigent defense systems can come from either state or local sources, and varies in amount and quality[36]; and

Whereas, Studies show that only about a quarter of indigent defense systems have enough funding to effectively represent assigned defendants[37]; and

Whereas, Due to lack of available attorney and long wait times, defendants are coerced to take pleas or stand trial without an attorney[37];

Promoting Rehabilitative Practices in Criminal Justice:

Whereas, According to a survey of violence survivors, victims preferred that the perpetrators of violent crime undergo violence prevention training over incarceration, short sentences and rehabilitation over long sentences, and investment in at-risk youth programs rather than investment in prisons[38]; and

Whereas, Multiples studies, including those focusing on California Proposition 47, the 2007 Crack Cocaine Amendment, and the Fair Sentencing Act, have found that reducing prison sentences does not increase the rate of recidivism[39-41]; and

Whereas, Many countries including Norway, Denmark, and Sweden have significantly shorter prison sentences, and this does not correlate with increased rates of crime[42]; and

Whereas, Our AMA has consistently shown support for public health based prevention and rehabilitation strategies, rather than incarceration or criminalization, with numerous policies attesting to the sentiment of prevention and health/social support rather than criminalization, including policies H-95.924 for criminal cannabis use, pregnant mothers who smoke or do drugs, people who exchange sex for money, H-515.958, or do drugs H-100.955; therefore be it

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

a. Advocating for implementation and incentivization of adequate funding and resources towards indigent defense systems;
b. Working with state medical societies to advocate for legislation that reduces or eliminates mandatory minimums and three-strike rules;

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c. Advocating for decreasing the magnitude of penalties including the length of prison sentences to create a criminal justice model that focuses on citizen safety rather than retribution;
d. Advocating for legislation and regulations that reduce the number of people placed in prison conditions, such as preventing people who were formerly incarcerated from being sent back to prison for minor parole violations for technicalities, such as missing appointments, not having a job, and not filling out paperwork;
e. Supporting continual review of sentences for people at various time points of sentence; and be it further

RESOLVED, That our AMA advocate for implementation of practices that promote access to stable employment and housing for formerly incarcerated people, including programs that facilitate access to immediate housing after release from carceral settings and laws that ensure employment non-discrimination for workers with previous non-felony criminal record; and be it further

RESOLVED, That our AMA partner with the American Public Health Association and other stakeholders to urge Congress, the Centers for Disease Control and Prevention, and the National Institutes of Health to fund research on the effectiveness of alternatives to incarceration in minimizing negative health consequences.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

Support Public Health Approaches for the Prevention and Management of Contagious Diseases in Correctional and Detention Facilities H-430.979

1. Our AMA, in collaboration with state and national medical specialty societies and other relevant stakeholders, will advocate for the improvement of conditions of incarceration in all correctional and immigrant detention facilities to allow for the implementation of evidence-based COVID-19 infection prevention and control guidance.
2. Our AMA will advocate for adequate access to personal protective equipment and SARS-CoV-2 testing kits, sanitizing and disinfecting equipment for correctional and detention facilities.
3. Our AMA will advocate for humane and safe quarantine protocols for individuals who are incarcerated or detained that test positive for or are exposed to SARS-CoV-2, or other contagious respiratory pathogens.
4. Our AMA supports expanded data reporting, to include testing rates and demographic breakdown for SARS-CoV-2 and other contagious infectious disease cases and deaths in correctional and detention facilities.
5. Our AMA recognizes that detention center and correctional workers, incarcerated persons, and detained immigrants are at high-risk for COVID-19 infection and therefore should be prioritized in receiving access to safe, effective COVID-19 vaccine in the initial phases of distribution, and that this policy will be shared with the Advisory Committee on Immunization Practices for consideration in making their final recommendations on COVID-19 vaccine allocation.
Alt. Res. 404, I-20

Support for Standardized Diagnosis and Treatment of Hepatitis C Virus in the Population of Incarcerated Persons H-430.985
Our AMA: (1) supports the implementation of routine screening for Hepatitis C virus (HCV) in prisons; (2) will advocate for the initiation of treatment for HCV when determined to be appropriate by the treating physician in incarcerated patients with the infection who are seeking treatment; and (3) supports negotiation for affordable pricing for therapies to treat and cure HCV among correctional facility health care providers, correctional facility health care payors, and drug companies to maximize access to these disease-altering medications.
Res. 404, A-17

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. Our AMA encourages state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have

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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. A-19; Modified: Res. 216, I-19; Modified: Res. 503, A-21; Reaffirmed: Res. 229, A-21)

Medications for Opioid Use Disorder in Correctional Facilities H-430.987
1. Our AMA endorses: (a) the medical treatment model of employing medications for opioid use disorder (OUD) as the standard of care for persons with OUD who are incarcerated; and (b) medications for persons with OUD who are incarcerated, an endorsement in collaboration with relevant organizations including but not limited to the American Society of Addiction Medicine and the American Academy of Addiction Psychiatry.
2. Our AMA advocates for legislation, standards, policies and funding that require correctional facilities to increase access to evidence-based treatment of OUD, including initiation and continuation of medications for OUD, in conjunction with psychosocial treatment when desired by the person with OUD, in correctional facilities within the United States and that this apply to all individuals who are incarcerated, including individuals who are pregnant, postpartum, or parenting.
3. Our AMA advocates for legislation, standards, policies, and funding that require correctional facilities within the United States to work in ongoing collaboration with addiction treatment physician-led teams, case managers, social workers, and pharmacies in the communities where patients, including individuals who are pregnant, postpartum, or parenting, are released to offer post-incarceration treatment plans for OUD, including education, medication for addiction treatment and counseling, and medication for preventing overdose deaths, including naloxone (or any other medication that is approved by the United States Food and Drug Administration for the treatment of an opioid overdose), and help ensure post-incarceration medical coverage and accessibility to mental health and substance use disorder treatments, that include medication and behavioral health and social supports for addiction treatment.
4. Our AMA advocates for all correctional facilities to use a validated screening tool to identify opioid withdrawal and take steps to determine potential need for treatment for OUD and opioid withdrawal syndrome for all persons upon entry.

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Res. 443, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Appended: Res. 223, I-17; Modified: Res. 503, A-21

Prevention and Control of HIV/AIDS and Tuberculosis in Correctional Facilities H-430.988
(1) Medical Testing and Care of Prisoners a) Federal and state correctional systems should provide comprehensive medical management for all entrants, which includes voluntary testing for HIV infection and mandatory testing for tuberculosis followed by appropriate treatment for those infected; b) During incarceration, prisoners should be tested for HIV infection as medically indicated or on their request; c) All inmates and staff should be screened for tuberculosis infection and retested at least annually. If an increase in cases of tuberculosis or HIV infection is noted, more frequent retesting may be indicated; d) Correctional institutions should assure that informed consent, counseling, and confidentiality procedures are in place to protect the patient, when HIV testing is appropriate; e) During their post-test counseling procedures, HIV-infected inmates should be encouraged to confidentially notify their sexual or needle-sharing partners; and f) Correctional medical care must, as a minimum, meet the prevailing standards of care for HIV-infected persons in the outside community at large. Prisoners should have access to approved therapeutic drugs and generally employed treatment strategies. (2) HIV/AIDS Education and Prevention Our AMA: a) Encourages the inclusion of HIV-prevention information as a regular part of correctional staff and inmate education. AIDS education in state and federal prisons should stress abstinence from drug use and high-risk sexual practices, as well as the proper use of condoms as one way of decreasing the spread of HIV; b) Will pursue legislation that encourages state, local, and federal correctional institutions to make condoms available to inmates; and c) Urges medical personnel in correctional institutions to work closely with state and local health department personnel to control the spread of HIV/AIDS, tuberculosis, and other serious infectious diseases within and outside these facilities. (3) Prison-based HIV Partner Notification Program Our AMA: a) Urges state health departments to take steps to initiate with state departments of correctional services the development of prison-based HIV Partner Notification Programs for inmates convicted of drug-related crimes and their regular sexual partners; and b) Believes that all parties should recognize that maximum effectiveness in an HIV Partner Notification Program will depend on the truly voluntary participation of inmates and the strict observance of confidentiality at all levels.
(CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13)

Disease Prevention and Health Promotion in Correctional Institutions H-430.989
Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public health systems toward the prevention and control of HIV/AIDS, substance abuse, tuberculosis, and hepatitis. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers and drug treatment center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase in direct referral by correctional systems of parolees with a recent, active history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs as a sentence or in connection with sentencing.
CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13

Update on Tuberculosis H-440.931
It is the policy of the AMA that: (1) All prison inmates should be tuberculin skin-tested upon arrival and annually thereafter. Those who are positive should be managed as medically appropriate, contact tracing performed, and provisions made for the continued treatment and follow-up of those who are released prior to the completion of their therapy. (2) Staff of both

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prisons and jails should be tuberculin-tested upon employment and annually thereafter. Those who are positive should be managed as medically appropriate and contact tracing performed. (3) Both public and health care worker education about TB, its transmission, and the necessity for preventive as well as therapeutic treatment should be increased. (4) Current CDC guidelines for the prevention of tuberculosis in congregate settings should be fully implemented. The protection of persons who are immunocompromised needs to be addressed especially by treatment centers housing such persons. (5) While powered air-purification respirators may be useful for the protection of HIV-infected and other immunocompromised health care workers who care for patients with infectious TB, their routine use for the prevention of the nosocomial transmission of TB is uncalled for in health care facilities where CDC guidelines are fully implemented. (6) States should review their TB control laws using current CDC recommendations and recent legal and ethical publications as guidelines. Where necessary to further protect the public health from the disease, existing laws should be modified and/or new ones added.
BOT Rep. JJ, A-93; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13

Health Status of Detained and Incarcerated Youth H-60.986
Our AMA (1) encourages state and county medical societies to become involved in the provision of adolescent health care within detention and correctional facilities and to work to ensure that these facilities meet minimum national accreditation standards for health care as established by the National Commission on Correctional Health Care;
(2) encourages state and county medical societies to work with the administrators of juvenile correctional facilities and with the public officials responsible for these facilities to discourage the following inappropriate practices: (a) the detention and incarceration of youth for reasons related to mental illness; (b) the detention and incarceration of children and youth in adult jails; and (c) the use of experimental therapies, not supported by scientific evidence, to alter behavior.
(3) encourages state medical and psychiatric societies and other mental health professionals to work with the state chapters of the American Academy of Pediatrics and other interested groups to survey the juvenile correctional facilities within their state in order to determine the availability and quality of medical services provided.
(4) advocates for increased availability of educational programs by the National Commission on Correctional Health Care and other community organizations to educate adolescents about sexually transmitted diseases, including juveniles in the justice system.
(CSA Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Appended: Res. 401, A-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: Res 917)

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)

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Ending Money Bail to Decrease Burden on Lower Income Communities H-80.993
Our AMA: (1) recognizes the adverse health effects of pretrial detention; and (2) will support legislation that promotes the use of non-financial release options for individuals charged with nonviolent crimes.
(Res. 408, 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)

Policing Reform H-65.954
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)

AMA 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

Preventing Assault and Rape of Inmates by Custodial Staff H-430.981
Our AMA urges: (1) that all states have legislation that protects prisoners from sexual misconduct and assault; and (2) physicians who work within prisons to ensure procedures are

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followed for preventing sexual misconduct and assault of prisoners by staff and appropriately managing prisoners if abuse or assault does occur; the investigation of sexual misconduct should be confidential with information disclosed only to those individuals involved in the process.
CSAPH Rep. 01, A-20.

Use of the Choke and Sleeper Hold in Prisons H-430.998
The AMA (1) 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 (2) advocates that with all incidents involving the application of choke and sleeper holds there should be timely medical surveillance of the inmate.
Res. 3, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15

Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes H-515.955
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.

Police Chases and Chase-Related Injuries H-15.964
The AMA encourages (1) communities, aided by government officials and medical scientists, to develop guidelines on the use of police vehicles that indicate when, how, and how long pursuits should be carried out and to address other key aspects of police pursuit; and (2) responsible government agencies to develop, test, and use instruments and techniques with advanced technologies, for example, coding and tracking devices, to discourage, eliminate, or replace high-speed chases.
CSA Rep. C, A-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13.

Mental Health Crisis Interventions H-345.972
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

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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.

Increased Use of Body-Worn Cameras by Law Enforcement Officers D-160.919
Our AMA: (1) will work with interested state and national medical specialty societies to support state legislation and/or regulation addressing implementation of body-worn camera programs for law enforcement officers, including funding for the purchase of body-worn cameras, training for officers and technical assistance for law enforcement agencies; (2) will continue to monitor privacy issues raised by body-worn cameras in health care settings; and (3) recommends that law enforcement policies governing the use of body-worn cameras in health care settings be developed and evaluated with input from physicians and others in the medical community and not interfere with the patient-physician relationship.
BOT Rep. 18, A-19.

Use of Conducted Electrical Devices by Law Enforcement Agencies H-145.977
Our AMA: (1) 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) that is modeled after available national guidelines; (2) encourages additional independent research involving actual field deployment of CEDs to better understand the risks and benefits under conditions of actual use. Federal, state, and local agencies should accurately report and analyze the parameters of CED use in field applications; and (3) policy is that law enforcement departments and agencies have a standardized protocol developed with the input of the medical community for the evaluation, management and post-exposure monitoring of subjects exposed to CEDs.
CSAPH Rep. 6, A-09; Modified: Res. 501, A-14.

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.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 47
(N-21)

Introduced by: Andrew Alexander, Texas A&M University Health Science Center College of Medicine; Shivani Bhatnagar, University of North Texas Health Science Center Texas College of Osteopathic Medicine; Adrian Falco, Texas Tech University Health Science Center School of Medicine; Krishna Channa, University of Connecticut School of Medicine; Sritej Devineni, Northeast Ohio Medical University; Dhruv Puri, University of California San Diego College of Medicine; William Liakos, Zucker School of Medicine at Hofstra/Northwell; Madeline Drake, Melissa Yang, UTHouston McGovern Medical School; Matthew Swanson, Franklin H. Netter MD School of Medicine at Quinnipiac University; Raag Agrawal, David Geffen School of Medicine at UCLA; Skyler Burke, Washington State University Elson S. Floyd College of Medicine; Ayesha Firdous, University of Pittsburgh School of Medicine; Kristofer Jackson, University of Toledo College of Medicine; Joel Mintz, Nova Southeastern University College of Allopathic Medicine; Sarah Mukhtar, Sidney Kimmel Medical College at Thomas Jefferson University; David Horovitz, University of South Carolina School of Medicine Columbia;

Sponsored by: n/a

Subject: Overcoming Medical Misinformation through Utilizing Bots to Provide Accurate Medical Information

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, Medical misinformation is a health-related claim that is based on anecdotal evidence, false, or misleading owing to the lack of existing scientific knowledge[1]; and

Whereas, Medical misinformation has led to distrust of the medical field on a variety of topics from smoking to statin use to vaccines[7]; and

Whereas, Misinformation is introduced on various social media platforms such as Twitter and Facebook by many sources including foreign intelligence agencies, politicians, and news sites,[2]; and

Whereas, Seventy-two percent of US adults looked online for health information in 2013[5,6]; and

Whereas, It was found that misinformation propagated significantly faster and more broadly than did accurate information than could be spread by individual researchers and physicians[3,4,9];and Whereas, During the 2015 Zika epidemic, 50% of top 10 new stories contained medical misinformation and were three times more likely to be shared than were verified stories[3,4]; and

Whereas, Parents who use the internet as a source of vaccine information are 1.75 times more likely to not view the CDC as a good or excellent source of vaccine information, and 1.69 times

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more likely to not view a health-care provider's advice as a good or excellent source of vaccine information[5,6,14]; and

Whereas, Bots are automated programs that can communicate at least partially autonomously on social media, often with the task of influencing the course of a discussion. Bots can also be utilized in bot networks, where a large group of bots are controlled by a user for a specific purpose[15]; and

Whereas, Although bots are capable of being used for positive purposes, malicious use of bots plays a critical role in amplifying the presence of low-credibility sources online, and bot networks designed to spread medical misinformation, including on vaccines, were found on Twitter, a social media platform that serves as one of the biggest sources of medical misinformation[6,8,9]; and

Whereas, In the hands of a malicious user, bots can be used to manufacture a false consensus to make an idea seem popular, cement polarization over an issue or agenda, increase chaos and confusion through the distribution of inaccurate information and rumors, and manipulate the algorithms used by social media platforms to recommend certain topics and viewpoints[15]; and

Whereas, Bots have been used on social media to erode public consensus on vaccination and other health measures such as masks[6,10]; and

Whereas, Bots comprise 6% of Twitter accounts and for the spread of 34% of all articles from low-credibility sources on Twitter[8]; and

Whereas, Public health research has focused on combating online antivaccine content instead of the sources of this content[6]; and

Whereas, More research is needed to understand who is most vulnerable to medical misinformation, and the socio-demographic and ideological motives to spread misinformation[11]; and

Whereas, While a current method of controlling bots is to identify them and ban them from social media, this is a field still in its nascency, and therefore unlikely to be a reliable tool for bot suppression, especially due to recent developments in bots that allow them to utilize artificial intelligence to make comments that appear to be written by a human. In addition, attempting to directly ban bots that pretend to be users may be seen by some as an attempt at censorship, putting credibility and public image at risk[9,12,15]; and

Whereas, Bots have been developed by the World Health Organization and others to spread instant and accurate information about COVID-19 on social media[13]; and

Whereas, In addition to combating medical misinformation, future bots may be able to assist in medication adherence, scheduling appointments, and issuing reminders[13]; therefore be it

RESOLVED, That our AMA recognize the disproportionately large impact bots, automated programs that are used to amplify ideas, movements or people on social media, have on the propagation of healthcare misinformation;

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RESOLVED, That our AMA recognize the benefit of combating this vector of misinformation by supporting research on the ethicality and viability of automated systems such as bots to distribute accurate medical information to educate the public.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

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An Urgent Initiative to Support COVID-19 Vaccination Programs D-440.921
Our AMA will institute a program to promote the integrity of a COVID-19 vaccination program by: (1) educating physicians on speaking with patients about COVID-19 vaccination, bearing in mind the historical context of "experimentation" with vaccines and other medication in communities of color, and providing physicians with culturally appropriate patient education materials; (2) educating the public about the safety and efficacy of COVID-19 vaccines, by countering misinformation and building public confidence; (3) forming a coalition of health care and public health organizations inclusive of those respected in communities of color committed to developing and implementing a joint public education program promoting the facts about, promoting the need for, and encouraging the acceptance of COVID-19 vaccination; and (4) supporting ongoing monitoring of COVID-19 vaccines to ensure that the evidence continues to support safe and effective use of vaccines among recommended populations.
(Res. 408, I-20; Reaffirmed: Res. 228, A-21)

Medical and Public Health Misinformation in the Age of Social Media D-440.915
Our AMA: (1) encourages social media companies and organizations to further strengthen their content moderation policies related to medical and public health misinformation, including, but not limited to enhanced content monitoring, augmentation of recommendation engines focused on false information, and stronger integration of verified health information; (2) encourages social media companies and organizations to recognize the spread of medical and public health misinformation over dissemination networks and collaborate with relevant stakeholders to address this problem as appropriate, including but not limited to altering underlying network dynamics or redesigning platform algorithms; (3) will continue to support the dissemination of accurate medical and public health information by public health organizations and health policy experts; and (4) will work with public health agencies in an effort to establish relationships with journalists and news agencies to enhance the public reach in disseminating accurate medical and public health information.
(Res. 421, A-21)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 48
(N-21)

Introduced by: Haley Nadone, Sunil Sathappan, Kendahl Servino University of Nevada, Reno School of Medicine

Sponsored by: Region 1, PsychSIGN

Subject: End Firearm Default Proceed Sales

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, The default proceed sale of firearms allows a federally licensed firearm dealer to sell a gun without background check findings if the Federal Bureau of Investigation (FBI) fails to deliver a decision within 3 business from the initial inquiry[1]; and

Whereas, People whose federal background checks span greater than 3 business days are 4 times more likely to be turned down when purchasing a firearm[2] ; and

Whereas, 10% of all federal background checks are delayed (take more than 3 business days to complete), with 3% delayed longer than 3 days [3]; and

Whereas, In 2020, greater than 438,000 background checks were thrown out before completion, doubling the number from 2019[8]; and

Whereas, As of 2021, the default sales of guns has enabled 75,000 prohibited persons to obtain a firearm since 1998[4]; and

Whereas, When the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) was able to finish completing a background check on those who received a default sale of a firearm, almost 25% of those were found to be ineligible for firearm purchase according to the FBI[5]; and

Whereas, Firearms purchasers who are involved in a default proceed sale are 8 times more likely to be an ineligible buyer[6]; and

Whereas, A 2016 report by the Government Accountability Office found that domestic violence flags on background checks have a greater completion timeframe[2]; and

Whereas, Between 2006 and 2015, 18,000 people who were prohibited legally to purchase a firearm due to domestic violence charges were able to purchase a gun since it took the FBI greater than 3 business days to complete the background checks[2]; and

Whereas, Domestic violence assaults involving a firearm are 12 times more likely to result in death then non-firearm-associated assaults[10]; and

Whereas, The default proceed sale on guns (now deemed the “Charleston Loophole”) enabled a gunman to obtain a firearm, which was purposed to murder 9 and injure 3 individuals at the

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Emanuel African Methodist Episcopal Church in Charleston, South Carolina during a Bible study in June 2015[7]; and

Whereas, The Charleston Loophole allowed close to 3,000 firearms to be sold to people with criminal records and other disqualifying characteristics in 2019, a number which was doubled in 2020 [7,8]; and

Whereas, In a 2013 study done following the Sandy Hook school shooting, 76.3% of Americans support the policy of extending the timeframe given to law enforcement to conduct background checks to 5 days[9]; and

Whereas, In 2018, there were 39,740 firearm deaths— 24,432 were suicides (about half of all suicides) and 13,958 were homicides[11]; and

Whereas, Greater than 200 Americans are killed or injured by a gun daily[12]; and

Whereas, As of September 2021, 31,000 people have been killed by gun violence in this year alone[13]; therefore be it

RESOLVED, That our AMA advocate cessation of the default proceed sales of firearms; and be it further

RESOLVED, That our AMA advocate extending the background check review period; and be it further

RESOLVED, That our AMA advocate requiring individuals to wait until a background check is finished before obtaining a firearm purchase.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

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.
(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)

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.
(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.

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(Res. 171, A-89; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation: A-07; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation: A-07; Reaffirmed: BOT Rep. 22, A-17; Reaffirmation: A-18)

Gun Regulation H-145.999
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)

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.
(CSAPH Rep. 04, A-18; Reaffirmed: BOT Rep. 11, I-18)

Strengthening our Gun Policies on Background Checks and the Mentally Ill 145.013MSS
AMA-MSS (1) supports strengthening of the National Instant Criminal Background CheckSystem (NICS) and encourages states to mandate reporting patients with mental illnesses who pose a risk to themselves or others so that their gun licenses can be suspended and their firearms removed until they are deemed fit; (2) encourages the use of smart gun technology on all firearms so that only the lawful owner can discharge a weapon; and (3) supports universal background checks for people buying guns through any medium. (MSS Res 18, A-13) (Reaffirmed: MSS GC Rep A, I-19)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 49
(N-21)

Introduced by: Sarah Costello, Bradley Fleming, University of Iowa Carver College of Medicine; Addie Netsanet, University of Colorado School of Medicine; Tara Shelby, Keck School of Medicine of USC; Kimberly Hernandez, CUNY School of Medicine-New York; Revati Gummaluri, Rowan University School of Osteopathic Medicine-Stratford; Alexandra Conry, Madeline Holt University of South Carolina School of Medicine Greenville; Meghna Peesapati, Marian University College of Osteopathic Medicine; Medha Reddy, New York Medical College; Rozena Shirvani, University of Texas Rio Grande Valley School of Medicine-Harlingen

Sponsored by: Region 3, Region 4, Region 5

Subject: Amend AMA Policy D-35.989, Midwifery Scope of Practice and Licensure to Support Licensing for Midwives whose Education Meets International Confederation of Midwives' Global Standards for Midwifery Education

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, In 2011, The International Confederation of Midwives (ICM) developed there Global Standards for Midwifery Regulation in response to requests globally from midwives, midwifery associations, governments, UN Agencies and other stakeholders, to promote regulatory mechanisms that protect the public (women and families) by ensuring that safe and competent midwives provide high standards of midwifery care to every woman and baby[1]; and

Whereas, ICM Global Standards for Midwifery Regulation provide framework for countries to ensure that all people claiming the title of "midwife" meet ICM's "International Definition of the Midwife" and "Global Standards for Midwifery Education," which describes minimum competencies in midwifery education and practice[1]; and

Whereas, In 2014, in the interest of public health and safety, the American College of Obstetricians and Gynecologists (ACOG) and American College of Nurse Midwives (ACNM) endorsed implementation of ICM Global Standards for Midwifery Regulation[2,3]; and

Whereas, In the US, there are three types of credentialed midwives who attend out-of-hospital births; including Certified Nurse Midwives (CNM), Certified Professional Midwives (CPM) and Certified Midwives (CM)[4]; and

Whereas, CNMs attain degrees in nursing and graduate level degrees in midwifery from programs accredited by the Accreditation Commission for Midwifery Education (ACME), to practice in any birth setting, with most practicing in hospitals, and are certified through the American Midwifery Certification Board (AMCB)[5]; and

Whereas, CMs are educated in the discipline of midwifery, earn graduate degrees, meet health and science education requirements, complete a midwifery education program accredited by

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ACME, and pass the same national certification examination as CNMs to receive the professional designation of CM and practice similar to CNMs[5]; and

Whereas, CPMs primarily provide out-of-hospital midwifery care (home births and community birth centers) and are the only type of midwives that absolutely require knowledge and experience about out-of-hospital midwifery[6]; and

Whereas, CPMs are certified by the North American Registry of Midwives (NARM) and must meet specific educational criteria before taking an exam to gain the CPM credential[7]; and

Whereas, Those seeking CPM certification through NARM can meet the education criteria in by various routes, including apprenticeship based training or graduation from educational programs accredited by the Midwifery Education Accreditation Council (MEAC)[7]; and

Whereas, MEAC and AMCB are both organization recognized by the U.S. Department of Education (USDE)[6]; and

Whereas, All midwives graduating from CNM, CM, and CPM programs accredited by AMCB or MEAC share similar competencies and meet requirements for ICM Global Standards for Midwifery Regulation, including ICM's "International Definition of the Midwife" and "Global Standards for Midwifery Education"[4,8,9]; and

Whereas, CPMs who did not graduate from a MEAC accredited program may complete the Midwifery Bridge Certificate, issued by NARM, based on the completion of 50 hours of accredited continuing education specific to content in emergency skills for pregnancy and birth, and newborn care, along with other midwifery topics addressing the core competencies of the ICM[6,10;] and

Whereas, Non-credentialed midwives and CPM midwives who did not graduate from a MEAC accredited program or obtain the Midwifery Bridge Certificate do not meet requirements for ICM Global Standards for Midwifery Regulation, including ICM's "International Definition of the Midwife" and "Global Standards for Midwifery Education"[8.9]; and

Whereas, In 2017, the National Center for Health Statistics reported 1 of every 62 births in the US was an out-of-hospital birth (1.61%), increasing from 35,578 out-of-hospital births in 2004 to 62,228 in 2017[11]; and

Whereas, Only two categories of midwife data are collected by the National Center for Health Statistic birth certificate: CNM/CM and non-CNM/CM, with non-CNM/CM including any other type of midwife besides CNM/CM, such as a CPM and non-credentialed (traditional) midwives"[11] ; and

Whereas, According to the National Center for Health Statistics, 34.1% of out-of-hospital births were attended by CNM/CM and 41.2% were attended by non-CNM/CM in 2017[11]; and

Whereas, Despite the increasing rate of out-of-hospital births and the development of the ICM Global Standards for midwifery regulation in 2011, there is no national standard in the United States (US) for midwifery regulation[6,12]; and

Whereas, CNMs are licensed and regulated under in all 50 states and District of Columbia, however CPM and CM regulation and licensing varies state-by-state depending on state

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legislation which can be influenced by state and national medical societies policies on midwifery licensing and scope of practice, with CPMs licensed in 36 states and CM licensed in 6 states[12,13,14]; and

Whereas, Considering the lack of US regulation standards for midwives, state midwifery licensure represents a way to ensure that people claiming to be midwives meet the "International Definition of the Midwife" and "Global Standards for Midwifery Education"[8.9]; and

Whereas, ACOG supports women having an informed choice in determining their care providers[3]; and

Whereas, Regulation and integration of CNMs, CMs, and CPMs into the healthcare system ensures minimum requirements for midwifery competency and education, the ability of midwives to function autonomously to their full scope of practice in community settings and improved interprofessional collaboration, particularly in situations where complications arise and transfer to a hospital is necessary[12]; and

Whereas, The best outcomes for mothers and babies occur in states where CNMs, CMs, and CPMs are regulated and integrated into the healthcare system, including higher rates of spontaneous vaginal birth, VBAC and breastfeeding at birth and at six months, as well as lower rates of obstetric interventions, preterm birth, low birth weight infants, and neonatal death.[12]; and

Whereas, In the 14 US states with no CPM regulation by state licensing board including, Iowa, Illinois, Georgia, Maryland, Connecticut, North Carolina, North Dakota, Nevada, Ohio, Nebraska, Pennsylvania, West Virginia, Kansas, and Mississippi as well as in three U.S. Territories, Puerto Rico, Guam, and the US Virgin Islands, women seeking out-of-hospital births attended by a CPM have no way to ensure that potential midwives have minimum competencies and education consistent with the ICMs Global Standards, physicians lack the knowledge and resources to effectively advise patients seeking out-of-hospital birth, and midwives who are not licensed are less likely to have a relationship with a transferring hospital or physician in the event of complications[12,13,14] ; and

Whereas, In the above mentioned 14 states, as well as in three U.S. Territories, Puerto Rico, Guam, and the US Virgin Islands, CPMs are at risk of criminal prosecution for practicing medicine or nursing without a license, which drives the practice of midwifery underground and creates barriers to access for women seeking maternity care[13]; and

Whereas, Black mothers are four times as likely to die from maternity-related complications than white mothers in the United States[15]; and

Whereas, Community-based models such as midwifery-led freestanding birth centers, home births attended by qualified midwives, and community-based doula care, have been identified as a potential way to address disparities and inequities in maternal health and provide an alternative to traditional hospital maternity care[12,15, 16,17]; and

Whereas, The altered hospital care, the real and/or perceived risks associated with the hospital, and the increased visibility of community midwives, resulting from the COVID-19 pandemic has reveal that the U.S. needs community midwives' previously undervalued skills[18]; and

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Whereas, Current AMA policy D-35.989 was implemented in 2008, prior to ACOGs endorsement of ICM Global regulatory standards in 2014, consequently it only advocates for licensure of midwives who are certified by American College of Nurse-Midwives (now AMCB), including CMNs and CMs, but leaves licensing and regulation of CPMs who graduated from MEAC accredited programs or completed the Midwifery Bridge Certificate unsupported and indistinguishable from other non-CNM/CMs who may not meet ICM requirements[15]; and therefore be it

RESOLVED, That our AMA will support licensing for midwives whose education meets International Confederation of Midwives' Global Standards for Midwifery Education by amending Policy D-35.989, Midwifery Scope of Practice and Licensure, by addition and deletion to read as follows:

> **Midwifery Scope of Practice and Licensure, D-35.989:** Our AMA will: (1) only advocate in legislative and regulatory arenas for the licensing of midwives ~~who are certified by the American College of Nurse-Midwives~~ <u>whose education meets International Confederation of Midwives' Global Standards for Midwifery Education</u>; (2) support state legislation regarding appropriate physician and regulatory oversight of midwifery practice, under the jurisdiction of state nursing and/or medical boards; (3) continue to monitor state legislative activities regarding the licensure and scope of practice of midwives; and (4) work with state medical societies and interested specialty societies to advocate in the interest of safeguarding maternal and neonatal health regarding the licensure and the scope of practice of midwives.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

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

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(1) only advocate in legislative and regulatory arenas for the licensing of midwives who are certified by the American College of Nurse-Midwives;
(2) support state legislation regarding appropriate physician and regulatory oversight of midwifery practice, under the jurisdiction of state nursing and/or medical boards;
(3) continue to monitor state legislative activities regarding the licensure and scope of practice of midwives; and
(4) work with state medical societies and interested specialty societies to advocate in the interest of safeguarding maternal and neonatal health regarding the licensure and the scope of practice of midwives.
(Res. 204, A-08; Reaffirmed: BOT Rep. 09, A-18)

Code of Medical Ethics Opinion 10.5
Physicians often practice in concert with optometrists, nurse anesthetists, nurse midwives, and other allied health professionals. Although physicians have overall responsibility for the quality of care that patients receive, allied health professionals have training and expertise that complements physicians'. With physicians, allied health professionals share a common commitment to patient well-being.

In light of this shared commitment, physicians' relationships with allied health professionals should be based on mutual respect and trust. It is ethically appropriate for physicians to:

Help support high quality education that is complementary to medical training, including by teaching in recognized schools for allied health professionals.
Work in consultation with or employ appropriately trained and credentialed allied health professionals.
Delegate provision of medical services to an appropriately trained and credentialed allied health professional within the individual's scope of practice.
(Issued: 2016)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 50
(N-21)

Introduced by:	Aparna Kanjhlia, Shefali Jain, Medical College of Georgia; Sanjana Satish, University of Miami Miller Medical School
Sponsored by:	Region 2, Region 4, PsychSIGN
Subject:	Encouraging Research of Testosterone and Pharmacological Therapies for Post-Menopausal Individuals with Decreased Libido
Referred to:	MSS Reference Committee (Zachary Dunton and Neha Siddiqui, Chair)

Whereas, The most recent epidemiological research shows that approximately 40% of women in the United States have sexual concerns, with 12% reporting distressing sexual problems[1]; and

Whereas, It is estimated that 1.2 billion women worldwide will be menopausal or postmenopausal by the year 2030[2]; and

Whereas, Sexual dysfunction in women can manifest in a number of ways, such as impaired arousal, inability to achieve orgasm, pain with sexual activity, or HSDD, which is defined as a deficiency or absence of sexual fantasies and desire for sexual activity that may cause personal distress or interpersonal difficulty[1,3]; and

Whereas, Decreased libido in women is currently evaluated and treated using the biopsychosocial model to account for biological, psychological, interpersonal, and sociocultural factors, yet some women may have decreased libido that is refractory to standard treatments[1,4]; and

Whereas, Testosterone plays a key role in maintaining libido in women, as evidenced by numerous studies that show testosterone significantly improves various aspects of libido in androgen-deficient, premenopausal, naturally post-menopausal, and surgically post-menopausal women, and testosterone levels in postmenopausal women are 50% lower compared to premenopausal women[5-10]; and

Whereas, A large meta-analysis, comprised of 43 articles, 36 randomized controlled trials, and 8480 naturally or surgically post-menopausal women monitored for at least 12 weeks, indicated that use of testosterone significantly increased various aspects of sexual function such as sexual frequency, sexual desire, pleasure, and orgasms, irrespective of concurrent use estrogens, with no statistically significant increase in adverse events[11-13]; and

Whereas, A double-blinded, placebo-controlled clinical trial with 53 postmenopausal women with low libido who were given 10 milligrams of testosterone gel for three months, in addition to their ongoing hormone replacement therapy, did not show any significant adverse effects and showed a positive effect on psychological well-being[6]; and

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Whereas, Doses of testosterone therapy that approximate physiologically premenopausal concentrations in postmenopausal women have been associated with mild increase in acne, body and facial hair growth but not with hair loss, clitoromegaly or changes in voice, but safety data is not available beyond 24 months and further studies are needed to evaluate potential long-term adverse effects[13,14]; and

Whereas, The effective dosage of testosterone for postmenopausal women has not been elucidated, as a study of 71 surgically menopausal women suggested that positive change in sexual function is achieved only with supraphysiologic dosing 12, while in 2019, a group of experts from leading women's health societies worldwide published a consensus statement supporting the benefit of testosterone therapy in doses that approximate physiologic concentrations in premenopausal women[14,15]; and

Whereas, Clinical practice guidelines published by the Endocrine Society and the American College of Obstetricians and Gynecologists recommend a 3 to 6 month trial of testosterone therapy for postmenopausal women with a diagnosis of HSDD, with close monitoring for overuse and cessation of therapy if unresponsive after 6 months, but no current United States Food & Drug Administration (FDA) approved testosterone treatments exist for women with HSDD[16]; and

Whereas, Compounded and off-label medications such as flibanserin and Bremelanotide have been prescribed for many years for both men and women who want to boost levels of sexual desire, arousal, and orgasm, these two medications received FDA approval for use in pre-menopausal women only, in 2015 and 2019 respectively[17]; and

Whereas, Although there are many FDA-approved testosterone preparations for men, and internationally accepted use of testosterone products in women, none are currently approved for women in the United States, further highlighting gender biases in healthcare and medical research that are evident from the incomplete understanding of pathophysiology of women's sexual response and its treatment[13,18]; and

Whereas, As evidenced by Code of Ethics 8.5 clause (i) the AMA supports "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;" and

Whereas, Due to the lack of FDA-approved medications for treating decreased libido in postmenopausal women, physicians are often reluctant to prescribe medications unless prompted by the patient and are forced to resort to modifying androgen formulations created for men, which can make dosing difficult when using these preparations for postmenopausal women[17,18]; and

Whereas, Compounded or off-label medications like Bremelanotide and fibanserin are expensive for patients as they are not covered by insurance or available at discounted rates, leaving many postmenopausal women to live with HSDD[17]; therefore be it

RESOLVED, That our AMA encourage expansion of research on the use of testosterone therapy and other pharmacological interventions in treatment of decreased libido in postmenopausal individuals.

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Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

Code of Medical Ethics 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.

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(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

Principles for the Implementation of clinical practice guidelines at the Local/State/Regional Level H-410.980
Our AMA has adopted the following principles regarding the implementation of clinical practice guidelines at the local/state/regional level: (1) Relevant physician organizations and interested physicians shall have an opportunity for input/comment on all issues related to the local/state/regional implementation of clinical practice guidelines, including: issue identification; issue refinement, identification of relevant clinical practice guidelines, evaluation of clinical practice guidelines, selection and modification of clinical practice guidelines, implementation of clinical practice guidelines, evaluation of impact of implementation of clinical practice guidelines, periodic review of clinical practice guideline recommendations, and justifications for departure from clinical practice guidelines..

(2) Effective mechanisms shall be established to ensure opportunity for appropriate input by relevant physician organizations and interested physicians on all issues related to the local/state/regional implementation of clinical practice guidelines, including: effective physician notice prior to implementation, with adequate opportunity for comment; and an adequate phase-in period prior to implementation for educational purposes.

(3) clinical practice guidelines that are selected for implementation at the local/state/regional level shall be limited to practice parameters that conform to established principles, including relevant AMA policy on practice parameters.

(4) Prioritization of issues for local/state/regional implementation of clinical practice guidelines shall be based on various factors, including: availability of relevant and high quality practice parameter(s), significant variation in practice and/or outcomes, prevalence of disease/illness, quality considerations, resource consumption/cost issues, and professional liability considerations.

(5) clinical practice guidelines shall be used in a manner that is consistent with AMA policy and with their sponsors' explanations of the appropriate uses of their clinical practice guidelines, including their disclaimers to prevent inappropriate use.

(6) clinical practice guidelines shall be adapted at the local/state/regional level, as appropriate, to account for local/state/regional factors, including demographic variations, patient case mix, availability of resources, and relevant scientific and clinical information.

(7) clinical practice guidelines implemented at the local/state/regional level shall acknowledge the ability of physicians to depart from the recommendations in clinical practice guidelines, when appropriate, in the care of individual patients.

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(8) The AMA and other relevant physician organizations should develop principles to assist physicians in appropriate documentation of their adherence to, or appropriate departure from, clinical practice guidelines implemented at the local/state/regional level.

(9) clinical practice guidelines, with adequate explanation of their intended purpose(s) and uses other than patient care, shall be widely disseminated to physicians who will be impacted by the clinical practice guidelines.

(10) Information on the impact of clinical practice guidelines at the local/state/regional level shall be collected and reported by appropriate medical organizations.

Decreasing Sex and Gender Disparities in Health Outcomes 525.007MSS
AMA-MSS will ask the AMA to (1) promote the use of health care guidelines, protocols, and decision support tools that identify existing sex and gender differences and disparities in health care; and (2) encourage the use of guidelines, and treatment protocols, and decision support tools specific to biological sex for conditions in which physiologic and pathophysiologic differences exist between sexes. (MSS Res 62-I-17)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 51
(N-21)

Introduced by: Lavanya Easwaran, Rhiya Mittal, University of Miami, Aaisha Gulani, University of Central Florida, Elora Friar, Florida State University

Sponsored by: Region 4

Subject: Amending Policy H-50.973 to Support the Implementation of Health Care Referrals in Blood Donation Centers for Donors at Risk for HIV

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, Current Food and Drug Administration (FDA) guidelines require men who have sex with men (MSM) abstain from all sexual contact for at least three months before being permitted to donate blood known as a deferral period[1]; and

Whereas, The FDA also requires a three month deferral period for women who have sex with MSM[1]; and

Whereas, In a study, the donor health questionnaire (DHQ) that assesses MSM activity was found to create deferral rates that are disproportionately high in relation to the incidence of disease, indicating the questionnaire's low sensitivity for positive disease screenings[2]; and

Whereas, Another study showed that to prevent one case of HIV transmission through blood donation, 300,000 to 600,000 potential donors had to be deferred based on their answers to the MSM activity question in the DHQ, indicating an extremely low positive predictive value[2]; and

Whereas, 26.7% of respondents to a survey about blood donation acknowledged that they did not disclose their deferral status as MSM when donating blood[3]; and

Whereas, Spain utilizes physicians to conduct risk assessments of donors, which allows for more accurate assessment of patient risk versus non-physician screening assessments[4]; and

Whereas, LGBTQ+ populations are at higher risk for STIs, cardiovascular disease, cancers, substance abuse, obesity, bullying, and mental illness than the general public[5]; and

Whereas, Blood donation counseling is an important tool for early diagnosis of medical conditions such as anemia or blood borne infections[6]; and

Whereas, Many blood donation centers do not have the infrastructure to provide effective blood donation counseling, while others do not consider counseling to be part of providing a quality service to donors[6]; and

Whereas, The guidelines for donor counseling developed by the World Health Organization and the International Federation of Red Cross and Red Cross Societies indicate that referrals for

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testing and treatment of infectious diseases are critical but do not provide standardized ways to implement this in individual donation centers[7]; and

Whereas, The AMA Code of Ethics policy 8.1 Routine Universal Screening for HIV states that "routine universal screening of adult patients for HIV helps promote the welfare of individual patients, avoid injury to third parties, and protect public health",

Whereas, Early detection and treatment of conditions such as HIV has shown to have better outcomes for patients[8]; and

Whereas, Successful early detection of HIV requires a patient's ability to pursue appropriate diagnostic testing when deemed high-risk by a blood donation center[9]; and

Whereas, AMA policy HIV Testing H-20.920 states that "full pre-test and post-test counseling procedures must be utilized for patients when... a history of high-risk behavior is present";

Whereas, Early detection of HIV allows for initiation of antiretroviral therapy during earlier stages of HIV infection markedly decreases the viral load in the patient, leading to slower disease progression, and possibly preventing progression to Acquired Immunodeficiency Syndrome (AIDS)[10];

Whereas, If identified early, individuals who are at high risk for HIV have a 99% chance of preventing HIV infection if given pre-exposure prophylaxis (PrEP)[11]; therefore be it

RESOLVED, That our AMA amend policy H-50.973, "Blood Donor Deferral Criteria" by addition and deletion, to read as follows:

> **Blood Donor Deferral Criteria, H-50.973**
> Our AMA: (1) supports the use of rational, scientifically-based blood and tissue donation deferral periods that are fairly and consistently applied to donors according to their individual risk; (2) opposes all policies on deferral of blood and tissue donations that are not based on evidence; (3) supports a blood donation deferral period for those determined to be at risk for transmission of HIV that is representative of current HIV testing technology; ~~and~~ (4) supports research into individual risk assessment criteria for blood donation; and (5) supports referrals for those deemed to be at high risk via individual risk assessment for HIV transmission to healthcare organizations for testing and treatment.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

Blood Donor Deferral Criteria, H-50.973

Our AMA: (1) supports the use of rational, scientifically-based blood and tissue donation deferral periods that are fairly and consistently applied to donors according to their individual risk; (2) opposes all policies on deferral of blood and tissue donations that are not based on evidence; (3) supports a blood donation deferral period for those determined to be at risk for transmission of HIV that is representative of current HIV testing technology; and (4) supports research into individual risk assessment criteria for blood donation.
Res. 514, A-13 Modified: Res. 008, I-16 Modified: Res. 522, A-19

Blood Donor Deferral Criteria Revisions H-50.972

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Our AMA will advocate for the elimination of current deferral policy and ask the Food and Drug Administration to develop recommendations for individual risk assessment during the public commentary period.
Res. 008, I-16

Routine HIV Screening D-20.992

Our AMA: (1) supports HIV screening policies which include: (a) routine HIV screening of adolescents and adults ages 13-64 and sexually active adults over 65, (b) patients receive an HIV test as a part of General Medical Consent for medical care with option to specifically decline the test, and (c) patients who test positive for HIV receive prompt counseling and treatment as a vital part of screening; (2) supports that the frequency of repeat HIV screening be determined based on physician clinical judgment and consideration of identified risks and prevalent community experience; (3) supports the Centers for Disease Control and Prevention's (CDC) 2006 Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Health Care Settings; (4) will continue to work with the CDC to implement the revised recommendations for HIV testing of adults, adolescents and pregnant women in health care settings, including exploring the publication of a guide on the use of rapid HIV testing in primary care settings; (5) will identify legal and funding barriers to the implementation of the CDC's HIV testing recommendations and develop strategies to overcome these barriers; (6) will publicize its newly adopted HIV screening policies via its existing professional electronic and print publications and to the public via news releases and commentaries to major media outlets; and (7) will formally request all public and private insurance plans to pay the cost of routine HIV screening testing of all insured individuals who receive routine HIV testing in accordance with new recommendations.
CSAPH Rep. 2, I-06 Modified: Res. 927, I-10 Reaffirmation I-13

8.1 Routine Universal Screening for HIV

Physicians' primary ethical obligation is to their individual patients. However, physicians also have a long-recognized responsibility to participate in activities to protect and promote the health of the public. Routine universal screening of adult patients for HIV helps promote the welfare of individual patients, avoid injury to third parties, and protect public health.

Medical and social advances have enhanced the benefits of knowing one's HIV status and at the same time have minimized the need for specific written informed consent prior to HIV testing. Nonetheless, the ethical tenets of respect for autonomy and informed consent require that physicians continue to seek patients' informed consent, including informed refusal of HIV testing.

To protect the welfare and interests of individual patients and fulfill their public health obligations in the context of HIV, physicians should:

(a) Support routine, universal screening of adult patients for HIV with opt-out provisions.

(b) Make efforts to persuade reluctant patients to be screened, including explaining potential benefits to the patient and to the patient's close contacts.

(c) Continue to uphold respect for autonomy by respecting a patient's informed decision to opt out.

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(d) Test patients without prior consent only in limited cases in which the harms to individual autonomy are offset by significant benefits to known third parties, such as testing to protect occupationally exposed health care professionals or patients.

(e) Work to ensure that patients who are identified as HIV positive receive appropriate follow-up care and counseling.

(f) Attempt to persuade patients who are identified as HIV positive to cease endangering others.

(g) Be aware of and adhere to state and local guidelines regarding public health reporting and disclosure of HIV status when a patient who is identified as HIV positive poses significant risk of infecting an identifiable third party. The doctor may, if permitted, notify the endangered third party without revealing the identity of the source person.

(h) Safeguard the confidentiality of patient information to the greatest extent possible when required to report HIV status.

AMA Principles of Medical Ethics: I,VI,VII
Issued: 2016

HIV Testing H-20.899

Our AMA endorses routine HIV screening/testing for individuals on admission to the hospital, visit to the emergency room or doctor's office as deemed appropriate by the attending physician. It is AMA policy that: (1) this testing should be a voluntary program in which patients may opt out if they desire not to be tested; (2) HIV screening permission be incorporated into general health care consent forms and that separate written consent is not recommended; (3) prevention counseling should not be a requirement for this testing program; (4) when tests are positive, appropriate public health measures be instituted for surveillance, prevention of transmission and dissemination of the virus; and (5) when positive HIV patients are identified, appropriate linkage to HIV care be established.
Res. 2, A-07 Reaffirmation I-13

HIV Testing H-20.920

(1) General Considerations
a) Persons who suspect that they have been exposed to HIV should be tested so that appropriate treatment and counseling can begin for those who are seropositive;
b) HIV testing should be consistent with testing for other infections and communicable diseases;
c) HIV testing should be readily available to all who wish to be tested, including having available sites for confidential testing;
d) The physician's office and other medical settings are the preferred settings in which to provide HIV testing;
e) Physicians should work to make HIV counseling and testing more readily available in medical settings.

(2) Informed Consent Before HIV Testing
a) Our AMA supports the standard that individuals should knowingly and willingly give consent before a voluntary HIV test is conducted, in a manner that is the least burdensome to the

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individual and to those administering the test. Physicians must be aware that most states have enacted laws requiring informed consent before HIV testing;
b) Informed consent should include the following information: (i) patient option to receive more information and/or counseling before deciding whether or not to be tested and (ii) the patient should not be denied treatment if he or she refuses HIV testing, unless knowledge of HIV status is vital to provide appropriate treatment; in this instance, the physician may refer the patient to another physician for care;
c) It is the policy of our AMA to review the federal laws including the Veteran's Benefits and Services Act, which currently mandates prior written informed consent for HIV testing within the Veterans Administration hospital system, and subsequently to initiate and support amendments allowing for HIV testing without prior consent in the event that a health care provider is involved in accidental puncture injury or mucosal contact by fluids potentially infected with HIV in federally operated health care facilities;
d) Our AMA supports working with various state societies to delete legal requirements for consent to medically indicated HIV testing that are more extensive than requirements generally imposed for informed consent to medical care.

(3) HIV Testing Without Explicit Consent
a) Explicit consent should not always be required prior to HIV testing. Physicians should be allowed, without explicit informed consent, and as indicated by their medical judgment, to perform diagnostic testing for determination of HIV status of patients suspected of having HIV infection;
b) General consent for treatment of patients in the hospital should be accepted as adequate consent for the performance of HIV testing;
c) Model state and federal legislation should be developed to permit physicians, without explicit informed consent and as indicated by their medical judgment, to perform diagnostic testing for determination of HIV status of patients suspected of having HIV infection;
d) Our AMA will work with the Centers for Disease Control and Prevention, the American Hospital Association, the Federation, and other appropriate groups to draft and promote the adoption of model state legislation and hospital staff guidelines to allow HIV testing of a patient maintaining privacy, but without explicit consent, where a health care worker has been placed at risk by exposure to potentially infected body fluids; and to allow HIV testing, without any consent, where a health care worker has been placed at risk by exposure to body fluids of a deceased patient.

(4) HIV Testing Procedures
a) Appropriate medical organizations should establish rigorous proficiency testing and quality control procedures for HIV testing laboratories on a frequent and regular basis;
b) Physicians and laboratories should review their procedures to assure that HIV testing conforms to standards that will produce the highest level of accuracy;
c) Appropriate medical organizations should establish a policy that results from a single unconfirmed positive ELISA test never be reported to the patient as a valid indication of HIV infection;
d) Appropriate medical organizations should establish a policy that laboratories specify the HIV tests performed and the criteria used for positive, negative, and indeterminate test results;
e) Our AMA recommends that training for HIV blood test counselors encourage patients with an indeterminate Western blot to be advised that three-to-six-month follow-up specimens may need to be submitted to resolve their immune status. Because of the uncertain status of their contagiousness, it is prudent to counsel such patients as though they were seropositive until such time as the findings can be resolved.

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(5) Routine HIV Testing
a) Routine HIV testing should include appropriate informed consent and pre-test and post-test counseling procedures;
b) State medical associations should work to create state laws that encourage hospitals and other medical facilities to initiate routine HIV testing programs; and
c) Supports coverage of and appropriate reimbursement for routine HIV testing by all public and private payers.

(6) Opt-out HIV Testing
a) Opt-out HIV testing should be provided with informed consent for individuals who may have come into contact with the blood, semen, or vaginal secretions of an infected person in a manner that has been shown to transmit HIV infection. Such testing should be encouraged for patients for whom the physician's knowledge of the patient's serostatus would improve treatment. Opt-out HIV testing should be regularly provided for the following types of individuals who give an informed consent: (i) patients at sexually transmissible disease clinics; (ii) patients at drug abuse clinics; (iii) individuals who are from areas with a high incidence of AIDS or who engage in high-risk behavior and are seeking family planning services; and (iv) patients who are from areas with a high incidence of AIDS or who engage in high-risk behavior requiring surgical or other invasive procedures;
b) The prevalence of HIV infection in the community should be considered in determining the likelihood of infection. If opt-out HIV testing is not sufficiently accepted, the hospital and medical staff may consider requiring HIV testing.

(7) Mandatory HIV Testing
a) Our AMA opposes mandatory HIV testing of the general population;
b) Mandatory testing for HIV infection is recommended for (i) military personnel; (ii) donors of blood and blood fractions; breast milk; organs and other tissues intended for transplantation; and semen or ova for artificial conception;
c) All entrants into federal and state prisons should be offered HIV screening, but it should only be mandatory when risk factors are present;
d) Our AMA will review its policy on mandatory testing periodically to incorporate information from studies of the unintended consequences or unexpected benefits of HIV testing in special settings and circumstances.

(8) HIV Test Counseling
a) Pre-test and post-test voluntary counseling should be considered an integral and essential component of HIV testing. Full pre-test and post-test counseling procedures must be utilized for patients when HIV is the focus of the medical attention, when an individual presents to a physician with concerns about possible exposure to HIV, or when a history of high-risk behavior is present;
b) Post-test information and interpretation must be given for negative HIV test results. All negative results should be provided in a confidential manner accompanied by information in the form of a simple verbal or written report on the meaning of the results and the offer, directly or by referral, of appropriate counseling and potentially pre-exposure prophylaxis treatment;
c) Post-test counseling is required when HIV test results are positive. All positive results should be provided in a confidential face-to-face session by a professional properly trained in HIV post-test counseling and with sufficient time to address the patient's concerns about medical, social, and other consequences of HIV infection.

(9) HIV Testing of Health Care Workers

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a) Our AMA supports routine voluntary HIV testing of physicians, health care workers, and students in appropriate situations;
b) Employers of health care workers should provide, at the employer's expense, serologic testing for HIV infection to all health care workers who have documented occupational exposure to HIV;
c) Our AMA opposes HIV testing as a condition of hospital medical staff privileges;
d) Physicians and other health care workers who perform exposure-prone patient care procedures should know their immune or infection status with respect to HIV.

(10) Counseling and Testing of Pregnant Women for HIV
Our AMA supports the position that there should be universal HIV testing of all pregnant women, with patient notification of the right of refusal, as a routine component of perinatal care, and that such testing should be accompanied by basic counseling and awareness of appropriate treatment, if necessary. Patient notification should be consistent with the principles of informed consent.

(11) HIV Home Test Kits
a) Our AMA does not oppose HIV home collection test kits that are linked with proper laboratory testing and counseling services, provided their use does not impede public health efforts to control HIV disease;
b) Standardized data should be collected by HIV home collection test kit manufacturers and reported to public health agencies.

(12) College Students
Our AMA encourages undergraduate campuses to conduct confidential, free HIV testing with qualified staff and counselors.
CSA Rep. 4, A-03 Appended: Res. 515, A-06 Reaffirmed: BOT Rep. 1, A-07 Appended: Res. 506, A-10 Modified: CSAPH Rep. 01, A-20

50.003MSS Blood Donation by Men who have Sex with Men (MSM): AMA-MSS will ask the AMA to encourage the Food and Drug Administration to continue evaluation and monitoring of regulations on blood donation by men who have had sex with other men, and to consider making modifications to the current deferral policies if sufficient scientific evidence becomes available to support such a change. (MSS Rep A, I-01) (AMA Sub Res 401, A-02 Adopted [H-50.977]) (Reaffirmed: MSS Rep F, I-06)
AMA-MSS Digest of Policy Actions/ 15
(Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16) (Amended LGBTQ+ Affairs Report A, A-21)

50.004MSS Blood Donor Deferral Criteria Revisions: AMA-MSS will ask that our AMA (1) amend policy H-50.973 by addition and deletion to read as follows: Blood Donor Deferral Criteria H-50.973 AMA: (1) supports the use of rational, scientifically-based blood and tissue donation deferral periods that are fairly and consistently applied to donors according to their level of individual risk; and (2) opposes the current lifetime a deferral on blood and tissue donations from men who have sex with men not based in science; and (3) supports research into Individual Risk Assessment criteria for blood donation. ; and (2) advocate for the elimination of current deferral policy and ask the Food and Drug Administration to develop recommendations for Individual Risk Assessment during the public commentary period. (MSS Res 25, I-16 Immediate Transmittal) (HOD Res. 008, I-16)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 52
(N-21)

Introduced by: Albert Dickan, Bahareh Jabbari, Darby Keirns, Abigail Jones, Lauren Townson, Monica Reeson, Sydney Scheel, Connor Tupper, Creighton University School of Medicine; Mary Grace Kenny, Creighton University School of Medicine Phoenix Regional Campus

Sponsored by: PsychSIGN

Subject: Early Intervention and Treatment Programs for Adolescents with Substance Use Disorders

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, More than 1 million surveyed 12-17 year olds in the U.S. reported abusing alcohol or using substances sometime between 2018-2019[1, 2]; and

Whereas, Substance use is defined as misuse of prescription psychotherapeutics, or the use of marijuana, cocaine and crack, heroin, hallucinogens, inhalants, or methamphetamine[1]; and

Whereas, Overdose deaths from opioids has increased by 500% among adolescents aged 15-to 24-years-old in the past 20 years[2]; and

Whereas, Approximately 4% of teens in the United States were found to meet criteria for a substance use disorder (SUD) in 2017[3]; and

Whereas, Half of all adult mental health and SUDs present by fourteen years of age [4, 5]; and

Whereas, In comparison to children and adults, adolescents are more vulnerable to initiating substance use and progressing to problematic use[6]; and

Whereas, Alcohol and other substances have a more potent effect on adolescents in comparison to adults due to the incomplete development of the brain[7]; and

Whereas, Early substance use in adolescence affects proper brain development, interferes with decision-making, and promotes use into adulthood and potentiates addiction[8]; and

Whereas, Earlier initiation of substance use is associated with a higher burden of mental health disorders, physical illnesses, school-related problems and neurocognitive impairments[9,10,11]; and

Whereas, Mental and substance use disorders are collectively the leading cause of disability in children and adolescents[12]; and

Whereas, 7.8% of adolescents qualify as needing treatment or some form of intervention however only 1.4% of adolescents received any form of treatment for their SUD[13]; and

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Whereas, Recovery is an achievable outcome for this age group with continued care[14]; and

Whereas, Evidence suggests significant benefits to different approaches to treatment for adolescents with SUD when compared to adults with SUD[15,16]; and

Whereas, Harm reduction approaches were more effective when relevant to the unique social context of adolescent patients[17]; and

Whereas, There are differences in response to therapies in adolescence, such as a lower adherence to treatment[18]; and

Whereas, Still, less is known about treatment for youth with SUD than with adults and further research is needed[19]; and

Whereas, The addition of pharmacotherapy to the standard of care for SUD has been proposed in adults patients, however, there is limited data regarding the efficacy in the adolescent population[19]; and

Whereas, Current AMA policy (*H-95.975)* addresses general support for treatment and intervention of SUDs, but does not address the unique issues in this patient population; therefore be it

RESOLVED, That our AMA recognize SUD treatment options for adolescents must be distinct from programs designed to treat addiction in adults; and be it further

RESOLVED, That our AMA advocate for funding dedicated to research to establish best practices for developmentally appropriate rehabilitative treatment options specifically targeted for youth with SUD.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

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

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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.
(CSAPH Rep. 01, A-18; Reaffirmed: BOT Rep. 14, I-20)

Substance Use Disorders during Pregnancy, H-420.950
Our AMA will: (1) oppose any efforts to imply that the diagnosis of substance use disorder during pregnancy represents child abuse; (2) support legislative and other appropriate efforts for the expansion and improved access to evidence-based treatment for substance use disorders during pregnancy; (3) oppose the removal of infants from their mothers solely based on a single positive prenatal drug screen without appropriate evaluation; and (4) advocate for appropriate medical evaluation prior to the removal of a child, which takes into account (a) the desire to preserve the individual's family structure, (b) the patient's treatment status, and (c) current impairment status when substance use is suspected.
(Res. 209, A-18; Modified: Res. 520, A-19)

Harmful Substance Use, H-95.967
Our AMA encourages every physician to make a commitment to join his/her community in attempting to reduce harmful substance use and that said commitment encourage involvement in at least one of the following roles: (1) donation of time to talk to local civic groups, schools, religious institutions, and other appropriate groups about harmful substance use; (2) join or organize local groups dedicated to the prevention of harmful substance use; (3) talk to youth groups about brain damage and other deleterious effects of harmful substance use; and (4) educate and support legislators, office holders and local leaders about ways to end harmful substance use and providing adequate treatment to patients with substance use disorder.
(Sub. Res. 36, I-90; Modified: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: CSAPH Rep. 01, A-20)

Enhanced Funding for and Access to Outpatient Addiction Rehabilitation, D-95.962
Our AMA will advocate for: (1) the expansion of federal grants in support of treatment for a substance use disorder to states that are conditioned on that state's adoption of law and/or regulation that prohibit drug courts, recovery homes, sober houses, correctional settings, and other similar programs from denying entry or ongoing care if a patient is receiving medication for an opioid use disorder or other chronic medical condition; and (2) sustained funding to states in support of evidence-based treatment for patients with a substance use disorder and/or co-occurring mental disorder, such as that put forward by the American Society of Addiction Medicine, American Academy of Addiction Psychiatry, American Psychiatric Association, American Academy of Child and Adolescent Psychiatry and other professional medical organizations.
(Res. 513, A-92; Reaffirmation: A-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: CSAPH Rep. 01, A-19)

Increased Funding for Substance Use Disorder Treatment, H-95.973

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Our AMA (1) urges Congress to substantially increase its funding for substance use disorder treatment programs; (2) urges Congress to increase funding for the expansion and creation of new staff training programs; and (3) urges state medical societies to press for greater commitment of funds by state and local government to expand the quantity and improve the quality of the substance use disorder treatment system.
(Res. 116, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: CSAPH Rep. 01, A-20)

Involuntary Civic Commitment for Substance Use Disorder, H-95.912
Our AMA opposes civil commitment proceedings for patients with a substance use disorder unless: a) a physician or mental health professional determines that civil commitment is in the patient's best interest consistent with the AMA Code of Medical Ethics; b) judicial oversight is present to ensure that the patient can exercise his or her right to oppose the civil commitment; c) the patient will be treated in a medical or other health care facility that is staffed with medical professionals with training in mental illness and addiction, including medications to help with withdrawal and other symptoms as prescribed by his or her physician; and d) the facility is separate and distinct from a correctional facility.
(BOT Rep. 7, I-20)

Addiction and Unhealthy Substance Use, H-95.976
Our AMA is committed to efforts that can help the national problem of addiction and unhealthy substance use from becoming a chronic burden. The AMA pledges its continuing involvement in programs to alert physicians and the public to the dimensions of the problem and the most promising solutions. The AMA, therefore:
(1) supports cooperation in activities of organizations in fostering education, research, prevention, and treatment of addiction;
(2) encourages the development of addiction treatment programs, complete with an evaluation component that is designed to meet the special needs of pregnant women and women with infant children through a comprehensive array of essential services;
(3) urges physicians to routinely provide, at a minimum, a historical screen for all pregnant women, and those of childbearing age for substance abuse and to follow up positive screens with appropriate counseling, interventions and referrals;
(4) supports pursuing the development of educational materials for physicians, physicians in training, other health care providers, and the public on prevention, diagnosis, and treatment of perinatal addiction. In this regard, the AMA encourages further collaboration in delivering appropriate messages to health professionals and the public on the risks and ramifications of perinatal drug and alcohol use;
(5) urges the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, and the Substance Abuse and Mental Health Services Administration to continue to support research and demonstration projects around effective prevention and intervention strategies;
(6) urges that public policy be predicated on the understanding that alcoholism and drug dependence, including tobacco use disorder as indicated by the Surgeon General's report, are diseases characterized by compulsive use in the face of adverse consequences;
(7) affirms the concept that addiction is a disease and supports developing model legislation to appropriately address perinatal addiction as a disease, bearing in mind physicians' concern for the health of the mother, the fetus and resultant offspring; and

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(8) calls for better coordination of research, prevention, and intervention services for women and infants at risk for both HIV infection and perinatal addiction.
(BOT Rep. Y, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmation: A-09; Modified: CSAPH Rep. 01, A-19)

Federal Drug Policy in the United States, H-95.981
The AMA, in an effort to reduce personal and public health risks of drug abuse, urges the formulation of a comprehensive national policy on drug abuse, specifically advising that the federal government and the nation should: (1) acknowledge that federal efforts to address illicit drug use via supply reduction and enforcement have been ineffective (2) expand the availability and reduce the cost of treatment programs for substance use disorders, including addiction; (3) lead a coordinated approach to adolescent drug education; (4) develop community-based prevention programs for youth at risk; (5) continue to fund the Office of National Drug Control Policy to coordinate federal drug policy; (6) extend greater protection against discrimination in the employment and provision of services to drug abusers; (7) make a long-term commitment to expanded research and data collection; (8) broaden the focus of national and local policy from drug abuse to substance abuse; and (9) recognize the complexity of the problem of substance abuse and oppose drug legalization.
(BOT Rep. NNN, A-88; Reaffirmed: CLRPD 1, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Modified: CSAPH Rep. 2, I-13; Reaffirmed: BOT Rep. 14, I-20)

- **Community-Based Treatment Centers, H-160.963**
Our AMA supports the use of community-based treatment centers for substance use disorders, mental health disorders and developmental disabilities.
(BOT Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11l Modified: CSAPH Rep. 1, A-21)

- **Involuntary Civic Commitment for Substance Use Disorders, D-95.963**
Our AMA will continue its work to advance policy and programmatic efforts to address gaps in voluntary substance use treatment services.
(BOT Rep. 7, I-20)

Youth Incarceration in Adult Facilities, H-60.916
1. Our AMA supports, with respect to juveniles (under 18 years of age) detained or incarcerated in any criminal justice facility: (a) early intervention and rehabilitation services, (b) appropriate guidelines for parole, and (c) fairness in the expungement and sealing of records.
2. Our AMA opposes the detention and incarceration of juveniles (under 18 years of age) in adult criminal justice facilities.
(Alt. Res. 917, I-16)

345.022MSS: Support for Mental Health Courts
AMA-MSS supports the establishment and use of mental health courts, including drug courts and sober courts, as an effective method of intervention for individuals with mental illness and substance use disorders who are convicted of nonviolent crimes and the state and local level in the United States. (MSS Res. 29, I-19) (Reaffirmed: MSS Res. 030, Nov. 2020)

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345.006MSS Reduced Incarceration and Improved Treatment of Individuals with Mental Illness or Illicit Drug Dependence

AMA-MSS will ask the AMA to amend policy H-430.989 by insertion and deletion as follows:

> **H-430.989 Disease Prevention and Health Promotion in Correctional Institutions**
>
> Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public health systems toward 1. the prevention and control of HIV/AIDS, substance abuse, tuberculosis and hepatitis, 2. the management and treatment of psychiatric disorders such as drug dependence, and 3. a reduction in reincarceration rates related to drug abuse and psychiatric disorders. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers, ~~and~~ drug treatment center staff, and psychiatric care center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase in direct referral by correctional systems of parolees with a history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs, as well as inpatient or outpatient psychiatric treatment programs, as a sentence or in connection with sentencing."

(MSS Res 30, I-11) (HOD Policy H-430.997 Amended in Lieu of AMA Res 502, A-12) (Reaffirmed: MSS GC Report A, I-16)

AMA 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)

Substance Use Disorders as a Public Health Hazard, H-95.975

Our AMA: (1) recognizes that substance use disorders are a major public health problem in the United States today and that its solution requires a multifaceted approach;
(2) declares substance use disorders are a public health priority;
(3) supports taking a positive stance as the leader in matters concerning substance use disorders, including addiction;
(4) supports studying innovative approaches to the elimination of substance use disorders and their resultant street crime, including approaches which have been used in other nations; and
(5) opposes the manufacture, distribution, and sale of substances created by chemical alteration of illicit substances, herbal remedies, and over-the-counter drugs with the intent of circumventing laws prohibiting possession or use of such substances.
(Res. 7, I-89; Appended: Sub. Res. 401; Reaffirmed: Sunset Report, I-99; Reaffirmed: CSAPH Rep. 1, A-09; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: CSAPH Rep. 01, A-19)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 53
(N-21)

Introduced by: Shivani Bhatnagar, Texas College of Osteopathic Medicine; Kristofer Jackson University of Toledo College of Medicine; Leelakrishna Channa, University of Connecticut School of Medicine; Skyler Burke, Washington State University Elson S. Floyd College of Medicine; Madeline Drake, McGovern Medical School at UTHealth Houston; Matthew Swanson, Frank H. Netter MD School of Medicine at Quinnipiac University; Andrew Alexander, Texas A&M College of Medicine; David J. Horovitz, University of South Carolina School of Medicine; Joel Mintz, Dr. Kiran C. Patel College of Allopathic Medicine; Adrian Falco, Texas Tech School of Medicine; Melissa Yang, McGovern Medical School at UTHealth Houston; Sarah Mukhtar, Sidney Kimmel Medical College at Thomas Jefferson University-Philadelphia; Raag Agrawal, David Geffen School of Medicine at UCLA-Los Angeles; Ayesha Firdous, University of Pittsburgh School of Medicine-Pittsburgh

Sponsored by: Region 3, Region 5

Subject: Digitizing and Centralizing Access to Advance Care Planning Documents

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, Advance Care Planning (ACP) is a dynamic process by which patients and physicians discuss and document patients' values and wishes for end-of-life treatment in the event that they are unable to express their wishes or if their decisional capacity becomes diminished[1]; and

Whereas, It is becoming increasingly common for patients to report a do-not-resuscitate (DNR) status while in-patient or while completing out-of-hospital ACP documents, yet many health systems operate on the assumption that everyone is “full code” until otherwise specified[2]; and

Whereas, Many ACP documents are still completed and retained in a physical format and patients are advised to keep multiple hard copies of their ACP documents, make sure their close contacts are aware of their updated ACP decisions, and physically bring these documents anytime they require healthcare[3,4]; and

Whereas, Current recommendations advising patients to keep photos of ACP documents on their smartphone, to rely on families to express wishes, and to depend on physicians to decide end-of-life care for the patient are often unreliable and can lead to outcomes that contradict the patient’s wishes[5–8]; and

Whereas, Family and caregivers are poor proxies for communicating resuscitation status as over one-third of healthcare surrogate decision-makers do not know the patient’s resuscitation status and over one-fourth of surrogate decision-makers have reported a resuscitation status that is incongruent with documentation in the EHR (Electronic Health Record)[5]; and

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Whereas, Our current use of EHR platforms has allowed for great improvements in patient care and communication, yet many hospital systems suffer from poor document sharing and poor interoperability between different facilities and systems[9]; and

Whereas, Miscommunication about a patient's advance care directives can, and has, led to preventable malpractice[6–8]; and

Whereas, A 2018 study showed that up to 55% of ACP discussions were defined as "not easily accessible" (i.e. recorded with free text in progress notes as opposed to documented in designated electronic posting locations) and up to 70% of electronically documented ACP discussions were outdated in addition to "not easily accessible," highlighting a need for accurate ACP documentation that is easily accessible within all EHRs to create safe, patient-centered care[10]; and

Whereas, Accommodating a standardized feature within all EHRs to digitally share updated ACP information is an important safety step to avoid the preventable malpractice, harm, and cost that come with miscommunicated resuscitation status[10]; and

Whereas, A key element of patient safety is utilizing forcing functions, defined as human factors engineering that prevent an unintended or undesirable event by allowing actions to happen only if another specific action is performed first[11–13]; and

Whereas, If a forcing function is poorly designed to hamper workers' abilities to complete tasks efficiently, then it encourages development of shortcuts, termed workarounds, to bypass policies and safety procedures, which can then pose significant patient safety risks[10]; and

Whereas, Currently available digital health documentation systems lack forcing functions within EHRs or otherwise, which encourage workarounds, such as documenting ACP discussions as free text within progress notes, and fail to avoid the preventable harms that come with miscommunication of non-digitized ACP information; therefore be it

RESOLVED, That our AMA work with appropriate stakeholders to investigate a common digitized system for hospitals to request, share, and complete Advance Care Planning (ACP) documents in a method such that the information is readily available to all providers without relying only on the patient to provide physical documents for this time-sensitive information; and be it further

RESOLVED, That our AMA encourage appropriate stakeholders to create a repository, either at the federal-level or state-level, for standardized digital storage and retrieval of up-to-date Advance Care Planning documents; and be it further

RESOLVED, That our AMA-MSS support the development of a centralized repository for ACP documents by amending policy 140.007MSS "AMA-MSS Support of Advance Directives" by addition as follows:

> **AMA-MSS Support of Advance Directives, 140.007MSS**
> (1) AMA-MSS affirms the need for advance directives for all patients, including young adults, and will provide its members with information about advance directives, and recommends medical students complete their own; (2) AMA-MSS will ask the AMA to

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encourage physicians to discuss advance directives and organ donation with all patients, including young adults, as a part of the ongoing doctor-patient relationship; (3) AMA-MSS will ask the AMA to (a) recommend that advance directives completed by a patient be placed in a prominent area of the patient's medical record and require EHR's to provide standardized, easily accessible digital storage space for advance care paperwork; and (b) recommend the inclusion of information on and eligibility requirements pertaining to organ and tissue donation in any advanced directive; (4) AMA-MSS will ask the AMA to support policies and legislation mandating physician reimbursement for time spent discussing advance directives with patients.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

D-140.953 Timely Promotion and Assistance in Advance Care Planning and Advance Directives
Our AMA will: (1) begin a low cost in-house educational effort aimed at physicians, to include relevant billing and reimbursement information, encouraging physicians to lead by example and complete their own advance directives; (2) encourage practicing physicians to voluntarily publicize the fact of having executed our own advance directives, and to share readily available educational materials regarding the importance and components of advance directives in offices and on practice websites, as a way of starting the conversation with patients and families; (3) strongly encourage all physicians of relevant specialties providing primary or/and advanced illness care to include advance care planning as a routine part of their patient care protocols when indicated, including advance directive documentation in patients' medical records (including electronic medical records), as a suggested standard health maintenance practice; (4) collaborate (prioritized and made more urgent by the ongoing COVID-19 pandemic) with stakeholder groups, such as legal, medical, hospital, medical education, and faith-based communities as well as interested citizens, to promote completion of advance directives by all individuals who are of legal age and competent to make healthcare decisions, and to promote the adoption and use of electronic systems to make patients' advance directives readily available to treatment teams regardless of location; and (5) actively promote the officially recognized designation of April 16 as National Healthcare Decisions Day.
(Res 602, A-21)

H-140.845 Encouraging the Use of Advance Directives and Health Care Powers of Attorney
Our AMA will: (1) encourage health care providers to discuss with and educate young adults about the establishment of advance directives and the appointment of health care proxies; (2) encourage nursing homes to discuss with resident patients or their health care surrogates/decision maker as appropriate, a care plan including advance directives, and to have on file such care plans including advance directives; and that when a nursing home resident patient's advance directive is on file with the nursing home, that advance directive shall accompany the resident patient upon transfer to another facility; (3) encourage all physicians and their families to complete a Durable Power of Attorney for Health Care (DPAHC) and an Advance Directive (AD); (4) encourage all medical schools to educate medical students and residents about the importance of having a DPAHC/AD before becoming severely ill and encourage them to fill out their own DPAHC/AD; (5) along with other state and specialty societies, work with any state that has technical problems with their DPAHC/AD to correct those problems; (6) encourage every state medical association and their member physicians to make information about Living Wills and health care powers of attorney continuously available in patient reception areas; (7) (a) communicate with key health insurance organizations, both private and public, and their institutional members to include information regarding advance directives and related forms and (b) recommend to state Departments of Motor Vehicles the distribution of information about advance directives to individuals obtaining or renewing a driver's license; (8) work with Congress and the Department of Health and Human Services to (a) make it a national public health priority to educate the public as to the importance of having a DPAHC/AD and to encourage patients to work with their physicians to complete a DPAHC/AD and (b) to develop incentives to individuals who prepare advance directives consistent with our current AMA policies and legislative priorities on advance directives; (9) work with the Centers for Medicare and Medicaid Services to use the Medicare enrollment process as an opportunity for patients to receive information about advance health care directives; (10) continue to seek other strategies to help physicians encourage all their patients to complete their DPAHC/AD; and (11) advocate for the implementation of secure electronic advance health care directives.

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(CCB/CLRPD Rep. 3, A-14; Reaffirmed: BOT Rep. 9, I-15; Reaffirmed: Res. 517, A-16; Reaffirmed: BOT Rep. 05, I-16; Reaffirmed in lieu of: Res. 121, A-17)

H-85.957 Encouraging Standardized Advance Directives Forms Within States
Our AMA encourages each state society to develop a standardized form of advance directives for use by physicians and other health care providers as a template to discuss end-of-life care with their patients. (Res. 5, I-11, Reaffirmed: BOT Rep. 05, I-16)

140.007MSS AMA-MSS Support of Advance Directives
AMA-MSS Support of Advance Directives: (1) AMA-MSS affirms the need for advance directives for all patients, including young adults, and will provide its members with information about advance directives, and recommends medical students complete their own; (2) AMA-MSS will ask the AMA to encourage physicians to discuss advance directives and organ donation with all patients, including young adults, as a part of the ongoing doctor-patient relationship; (3) AMA-MSS will ask the AMA to (a) recommend that advance directives completed by a patient be placed in a prominent area of the patient's medical record; and (b) recommend the inclusion of information on and eligibility requirements pertaining to organ and tissue donation in any advanced directive; (4) AMA-MSS will ask the AMA to support policies and legislation mandating physician reimbursement for time spent discussing advance directives with patients. (MSS Res 27, I-90, MSS Sub Res 59, I-98, MSS Res 20, I-09, MSS GC Rep A, I-06, MSS GC Rep I, I-84, Consolidated: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep A, I-14) (Modified: MSS Res 04, I-16)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 54
(N-21)

Introduced by: Rozena Shirvani, University of Texas Rio Grande Valley; Medha Reddy, New York Medical College; Sarah Costello, University of Iowa Carver College of Medicine; Meghna Peesapati, Marian University College of Osteopathic Medicine; Sanjana Satish, University of Miami Miller Medical School

Sponsored by: Region 4, Region 5, Region 6

Subject: Expansion of Medicaid Coverage of HPV Screening

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, Cervical cancer caused by the human papillomavirus (HPV) infection is one of the most prolific cancers, which disproportionately affects low income and minority populations[1]; and

Whereas, Annual age-adjusted cervical cancer incidence in the United States was 7.4 cases per 100,000 women and mortality was 2.3 deaths per 100,000 women (2011-2015), with the highest incidence among black (8.4 per 100,000) and Hispanic (8.9 per 100,000) women[2]; and

Whereas, According to a 2003 worldwide meta-analysis, being of disadvantaged socioeconomic status was associated with almost a 100% increased risk of cervical cancer development and with 60% increased risk of dysplasia[3]; and

Whereas, Access to adequate cervical cancer screening and preventative care remains critical to eliminating racial disparities among cancer mortality rates in the US[4]; and

Whereas, The National Breast and Cervical Cancer Early Detection Program was enacted in 2000 to provide low income and uninsured women access to screening and diagnostic services and resulted in a 46% decrease in screening from 2011 to 2018, which the CDC also attributes in part to improved access to screening under the Patient Protection and Affordable Care Act which expanded Medicaid coverage[5]; and

Whereas, The Centers for Medicare & Medicaid Services (CMS) provides coverage for Medicare HPV testing in conjunction with the Pap smear test once every five years using U.S. Food and Drug Administration (FDA) approved laboratory tests but does not cover primary HPV screening alone[6]; and

Whereas, The American Academy of Family Physicians (AAFP) requested the CMS to update their coverage as above in 2014 and after a national coverage analysis by CMS they agreed to follow the latest recommendations and update their coverage in 2015, therefore it is appropriate for organizations such as the AMA to take the initiative in advancing the CMS[7]; and

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Whereas, Of 41 surveyed states, all cover pap screening for cervical cancer while HPV DNA testing is considered one of the three follow up screening methods after an abnormal Pap test which is covered by 40 out of 41 surveyed states in their traditional Medicaid program[8]; and

Whereas, The American Cancer Society's (ACS) 2020 guidelines for cervical cancer screening states that the preferred method of cervical cancer screening for ages 25-65 years old is an FDA-approved primary HPV test alone every 5 years[9]; and

Whereas, The ACS also states that HPV co-testing or cytology testing alone is acceptable where access to primary HPV testing is limited or not available, and as the United States transitions to primary HPV testing, the use of contesting or cytology alone will not be included in future guidelines for cervical cancer screening[9]; and

Whereas, The United States Preventive Services Task Force (USPSTF) in 2018 concluded with high certainty, that the benefits of cervical cancer screening with HPV testing alone every 5 years in ages 30-65 outweigh the harms[10]; and

Whereas, The American College of Obstetricians and Gynecologists (ACOG) joined the Society of Gynecologic Oncology and American Society for Colposcopy and Cervical Pathology in endorsing the USPSTF recommendations in their updated 2021 cervical cancer screening guidelines[11]; and

Whereas, There are two FDA-approved primary HPV testing methods including cobas ThinPrep (approved in 2014) and BD Onclarity SurePath (approved in 2018) which have a sensitivity for cervical intraepithelial neoplasia 2/3 (CIN) of 71.1%-99% and 85.7%-100% respectively[12]; and

Whereas, Primary HPV testing was found to be more sensitive but less specific than cytology screening for CIN2+ and screening with HPV16/18 followed by reflex cytology had similar sensitivity and superior specificity to co-testing, making it appropriate for cervical screening programs[13]; and

Whereas, Primary HPV testing is less likely to miss cases of CIN 2+ and CIN 3+, and while these tests do lead to more non-essential referrals, a negative primary HPV test remains more reassuring than a negative cytological test, as the latter has a greater chance of being falsely negative, which could lead to delays in receiving appropriate treatment[14]; and

Whereas, Four randomized controlled trials (RCT) comparing primary HPV testing with cytology all suggested HPV testing alone led to an increase in the rate of CIN 3+ detection in the first round of screening and two of the trials had twice and three times the rate of detection respectfully[15]; and

Whereas, Several analyses show an increase in detection and decrease in cost burden by using primary HPV testing; specifically of 99,549 patients, primary HPV testing detected 294 cases of CIN3+ with having 2422 colposcopies and incurred a cost of $3.47M, cytology detected fewer cases (285) and cost $4.79M, co-testing detected more cases (308) but required over 100,000 more cytology tests and 566 more colposcopies costing $2.38 million more than primary HPV testing[16]; and

Whereas, Reflex cytology, the cytology following an HPV positive case from HPV testing, was less expensive than the co-test, cytology in conjunction with HPV testing, because it was only needed for a limited number of cases and there was no need to repeat sampling[16]; and

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Whereas, In areas and populations with low screening rates, HPV self-sampling, which may be done at home by patients themselves, may be an important modality to study, to ultimately increase screening participation[17]; and

Whereas, The British Medical Journal meta-analysis of 33 studies with over 360,000 participants found that women are twice as likely to seek cervical cancer screening if offered self-sampling kits, women who received kits from door-to-door health care providers were three times as likely to seek cervical cancer screening, and women who received kits through the mail were twice as likely to undergo cervical cancer screening[18]; and

Whereas, A systematic review of 72 studies totaling over 50,000 participants estimated a 59% of women preferred self-sampling to office-based screening, citing ease of use, privacy, convenience, and physical and emotional comfort as major reasons for their preference[19]; and

Whereas, For the detection of CIN2+, self-sampled HPV tests had similar rates to HPV and cytology co-testing but the RCT showed that repeated self-sampled HPV tests were associated with two-fold higher detection rates of CIN2+ than cytology [20]; and

Whereas, The World Health Organization states that HPV self-sampling can help improve cervical cancer screening coverage to 70% by 2030[21]; therefore be it

RESOLVED, That our AMA submit a formal request to the Centers for Medicare and Medicaid Services to expand coverage of primary HPV testing without cytology, and be it further

RESOLVED, That our AMA request the CMS to endorse national incentives for states to cover primary HPV testing by Medicaid, and be it further

RESOLVED, That our AMA support further research of HPV self-sampling in the U.S. for cervical cancer screening.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS 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.
(Res. 503, A-07; Appended: Res. 6, A-12)

Screening and Treatment for Breast and Cervical Cancer Risk Reduction H-55.971
1. Our AMA supports programs to screen all women for breast and cervical cancer and that government funded programs be available for low income women; the development of public information and educational programs with the goal of informing all women about routine cancer screening in order to reduce their risk of dying from cancer; and increased funding for comprehensive programs to screen low income women for breast and cervical cancer and to assure access to definitive treatment.

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2. Our AMA encourages state and local medical societies to monitor local public health screening programs to ensure that they are linked to treatment resources in the public or private sector.
(CCB/CLRPD Rep. 3, A-14)

Human Papillomavirus (HPV) Inclusion in 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.
(Res. 418, A-06; Reaffirmed: CSAPH Rep. 01, A-16; Modified: Res. 404, A-18)

Increasing HPV Education 170.008MSS

AMA-MSS will ask the AMA to: (1) support specific teaching concerning transmission and sequelae in STD education; and (2) reaffirm a commitment to specific HIV and general STD education.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 55
(N-21)

Introduced by: Mariana L. Henry, Michael K. Koo, Lily J. Greene, Geisel School of Medicine at Dartmouth

Sponsored by: ANAMS, APAMSA

Subject: Residency Application Support for Students of Low Income Backgrounds

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, Students of low socioeconomic backgrounds constitute a low percentage of medical matriculants, as the 2018 Medical Student Questionnaire found that only 5% of all medical school matriculants who provided parental income data were in the lowest household-income quintile, whereas 24% were in the top 5%[1]; and

Whereas, To begin to address these disparities within the medical student population, the AMCAS Fee Assistance Program (FAP) was created to offer students of low-income households discounted primary and secondary applications, discounted MCAT registration fees, and free MCAT study materials[2]; and

Whereas, The FAP has been proven to be successful, as FAP awardees accepted to medical school tripled from 2.2 to 6.6 percent of all those accepted to medical school, and the likelihood that an individual accepted to medical school was a FAP awardee outpaced the growth of FAP awardees in the applicant pool, increasing by a factor of 3.0[2]; and

Whereas, Medical school tuition and medical student debt have been drastically increasing, with the median debt in 2019 being $200,000, and with 73% of students graduating with debt[3]; and

Whereas, Ethnic minority students and students from families that are low income are more likely to have high educational debt once in medical school, and this increasing debt and fear of costs frequently deters pre-medical students of these backgrounds from pursuing a medical education[4]; and

Whereas, Higher levels of educational debt are positively associated with burnout and decreased academic performance among residents[5], decreased mental well being among medical students [6], and medical students with higher scores on a continuous measure of socioeconomic disadvantage (SED) have been shown to have worse academic performance than those with lower SED scores, and further support is necessary to create a more equitable environment for low-income students during their medical school education [7]; and

Whereas, The number of residency applications submitted per applicant has nearly doubled[8], as the current mean number of programs for U.S. medical students is 70, costing approximately $1499 in ERAS fees[8-9]; and

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Whereas, ERAS application fees are only one part of the residency application process, as attending interviews in person can exceed $10,000 for competitive specialties[8]; and

Whereas, The increasing financial costs of residency applications creates concerns regarding equity in the application process, as the ability to afford or willingness to accrue debt may impact an applicant's ability to match, and cost has been listed as a reason why students may not submit extra applications[8,10]; and

Whereas, Qualitative data from the AAMC has noted that finances may impact an applicant's ability to interview and rank as desired, and that personal savings and access to family savings may confer an advantage in the residency application process[11]; and

Whereas, Within specialties such as dermatology, ophthalmology, and neurosurgery, which receive the highest number of applications per applicant, research has detected a trend such that these specialties also have among the lowest mean educational debt and the greatest percentage of incoming residents who have no educational debt at all[12]; and

Whereas, It has been recognized that efforts to lower debt burdens may help to recruit and retain underrepresented minorities and students of lower socioeconomic status in medicine[13]; and

Whereas, This retention is important as, researchers have found that doctors who are not of lower socioeconomic status often stereotype patients from lower socioeconomic status as less responsible and less intelligent, and as such, in clinical care, these patients may not always receive the same level of explanation or treatment options[14]; and

Whereas, Similar trends have been detected amongst medical students such that medical students have a bias with regard to socioeconomic status, and have been documented to have implicit preference for persons who are white and those in the upper class[15,16]; and

Whereas, Interactions with students of diverse backgrounds during medical education is critical in helping students to expand and challenge their perspectives, and increase their understanding of different cultures[4-5]; and

Whereas, Medical students from disadvantaged backgrounds are more likely to serve patients from similar circumstances than their non-disadvantaged peers, and thus improve existing health disparities[14,17]; therefore be it

RESOLVED, That our AMA supports 1) The creation of a Fee Assistance Program for ERAS and or funding opportunities for students of low-income backgrounds as they apply for residency. 2) Encouraging medical schools to provide similar funding opportunities and or scholarships for students of low-income backgrounds for their residency applications.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

Minorities in the Health Professions H-350.978
The policy of our AMA is that (1) Each educational institution should accept responsibility for increasing its enrollment of members of underrepresented groups.
(2) Programs of education for health professions should devise means of improving retention rates for students from underrepresented groups.
(3) Health profession organizations should support the entry of disabled persons to programs of education for the health professions, and programs of health profession education should have established standards concerning the entry of disabled persons.
(4) Financial support and advisory services and other support services should be provided to disabled persons in health profession education programs. Assistance to the disabled during the educational process should be provided through special programs funded from public and private sources.
(5) Programs of health profession education should join in outreach programs directed at providing information to prospective students and enriching educational programs in secondary and undergraduate schools.
(6) Health profession organizations, especially the organizations of professional schools, should establish regular communication with counselors at both the high school and college level as a means of providing accurate and timely information to students about health profession education.
(7) The AMA reaffirms its support of: (a) efforts to increase the number of black Americans and other minority Americans entering and graduating from U.S. medical schools; and (b) increased financial aid from public and private sources for students from low income, minority and socioeconomically disadvantaged backgrounds.
(8) The AMA supports counseling and intervention designed to increase enrollment, retention, and graduation of minority medical students, and supports legislation for increased funding for the HHS Health Careers Opportunities Program.
CLRPD Rep. 3, I-98Reaffirmed: CLRPD Rep. 1, A-08Reaffirmed: CEJA Rep. 06, A-18

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.

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(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-98Reaffirmed: CLRPD Rep. 1, A-08Reaffirmed: CME Rep. 01, A-18

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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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

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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-18Appended: Res. 953, I-18Reaffirmation: A-19Appended: Res. 316, A-19Appended: Res. 226, A-21Reaffirmed in lieu of: Res. 311, A-21

Financial Aid to Medical Students H-305.999
Our AMA urges physicians to contribute to the AMA Foundation for support of medical education and provision of scholarships to medical students.
Res. 6, A-70Reaffirmed: CLRPD Rep. C, A-89Reaffirmed: Sunset Report, A-00Modified: CME Rep. 2, A-10Reaffirmed: CME Rep. 01, A-20

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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.
Modified: CME Rep. 01, A-18Appended: Res. 207, I-18Reaffirmation: A-19Appended: Res. 304, A-19Appended: Res. 319, A-19Modified: CME Rep. 5, A-21

Residency Interview Costs H-310.966
1. It is the policy of the AMA to pursue changes to federal legislation or regulation, specifically to the Higher Education Act, to include an allowance for residency interview costs for fourth-year medical students in the cost of attendance definition for medical education.

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2. Our AMA will work with appropriate stakeholders, such as the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education, in consideration of the following strategies to address the high cost of interviewing for residency/fellowship: a) establish a method of collecting data on interviewing costs for medical students and resident physicians of all specialties for study, and b) support further study of residency/fellowship interview strategies aimed at mitigating costs associated with such interviews.
Res. 265, A-90Reaffirmed: Sunset Report, I-00Modified: CME Rep. 2, A-10Appended: Res. 308, A-15

Medical Honor Society Inequities and Reform:295.225 MSS
AMA-MSS will ask the AMA to (1) recognize that demographic and socioeconomic inequities exist in medical student membership in medical honor societies; and (2) study reforms to mitigate demographic and socioeconomic inequities in the selection of medical students for medical honor societies, including Alpha Omega Alpha and the Gold Humanism Honor Society, as well as the implications of ending the selection of medical students to these societies on equity in the residency application process and report back by the November 2021 HOD meeting.
(MSS Res. 003, A-21)(Immediately Forwarded to HOD but not considered, A-21)

Availability of Medical Education 295.005MSS
AMA-MSS supports the following principles: (1) A determined, conscientious effort to accept, matriculate, and graduate minority physicians must be undertaken. (2) Support for programs with a commitment to the training of minority medical professionals, particularly the three predominantly black medical schools (Howard, Meharry, Morehouse) must be increased as necessary and maintained. (3) Adequate financial aid packages for minority students must be provided. These may include combinations of grants, loans, scholarships, or service- obligated programs. (4) Efforts should be made to increase the proportion of minorities in medical school faculties and administrative positions. (5) Efforts must be made to improve retention rates of minority students in medical schools.
Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS Res 19, I-17)

US Medical Student Match Fees: 295.110MSS
US Medical Student Match Fees: AMA-MSS strongly encourages the NRMP staff to develop and implement an equitable NRMP Match fee structure for both U.S. Medical Students and Independent Applicants that appropriately reflects actual costs for each group. (MSS Sub Late Res 1, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

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MSS Financial Burden of Application to Medical School and Residency: 305.083 MSS
The AMA-MSS recognizes the financial burden associated with applying to and attending medical school and applying to residency, and supports the following principles:
1. AMA MSS supports the incorporation of admissions practices that objectively evaluate applicants' behavioral competencies into future AMA medical education funding initiatives.
2. That the AMA-MSS will ask the AMA to (a) support medical school admission policies that do not discriminate against students who may require financial aid to pursue a medical education; (b) encourage all US medical schools to adopt an active policy of informing medical school applicants of estimated tuition and fees for each year of undergraduate medical education and the sources of financial aid available; and (c) continue to encourage the maintenance and development of resources, both public and private, to help meet the financial needs of students attending American medical schools.
3. That the AMA-MSS will ask our AMA to consider the following strategies to address the high cost of interviewing for residency: (a) establishing a method of collecting data on interviewing costs for medical students of all specialties (e.g., NRMP survey collaboration) for further study, (b) supporting further study of residency interview strategies aimed at mitigating costs associated with residency interviews, (c) producing and providing a toolkit of recommended resources for 4th year medical students who are interviewing on the AMA-MSS webpage, (d) creating and/or promoting specific websites related to med student travel, and (e) providing or recommending and online forum where students can accommodate other medical students who are interviewing in their area.
(MSS GC Rep A, I-17)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 56
(N-21)

Introduced by: Tabitha Moses, Mirna Kaafarani, Vikas Kanneganti, Alicia Kevelin, Jennifer Sylvester, Wane State University School of Medicine; Hendrik Stegall, The Ohio State University College of Medicine; Reilly Bealer, Elson S. Floyd College of Medicine

Sponsored by: Region 1, Region 4, Region 5

Subject: Support Removal of Body Mass Index (BMI) as a Standard Measure in Medicine

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, Body Mass Index (BMI) is calculated from a person's height and weight and is a screening tool in healthcare that is frequently utilized as a surrogate estimation of body fat through the measurement of total body weight rather than total body fat[1]; and

Whereas, BMI is used across medicine as a screening tool to classify individuals as underweight, healthy weight, overweight, and obese, classifications which are often used in the screening for, diagnosis, and treatment of various pathologies[2,3]; and

Whereas, Underlying assumptions are that BMI directly correlates to levels of body fat (adiposity); however, many factors besides body fat (adiposity) impact BMI, including muscle mass, gender, and race/ethnicity, and such factors limit the ability of BMI to be used to reliably predict general health and disease risk[4]; and

Whereas, There is minimal evidence supporting the clinical utility of BMI; however, in many clinical settings certain BMI ranges are broadly correlated with increased rates of morbidity and mortality secondary to several different disease processes without consideration of individual and population level differences[5]; and

Whereas, The concept of BMI was created by a statistician--rather than a physician--to understand the link between weight and height as it changes throughout the lifespan[6]; and

Whereas, The development of BMI was based solely on those of European descent in an effort to define the characteristics of the "normal man" [6]; and

Whereas, The specific weight ranges associated with optimal health have varied drastically since the development of BMI; for example, in the 19th century life insurance companies showed favor towards those with above-average weight; however, improved sanitation, living, and work conditions resulted in a decline in infectious diseases and resultant research by life insurance actuaries, mostly on white bodies, concluded there to be a link between mortality and what is now referred to as BMI[4]; and

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Whereas, Both the development of BMI and its apparent association with specific disease processes were based on primarily white males of European descent and is not a standardized across racial and ethnic groups and has limited predictive validity in these groups[4,7,8]; and

Whereas, The association between BMI levels and risks varies among different racial groups; for example, there is a link between BMI and metabolic abnormalities in the white population, but this association is not found among racial minority groups[9]; and

Whereas, BMI has been shown to have a low sensitivity for body fat mass and may lead to inadequate prevention of obesity-related health complications, especially in at-risk populations such as women and children[7,10,11]; and

Whereas, BMI categorization fails to serve as a predictor for obesity in white, Black or Hispanic women either pre- or post-menopause[12,13]; and

Whereas, Despite limited evidence for its clinical validity, BMI is used as an indicator of eating disorder presence and severity, which impairs access to treatment and is not predictive of the severity of eating disorder psychology, and in fact may be inversely correlated[14–17]; and

Whereas, Numerous medical specialty organizations recognize waist circumference as a useful adjunct or alternative to BMI when evaluating adults for metabolic and cardiovascular disease, and waist circumference has both historically and recently been emphasized by the United States Preventive Service Task Force as a functional and, in some cases, more accurate alternative to BMI[18–23]; and

Whereas, There are several alternatives to BMI that could be used clinically, including relative fat mass, body adiposity index, and the body volume index, all of which have been studied in the literature[8,24–26]; and

Whereas, Relative fat mass (RFM) has been consistently shown to be easier to calculate than the BMI with the equation being 64 − (20 × height/waist circumference) + (12 × sex), less likely to misclassify individuals as obese, have better screening capability and be more predictive of individuals developing metabolic syndrome and comorbid conditions, and more accurate in estimating the whole-body fat percentage across both genders and multiple ethnic groups[8,24,26]; and

Whereas, Stigma associated with a health care provider's assessment of body weight is associated with medication nonadherence, mistrust of the provider, and avoidance of medical care[27]; and

Whereas, Inclusive, non-stigmatizing approaches to health promotion must also acknowledge the social and economic determinants of health and take into consideration the patient's lived environment in order for physicians to help patients achieve meaningful and sustainable health goals[27]; and

Whereas, Our American Medical Association (AMA) has set precedents for supporting additional research on the efficacy of screening for obesity using different indicators other than BMI in the pursuit of improving various clinical outcomes across populations (H-440.866) and increased funding for research on the diagnosis of eating disorders (H-150.928); and

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Whereas, In 2013 the AMA Council on Science and Public Health (CSAPH) released a report that recognized the need for better measures of obesity than BMI and rescinded policy D-440.971, "Recommendations for Physician and Community Collaboration on the Management of Obesity" which encouraged physicians to incorporate BMI in the routine adult physical examination; this recommendation demonstrated our AMA's recognition of the lack of evidence supporting the routine clinical use of BMI[28]; therefore be it

RESOLVED, That our AMA recognize the significant limitations and potential harms associated with the widespread use of body mass index (BMI) in clinical settings and supports its use only in a limited screening capacity when used in conjunction with other more valid measures of health and wellness; and be it further

RESOLVED, That our AMA support the use of validated, easily-obtained alternatives to BMI (such as relative fat mass, body adiposity index, and the body volume index) for estimating risk of weight-related disease; and be it further

RESOLVED, That our AMA support the removal of BMI as a standard variable in health research and advocate for major health organizations to stop stratifying data based on this measure; and be it further

RESOLVED, That our AMA advocates for the removal of BMI as a diagnostic marker and for the use of inclusive, non-stigmatizing approaches to health promotion that also acknowledge the impact of social and economic determinants of health and patients' lived environment; and be it further

RESOLVED, That our AMA amend policy H-440.866: The Clinical Utility of Measuring Body Mass Index and Waist Circumference in the Diagnosis and Management of Adult Overweight and Obesity as by addition and deletion as follows:

> **The Clinical Utility of Measuring ~~Body Mass Index~~ Weight, Adiposity, and Waist Circumference in the Diagnosis and Management of Adult Overweight and Obesity, H-440.866**
> Our AMA supports:
> (1) greater emphasis in physician educational programs on the risk differences ~~among ethnic and age~~ within and between demographic groups at varying weights and levels of adiposity ~~BMI~~ and the importance of monitoring waist circumference in all individuals ~~with BMIs below 35 kg/m2~~;
> (2) additional research on the efficacy of screening for overweight and obesity, using different indicators, in improving various clinical outcomes across populations, including morbidity, mortality, mental health, and prevention of further weight gain; and
> (3) more research on the efficacy of screening and interventions by physicians to promote healthy lifestyle behaviors, including healthy diets and regular physical activity, in all of their patients to improve health and minimize disease risks
> (4) the understanding that weight does not inherently predict health and the recognition that physicians should evaluate the social and economic determinants of health and take into consideration the patient's lived environment to help patients achieve meaningful and

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sustainable health goals regardless of their intentions to alter their weight.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

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H-440.866: The Clinical Utility of Measuring Body Mass Index and Waist Circumference in the Diagnosis and Management of Adult Overweight and Obesity
Our AMA supports:
(1) greater emphasis in physician educational programs on the risk differences among ethnic and age groups at varying levels of BMI and the importance of monitoring waist circumference in individuals with BMIs below 35 kg/m2;
(2) additional research on the efficacy of screening for overweight and obesity, using different indicators, in improving various clinical outcomes across populations, including morbidity, mortality, mental health, and prevention of further weight gain; and
(3) more research on the efficacy of screening and interventions by physicians to promote healthy lifestyle behaviors, including healthy diets and regular physical activity, in all of their patients to improve health and minimize disease risks.
(CSAPH Rep. 1, A-08Reaffirmed: CSAPH Rep. 3, A-13)

G-600.064: AMA Endorsement of Screening Tests or Standards
(1) Delegates, state, or specialty societies submitting a resolution seeking endorsement or AMA adoption of specific screening tests must also submit an evidence-based review that determines the strength or quality of the evidence supporting their request, and that evaluates the degree to which the test satisfies the minimal criteria for validating the appropriateness of the screening test, which are: (a) the test must be able to detect the target condition earlier than without screening and with sufficient accuracy to avoid producing large numbers of false-positive and false-negative results; and (b) screening for and treating persons with early disease should improve the likelihood of favorable health outcomes compared with treating patients when they present with signs or symptoms of disease. (2) This review will be made available to the reference committee, which will either recommend to the House of Delegates that the resolution be referred or not be adopted.
(CSA Rep. 7, A-02CC&B Rep. 3, I-08Reaffirmed: CCB/CLRPD Rep. 3, A-12)

H-170.995 Healthful Lifestyles
The AMA believes that consumers should be encouraged and assisted to learn healthful practices by: (1) educating and motivating the consumers to adopt more healthful lifestyles; (2) exploring methods of utilizing public communication more effectively in health education efforts directed towards motivating consumers to adopt healthful lifestyles; (3) encouraging consumers, in appropriate risk groups, to utilize professional preventive health care services which would permit the early detection and treatment, or the prevention, of illness; and physicians demonstrating these practices through personal examples of health lifestyles.
(BOT Rep. A, NCCMC Rec. 48, A-78Reaffirmed: CLRPD Rep. C, A-89Res. 402, I-94Reaffirmed: CSA Rep. 6, A-04, Reaffirmed: BOT Rep. 8, I-06Reaffirmed: CSAPH Rep. 01, A-16)

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, binge-eating, dieting and weight restrictive behaviors in adolescents and to offer education and appropriate referral of adolescents and their families for culturally informed interventional counseling; and (4) participates in this effort by consulting with appropriate specialty societies and by assisting in

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the dissemination of appropriate and culturally informed educational and counseling materials pertaining to unhealthy eating, binge-eating, dieting, and weight restrictive behaviors.
(Res. 417, A-92Appended by Res. 503, A-98Modified and Reaffirmed: CSAPH Rep. 2, A-08Reaffirmed: CSAPH Rep. 01, A-18)

H-150.928: Eating Disorders and Promotion of Healthy Body Image
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. 01, A-17)

H-150.953: Obesity as a Major Public Health Problem
Our AMA will: (1) urge physicians as well as managed care organizations and other third party payers to recognize obesity as a complex disorder involving appetite regulation and energy metabolism that is associated with a variety of comorbid conditions;
(2) work with appropriate federal agencies, medical specialty societies, and public health organizations to educate physicians about the prevention and management of overweight and obesity in children and adults, including education in basic principles and practices of physical activity and nutrition counseling; such training should be included in undergraduate and graduate medical education and through accredited continuing medical education programs;
(3) urge federal support of research to determine: (a) the causes and mechanisms of overweight and obesity, including biological, social, and epidemiological influences on weight gain, weight loss, and weight maintenance; (b) the long-term safety and efficacy of voluntary weight maintenance and weight loss practices and therapies, including surgery; (c) effective interventions to prevent obesity in children and adults; and (d) the effectiveness of weight loss counseling by physicians;
(4) encourage national efforts to educate the public about the health risks of being overweight and obese and provide information about how to achieve and maintain a preferred healthy weight;
(5) urge physicians to assess their patients for overweight and obesity during routine medical examinations and discuss with at-risk patients the health consequences of further weight gain; if treatment is indicated, physicians should encourage and facilitate weight maintenance or reduction efforts in their patients or refer them to a physician with special interest and expertise in the clinical management of obesity;
(6) urge all physicians and patients to maintain a desired weight and prevent inappropriate weight gain;
(7) encourage physicians to become knowledgeable of community resources and referral services that can assist with the management of overweight and obese patients; and
(8) urge the appropriate federal agencies to work with organized medicine and the health insurance industry to develop coding and payment mechanisms for the evaluation and management of obesity.
(CSA Rep. 6, A-99Reaffirmation A-09Reaffirmed: CSAPH Rep. 1, A-09Reaffirmation A-10Reaffirmation I-10Reaffirmation A-12Reaffirmed in lieu of Res. 434, A-12, Reaffirmation A-13Reaffirmed: CSAPH Rep. 3, A-13Reaffirmation: A-19)

H-440.902: Obesity as a Major Health Concern
The AMA: (1) recognizes obesity in children and adults as a major public health problem; (2) will study the medical, psychological and socioeconomic issues associated with obesity, including reimbursement for evaluation and management of patients with obesity; (3) will work with other

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professional medical organizations, and other public and private organizations to develop evidence-based recommendations regarding education, prevention, and treatment of obesity; (4) recognizes that racial and ethnic disparities exist in the prevalence of obesity and diet-related diseases such as coronary heart disease, cancer, stroke, and diabetes and recommends that physicians use culturally responsive care to improve the treatment and management of obesity and diet-related diseases in minority populations; and (5) supports the use of cultural and socioeconomic considerations in all nutritional and dietary research and guidelines in order to treat patients affected by obesity.
(Res. 423, A-98Reaffirmed and Appended: BOT Rep. 6, A-04Reaffirmation A-10Reaffirmed in lieu of Res. 434, A-12Reaffirmation A-13Modified: Res. 402, A-17)

D-440.954: Addressing Obesity
1. Our AMA will: (a) assume a leadership role in collaborating with other interested organizations, including national medical specialty societies, the American Public Health Association, the Center for Science in the Public Interest, and the AMA Alliance, to discuss ways to finance a comprehensive national program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; (b) encourage state medical societies to collaborate with interested state and local organizations to discuss ways to finance a comprehensive program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; and (c) continue to monitor and support state and national policies and regulations that encourage healthy lifestyles and promote obesity prevention.
2. Our AMA, consistent with H-440.842, Recognition of Obesity as a Disease, will work with national specialty and state medical societies to advocate for patient access to and physician payment for the full continuum of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions).
3. Our AMA will: (a) work with state and specialty societies to identify states in which physicians are restricted from providing the current standard of care with regards to obesity treatment; and (b) work with interested state medical societies and other stakeholders to remove out-of-date restrictions at the state and federal level prohibiting healthcare providers from providing the current standard of care to patients affected by obesity.
(BOT Rep. 11, I-06Reaffirmation A-13Appended: Sub. Res. 111, A-14Modified: Sub. Res. 811, I-14Appended: Res. 201, A-18)

H-320.953: Definitions of "Screening" and "Medical Necessity"
(1) Our AMA defines screening as: Health care services or products provided to an individual without apparent signs or symptoms of an illness, injury or disease for the purpose of identifying or excluding an undiagnosed illness, disease, or condition.
(2) Our AMA recognizes that federal law (EMTALA) includes the distinct use of the word screening in the term "medical screening examination"; "The process required to reach, with reasonable clinical confidence, the point at which it can be determined whether a medical emergency does or does not exist."
(3) Our AMA defines medical necessity as: Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider.
(4) Our AMA incorporates its definition of "medical necessity" in relevant AMA advocacy documents, including its "Model Managed Care Services Agreement." Usage of the term

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"medical necessity" must be consistent between the medical profession and the insurance industry. Carrier denials for non-covered services should state so explicitly and not confound this with a determination of lack of "medical necessity".
(5) Our AMA encourages physicians to carefully review their health plan medical services agreements to ensure that they do not contain definitions of medical necessity that emphasize cost and resource utilization above quality and clinical effectiveness.
(6) Our AMA urges private sector health care accreditation organizations to develop and incorporate standards that prohibit the use of definitions of medical necessity that emphasize cost and resource utilization above quality and clinical effectiveness.
(7) Our AMA advocates that determinations of medical necessity shall be based only on information that is available at the time that health care products or services are provided.
(8) Our AMA continues to advocate its policies on medical necessity determinations to government agencies, managed care organizations, third party payers, and private sector health care accreditation organizations.
(CMS Rep. 13, I-98Reaffirmed: BOT Action in response to referred for decision Res. 724, A-99Modified: Res. 703, A-03Reaffirmation I-06, Reaffirmed: CMS Rep. 01, A-16)

D-440.980: Recognizing and Taking Action in Response to the Obesity Crisis
Our AMA will: (1) collaborate with appropriate agencies and organizations to commission a multidisciplinary task force to review the public health impact of obesity and recommend measures to better recognize and treat obesity as a chronic disease; (2) actively pursue, in collaboration and coordination with programs and activities of appropriate agencies and organizations, the creation of a "National Obesity Awareness Month"; (3) strongly encourage through a media campaign the re-establishment of meaningful physical education programs in primary and secondary education as well as family-oriented education programs on obesity prevention; (4) promote the inclusion of education on obesity prevention and the medical complications of obesity in medical school and appropriate residency curricula; and (5) make Council on Medical Education Report 3, A-17, Obesity Education, available on the AMA website for use by medical students, residents, teaching faculty, and practicing physicians.
(Res. 405, A-03Reaffirmation A-04Reaffirmation A-07Appended: Sub. Res. 315, A-15Modified: CME Rep. 03, A-17)

H-440.842: Recognition of Obesity as a Disease
Our AMA recognizes obesity as a disease state with multiple pathophysiological aspects requiring a range of interventions to advance obesity treatment and prevention.
(Res. 420, A-13)

H-425.994: Medical Evaluations of Healthy Persons
The AMA supports the following principles of healthful living and proper medical care: (1) The periodic evaluation of healthy individuals is important for the early detection of disease and for the recognition and correction of certain risk factors that may presage disease. (2) The optimal frequency of the periodic evaluation and the procedures to be performed vary with the patient's age, socioeconomic status, heredity, and other individual factors. Nevertheless, the evaluation of a healthy person by a physician can serve as a convenient reference point for preventive services and for counseling about healthful living and known risk factors. (3) These recommendations should be modified as appropriate in terms of each person's age, sex, occupation and other characteristics. All recommendations are subject to modification, depending upon factors such as the sensitivity and specificity of available tests and the prevalence of the diseases being sought in the particular population group from which the person comes. (4) The testing of individuals and of population groups should be pursued only when adequate treatment and follow-up can be arranged for the abnormal conditions and risk

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factors that are identified. (5) Physicians need to improve their skills in fostering patients' good health, and in dealing with long recognized problems such as hypertension, obesity, anxiety and depression, to which could be added the excessive use of alcohol, tobacco and drugs. (6) Continued investigation is required to determine the usefulness of test procedures that may be of value in detecting disease among asymptomatic populations.
(CSA Rep. D, A-82Reaffirmed: CLRPD Rep. A, I-92Reaffirmed: CSA Rep. 8, A-03Reaffirmed: CSAPH Rep. 1, A-13Reaffirmed: CMS Rep. 03, I-17)

60.015MSS Promotion of Healthy Body Image in Pre-Adolescent Children
AMA-MSS will ask the AMA to support school-based primary prevention programs for pre-adolescent children in order to prevent the onset of eating disorders and other behaviors associated with a negative body image. (MSS Res 11, I-05) (AMA Res 420, A-06 Referred) (CSAPH Rep 8, A-07 Adopted [D-150.984]) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

170.013MSS Public School Screening for Childhood Obesity
AMA-MSS will ask the AMA to (1) encourage research and evaluative studies to develop a unified, evidence-based tool to accurately determine youth and adolescent weight status; and (2) encourage widescale, comprehensive, school-based obesity prevention that includes didactic curriculum, nutrition standards, physical education programs, and parent and teacher involvement. (MSS GC Report E, A-07) (AMA Policy Reaffirmed in Lieu of AMA Res 803) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I17)

440.013MSS Obesity as a Chronic Disease
AMA-MSS will ask the AMA to: (1) recognize childhood and adult obesity as a major public health problem; and (2) work with other public and private organizations to develop ethical and evidence based recommendations regarding education, prevention, and treatment of obesity. (MSS Amended Sub Res 33, A-98) (AMA Amended Res 423, A-98 Adopted [H-440.902]) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Rep A, I-19)

440.018MSS Childhood Obesity as a Public Health Epidemic
AMA-MSS urges physicians to work with appropriate federal agencies, medical specialty societies, and public health organizations to overcome cultural, temporal, and economic barriers to exercise prescription by developing and demonstrating the effectiveness of culturally appropriate and necessary tools, including mass media based efforts, to help physicians more effectively counsel obese and overweight children and their families with special emphasis on targeting high risk groups. (MSS Sub Res 5, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 57
(N-21)

Introduced by: Omer Ashruf, Warren Lee, Meghana Chanamolu, Krithika Sundaram, Zeel Vaghasia, Varun Aitharaju, Rommel Morales, Meghana Chalasani, Vardhan Avasarala, Northeast Ohio Medical University; Sarah Cole, Florida Atlantic University College of Medicine; Tsola Efejuku, University of Texas Medical Branch; Zehra Rizvi, NSU Dr. Kiran C. Patel College of Osteopathic Medicine; Preetha Ghosh, Wayne State University School of Medicine; Dilpreet Kaeley, University of Toledo College of Medicine; Colton Goebel, Indiana University School of Medicine; Stephanie Lin, Zucker School of Medicine at Hofstra/Northwell; Harinandan Sainath, University of Texas Health San Antonio Long School of Medicine; Haley Nadone, University of Nevada Reno School of Medicine; Krishna Channa, University of Connecticut School of Medicine; Christopher Prokosch, University of Minnesota - Twin Cities

Sponsored by: Region 3, Region 4, Region 5, Region 7

Subject: Ensuring Competitive Pricing of Pharmaceutical Drugs

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Pharmaceutical Prices in the US

Whereas, Pharmaceutical drug prices in the United States are at an all-time high and more expensive than the rest of the industrialized world[1,2,3]; and

Whereas, Government-protected monopoly rights and limited negotiating power of public and private payers contribute to high drug prices in the U.S.[4]; and

Whereas, In the U.S., drug approval and the federal reimbursement process are tightly linked, with federal law requiring the Center for Medicare and Medicaid Services (CMS) to reimburse most, and in many cases all, drugs approved by the Food and Drug Administration (FDA)[5,6,7]; and

Whereas, Medicare must rely on the drug prices that have been negotiated by private insurers with pharmacies and manufacturers[5,8]; and

Whereas, Medicaid pricing is capped by federal upper limit and state maximum allowable costs, pricing points remain obscurely set as an integration of several benchmarks including acquisition costs, manufacturer prices, wholesale prices, and existing cost-sharing strategies[9]; and

Whereas, The Indian Health Services provides care for American Indian and Alaska Natives according to patient insurance, including Medicare and Medicaid pricing strategies, along with

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cost-sharing strategies such as discounted outpatient drugs to indigent populations (340B Drug Pricing Program)[10,11,12]; and

Whereas, Proposals that attempt to increase access and minimize costs to market drugs by removing parts of the FDA regulatory process are inherently complicated by laws requiring reimbursement for FDA-approved drugs and result in approval of highly expensive drugs with uncertain clinical efficacy[5,13]; and

Whereas, Faults in the FDA approval process are magnified due to the linked relationship of FDA drug approval and CMS coverage[5,13]; and

Whereas, The recent approval of the Alzheimer's drug *Aducanumab*, which was criticized by the FDA's own Advisory Committee for inadequate evidence on its clinical efficacy, could double the current Medicare expenditure on prescription drugs and force patients to pay up to $11,000 per year out-of-pocket[13,14,15]; and

Delinking Drug Approval and Automatic Coverage

Whereas, The "noninterference clause" of Medicare Part D prevents the Secretary of Health and Human Services and the federal government from being involved in drug price and coverage negotiations between drug manufacturers, insurers, and pharmacies or establishing a national drug formulary under the guise of market competition[16]; and

Whereas, Existing policy D-330.954 aims to restore negotiating power to the federal government, but the Congressional Budget Office concluded that providing negotiating authority to the federal government by itself would have a negligible impact on federal spending[17,18]; and

Whereas, Delinking FDA approval from CMS coverage can save more than $450 billion over 10 years in federal health plans, result in an average drug price reduction of 68 percent, and reduce premiums, as calculated by the Congressional Budget Office[19,20,21]; and

Whereas, A delinked model has been hypothesized to bolster drug innovation and enforce standards, and provide the CMS with information regarding comparative costs and benefits of drugs (that is otherwise disregarded during the FDA approval process)[22,23]; and

Whereas, While Medicare drug coverage is linked to FDA approval, drug coverage under the Department of Veterans Affairs (VA) is not linked to approval, providing the VA with greater leverage when negotiating prices with pharmaceutical companies and resulting in prices that are approximately 60% that of Medicare Part D plans;[5,24,25]; and

Whereas, Medicare Part D plans could save $14-22 billion per year if it paid the same for medications as the VA,[5,24,25]; and

Whereas, European models that negotiate price based on added therapeutic value incentivize innovation with clinical impact and result in lower drug prices compared to the U.S.[26,27,28,29]; and

Whereas, Transition to a delinked system has surfaced concerns about reduced access to/coverage of certain medications, when in reality the status-quo relationship between approval and reimbursement is on trajectory to create a state of "financial toxicity," potentially rendering

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CMS insolvent by 2024 and, in turn, leading to decreased access of expensive medications[30,31]; and

Whereas, The VA coverage model is associated with lower rates of cost-related medication nonadherence, which is especially pronounced in ethnic minorities and groups of low socioeconomic status[32]; and

Whereas, International delinkage models have not seen a reduction in drug access and have experienced success in negotiations[33]; and

Whereas, The U.S. federal government has shown repeated competence in negotiations efforts[34,35]; and

Coverage Determination

Whereas, In an attempt to link coverage decisions to the clinical and social value of pharmaceutical drugs, many countries and programs have implemented a formal cost-effectiveness analysis to help inform drug negotiations[36]; and

Whereas, Medicare Part D plans are increasingly imposing formulary exclusions, establishing a need for such thresholds: an analysis of thousands of plans found that over a 9 year span, the proportion of FDA-approved drugs covered by the average Part D plan dropped from 73% to 56%[37,38]; and

Whereas, Regional public payer statements have indicated that cost-effective analyses put forth by the Institute for Clinical and Economic Review (ICER) are likely to play a large role in coverage decisions and 9 out of 10 payers see a need in such assessments, with 64.5% saying they are 'likely' and 'extremely likely' to follow such thresholds[39,40]; and

Whereas, The Quality-Adjusted Life Year (QALY) has been deemed the “gold standard” by health organizations such ICER and The National Institute for Health and Care Excellence for measuring how well a medical treatment lengthens patients’ lives, and therefore has served as a integral component of cost-effectiveness in the United State and abroad for more than 30 years[41]; and

Whereas, QALY presents its results in terms of cost per life-year gained, cost per condition-specific measures of health benefits, and cost per “equal value of life years gained” (evLYG)[42]; and

Whereas, ICER’S QALY metrics are not used to compare between patients’ quality of life to determine who receives a drug, rather it is used to compare efficacy between medications, resolving concerns about patient discrimination[42]; and

Whereas, The Department of Veterans Affairs (VA) uses the cost-effectiveness threshold as a benchmark for coverage determinations and has partnered with ICER to supplement better price negotiations[43]; and

Whereas, This aforementioned partnership has been advantageous to both parties, as the VA better understands the relative clinical and social value of new drugs and provides more concrete pricing benchmarks for medications that are extremely costly upon release[43]; and

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Whereas, Concerns that cost-effectiveness thresholds would restrict VA access have not materialized[43]; and

Whereas, In the case of failed negotiations between the federal government and drug manufacturers, the National Institute for Health and Care Excellence (NICE) institutes a delayed phase-in period, in which a quota is set to prioritize drug allocation to the population most in need while negotiations are resumed[45]; and

Whereas, Since 2017, NICE has been able to negotiate almost all drugs that met the budget impact threshold[44,45]; and

Whereas, A publicly-funded value-based assessment of each drug would reduce the power imbalance between a sole-supplier and multiple consumers[46]; therefore be it

RESOLVED, That our AMA support federal legislation which advocates for the full delinkage of the Food and Drug Administration drug approval process and the Center for Medicare and Medicaid Services coverage determination; and be it further

RESOLVED, That our AMA support the use of Quality of Added Life Years (QALY) thresholds by the Center for Medicare and Medicaid Services to determine and compare clinical effectiveness and social value of pharmaceutical drugs as thresholds to decide coverage, reimbursement, and incentive programs.

a) In the case of failed negotiations with respective insurers, pharmacies, and brand manufacturers, the federal government institute a delayed phase-in period for the negotiated drug.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

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)

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)

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:

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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)

100.014MSS - Drug Pricing Reform
AMA-MSS (1) supports enabling Medicare and other federal health systems to negotiate drug prices with pharmaceutical companies, and support states who wish to negotiate with pharmaceutical companies, and support states who wish to negotiate with pharmaceutical companies for their state-run health programs; and (2) supports legislation that requires increased transparency and public accessibility to drug manufacturing costs from all players in the drug supply production chain, including but not limited to: drug manufacturers, pharmaceutical company marketing information, pharmaceutical research and development costs and distribution companies.

100.023MSS - Ensuring Fair Pricing of Drugs Developed with the United States Government
Our American Medical Association amend Policy H-110.987 by addition to read as follows:
Pharmaceutical Costs, H-110.987

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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.
14. Our AMA will support trial programs using international reference pricing for pharmaceuticals as an alternative drug reimbursement model for Medicare, Medicaid, and/or any other federally-funded health insurance programs, either as in individual solution or in conjunction with other approaches.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 58
(N-21)

Introduced by: Juliana Colvin, Kylie Rostad, Carly Polcyn, University of Toledo College of Medicine and Life Sciences; Cecilia Paterson, University of Utah School of Medicine

Sponsored by: Region 5
Subject: Advocating for Breastfeeding Protections for Medical Students
Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, Undergraduate and graduate medical education lasts on average 7-11 years[1], with completion of training between 30-34 years of age, thus creating an overlap between prime child-bearing years[2] and medical education; and

Whereas, The national average incoming medical class was 52% female in 2019[3] and an estimated 3%, or 435 students, had children during or prior to beginning medical school[4]; and

Whereas, The average age of matriculation to medical school is 24[3]and the average age of first-time motherhood is 26[5], creating a significant overlap between education and childbearing years; and

Whereas, The American Academy of Pediatrics, American College of Obstetrics and Gynecology, American Academy of Family Physicians (AAFP), and the World Health Organization all recommend breastfeeding as a primary source of infant nutrition[6] for the first six months of life; and

Whereas, Breastfeeding has many benefits to infants, including but not limited to a more robust immune system, lower rates of Sudden Infant Death Syndrome, and fewer allergic conditions such as eczema and asthma[7]; and

Whereas, Breastfeeding provides physical benefits to mothers, such as improved postpartum course, risk reduction for breast and ovarian cancer, and fewer postpartum urinary tract infections[7]; and

Whereas, Breastfeeding has emotional benefits to mothers, such as increased infant bonding and decreased rates of postpartum depression[7]; and

Whereas, Lactation success is dependent on a maternal interest in breastfeeding, which is negatively impacted by stress[8, 16]; and

Whereas, Lactation success is related to a mother's perception of her ability to meet the needs of her infant[8], which may be negatively impacted by barriers such as work and school; and

Whereas, Physician mothers report increased breastfeeding success with accommodating schedules and dedicated locations to pump breast milk[9]; and

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Whereas, Many medical trainees report inadequate breastfeeding[6] support from their training institutions and subsequently do not reach breastfeeding goals[10]; and

Whereas, Those medical trainees who did not meet their personal breastfeeding goals had associated negative emotions which influenced their personal attitudes when counseling patients on breastfeeding[10]; and

Whereas, A recent JAMA study evaluating the barriers of breastfeeding for physician mothers found that nearly half of mothers reported that they would have breastfed longer with greater support and accommodations from their workplace[9]; and

Whereas, Nearly one-third of physician mothers had to stop breastfeeding earlier than they desired[9]; and

Whereas, The AAFP recognizes that medical trainees face challenges that make it difficult to reach breastfeeding goals, and has recommended dismissing students to breastfeed whenever possible, and encourages the implementation of designated lactation rooms for medical trainees[6]; and

Whereas, The US Department of Education encourages educational institutes to offer lactation rooms[11] but does not provide specific instructions on how to do so; and

Whereas, The Accreditation Council for Graduate Medical Education has requirements and guidelines for lactation facilities for resident physician trainees, but medical students do not have similar guidelines from their accreditation bodies such as the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation but not medical students[6]; and

Whereas, Sufficient time allotments are needed to express breast milk: 20-30 minutes per session every 2-3 hours, and this time should be protected for all trainees[6]; and

Whereas, Medical students have reported pumping breast milk in closets and bathrooms due to lack of designated space[12]; and

Whereas, Federal law mandates all employers must give nursing mothers reasonable break time to express breast milk as well as a place, other than a bathroom, that is shielded from view and free from intrusion[13]; and

Whereas, Medical students are not considered hospital employees, thus many existing breastfeeding policies may not apply to them[14]; and

Whereas, Medical student mothers' right to breastfeed and avoid subsequent challenges to their education is protected under Title IX[15]; and

Whereas, Our AMA recognizes that breastfeeding is the optimal form of nutrition for most infants and supports increased availability of public facilities for breastfeeding and breast pumping (H-245.982); and

Whereas, Our AMA supports healthcare worker's right to safe and accessible spaces for breastfeeding and breast pumping (H-245.982); therefore be it,

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RESOLVED, That our AMA amend policy H-245.982 by addition and deletion to read as follows

AMA 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 breastfeeding; 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 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) advocates for the creation of comprehensive breastfeeding and breast pumping policies for medical students and healthcare trainees including lists of predetermined lactation rooms within reasonable distance with visual directions for all possible clinical sites and medical school campuses; (d) advocates to make information regarding breastfeeding and breast pumping locations and storage facilities for breast pumps, supplies, and milk available to medical students and healthcare trainees in student handbooks and clerkship handbooks; ~~(c)~~ (e) encourages the education of patients during prenatal care on the benefits of breastfeeding; ~~(d)~~ (f) supports breastfeeding in the health care system by encouraging hospitals to provide written breastfeeding policy that is communicated to all health care staff and students ~~(e)~~ (g) 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)~~ (h) 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

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formula and bottle-feeding options; and ~~(g)~~ (i) 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.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

AMA 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 medical education programs to support all residents, medical students and faculty who provide

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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 and 410, A-12; Appended: Res. 410, A-16; Appended: Res. 906, I-17; Reaffirmation: I-18)

245.002MSS AMA Support for Breastfeeding
AMA-MSS will ask the AMA to encourage 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: (a) education of parents about the medical benefits of breastfeeding and encouragement of its practice, and (b) education of parents about formula and bottle-feeding options.
(AMA Amended Res 506, A-93 Adopted [H-245.982]) (Reaffirmed: MSS Rep B, I00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

245.011MSS Protecting a Mother’s Right to Breastfeed

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AMA-MSS supports state legislation that clarifies and enforces a mother's right to breastfeed in a public place and will encourage all states to adopt breastfeeding legislation which clarifies and protects a mother's right to breastfeed in a public place. (MSS Res 15, A-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)

245.013MSS Promoting Breastfeeding in Hospitals:
AMA-MSS will ask the AMA to: (1) strengthen the support for breastfeeding in the health care system by encouraging hospitals to provide written breastfeeding policy that is communicated to health care staff; and (2) encourage 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.
(MSS Res 27, I-03) (AMA Amended Res 412, A-04 Adopted [D-245.997]) (Amended: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (D-245.997 Rescinded: CCB/CLRPD Rep. 1, A-14) (Reaffirmed: MSS GC Rep A, I-19)

270.017MSS Support for Legislation for Businesses to Provide Breastfeeding Employees Time, Facilities and Equipment for Breastfeeding:
AMA-MSS will ask the AMA to support legislation encouraging and promoting breast feeding, such as tax credits for businesses that provide facilities and equipment for employed breastfeeding mothers to breastfeed or express milk on business premises.
(MSS Sub Res 12, A-01) (AMA Res 243, A-01 Not Adopted) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

295.207MSS Family Planning for Medical Students:
AMA-MSS (1) encourages medical schools to create informative resources that promote a culture that is supportive of their students who are parents and to provide openly accessible information to prospective and current students regarding family planning in the specific medical school including parental leave and relevant make up work, options to preserve fertility, breastfeeding policies, accommodations during pregnancy, and resources for childcare that span the institution and surrounding area; and (2) supports the development of comprehensive requirements for medical schools regarding guidelines and resources for family leave and parenthood; and (3) supports medical schools providing six weeks of parental leave for medical students of all genders, medical school or broader licensure-related policies that allow for students to take a full six week leave without delaying graduation, and (4) encourages medical schools to make these formal policies easily accessible for both current and prospective students.
(MSS Res. 51, I-19) (Amended MSS WIM Report A, A-21)

665.016MSS Amending G-630.140 Lodging, Meeting Venues and Social Functions
AMAMSS will ask our AMA to amend policy G-630.140

> Lodging, Meeting Venues, and Social Functions to read as follows: Lodging, Meeting Venues, and Social Functions G-630.140 AMA-MSS Digest of Policy Actions/ 259 (1) Our AMA supports choosing hotels for its meetings, conferences, and conventions based on size, service, location, cost and similar factors. (2) Our AMA shall attempt, when allocating meeting space, to locate the Section Assembly Meetings in the House of Delegates Meeting hotel, or in a hotel close in proximity. (3) All meetings and conferences organized and/or primarily sponsored by our AMA will be held in a town, city, county or state that has enacted comprehensive legislation requiring smoke-free

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worksites and public places (including restaurants and bars), unless intended or existing contracts or special circumstances to justify an exception to this policy, and our AMA encourages state and local medical societies, national medical specialty societies and other health organizations to adopt a similar policy. (4) It is the policy of our AMA not to hold national meetings organized and/or primarily sponsored by our AMA, in cities, counties, or states, or pay member, officer or employee dues in any club, restaurant, or other institution, that has exclusionary policies, including but not limited to, policies based on race, color, religion, national origin, ethnic origin, language, creed, sex, sexual orientation, gender, gender identity and gender expression, disability, or age unless intended or existing contracts or special circumstances justify an exception to this policy. (5) Our AMA staff will work with facilities where AMA meetings are held to designate an area for breastfeeding and breast pumping.
(MSS Res 17, A-19)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 59
(N-21)

Introduced by: Brent Heineman, Ryan Englander, Zachary Towne, Leelakrishna Channa, Rodolfo Valentini, Annie Yao, University of Connecticut School of Medicine; Anand Singh, Texas Christian University and University of North Texas Health Science Center School of Medicine; Michelle Troup; University of South Carolina School of Medicine Greenville; Rhiya Mittal; University of Miami Miller School of Medicine

Sponsored by: Region 2
Subject: Supporting Healthcare Worker Mental Health during Disasters
Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, According to the United Nations Office for Disaster Risk Reduction, a disaster is "a serious disruption of the functioning of a community or society involving widespread human, material, economic or environmental losses and impacts, which exceeds the ability of the affected community or society to cope with its own resources[1];" and

Whereas, In the United States, approximately 40% of the population lives where there is a shortage of mental health professionals and 60% of counties lack a psychiatrist[2,3]; and

Whereas, Disasters worsen the mental health of affected communities[4-6]; and

Whereas, Post-traumatic stress disorder, anxiety, depression, and other mental health morbidities increase in prevalence among healthcare workers (HCWs) following natural, man-made, and public health disasters[7-10]; and

Whereas, Physicians and medical trainees have higher rates of suicide and depression compared to the general population[11]; and

Whereas, Mental health outcomes among HCWs have worsened during the COVID-19 pandemic, with HCWs citing challenges obtaining appropriate personal protective equipment, retaining sufficient staffing, and working long shifts in high-stress environments[12-14]; and

Whereas, The Physicians Foundation's 2020 survey found that approximately 60% of physician respondents experienced feelings of burnout, an increase from 40% in 2018, and that only 13% sought treatment for pandemic-related mental health concerns[15,16]; and

Whereas, An October 2020 American College of Emergency Physicians report found 72% of emergency medicine physicians experienced more professional burnout since the pandemic's start, but 73% felt stigma regarding mental health treatment in their workplace[17]; and

Whereas, Physicians also attribute adverse mental health outcomes among HCWs during the pandemic to financial barriers such as the cost of mental health services available to them[18,19]; and

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Whereas, Physicians currently face a variety of barriers to mental health services including fear of negative impact on their career and lack of institutional infrastructure support for mental health services[15,20]; and

Whereas, The COVID-19 pandemic has caused an increased need for mental health services, yet offices are closing due to increased operational costs and decreased revenue[21,22]; and

Whereas, In 2020, the estimated lost revenue attributed to the COVID-19 pandemic for community behavioral health organizations was approximately $40 billion, justifying a need for emergency funding[21]; and

Whereas, The Coronavirus Aid, Relief, and Economic Security (CARES) Act allocates funding to address community mental health needs and to financially support struggling providers, but does not specifically fund mental health care or interventions for providers during the pandemic[23]; and

Whereas, The Federal Emergency Management Agency (FEMA) funds the Crisis Counseling Assistance and Training Program (CCP), a short-term disaster relief grant provided to states, U.S. territories, and federally recognized tribes, following presidential disaster declarations[24]; and

Whereas, CCP grants only account for 1% of FEMA's annual total relief fund, and this support reaches only a fraction of survivors and typically lasts for a year, even though the mental health toll of disasters lasts much longer[24-27]; and

Whereas, The number of billion-dollar weather and climate disasters across the United States is steadily increasing, exposing more communities and providers to disaster each year[28]; and

Whereas, Resolution H-295.858 encourages medical schools and residency/fellowship programs to make urgent and emergent mental health care available but does not acknowledge or specify the need for these programs to provide adequate care to match the increased need for mental health care during disasters and emergencies[29-32]; and

Whereas, Current AMA advocacy upholds provider mental health by encouraging providers to seek mental health care, urging healthcare institutions to remove barriers to accessing care, and supporting legislation that encourages grants and interventions to reduce burnout, depression, and suicide among physicians, but does not emphasize the need for increased mental health funding during disasters; therefore be it

RESOLVED, That our AMA recognizes provider mental health as a crucial component of disaster and emergency preparedness and response; and be it further

RESOLVED, That our AMA encourages healthcare institutions to work with federal, state, and local stakeholders to secure sufficient funding and personnel to treat the mental health needs of their physicians, trainees, and other providers to prepare for and respond to all disasters; and be it further

RESOLVED, That our AMA advocates for legislation that creates an emergency fund for provider mental health which expeditiously allocates funding to support the acute and long-term

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mental health needs of physicians, trainees, and other providers in hospitals facing disasters; and be it further

RESOLVED, That our AMA amend Access to Confidential Health Services for Medical Students and Physicians H-295.858 by addition to read as follows:

Access to Confidential Health Care Services for Physicians and Trainees, D-405.978

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; and (4) can accommodate increased demand during disasters;

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:

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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.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY.

Pandemic Ethics and the Duty of Care D-130.960
The Council on Ethical and Judicial Affairs will reconsider its guidance on pandemics, disaster response and preparedness in terms of the limits of professional duty of individual physicians, especially in light of the unique dangers posed to physicians, their families and colleagues during the COVID-19 global pandemic.
(Res. 023, A-21)

Access to Confidential Health Care Services for Physicians and Trainees D-405.978
1. Our AMA will advocate that: (a) physicians, medical students and all members of the health care team (i) maintain self-care, (ii) are supported by their institutions in their self-care efforts, and (iii) in order to maintain the confidentiality of care, have access to affordable health care, including mental and physical health care, outside of their place of work or education; and (b) employers support access to mental and physical health care including but not limited to providing access to out-of-network in person and/or via telemedicine, thereby reducing stigma, eliminating discrimination, and removing other barriers to treatment.
2. Our AMA will advocate for best practices to ensure physicians, medical students and all members of the health care teams have access to appropriate behavioral, mental, primary, and specialty health care and addiction services.
(Res. 7, I-20)

Medical and Mental Health Services for Medical Students and Resident and Fellow Physicians H-345.973
Our AMA promotes the availability of timely, confidential, accessible, and affordable medical and mental health services for medical students and resident and fellow physicians, to include needed diagnostic, preventive, and therapeutic services. Information on where and how to access these services should be readily available at all education/training sites, and these services should be provided at sites in reasonable proximity to the sites where the education/training takes place.
(Res. 915, I-15; Revised: CME Rep. 01, I-16)

Pandemic Preparedness for Influenza H-440.847
In order to prepare for a potential influenza pandemic, our AMA: (1) urges the Department of Health and Human Services Emergency Care Coordination Center, in collaboration with the

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leadership of the Centers for Disease Control and Prevention (CDC), state and local health departments, and the national organizations representing them, to urgently assess the shortfall in funding, staffing, vaccine, drug, and data management capacity to prepare for and respond to an influenza pandemic or other serious public health emergency; (2) urges Congress and the Administration to work to ensure adequate funding and other resources: (a) for the CDC, the National Institutes of Health (NIH) and other appropriate federal agencies, to support implementation of an expanded capacity to produce the necessary vaccines and anti-viral drugs and to continue development of the nation's capacity to rapidly vaccinate the entire population and care for large numbers of seriously ill people; and (b) to bolster the infrastructure and capacity of state and local health department to effectively prepare for, respond to, and protect the population from illness and death in an influenza pandemic or other serious public health emergency; (3) urges the CDC to develop and disseminate electronic instructional resources on procedures to follow in an influenza epidemic, pandemic, or other serious public health emergency, which are tailored to the needs of physicians and medical office staff in ambulatory care settings; (4) supports the position that: (a) relevant national and state agencies (such as the CDC, NIH, and the state departments of health) take immediate action to assure that physicians, nurses, other health care professionals, and first responders having direct patient contact, receive any appropriate vaccination in a timely and efficient manner, in order to reassure them that they will have first priority in the event of such a pandemic; and (b) such agencies should publicize now, in advance of any such pandemic, what the plan will be to provide immunization to health care providers; (6) will monitor progress in developing a contingency plan that addresses future influenza vaccine production or distribution problems and in developing a plan to respond to an influenza pandemic in the United States.
(CSAPH Rep. 5, I-12; Reaffirmation: A-15; Modified: Res. 415, A-21)

The Effect of the COVID-19 Pandemic on Graduate Medical Education D-310.946
Our AMA will: (1) work with relevant stakeholders to advocate for equitable compensation and benefits for residents and fellows who are redeployed to fulfill service needs that may be outside the scope of their specialty training; and (2) urge the Accreditation Council for Graduate Medical Education (ACGME) and specialty boards to consider reducing case numbers and clinic visits with revised holistic measures to recognize resident/fellow learning, given the drastic educational barriers confronted during the COVID-19 pandemic.
(Res. 319, A-21)

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.

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(Res. 114, I-20)

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)

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.
(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)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 60
(N-21)

Introduced by: Alexandra Richards, Northwestern University Feinberg School of Medicine; Alexandra Piselli, Georgetown University School of Medicine; Alexandra Conry, University of South Carolina School of Medicine Greenville; Emily Smith, Carle Illinois College of Medicine; Jara Crawford, Indiana University School of Medicine.

Sponsored by: Region 2, Region 5

Subject: National Fertility Preservation Coverage Mandate

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, The medical definition of infertility, as defined by the American College of Obstetricians and Gynecologists (ACOG), the American Society for Reproductive Medicine (ASRM), the Centers for Disease Control and Prevention (CDC), and the World Health Organization (WHO), is the failure to conceive within one year of regular unprotected sexual intercourse[1,2,3,4]; and

Whereas, As the medical definition of infertility is not inclusive of non-heterosexual couples or those who experience acute iatrogenic infertility, ASRM provides a broader definition of infertility as "an impairment of a person's capacity to reproduce either as an individual or with her/his partner"[4]; and

Whereas, Infertility has been recognized as a disease by the WHO and the American Medical Association (AMA) since 2009[1,2]; and

Whereas, The CDC reports that about 8.8% of married women aged 15 to 44 years in the United States were unable to get pregnant after one year of trying from 2015-2017, which increased from 6.7% in 2011-2015 and 6% in 2006-2010[5]; and

Whereas, From 1970 to 2012, the percentage of women in the U.S. of advanced maternal age (35–44 years old) having children for the first time increased more than five-fold from 2.5 to 13.3 per 1000 women[6]; and

Whereas, Egg cryopreservation with a healthy, fertile woman that plans to become pregnant later in life (i.e. 45-50 years old) should ideally be performed for women less than 30 years of age, as clinical pregnancy rates decline with advanced maternal age at egg freezing[7,8]; and

Whereas, Egg freezing, embryo freezing, and ovarian tissue cryopreservation cost an average of $10,000-$15,000 with an annual storage cost of $300-$600, and in vitro fertilization (IVF) costs an average of $9,547 per cycle, all of which are often out-of-pocket costs[9,10]; and

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Whereas, Cost is a significant barrier to access for IVF, as a study from 2015 found that 70% of women who underwent IVF went into debt and 34% stopped fertility treatment due to costs[11]; and

Whereas, Women without insurance coverage of IVF treatments were three times more likely to discontinue IVF treatments compared to women with coverage[11]; and

Whereas, Nineteen states have infertility treatment and/or fertility preservation insurance coverage laws, but they vary widely from state to state in which services are covered[12,13]; and

Whereas, Nine states with infertility insurance coverage laws require the period of infertility to be longer than the medically defined period of one year in order to be eligible for assisted reproductive technologies[14]; and

Whereas, Cutler and Zeckhauser of the National Bureau of Economic Research have demonstrated the necessity of universal coverage for a health condition across insurance providers and plans, because when a single insurance plan offers additional coverage in the presence of plans that do not, it will attract an unhealthier patient population, resulting in increased costs, which generate cyclically increasing premiums, known as an adverse selection death spiral[15]; and

Whereas, A bill proposed in California to require private plans and Medi-Cal managed care plans to cover IVF services estimated that per member per month premiums would increase by approximately $5 in the private market and less than a $1.00 for Medi-Cal plans, and overall out of pocket spending for individuals seeking services would substantially decrease[16]; and

Whereas, Data from Massachusetts, Connecticut, and Rhode Island, which have been mandating infertility benefits for over 30 years, estimate the cost of infertility coverage to be less than 1% of total premium costs[13]; and

Whereas, A recently published international study demonstrated that Americans would be willing to pay the most on a monthly basis towards federal fertility treatment protections for individuals that struggle with fertility[16]; and

Whereas, Mercer's 2017 National Survey of Employer-Sponsored Health Plans demonstrates that employment-based fertility preservation coverage is often incomplete in scope, often only including fertility testing but lacking coverage for expensive treatments like IVF[13]; and

Whereas, Employer-based insurance plans exacerbate pre-existing socioeconomic barriers to access, given that such plans can often exclude employees that have less education, or those that work short-term or part-time[17]; and

Whereas, Social egg freezing and egg banking can play a role in fertility treatment by enabling childbearing for both LGBTQIA+ communities and unmarried persons[18]; and

Whereas, In the U.S., there exists racial disparities in seeking fertility treatment, as black women have been found to wait a longer period of time before visiting a physician for concerns of infertility compared to white women[19]; and

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Whereas, Eighty-five and one half percent of assisted reproductive technology is used by non-Hispanic white females, most commonly among those that have incomes >300% of the poverty level[20]; and

Whereas, Black women with military insurance coverage utilize IVF treatments at the same rate as white women with military insurance coverage, which suggests that lack of insurance coverage is a significant barrier to access[11]; and

Whereas, Racial minorities have been found to have a higher prevalence of STIs, and black women are more likely to have fibroids compared to white women, which are factors that contribute to infertility[20]; and

Whereas, AMA policy H-65.956 recognizes the right for transgender and non-binary individuals to access gamete preservation therapies prior to initiating gender affirming treatments, but fails to advocate for measures to ensure coverage for these fertility preservation services; and

Whereas, While AMA policy H-185.990 supports fertility preservation and infertility treatment insurance coverage, it only protects those with diagnosed infertility or iatrogenic infertility; and

Whereas, The American Cancer Society projects that 140,000 people are at risk for iatrogenic infertility each year, so expansion of coverage to anyone that cannot become pregnant or carry to term (known as impaired fecundity) would thus significantly expand services to cover the 13.1% of all women ages 15-49 to which this problem applies, which is almost 9.46 million women[5,21,22,23]; and

Whereas, Congress introduced bill "S.1461 - Access to Infertility Treatment and Care Act" in 2019 to require health insurance coverage fertility treatments[24]; therefore be it

RESOLVED, That our AMA support congressional bill S.1461- Access to Infertility Treatment and Care Act; and be it further

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

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 and will lobby for ~~payment for~~ federal protections that ensure insurance coverage for fertility preservation ~~therapy~~ services by all payers, including but not limited to diagnostic testing, treatment services including in vitro fertilization, and cryopreservation, ~~when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician~~ regardless of whether the services are in response to an infertility diagnosis or are preventative in nature. ~~and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic~~

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~~infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician.~~

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

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

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caused directly or indirectly by necessary medical treatments as determined by a licensed physician.
(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)

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.
(Res. 005, A-19)

Right for Gamete Preservation Therapies H-185.922
3. Our AMA supports insurance coverage for gamete preservation in any individual for whom a medical diagnosis or treatment modality is expected to result in the loss of fertility.
(Res. 005, A-19)

Infertility Benefits for Veterans H-510.984
1. Our AMA supports: (A) 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; and (B) 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 (C) 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.
2. Our AMA encourages: (A) 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, and (B) 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.
(CMS Rep. 01, I-16; Appended: Res. 513, A-19)

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)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 61
(N-21)

Introduced by: Rishab Chawla, Medical College of Georgia; Sereena Jivraj, Texas Christian University and University of North Texas Health Science Center School of Medicine; Samantha Pavlock, Florida State University School of Medicine; Kaitlyn Blair, Philadelphia College of Osteopathic Medicine; Christopher Prokosch, University of Minnesota Medical School; Dilpreet Kaeley, University of Toledo College of Medicine

Sponsored by: Region 4, Region 5, PsychSIGN

Subject: Support for Creation of Diagnostic Category for Climate-Associated Distress

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, Climate change increases the duration, frequency, and intensity of extreme weather, with the past decade bringing the highest temperatures ever recorded and in turn, droughts, floods, hurricanes, and wildfires[1-3]; and

Whereas, The 2021 Intergovernmental Panel on Climate Change Sixth Assessment Report found that global warming to 1.5 degrees Celsius is practically inevitable by 2040, and an atmospheric temperature increase of only 2 degrees Celsius is predicted to increase the number of level 4-5 Tropical Cyclones that are reported by 13%[4-5]; and

Whereas, The 2019 Lancet Countdown on Health and Climate Change Report underscored harrowing public health risks as a result of climate change, including food insecurity, infectious diseases, air pollution, and increased morbidity and mortality from exposure to extreme weather events[6]; and

Whereas, As a result of the drastic environmental ramifications and subsequent public health crises caused by extreme weather events, climate change has led to significant mental health implications[7-8]; and

Whereas, Numerous recent studies demonstrate that three categories of climate change (acute effects such as natural disasters, subacute effects such as drought, and chronic effects such as rising temperatures and sea levels) can affect mental health directly, due to aftermath of extreme weather, and indirectly, due to existential angst about the fate of the planet[9-10]; and

Whereas, Ecoanxiety, or chronic fear of environmental doom, across the US may be experienced by the 55% of adults who felt anxious about climate change's impact on their mental health in a 2020 American Psychiatric Association poll and 57% of teenagers who felt scared about climate change (and only 29% feeling hopeful) in a 2019 Kaiser Family Foundation poll[11-13]; and

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Whereas, A 2020 systematic review of 163 papers found that climate change is both directly and indirectly linked to the emergence of psychiatric disorders such as post-traumatic stress disorder (PTSD), depression, and anxiety[14]; and

Whereas, A retrospective analysis revealed a 0.7% rise in US counties and 2.1% rise in Mexican municipalities for a 1 °C increase in monthly average temperature[15]; and

Whereas, Survivors of Hurricane Maria and Hurricane Katrina were found to have substantially high rates of acute stress disorder and PTSD[16-17]; and

Whereas, Marginalized populations such as many Indigenous communities are particularly impacted by mental health consequences of climate change because their practice of subsistence living is an essential part of their culture and well-being[8, 17]; and

Whereas, The International Classification of Disease Tenth Edition (ICD-10), a system used by physicians and other healthcare providers to classify and code all diagnoses, is used not only in clinical settings but to advance understanding of public health and direct resources toward prevention and treatment[18-19]; and

Whereas, There are ICD-10 codes for socially-mediated diseases such as “Z60.9 problem related to social environment, unspecified,” but no reference to climate-related mental health conditions, though a variety of terms have been proposed to encapsulate several aspects such as “climate-related anxiety,” “ecological grief,” and “climate activist’s burnout” [14, 20-21]; and

Whereas, “Global Climate Change and Human Health H-135.938” acknowledges the public health implications of climate change and thus the creation of an ICD-11 code specifically for the mental health implications of climate change would be novel and in line with past AMA policy[22]; and therefore be it

RESOLVED, That our AMA work with relevant stakeholders such as the American Psychiatric Association (APA) to support the creation of an International Classification of Disease (ICD) code for distress caused by climate change.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS 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)

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.
(Res. 302, A-19)

Statement of Principles on Mental Health H-345.999
(1) Tremendous strides have already been made in improving the care and treatment of patients with psychiatric illness, but much remains to be done. The mental health field is vast and includes a network of factors involving the life of the individual, the community and the nation. Any program designed to combat psychiatric illness and promote mental health must, by the nature of the problems to be solved, be both ambitious and comprehensive.
(2) The AMA recognizes the important stake every physician, regardless of type of practice, has in improving our mental health knowledge and resources. The physician participates in the mental health field on two levels, as an individual of science and as a citizen. The physician has much to gain from a knowledge of modern psychiatric principles and techniques, and much to contribute to the prevention, handling and management of emotional disturbances. Furthermore,

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as a natural community leader, the physician is in an excellent position to work for and guide effective mental health programs.
(3) The AMA will be more active in encouraging physicians to become leaders in community planning for mental health.
(4) The AMA has a deep interest in fostering a general attitude within the profession and among the lay public more conducive to solving the many problems existing in the mental health field.
(A-62 Reaffirmed: CLRPD Rep. C, A-88 Reaffirmed: Sunset Report, I-98 Reaffirmation A-99 Reaffirmed: CSAPH Rep. 1, A-09 Modified: CSAPH Rep. 01, A-19)

Toward Environmental Responsibility 135.012MSS
AMA-MSS will ask the AMA to recognize the negative impact of climate change on global human health, particularly in the areas of infectious disease, the direct effects of heat, severe storms, food and water availability, and biodiversity.
(MSS Amended Rep A, I-07) (AMA Res 607, A-08 Referred) (Modified: MSS GC Report A, I-16)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 62
(N-21)

Introduced by: Haley Marber, University of Miami Miller School of Medicine; Kaivalya Gudooru, Long School of Medicine

Sponsored by: Region 4, PsychSIGN

Subject: Expanding Access to Behavioral Therapy in Attention-Deficit Hyperactivity Disorder

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, Attention-Deficit Hyperactivity Disorder (ADHD) is the most common behavioral disorder in childhood, with a prevalence of approximately 8.4%[1]; and

Whereas, Robust clinical trials have shown the benefits and efficacy of behavioral therapy including individual behavioral therapy, parent management training, and classroom behavior interventions, in treatment of ADHD[2-4]; and

Whereas, Parent management training and classroom behavior interventions promote behavioral and socioemotional development, and the CDC recommends these for all children under the age of 6 years with ADHD prior to beginning treatment with stimulants[5]; and

Whereas, Combined behavioral and medication treatment provides better outcomes for children in terms of “oppositional/aggressive symptoms, internalizing symptoms, teacher rated social skills, parent-child relations and reading achievement” than solely medical treatment [6]; and

Whereas, The treatment of ADHD poses a large financial burden on families across the United States due a variety of factors including cost of physician visit copays, medication, and behavior therapy[7-8]; and

Whereas, Children of low socio-economic status (SES) and who identify as racial minorities receive a lower quality of care than their high-SES and white counterparts[9]; and

Whereas, Patients with lower socio-economic backgrounds tend to have more severe presentation of ADHD[10]; and

Whereas, Behavioral therapy is significantly underutilized and under-prescribed in children with ADHD, with less than 50% of children with ADHD having documented insurance claims for any type of psychological services, and only 60% of children with ADHD receiving behavioral therapy[11-12]; and

Whereas, Medicaid in only 38 states covers the cost of parent-child dyadic therapy, and in only 12 states covers the cost of evidence-based parent management training[13]; and

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Whereas, Medicaid in only 34 states covers the cost of evidence-based interventions with mental health specialists that take place in early education or day care programs despite evidence that programming within educational settings is highly effective[13]; therefore it be

RESOLVED, That our AMA support private and public insurance reimbursement for evidence-based behavioral management of Attention-Deficit Hyperactivity Disorder; and it be further

RESOLVED, That our AMA encourage providers to utilize multimodal treatment in the management of Attention-Deficit Hyperactivity Disorder; and it be further

RESOLVED, That our AMA support national Medicaid coverage for evidence-based parent-child dyadic and parent management training for the treatment of Attention-Deficit Hyperactivity Disorder; and it be further

RESOLVED, That our AMA support national Medicaid coverage for evidence-based therapies administered in early education settings for the treatment of Attention-Deficit Hyperactivity Disorder.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

Medical Care of Persons with Developmental Disabilities H-90.968
1. Our AMA encourages: (a) clinicians to learn and appreciate variable presentations of complex functioning profiles in all persons with developmental disabilities; (b) medical schools and graduate medical education programs to acknowledge the benefits of education on how aspects in the social model of disability (e.g. ableism) can impact the physical and mental health of persons with Developmental Disabilities; (c) medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental disabilities, to improve quality in clinical care; (d) the education of physicians on how to provide and/or advocate for quality, developmentally appropriate medical, social and living supports for patients with developmental disabilities so as to improve health outcomes; (e) medical schools and residency programs to encourage faculty and trainees to appreciate the opportunities for exploring diagnostic and therapeutic challenges while also accruing significant personal rewards when delivering care with professionalism to persons with profound developmental disabilities and multiple co-morbid medical conditions in any setting; (f) medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for the developmentally disabled; and (g) cooperation among physicians, health & human services professionals, and a wide variety of adults with developmental disabilities to implement priorities and quality improvements for the care of persons with developmental disabilities.
2. Our AMA seeks: (a) legislation to increase the funds available for training physicians in the care of individuals with intellectual disabilities/developmentally disabled individuals, and to increase the reimbursement for the health care of these individuals; and (b) insurance industry and government reimbursement that reflects the true cost of health care of individuals with intellectual disabilities/developmentally disabled individuals.
3. Our AMA entreats health care professionals, parents and others participating in decision-making to be guided by the following principles: (a) All people with developmental disabilities, regardless of the degree of their disability, should have access to appropriate and affordable medical and dental care throughout their lives; and (b) An individual's medical condition and welfare must be the basis of any medical decision. Our AMA advocates for the highest quality medical care for persons with profound developmental disabilities; encourages support for health care facilities whose primary mission is to meet the health care needs of persons with profound developmental disabilities; and informs physicians

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that when they are presented with an opportunity to care for patients with profound developmental disabilities, that there are resources available to them.
4. Our AMA will continue to work with medical schools and their accrediting/licensing bodies to encourage disability related competencies/objectives in medical school curricula so that medical professionals are able to effectively communicate with patients and colleagues with disabilities, and are able to provide the most clinically competent and compassionate care for patients with disabilities.
5. Our AMA recognizes the importance of managing the health of children and adults with developmental disabilities as a part of overall patient care for the entire community.
6. Our AMA supports efforts to educate physicians on health management of children and adults with developmental disabilities, as well as the consequences of poor health management on mental and physical health for people with developmental disabilities.
7. Our AMA encourages the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, and allopathic and osteopathic medical schools to develop and implement curriculum on the care and treatment of people with developmental disabilities.
8. Our AMA encourages the Accreditation Council for Graduate Medical Education and graduate medical education programs to develop and implement curriculum on providing appropriate and comprehensive health care to people with developmental disabilities.
9. Our AMA encourages the Accreditation Council for Continuing Medical Education, specialty boards, and other continuing medical education providers to develop and implement continuing education programs that focus on the care and treatment of people with developmental disabilities.
10. Our AMA will advocate that the Health Resources and Services Administration include persons with intellectual and developmental disabilities (IDD) as a medically underserved population.
(CCB/CLRPD Rep. 3, A-14; Appended: Res. 306, A-14; Appended: Res. 315, A-17; Appended: Res. 304, A-18; Reaffirmed in lieu of the first Resolved: Res. 304, A-18)

Diagnosis and Treatment of Attention Deficit/Hyperactivity Disorder in School-Age Children H-60.950:
Our AMA: (1) encourages physicians to utilize standardized diagnostic criteria in making the diagnosis of ADHD, such as the American Psychiatric Association's DSM-5™, as part of a comprehensive evaluation of children and adolescents presenting with attentional or hyperactivity complaints; (2) urges that attention be directed toward establishing developmentally appropriate criteria for the diagnosis and treatment of ADHD in adults; (3) encourages the creation and dissemination of practice guidelines for ADHD by appropriate specialty societies and their use by practicing physicians and assist in making physicians aware of their availability; (4) encourages efforts by medical schools, residency programs, medical societies, and continuing medical education programs to increase physician knowledge about ADHD and its treatment; (5) encourages the use of individualized therapeutic approaches for patients diagnosed with ADHD, which may include pharmacotherapy, psycho-education, behavioral therapy, school-based and other environmental interventions, and psychotherapy as indicated by clinical circumstances and family preferences; (6) encourages physicians and medical groups to work with schools to improve teachers' abilities to recognize ADHD and appropriately recommend that parents seek medical evaluation of potentially affected children; and (7) encourages further research on the relative risks and benefits of medication used to treat ADHD, including evaluation of the impact of labeling changes on access to treatment and physician prescribing.
(CSA Rep. 5, A-97; Modified: CSAPH Rep. 10, A-07; Modified: CSAPH Rep. 01, A-17)

Children and Youth With Disabilities H-60.974

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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 Rep. J, I-91; Modified: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 1, A-21)

Standardizing Coverage of Applied Behavioral Analysis Therapy for Persons with Autism Spectrum Disorder H-185.921
Our AMA supports coverage and reimbursement for evidence-based treatment of Autism Spectrum Disorder including, but not limited to, Applied Behavior Analysis Therapy.
(Res. 123, A-19)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 63
(N-21)

Introduced by: Ryan Englander, Brent Heineman, University of Connecticut School of Medicine; Sarah Mae Smith, University of California-Irvine School of Medicine.

Sponsored by: Region 1, Region 7, APAMSA, PsychSIGN

Subject: Support for Democracy

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, Democracy is most commonly defined as a system of government wherein the people exercise power either directly or indirectly through representatives who are periodically chosen in free and fair elections[1-4]; 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"[5]; and

Whereas, Multiple studies have shown a clear positive correlation between electoral integrity in democracies and improvements in indicators of population health, including infant mortality, mortality from cardiovascular disease and other communicable diseases, and tuberculosis[6-9]; and

Whereas, A recent study including data from 168 countries from 1960 through 2010 found a positive association between democracy and life expectancy that remained even after controlling for potential confounders like GDP per capita[10]; and

Whereas, An analysis of the shift to electronic voting in Brazil, which disproportionately enabled the poor and less well-educated to participate in elections, showed the change led to increases in health spending that increased utilization of prenatal care and decreased the number of children being born at low weight, suggesting that increasing access to meaningful elections can improve population health[11]; and

Whereas, A 2018 analysis comparing different Indian states across core attributes of democracy showed that having higher voter turnout and more political parties were both significantly associated with reductions in infant mortality[12]; and

Whereas, One study showed that the presence of competitive elections in autocracies was associated with better life expectancy and rates of infant mortality as compared to autocracies without competitive elections[13]; and

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Whereas, Studies have shown that democracies may enhance the beneficial effects of various societal transformations, including trade liberalization and foreign aid, on population health[14-17]; and

Whereas, Studies have shown that democracies may suppress the harmful effects of a variety of negative economic indicators and disasters, including storms, floods, droughts, and other environmental disruptions, extreme price volatility, and excessive mining and mineral extraction, on overall population health[18-20]; and

Whereas, An August 2021 analysis of 170 countries over the time period from 1990 to 2019 published in *Health Affairs* indicated that democratic quality and universal health coverage have a statistically-significant positive association, with free and fair elections identified as having the strongest association with higher universal health coverage[21]; and

Whereas, A 2020 *BMJ* study of 17 countries found that decreases in democratic traits, including free and fair elections, freedom of expression, freedom of civil and political association, between 2000 and 2010 were associated with lower life expectancy, reduced progress toward universal health coverage, and increased out-of-pocket spending on healthcare[22]; and

Whereas, The annual Freedom House reports, which rate the political and civil rights of countries around the globe, have tracked a steady decline in multiple dimensions of democracy in the United States from 2010 to 2020[23-25]; and

Whereas, From November 2020 to January 2021, multiple key government officials attempted to subvert the results of the 2020 presidential election through a variety of mechanisms[26-30]; and

Whereas, During the counting of electoral votes on January 6-7, 2021, hundreds of Representatives and Senators in Congress voted to reject electoral votes from key states in an attempt which, if it had been successful, would have overturned the results of the 2020 presidential election[31-33]; and

Whereas, Multiple state legislatures have since passed laws that provide unprecedented control over state and local elections and could permit those legislatures to subvert election results[34-37]; and

Whereas, These antidemocratic trends in the United States directly threaten the ability of physicians and their patients to make their voices heard, thereby depriving them of a key avenue to maximize their health and well-being; therefore be it

RESOLVED, That our AMA unequivocally support the democratic process, wherein representatives are regularly chosen through free and fair elections, as essential for maximizing the health and well-being of all Americans; and be it further

RESOLVED, That our AMA strongly oppose attempts to subvert the democratic process; and be it further

RESOLVED, That our AMA assert that every candidate for political office and every officeholder in the public trust must support the democratic process and never take steps or support steps by others to subvert it; and be it further

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RESOLVED, That our AMA encourage AMPAC to permanently cease donations to political candidates who failed to certify the results of the 2020 presidential election in Congress, and further encourage AMPAC to publicly commit to ceasing donations to political candidates who attempt to subvert election results in the future.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

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.
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

Endorsements for Public Office G-605.035
Our AMA requires that all of its endorsements of nominations of appointed officials for public office be considered and voted upon by our Board of Trustees prior to any public pronouncements of support.

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Rep. of the Task Force on Recording and Reporting of Trustees' Votes, A-11; Reaffirmed: CCB/CLRPD Rep. 3, A-12

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 64
(N-21)

Introduced by: Raag Agrawal, UCLA; Skyler Burke, Washington State University Elson S. Floyd College of Medicine; Michael Rigby, University of Wisconsin School of Medicine and Public Health

Sponsored by: n/a

Subject: Protecting Clinical AI from Adversarial Attacks

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, Clinical 'Augmented Intelligence' (AI) Tools have immense potential to transform clinical practice, there is a concerning potential for adversarial attacks that could compromise clinical AI and expose patient data[1]; and

Whereas, Cyberattacks against healthcare institutions are becoming increasingly common, with a reported 300% increase since the beginning of 2020[2,3]; and

Whereas, AI models can themselves be manipulated to change their behavior and outputs - for example, misclassifying a malignant mole as benign[1]; and

Whereas, Augmented Intelligence systems have been demonstrated to be vulnerable to manipulation by images that appear unmanipulated by human users[4]; and

Whereas, Future cyberattacks could potentially go beyond ransoming patient data, and inject otherwise innocuous images into models to transform their behavior and negatively impact patient care[5]; therefore be it

RESOLVED, That our AMA amend the following policy by addition as follows:

H-480.940 Augmented Intelligence in Health Care

As a leader in American medicine, our AMA has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community.

To that end our AMA will seek to:
1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians' professional satisfaction to help set priorities for health care AI.
2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and

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implementation of health care AI.
3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:
a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;
b. is transparent;
c. conforms to leading standards for reproducibility;
d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and
e. safeguards patients' and other individuals' privacy interests and preserves the security and integrity of personal information.
4. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.
5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI. <u>This should include supporting the development of guidelines and standards that require health care AI to be audited regularly for possible adversarial manipulation that may change its behavior.</u>

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

D-478.960: Ransomware and Electronic Health Records

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1. Our AMA acknowledges that healthcare data interruptions are especially harmful due to potential physical harm to patients and calls for prosecution to the fullest extent of the law for perpetrators of ransomware and any other malware on independent physicians and their practices, healthcare organizations, or other medical entities involved in providing direct and indirect care to patients.
2. Our AMA will: (a) advocate for federal legislation which provides for the prosecution of perpetrators of ransomware and any other malware on any and all healthcare entities, involved in direct and indirect patient care, to the fullest extent of the law; (b) encourage health care facilities and integrated networks that are under threat of ransomware attacks to upgrade their cybersecurity and to back up data in a robust and timely fashion; (c) advocate that the security of protected healthcare information be considered as an integral part of national cybersecurity protection; and (d) seek inclusion of federal cybersecurity resources allocated to physician practices, hospitals, and health care entities sufficient to protect the security of the patients they serve, as part of infrastructure legislation.
(Res. 210, A-21)

3.3.3: Breach of Security in Electronic Medical Records
When used with appropriate attention to security, electronic medical records (EMRs) promise numerous benefits for quality clinical care and health-related research. However, when a security breach occurs, patients may face physical, emotional, and dignitary harms.

Dedication to upholding trust in the patient-physician relationship, to preventing harms to patients, and to respecting patients' privacy and autonomy create responsibilities for individual physicians, medical practices, and health care institutions when patient information is inappropriately disclosed.

The degree to which an individual physician has an ethical responsibility to address inappropriate disclosure depends in part on his or her awareness of the breach, relationship to the patient(s) affected, administrative authority with respect to the records, and authority to act on behalf of the practice or institution.

When there is reason to believe that patients' confidentiality has been compromised by a breach of the electronic medical record, physicians should:

(a) Ensure that patients are promptly informed about the breach and potential for harm, either by disclosing directly (when the physician has administrative responsibility for the EMR), participating in efforts by the practice or health care institution to disclose, or ensuring that the practice or institution takes appropriate action to disclose.

(b) Follow all applicable state and federal laws regarding disclosure. Physicians have a responsibility to follow ethically appropriate procedures for disclosure, which should at minimum include:

(c) Carrying out the disclosure confidentially and within a time frame that provides patients ample opportunity to take steps to minimize potential adverse consequences.

(d) Describing what information was breached; how the breach happened; what the consequences may be; what corrective actions have been taken by the physician, practice, or

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institution; and what steps patients themselves might take to minimize adverse consequences.

(e) Supporting responses to security breaches that place the interests of patients above those of the physician, medical practice, or institution.
(f) Providing information to patients to enable them to mitigate potential adverse consequences of inappropriate disclosure of their personal health information to the extent possible.
(Issued: 2016)

H-480.971: The Computer-Based Patient Record
The following steps will allow the AMA to act as a source of physician input to the revolutionary developments in computer-based medical information applications, as a coordinator, and as an educational resource for physicians. The AMA will: (1) Provide leadership on these absolutely critical and rapidly accelerating issues and activities. (2) Work, in cooperation with state and specialty associations, to bring computer education and information to physicians. (3) Work to define the characteristics of an optimal medical record system; the goal being to define the content, format and functionality of medical record systems, and aid physicians in evaluating systems for office practice computerization. (4) Focus on the CPR aspect of human-computer interaction (the physician data input step) and work with software venders on the design of facile interfaces. (5) Provide guidance on the use of computer diagnosis and therapeutic support systems. (6) Continue to be involved in national forums on issues of electronic medical data control, access, security, and confidentiality. (7) Continue to work to ensure that issues of patient confidentiality and security of data are continually addressed with implementation resolved prior to the implementation and use of a computer-based patient record.
(BOT Rep. 29, A-96; Reaffirmation: A-04; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation: I-08; Reaffirmation: A-09; Reaffirmed in lieu of Res. 724, A-13; Reaffirmed: BOT Rep. 17, A-15; Reaffirmed: BOT Rep. 19, A-18)

H-480.940: Augmented Intelligence in Health Care

As a leader in American medicine, our AMA has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community.

To that end our AMA will seek to:
1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians' professional satisfaction to help set priorities for health care AI.
2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.
3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:
a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;
b. is transparent;
c. conforms to leading standards for reproducibility;
d. identifies and takes steps to address bias and avoids introducing or exacerbating health

care disparities including when testing or deploying new AI tools on vulnerable populations; and
e. safeguards patients' and other individuals' privacy interests and preserves the security and integrity of personal information.
4. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.
5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI.
(BOT Rep. 41, A-18)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 65
(N-21)

Introduced by: Hira Ali, Mariha Syed, Annie Huang, Avrohom Levy, Safiya Shaikh, Midwestern University Arizona College of Osteopathic Medicine; Jeffrey Marsal, A.T. Still University School of Osteopathic Medicine Arizona; Rebecca Anderson, University of Nebraska Medical Center

Sponsored by: n/a

Subject: Providing Pain Management Standards and Protocols for Outpatient Gynecologic Procedures

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, Procedural pain is well known to reduce the efficacy of any procedure, decrease procedure completion, patient cooperation during the procedure, satisfaction with the procedure, and likelihood to undergo same or similar procedure in the future, thus diminishing continuity and quality of care[1,2,3]; and

Whereas, Unrelieved acute pain has consequences beyond the immediate perception of pain and can negatively impact patients' well-being on multiple levels including reduced quality of life, impaired sleep, impaired physical function, high economic costs of unrelieved pain, and physiological consequences of unrelieved pain[4]; and

Whereas, Women experience severe acute pain (mean scores of 7 to 9 out of 10) during uterine intervention[5]; and

Whereas, Most women have a high expectation of pain prior to IUD insertion, endometrial biopsy, colposcopy and other office visit gynecologic procedures[6]; and

Whereas, Women who are nulliparous, are postmenopausal, have a history of dysmenorrhea, or suffer from anxiety are more likely to experience greater pain with gynecologic procedures [7]; and

Whereas, There is limited evidence on interventions to decrease pain experienced by patients during gynecologic procedures, and of the studies that have been done on this topic, many have small sample sizes [7-10]; and

Whereas, Current prophylactic interventions including NSAID use, paracervical block, and misoprostol with IUD insertions has demonstrated mild to no positive patient benefit[9]; and

Whereas, Topical anesthetic use on the cervix has not been an effective form of pain management, specifically in regards to tenaculum placement which is commonplace for many gynecologic procedures[7]; and

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Whereas, The International Classification of Diseases currently does not recognize gynecologic pain during procedures as a diagnosis[11]; and

Whereas, Many minor gynecological procedures are surgical procedures and done in office[12, 13]; and

Whereas, Outpatient gynecologic procedures can increase both patient and provider convenience, avoid the risk of general anesthesia, and decrease healthcare costs[7]; and

Whereas, Office setting gynecologic interventions diminish the risks of anesthesia complications and hospitalization, while minimizing recovery time, as well as the need for equipment and associated costs when compared to outpatient gynecologic interventions performed in the operating room under general anesthesia[14];and

Whereas, There exist guidelines for the provision of analgesia/sedation by non-anesthesiologists to maximize patient safety during outpatient procedures[15]; and

Whereas, It is recognized by Medical Boards that controlled substances, including opioid analgesics, may be essential in the treatment of acute pain due to trauma or surgery and chronic pain, whether due to cancer or non-cancer origins[16]; and

Whereas, Current federal opioid legislation requires the FDA to develop evidence-based opioid analgesic prescribing guidelines for the indication-specific treatment of acute pain and requires the Centers for Medicaid and Medicare to publish a guideline for prescribing opioids to Medicare patients[17]; and

Whereas, Increased use of long-acting reversible contraception (LARC), intrauterine devices (IUDs) and the contraceptive implant, can have a profound impact on decreasing rates of unintended pregnancies and abortions and may help reduce health disparities. Programs that increase LARC use contribute to declines in pregnancy and abortion rates among young, low-income women[18,19]; and

Whereas, Poorly managed non-gynecologic pain in the context of poor patient education decreases patient satisfaction, the ability to progress functionally and has been found to increase the likelihood of persistent pain following certain procedures[21] and patient-based pain educational programs can lead to improvements of relevant patient-reported outcomes[20]; and

Whereas, Patient- and family-centered care applied to diverse populations and health-care providers, improved knowledge of health, skills to manage self-care behaviors, satisfaction, quality of life, and reduced admissions and length of the hospital stay. Regarding health-care providers, the interventions improve job satisfaction and confidence, quality of care, and reduce stress and burnout[22]; therefore be it

RESOLVED That our AMA partner with and seek feedback from the American College of Obstetricians and Gynecologists, and other relevant stakeholders to identify resources and up-to-date information to empower physicians to have a more individualized and multi-modal approach incorporating patient collaboration and education to manage pain in outpatient gynecologic procedures; and be it further

RESOLVED That our AMA encourage the Centers for Medicare & Medicaid Services to recognize gynecologic pain during procedures as a diagnostic problem; and be it further

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RESOLVED That our AMA support research initiatives to determine a patient-centered standard practice of care for individualized pain management during outpatient gynecologic procedures; and be it further

RESOLVED That our AMA encourage the Federal Drug Administration to consider the unique needs of patients undergoing gynecologic procedures when developing opioid analgesic prescribing guidelines for the indication-specific treatment of acute pain.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

Promotion of Better Pain Care D-160.981
1. Our AMA: (a) will express its strong commitment to better access and delivery of quality pain care through the promotion of enhanced research, education and clinical practice in the field of pain medicine; and (b) encourages relevant specialties to collaborate in studying the following: (i) the scope of practice and body of knowledge encompassed by the field of pain medicine; (ii) the adequacy of undergraduate, graduate and post graduate education in the principles and practice of the field of pain medicine, considering the current and anticipated medical need for the delivery of quality pain care; (iii) appropriate training and credentialing criteria for this multidisciplinary field of medical practice; and (iv) convening a meeting of interested parties to review all pertinent matters scientific and socioeconomic.

2. Our AMA encourages relevant stakeholders to research the overall effects of opioid production cuts.

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3. Our AMA strongly urges the US Drug Enforcement Administration to base any future reductions in aggregate production quotas for opioids on actual data from multiple sources, including prescribing data, and to proactively monitor opioid quotas and supply to prevent any shortages that might develop and to take immediate action to correct any shortages.

4. Our AMA encourages the US Drug Enforcement Administration to be more transparent when developing medication production guidelines.

5. Our AMA and the physician community reaffirm their commitment to delivering compassionate and ethical pain management, promoting safe opioid prescribing, reducing opioid-related harm and the diversion of controlled substances, improving access to treatment for substance use disorders, and fostering a public health based-approach to addressing opioid-related morbidity and mortality.

Res. 321, A-08; Appended: Res. 522, A-10; Reaffirmed in lieu of Res. 518, A-12; Reaffirmed: BOT Rep. 19, A-16; Reaffirmed in lieu of Res. 117, A-16; Appended: Res. 927, I-16; Appended: Res. 526, A-17; Modified: BOT Action in response to referred for decision Res. 927, I-16; Reaffirmed: Res. 235, I-18; Reaffirmed in lieu of: Res. 228, I-18; Reaffirmation: A-19

Pain Management D-120.976

Our AMA will: (1) support more effective promotion and dissemination of educational materials for physicians on prescribing for pain management; (2) take a leadership role in resolving conflicting state and federal agencies' expectations in regard to physician responsibility in pain management; (3) coordinate its initiatives with those state medical associations and national medical specialty societies that already have already established pain management guidelines; and (4) disseminate Council on Science and Public Health Report 5 (A-06), "Neuropathic Pain," to physicians, patients, payers, legislators, and regulators to increase their understanding of issues surrounding the diagnosis and management of maldynia (neuropathic pain); and (5) disseminate Council on Science and Public Health Report 5 (A-10), "Maldynia: Pathophysiology and Nonpharmacologic Approaches," to physicians, patients, payers, legislators, and regulators to increase their understanding of issues surrounding the diagnosis and management of maldynia (neuropathic pain).

Res. 809, I-04; Appended: CSAPH Rep. 5, A-06; Appended: CSAPH Rep. 5, A-10; Reaffirmed in lieu of Res. 518, A-12; Reaffirmation: A-19

Pain as the Fifth Vital Sign D-450.956

Our AMA will: (1) work with The Joint Commission to promote evidence-based, functional and effective pain assessment and treatment measures for accreditation standards; (2) strongly support timely and appropriate access to non-opioid and non-pharmacologic treatments for pain, including removing barriers to such treatments when they inhibit a patient's access to care; (3) advocate that pain as the fifth vital sign be eliminated from professional standards and usage; and (4) advocate for the removal of the pain management component of patient satisfaction surveys as it pertains to payment and quality metrics.

BOT Rep. 19, A-16; Reaffirmation: A-19

Promotion of Better Pain Care D-160.981
1. Our AMA: (a) will express its strong commitment to better access and delivery of quality pain care through the promotion of enhanced research, education and clinical practice in the field of pain medicine; and (b) encourages relevant specialties to collaborate in studying the following:

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(i) the scope of practice and body of knowledge encompassed by the field of pain medicine; (ii) the adequacy of undergraduate, graduate and post graduate education in the principles and practice of the field of pain medicine, considering the current and anticipated medical need for the delivery of quality pain care; (iii) appropriate training and credentialing criteria for this multidisciplinary field of medical practice; and (iv) convening a meeting of interested parties to review all pertinent matters scientific and socioeconomic. 2. Our AMA encourages relevant stakeholders to research the overall effects of opioid production cuts. 3. Our AMA strongly urges the US Drug Enforcement Administration to base any future reductions in aggregate production quotas for opioids on actual data from multiple sources, including prescribing data, and to proactively monitor opioid quotas and supply to prevent any shortages that might develop and to take immediate action to correct any shortages. 4. Our AMA encourages the US Drug Enforcement Administration to be more transparent when developing medication production guidelines. 5. Our AMA and the physician community reaffirm their commitment to delivering compassionate and ethical pain management, promoting safe opioid prescribing, reducing opioid-related harm and the diversion of controlled substances, improving access to treatment for substance use disorders, and fostering a public health based-approach to addressing opioid-related morbidity and mortality.
Res. 321, A-08; Appended: Res. 522, A-10; Reaffirmed in lieu of Res. 518, A-12; Reaffirmed: BOT Rep. 19, A-16; Reaffirmed in lieu of Res. 117, A-16; Appended: Res. 927, I-16; Appended: Res. 526, A-17; Modified: BOT Action in response to referred for decision Res. 927, I-16; Reaffirmed: Res. 235, I-18; Reaffirmed in lieu of: Res. 228, I-18; Reaffirmation: A-19

Workforce and Coverage for Pain Management H-185.931
1. Our AMA supports efforts to improve the quality of care for patients with pain, 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. 2. Our AMA supports guidance on pain management for different clinical indications developed by the specialties who manage those conditions and disseminated the same way other clinical guidelines are promoted, such as through medical journals, medical societies, and other appropriate outlets. 3. Our AMA will advocate for an increased focus on comprehensive, multidisciplinary pain management approaches that include the ability to assess co-occurring mental health or substance use conditions, are physician led, and recognize the interdependency of treatment methods in addressing chronic pain. 4. Our AMA 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. 5. Our AMA supports efforts to expand the capacity of practitioners and programs capable of providing physician-led interdisciplinary pain management services, as well as an expanded behavioral health workforce to improve the availability of services to address the psychological, behavioral, and social aspects of pain and pain management within multidisciplinary pain clinics. Patients and their caregivers should be involved in the decision-making process. 6. Our AMA supports an expanded availability of comprehensive multidisciplinary pain medicine clinics for patients in both urban and rural areas, and an improvement in payment models for comprehensive multidisciplinary pain clinics services such that such services can become more financially viable.
CMS/CSAPH Rep. 1, A-15; Reaffirmed: BOT Rep. 5, I-15; Reaffirmed: BOT Rep. 19, A-16; Reaffirmed in lieu of Res. 117, A-16; Modified: BOT Rep. 38, A-18; Reaffirmed in lieu of: Res. 228, I-18; Reaffirmation: A-19

Research, Education and Awareness Regarding Non-Opioid Pain Management Treatments 100.018 MSS

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AMA-MSS supports the efforts of the AMA Opioid Task Force and its goal to reduce opioid abuse. *MSS Res 35, A-17*

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 66
(N-21)

Introduced by: Shyon Parsa, Omar Shaikh UT Southwestern Medical School

Sponsored by: n/a

Subject: Earmarking for More Research Targeted towards Preventative Medicine and Cardiology Care using Artificial Intelligence

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, Chronic diseases from preventable causes can profoundly reduce quality of life[1]; and

Whereas, Chronic diseases that develop from preventable causes heart disease, stroke, diabetes, and kidney disease cost the United States $1 trillion dollars in 2016 alone[2]; and

Whereas, Artificial intelligence has been shown to be able to effectively help detect when patients are at risk for chronic disease[3]; and

Whereas, The incidence of heart failure, a complication of chronic heart disease, continues to rise across the world with at least 26 million people with the condition[4], and 915,000 new cases each year in the United States[4]; and

Whereas, An aging population is playing a large role in this phenomena[5–8]; and

Whereas, Current methods of ascertaining asymptomatic heart failure use cardiovascular magnetic resonance (CMR) data on cardiac structure and function[9,10]; and

Whereas, The costly nature of this imaging modality has prevented widespread utilization of the modality in clinical practice[11–13]; and

Whereas, Cardiac biomarkers such as troponin t and blood B-type natriuretic peptide (nt-BNP) increase with worsening heart failure status and serve as a prognostic marker for the development of disease[14,15]; and

Whereas, A model that could predict cardiac structure and function without necessitating the use of CMR, and one that would correlate to cardiac biomarkers in the blood without requiring routine testing, would be both cost effective and simple to implement on a broad scale, an important consideration for a risk stratification model[16]; and

Whereas, A risk prediction model should have predictive ability for an outcome of interest that would improve mortality with a clinically proven intervention, with the variables of interest the model has calculated being low cost and easily accessible to allow for implementation of the metric in a variety of healthcare settings[16]; therefore be it

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RESOLVED, That our AMA-MSS will support the earmarking of funding towards research endeavors that target preventative measures that reduce the incidence of chronic disease by using artificial intelligence, and be it further

RESOLVED, That our AMA-MSS will support community-based cardiology care practices including but not limited to the utilization of artificial intelligence in modeling rates of heart failure in patient populations and machine learning algorithms to create risk models for heart failure outcomes.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

Augmented Intelligence in Health Care H-480.939

Our AMA supports the use and payment of augmented intelligence (AI) systems that advance the quadruple aim. AI systems should enhance the patient experience of care and outcomes, improve population health, reduce overall costs for the health care system while increasing value, and support the professional satisfaction of physicians and the health care team. To that end our AMA will advocate that:

1. Oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment.

2. Payment and coverage for all health care AI systems must be conditioned on complying with all appropriate federal and state laws and regulations, including, but not limited to those governing patient safety, efficacy, equity, truthful claims, privacy, and security as well as state medical practice and licensure laws.

3. Payment and coverage for health care AI systems intended for clinical care must be conditioned on (a) clinical validation; (b) alignment with clinical decision-making that is familiar to physicians; and (c) high-quality clinical evidence.

4. Payment and coverage for health care AI systems must (a) be informed by real world workflow and human-centered design principles; (b) enable physicians to prepare for and transition to new care delivery models; (c) support effective communication and engagement between patients, physicians, and the health care team; (d) seamlessly integrate clinical, administrative, and population health management functions into workflow; and (e) seek end-user feedback to support iterative product improvement

5. Payment and coverage policies must advance affordability and access to AI systems that are designed for small physician practices and patients and not limited to large practices and institutions. Government-conferred exclusivities and intellectual property laws are meant to foster innovation, but constitute interventions into the free market, and therefore, should be appropriately balanced with the need for competition, access, and affordability.

6. Physicians should not be penalized if they do not use AI systems while regulatory oversight, standards, clinical validation, clinical usefulness, and standards of care are in flux. Furthermore, our AMA opposes:

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a. Policies by payers, hospitals, health systems, or governmental entities that mandate use of health care AI systems as a condition of licensure, participation, payment, or coverage.

b. The imposition of costs associated with acquisition, implementation, and maintenance of healthcare AI systems on physicians without sufficient payment.

7. Liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. Our AMA will further advocate:

a. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.

b. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.

c. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm

8. Our AMA, national medical specialty societies, and state medical associations—

a. Identify areas of medical practice where AI systems would advance the quadruple aim;

b. Leverage existing expertise to ensure clinical validation and clinical assessment of clinical applications of AI systems by medical experts;

c. Outline new professional roles and capacities required to aid and guide health care AI systems; and

d. Develop practice guidelines for clinical applications of AI systems.

9. There should be federal and state interagency collaboration with participation of the physician community and other stakeholders in order to advance the broader infrastructural capabilities and requirements necessary for AI solutions in health care to be sufficiently inclusive to benefit all patients, physicians, and other health care stakeholders. (New HOD Policy)

10. AI is designed to enhance human intelligence and the patient-physician relationship rather than replace it.

BOT Rep. 21, A-19

Augmented Intelligence in Health Care H-480.940

As a leader in American medicine, our AMA has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community.

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To that end our AMA will seek to:

1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians' professional satisfaction to help set priorities for health care AI.

2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.

3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:

a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;

b. is transparent;

c. conforms to leading standards for reproducibility;

d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and

e. safeguards patients' and other individuals' privacy interests and preserves the security and integrity of personal information.

4. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.

5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI.

BOT Rep. 41, A-18

Promotion of Healthy Lifestyles I: Reducing the Population Burden of Cardiovascular Disease by Reducing Sodium Intake H-150.929

Our AMA encourages:

(1) accrediting and licensing bodies to study how AI should be most appropriately addressed in accrediting and licensing standards;

(2) medical specialty societies and boards to consider production of specialty-specific educational modules related to AI;

(3) research regarding the effectiveness of AI instruction in medical education on learning and clinical outcomes;

(4) institutions and programs to be deliberative in the determination of when AI-assisted technologies should be taught, including consideration of established evidence-based

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treatments, and including consideration regarding what other curricula may need to be eliminated in order to accommodate new training modules;

(5) stakeholders to provide educational materials to help learners guard against inadvertent dissemination of bias that may be inherent in AI systems;

(6) the study of how differences in institutional access to AI may impact disparities in education for students at schools with fewer resources and less access to AI technologies;

(7) enhanced training across the continuum of medical education regarding assessment, understanding, and application of data in the care of patients;

(8) the study of how disparities in AI educational resources may impact health care disparities for patients in communities with fewer resources and less access to AI technologies;

(9) institutional leaders and academic deans to proactively accelerate the inclusion of nonclinicians, such as data scientists and engineers, onto their faculty rosters in order to assist learners in their understanding and use of AI; and

(10) close collaboration with and oversight by practicing physicians in the development of AI applications.

CME Rep. 04, A-19

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 67
(N-21)

Introduced by: Laila Koduri, Tulane University School of Medicine; Shreya Mandava, University of Virginia School of Medicine; Krithika Sundaram, Meghana Chanamolu, Northeast Ohio Medical University.

Sponsored by: n/a

Subject: Additional Safeguards for Children Enrolled in Clinical Studies.

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, Children are unable to give legal consent because they are under the legal age of 18 years, therefore consent is given on their behalf by a parent or legal guardian[1]; and

Whereas, in 2019, 63.6% of the deaths that occured in children in the United States were due to non-traumatic, non-intentional causes[12]; and

Whereas, clinical trials in children are an essential tool for formulating treatments for preventable diseases, as well as the safety and efficacy of medications since their anatomy and physiology is significantly different compared to adults[12]; and

Whereas, Clinical trials are necessary to provide information about the safety and efficacy of drugs for children and prevent the off-label use of medications approved for adults [3]; and

Whereas, There has been a significant increase in the number of children enrolled in clinical studies in the recent years [4, 11]; and

Whereas, In 2015, 27% of the world's population are children[5]; and

Whereas, In 2015, Pediatric trials made up only 16.7% of the total number of clinical trials listed[5], and

Whereas, The conditions studied in current pediatric clinical trials account for only 12% of the 60% of total pediatric disease burden [5]; and

Whereas, Currently, children enrolled in research studies are given protection with regulations such as risk minimization,requirements for permission, and standard for investigators' knowledge base in pediatrics[1]; and

Whereas, even though there are regulations that protect children involved in clinical trials, challenges still exist, particularly, when acquiring consent from children in research studies due to variability in age, maturity, health literacy levels and high levels of miscommunication [6]; and

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Whereas, Children have been found to be more susceptible to adverse events, such as irritability, infection, and blood abnormalities, in clinical trials compared to other age groups [7]; and

Whereas, It is critical to balance the inclusion of children in high-quality studies for their potential benefits with the responsibility to minimize adverse events and protect their autonomy [8]; and

Whereas, Basic ethical principles for the protection of human research participants including respect for persons, beneficence, and justice should be considered when conducting research on children in additional to adults [8];

Whereas, the Children's Health act, a bipartisan legislation signed by President Bush in 2000 that increased research on childhood conditions like diabetes, asthma, and developmental disorders, increased funding for children's hospitals with academic training programs, and increased health service access for pregnant women and infants to decrease infant mortality [9, 10]; and

Whereas, The Department of Health and Human services (DHHS) considers children as a vulnerable population and grants them additional protections as research subjects[1]; and

Whereas, DHHS regulations are only applicable to the U.S. Food and Drug Administration (FDA)-regulated products[1]; and

Whereas, A significant number of clinical trials use drugs, biologics, or devices that are not FDA-regulated[13]; and

Whereas, Although federal agencies have recognized the priority medication safety in children, there is a lack of research in pediatric medication safety[14]; and

Whereas, There is a high risk for adverse drug reactions in pediatric populations suggesting a lack of adequate clinical trial data[15]; and

Whereas, Evidence suggests that children can validly report their health status at as young as 8 years of age[14]; and

Whereas, Clinicians and researchers continue to ask caregivers to provide proxy health reports for children even though they are only weakly correlated with the child's reports[14]; and

Whereas, AMA has previous policy promoting inclusion of women and minority populations in clinical trials (H-460.911), however there is no current AMA policy advocating for the inclusion of and additional safeguards for children in any type of clinical trial; therefore be it

RESOLVED, That our AMA support promoting the participation of and implementing additional protections for children enrolled in all clinical trials including but not limited to

1. Use of child-friendly, collaborative efforts when providing information
2. Safe optimization of drug doses to avoid adverse drug events
3. Strict guidelines on monitoring and addressing any adverse effects
4. Assessing child-reported outcomes for studying adverse effects

; and be it further

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RESOLVED, That our AMA support legislative efforts to require that all research involving children be in compliance with the Department of Health and Human Services' regulations.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

Increasing Minority Participation in Clinical Research H-460.911
1. Our AMA advocates that:
a. The Food and Drug Administration (FDA) conduct annual surveillance of clinical trials by gender, race, and ethnicity, including consideration of pediatric and elderly populations, to determine if proportionate representation of women and minorities is maintained in terms of enrollment and retention. This surveillance effort should be modeled after National Institute of Health guidelines on the inclusion of women and minority populations.
b. The FDA have a page on its web site that details the prevalence of minorities and women in its clinical trials and its efforts to increase their enrollment and participation in this research; and
c. Resources be provided to community level agencies that work with those minorities who are not proportionately represented in clinical trials to address issues of lack of access, distrust, and lack of patient awareness of the benefits of trials in their health care. These minorities include Hispanics, Asians/Pacific Islanders/Native Hawaiians, and Native Americans.

2. Our AMA recommends the following activities to the FDA in order to ensure proportionate representation of minorities in clinical trials:
a. Increased fiscal support for community outreach programs; e.g., culturally relevant community education, community leaders' support, and listening to community's needs;
b. Increased outreach to female physicians to encourage recruitment of female patients in clinical trials;
c. Continued minority physician education on clinical trials, subject recruitment, subject safety, and possible expense reimbursements;
d. Support for the involvement of minority physicians in the development of partnerships between minority communities and research institutions; and
e. Fiscal support for minority recruitment efforts and increasing trial accessibility through transportation, child care, reimbursements, and location.

3. Our AMA advocates that specific results of outcomes in all clinical trials, both pre- and post-FDA approval, are to be determined for all subgroups of gender, race and ethnicity, including consideration of pediatric and elderly populations; and that these results are included in publication and/or freely distributed, whether or not subgroup differences exist.
(BOT Rep. 4, A-08; Reaffirmed: CSAPH Rep. 01, A-18)

Principles for Conduct and Reporting of Clinical Trials H-460.912

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Our AMA: (1) endorses the Association of American Medical Colleges' "Principles for Protecting Integrity in the Conduct and Reporting of Clinical Trials"; (2) commends the AAMC, the Centers for Education and Research in Therapeutics and the BlueCross BlueShield Association for the development and dissemination of these principles; (3) supports the timely dissemination of clinical trial data for public accessibility as permitted by research design and/or regulatory protocol; (4) supports the promotion of improved data sharing and the reaffirmation and enforcement of deadlines for submitting results from clinical research studies; (5) encourages the expansion of clinical trial registrants to ClinicalTrials.gov; and (6) will sign the petition titled "All Trials Registered; All Results Reported" at Alltrials.net that supports the registration of all past, present and future clinical trials and the release of their summary reports.
(Res. 544, A-06; Appended: Res. 907, I-15; BOT Action in response to referred for decision: Res. 907, I-15)

Genomics in Hypertension: Risk Prediction and Treatment H-460.901

Our AMA encourages continued research on the genetic control of blood pressure, including in pediatric populations, and the development of genomic-based tools that may assist health professionals in better predicting risk and targeting therapy for hypertension, and supports the view that hypertension clinical trial designs should attempt to reduce phenotypic heterogeneity in order to improve the quality and interpretation of results.
(CSAPH Rep. 1, I-14)

Reduction of Sports-Related Injury and Concussion H-470.954

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.

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5. Our AMA supports research into the detection, causes, and prevention of injuries along the continuum from sub concussive head impacts to conditions such as chronic traumatic encephalopathy (CTE).
(CSAPH Rep. 3, A-15; Appended: Res. 905, I-16)

Use of Atypical Antipsychotics in Pediatric Patients D-120.950

Our AMA will: (1) urge the National Institute of Mental Health to assist in developing guidance for physicians on the use of atypical antipsychotic drugs in pediatric patients; and (2) encourage and support ongoing federally funded research, with a focus on long term efficacy and safety studies, on the use of antipsychotic medication in the pediatric population.
(CSAPH Rep. 1, I-12)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 68
(N-21)

Introduced by: Jennifer Concepcion; Ryan Andrade; Brandon Poppe, A.T. Still University School of Osteopathic Medicine Arizona

Sponsored by: n/a

Subject: Improving Care Coordination Among Patients, PCPs, and Specialists

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

Whereas, Referrals from primary care physicians to specialists in the United States more than doubled from 41 million to 105 million in the years 1999-2009, and continues to rise[1,2]; and

Whereas, Referrals introduce more providers into care, which requires coordinated care to avoid higher costs, duplication, and overuse of diagnostic procedures, multiple medication prescriptions, and conflicting therapies, especially in patients with chronic conditions[3,4]; and

Whereas, These adverse outcomes can be attributed to incoherence between healthcare levels, with a lack of interaction and trust between primary care and specialized care professionals identified as part of the problem[5]; and

Whereas, Poor communication between primary care and specialists is a significant problem within the U.S. healthcare system and interferes with effective care coordination[6]; and

Whereas, Successful care coordination is reliant on a specialty “triad” which includes the patient, primary care provider (PCP), and specialist; yet, the responsibility is often solely placed on the PCP, and the patient is often omitted from coordination efforts likely secondary to difficulties with eliciting patient values, preferences, and needs regarding the delivery of their care[7,8]; and

Whereas, Appropriate care coordination has been associated with better patient experiences, depression management, cost management, and lower utilization of services; however, in the context of higher specialty care utilization, the PCP’s ability to coordinate effectively is reduced[9-12]; and

Whereas, Lack of coordination results from poorly defined roles and responsibilities that may be secondary to disagreements about what constitutes an appropriate and complete referral and which provider should continue care after specialty visits[7]; and

Whereas, Electronic health records (EHR) are increasingly being used to facilitate referral communication in the outpatient setting since the passage of Health Information Technology for Economic and Clinical Health Act in 2009, but key capabilities required for effective coordination are still needed[13,14]; and

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Whereas, The Veterans Health Administration, the largest integrated health system serving over 6 million patients annually, has used a comprehensive electronic medical records (EMR) system to bridge the gap between primary care and specialty care, but continues to report unexplained breakdowns in primary-specialty referral communication, rendering the EMR alone insufficient[6,10,15]; and

Whereas, Our American Medical Association (AMA) already supports timely and consistent communication between hospital providers and primary care physicians to minimize gaps in care that may occur when patients are transitioning between the inpatient and outpatient setting, but lacks support for transitions between primary and specialty care; and

Whereas, Our AMA has approved efforts to establish a nationwide health information network via EMRs and other interoperability initiatives, but current policy does not address supplemental or adjunctive measures to improve overall care coordination; and

Whereas, Referral templates, a supplementary measure to the EHR, that highlight pertinent patient history, the need for specialist evaluation, and the condition to be addressed during the consultation with the specialist have been successful in expressing the appropriateness, clarity, and completeness of a referral[2]; and

Whereas, Care coordination agreements, another supplementary measure created primarily by the PCP and specialist to outline shared responsibility, have been a promising program approach to address the need for clarity during and most importantly, after the referral process, especially in the context of practices that comanage specific medical conditions[7,8,10,16,17]; and

Whereas, In 2010, the American College of Physicians proposed guiding principles for care coordination agreements, including (a) defining the types of referral, consultation, and co-management agreements, (b) specifying accountability between providers, (c) addressing the handling of secondary referrals, and (d) developing methods to review the agreements' effectiveness to improve collaboration between the PCP and specialist[8]; and

Whereas, Opportunities for direct communication through phone and email messaging to compensate for the lack of pre-existing role clarity and limitations to the EMR have been identified, and when utilized, may protect patient safety, especially during time-sensitive shifts in care that require prompt collaboration[3]; and

Whereas, E-consults, another supplementary method used to facilitate communication between the PCP and specialist, offered more timely access to specialist opinions, improved patient access to specialty care, expedited communication between providers, promoted effective management of patients with chronic disease, and increased patient, PCP, and specialist satisfaction[18-24]; and

Whereas, Patients have identified a central role for other healthcare personnel (nurses and clinical pharmacists) in specialty care, but PCPs and specialists did not recognize this role which highlights a potential opportunity to leverage other members of the healthcare team to facilitate interprofessional teamwork, an approach supported by the Interprofessional Teamwork Innovation Model, and improve specialty care and patient advocacy efforts[7,25]; therefore be it,

RESOLVED, Our AMA research supplementary measures to the electronic health record in the referral process including, but not limited to, referral templates (outlining pertinent patient

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history, specific indication for referral, and the medical condition to be addressed), coordinated care agreements that involve patients to outline shifts in anticipated roles and responsibilities, and other forms of direct communication between specialists and primary care physicians (e-consults, messaging via phone and email) to assess their clinical utility in improving care coordination between primary care physicians, specialists, and patients; and be it further

RESOLVED, Our AMA study the utilization of other healthcare personnel including, but not limited to, social workers, case managers, nurses, and clinical pharmacists to assist with the implementation of supplementary measures and reduce the burden placed on primary care providers and specialists when appropriate and evaluate the effectiveness of an interprofessional approach to improve overall specialty care coordination and patient satisfaction.

Fiscal Note: TBD

Date Received: 09/15/2021

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RELEVANT AMA AND AMA-MSS POLICY

D-160.945 - Communication Between Hospitals and Primary Care Referring Physicians

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Our AMA:

1. advocates for continued Physician Consortium for Performance Improvement? (PCPI) participation in the American College of Physicians (ACP), the Society of General Internal Medicine (SGIM), and the Society of Hospital Medicine (SHM) work to develop principles and standards for care transitions that occur between the inpatient and outpatient settings;
2. advocates for timely and consistent inpatient and outpatient communications to occur among the hospital and hospital-based providers and physicians and the patient's primary care referring physician; including the physician of record, admitting physician, and physician-to-physician, to decrease gaps that may occur in the coordination of care process and improve quality and patient safety;
3. will continue its participation with the Health Information Technology Standards Panel (HITSP) and provide input on the standards harmonization and development process;
4. continues its efforts with The Joint Commission, the Centers for Medicare & Medicaid Services, and state survey and accreditation agencies to develop accreditation standards that improve patient safety and quality; and
5. will explore new mechanisms to facilitate and incentivize communication and transmission of data for timely coordination of care (via telephone, fax, e-mail, or face-to-face communication) between the hospital-based physician and the primary physician.

(BOT Rep. 1, A-08; Reaffirmed in lieu of Res. 731, A-09; Appended: Res. 722, A-11; Reaffirmed: CMS Rep. 3, I-12; Reaffirmed: CMS Rep. 06, A-16; Reaffirmed: CMS Rep. 017, I-16; Reaffirmed: BOT Action in response to referred for decision Res. 816, I-16)

H-160.902 - Hospital Discharge Communications

1. Our AMA encourages the initiation of the discharge planning process, whenever possible, at the time patients are admitted for inpatient or observation services and, for surgical patients, prior to hospitalization.
2. Our AMA encourages the development of discharge summaries that are presented to physicians in a meaningful format that prominently highlight salient patient information, such as the discharging physician's narrative and recommendations for ongoing care.
3. Our AMA encourages hospital engagement of patients and their families/caregivers in the discharge process, using the following guidelines:
    a. Information from patients and families/caregivers is solicited during discharge planning, so that discharge plans are tailored to each patient's needs, goals of care and treatment preferences.
    b. Patient language proficiency, literacy levels, cognitive abilities and communication impairments (e.g., hearing loss) are assessed during discharge planning. Particular attention is paid to the abilities and limitations of patients and their families/caregivers.
    c. Specific discharge instructions are provided to patients and families or others responsible for providing continuing care both verbally and in writing. Instructions are provided to patients in layman's terms, and whenever possible, using the patient's preferred language.
    d. Key discharge instructions are highlighted for patients to maximize compliance with the most critical orders.
    e. Understanding of discharge instructions and post-discharge care, including warning signs and symptoms to look for and when to seek follow-up care, is confirmed with patients and their families/caregiver(s) prior to discharge from the hospital.

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4. Our AMA supports making hospital discharge instructions available to patients in both printed and electronic form, and specifically via online portals accessible to patients and their designated caregivers.
5. Our AMA supports implementation of medication reconciliation as part of the hospital discharge process. The following strategies are suggested to optimize medication reconciliation and help ensure that patients take medications correctly after they are discharged:
    a. All discharge medications, including prescribed and over-the-counter medications, should be reconciled with medications taken pre-hospitalization.
    b. An accurate list of medications, including those to be discontinued as well as medications to be taken after hospital discharge, and the dosage and duration of each drug, should be communicated to patients.
    c. Medication instructions should be communicated to patients and their families/caregivers verbally and in writing.
    d. For patients with complex medication schedules, the involvement of physician-led multidisciplinary teams in medication reconciliation including, where feasible, pharmacists should be encouraged.
6. Our AMA encourages patient follow-up in the early time period after discharge as part of the hospital discharge process, particularly for medically complex patients who are at high-risk of re-hospitalization.
7. Our AMA encourages hospitals to review early readmissions and modify their discharge processes accordingly.

(CMS Rep. 07, I-16)

H-155.994 - Sharing of Diagnostic Findings

The AMA

1. urges all physicians, when admitting patients to hospitals, to send pertinent abstracts of the patients' medical records, including histories and diagnostic procedures, so that the hospital physicians sharing in the care of those patients can practice more cost-effective and better medical care;
2. urges the hospital to return all information on in-hospital care to the attending physician upon patient discharge; and
3. encourages providers, working at the local level, to develop mechanisms for the sharing of diagnostic findings for a given patient in order to avoid duplication of expensive diagnostic tests and procedures.

(BOT Rep. A, NCCMC Rec. 26, A-78; Sub. Res. 115, I-78; Reaffirmed: CLRPD Rep. C, A-89; CMS Rep. 12, A-95; Reaffirmed: CMS Rep. 7, A-05; Reaffirmed: CMS Rep. 1, A-15)

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;

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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)

315.003MSS: Enabling Contiguous, National Electronic Health Record Network
AMA- MSS

1. supports collaboration with appropriate federal government agencies and industry partners to develop and promote legislative and policy initiatives that require the interoperability of independent healthcare systems such that electronic health records data be entirely transferable; and
2. will ask the AMA to study private and public sector initiatives regarding efforts to establish a nationwide health information network and other relevant interoperability initiatives. (MSS Res 12, A-13) (Reaffirmed: MSS GC Rep A, I-19)

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REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON BIOETHICS AND HUMANITIES AND COMMITTEE ON ECONOMICS AND QUALITY IN MEDICINE

MSS CBH CEQM Report A
(N-21)

Introduced by: MSS Committee on Bioethics and Humanities and Committee on Economics and Quality in Medicine

Subject: Opposing the Marketing of Pharmaceuticals to Parties Responsible for Captive Populations

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

INTRODUCTION

At the 2020 November Meeting, the AMA-MSS referred for study MSS Resolution 102, "Opposing the Marketing of Pharmaceuticals to Parties Responsible for Captive Populations," which states the following:

> RESOLVED, That our AMA will actively oppose the practice of pharmaceutical marketing towards those who make decisions for captive populations, including, but not limited to, doctors working in a correctional capacity, judges, wardens, sheriffs, correctional officers, and other detention administrators; and be it further
>
> RESOLVED, That our AMA will advocate for the inclusion of physicians in the selection and negotiation of which drugs are available to vulnerable populations such as inmates; and be it further
>
> RESOLVED, That our AMA will work with states legislatures and their respective Departments of Corrections to adopt transparency-increasing measures, including, but not limited to: (1) requiring those responsible for medical procurement to report gifts from pharmaceutical companies over a de minimis amount; and (2) centralizing formulary choices to the extent they are not already, in a physician-led office, agency, or commission.

Accordingly, the MSS Governing Council (GC) referred this report to your MSS Committee on Bioethics and Humanities (CBH) and Committee of Economics & Quality in Medicine (CEQM). Your CBH and CEQM ("the authors") examined the nature and scope of healthcare delivery to people who are incarcerated, and assessed the various administrative and logistical mechanisms by which jail and prison systems supply prescription medication and other treatments to people under their supervision. Additionally, the authors studied who is financially responsible for this care, and who else besides an appropriate medical professional may have influence over which medication an incarcerated person is prescribed. The authors then reviewed examples of pharmaceutical company influence on non-physician administrators and assessed any associated medical risk to the incarcerated individual. Finally, the authors

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reviewed existing AMA policy that was relevant to the asks of the resolution in question and determined the need for specific policy.

BACKGROUND

Health in Prisons

The United States has over 2 million individuals in its prisons or jails at any given time[1]. Among these incarcerated individuals, there are disparities relative to the general population. The scope of disease and healthcare in incarcerated populations is focused mainly on mental healthcare and infectious disease, but overall is likely underestimated. An estimated 44% of incarcerated individuals have a chronic medical condition such as hypertension, diabetes or asthma. Similarly, incarcerated populations have higher rates of infectious diseases. According to the Bureau of Justice Statistics, the rate of HIV prevalence was approximately 1.3% for incarcerated persons in 2015 as compared to 0.4% in the general population. Further, about 14% of incarcerated persons have had TB, Hepatitis B or C, or a form of STD. For all of these conditions, a study indicated that 1 in 5 incarcerated individuals were taking a prescription medication prior to entering prison, and of these, 20-40% stopped taking the medication once they entered[2].

Mental Health and Racial Disparities

Mental illness, for example, is increasingly prevalent in the incarceration system, with 20% of individuals in jails and 15% of individuals in prison estimated to have serious mental illness[3]. Studies estimate that half of incarcerated persons have a diagnosable mental health condition. In 44 states, a jail or prison holds more mentally ill individuals than the largest state psychiatric hospital[3]. In addition to mental health disorders, the incarceration system also has significant racial disparities. In 2017, Black individuals made up only 12% of the U.S. adult population, yet represented 33% of the US prison population. Meanwhile, White individuals account for 64% of the adult population but only 30% of the prison population. In terms of rates, Black people have nearly six times the imprisonment rate than that of White people and nearly double the rate of Hispanic individuals[4].

Incarcerated Individuals' Autonomy

By definition, incarcerated people are held against their will with limited ability to make decisions for themselves[5]. Incarceration generally constrains individuals and restricts their ability to make truly voluntary and unforced decisions. Given this and the disparities that exist within the system, incarcerated individuals constitute a vulnerable population for which special protections are warranted[5]. When it comes to human subjects research, incarcerated individuals have specific sets of protections under 45 CFR 46 Subpart C, indicating the same acknowledgement by the U.S. government[6].

The loss of autonomy is even more pronounced for detainees of Immigration and Customs Enforcement (ICE). Non-citizens are not entitled to a lawyer, so while submitted complaints by detainees are supposed to be reviewed and addressed, detainees have very few avenues to make sure that happens; this population is even more captive than even a "standard" prison population composed of citizens[7,8].

Incarcerated individuals lack autonomy in advocating for their own healthcare, and despite being one of the only populations to be constitutionally guaranteed healthcare, incarcerated people's decisions are restricted for a number of reasons. These individuals are restricted by the financial interests of management, the safety of other incarcerated individuals, and the discrimination of their providers[9]. These issues affect prisoners long after their incarceration[10]. Many formerly incarcerated individuals lack health literacy about their medical care, continuity in providers, and adequate addiction treatment while imprisoned. These effects follow them once

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released as well, and this particular population is 129 times more likely to die of a drug overdose within the first two weeks of release as compared to the general population.

Health in Detention Centers

Similar to prisons, persons being detained by Immigration and Customs Enforcement (ICE) are entitled to medical care during their detention. Medical facilities within a detention facility, whether they are run by ICE directly, run by contractors, or run by a different prison system, must achieve and maintain current accreditation with the National Commission on Correctional Health Care (NCCHC). Detainees are provided access to a continuum of health care services, including screening, prevention, health education, diagnosis and treatment[11]. Detainees with chronic conditions are entitled to receive care and treatment, as needed, that includes monitoring of medications, diagnostic testing and chronic care clinics[11]. ICE has standards for all these facilities, but drug procurement at each is different[12].

ICE manages three types of facilities: service processing centers (SPCs), contract detention facilities (CDFs), and local, state, and federal jails[12]. SPCs are detention facilities run wholly by ICE. The agency directly hires medical staff at these facilities, who are then responsible for delivering medical care to detainees. CDFs are detention facilities exclusively for individuals held by ICE that are managed by third parties under contract with ICE. These third parties are responsible for providing medical staff and healthcare services according to the standards set forth by ICE. Finally, ICE may reimburse local, state, or federal jails in order to house detainees at those facilities, which are then directly responsible for delivering medical care.

The ICE Health Service Corps (IHSC) is the division of ICE responsible for providing medical care to SPCs and for financial reimbursement for medical care, including pharmaceuticals, provided by CDFs and ICE-contracted jails[13]. For detainees who require treatment with medication, ICE is required to provide any appropriate pharmaceuticals during detention, as well as a 30 day supply upon release[11].

IHSC operates a formulary consisting of approved medications that applies to pharmaceuticals prescribed and dispensed at non-IHSC staffed facilities[14]. Non-formulary prescriptions require prior authorization by IHSC[15]. While the pharmacy benefits provided by IHSC appear to be administered by the pharmacy benefit manager Script Care[15], no information is publicly available as to how IHSC sets its formulary or makes decisions on prior authorizations. Further, the notable lack of transparency in the formulary-setting process leaves it vulnerable to unethical incentives derived from marketing to physicians, financial benefits accrued to pharmacy benefit managers by certain formulary decisions, and other sources.

Mechanisms of Medication Procurement by Prisons and Infirmary Stocking

Currently there are no universally applied standards for the procurement or availability of medications in prisons. Although the Federal Bureau of Prisons maintains its own formulary, it is not followed by other departments; the Office of Justice Programs only requires that for jail health services a formulary be created[16, 17]. This lack of standardization contributes to inconsistencies between county, state, and Medicaid formularies. The NCCH stipulates that departments of correction must have a method for approving off-formulary medications, but these are only recommendations and may not consistently be approved[18]. This is especially burdensome for individuals transitioning psychiatric and anti-seizure medications. In theory, formularies should only encourage therapeutic interchange when there is substantial evidence for its efficacy and safety[19].

The primary driver of formulary creation in prisons is to reduce cost[20]. On average, state prison systems have to dedicate 15-23% of their health benefit expenditures to pharmaceuticals, which is more than private and government insurance companies on average. This may be due to limited negotiating power compared to insurance companies serving larger populations. While

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the Federal Bureau of Prisons has guidelines for securing the lowest-cost medications, these guidelines are not followed universally[21]. The visibility into decision making for formularies is limited, largely due to the variety of approaches for purchasing. Methods for procurement of pharmaceuticals include[20]:

- Direct purchase by Department of Corrections (DOC) Physicians
- Bulk purchases via contracts with private groups for all medical care
- Purchase through State Universities when these provide medical care
- Hybrid, or centralized ordering and distribution (as seen in Massachusetts)

Therefore, there are a variety of parties involved in crafting formularies and reducing costs: from physicians, to facility pharmacy directors, government administrators, private contractors, or even in some cases sheriffs. The American Society of Health-System Pharmacists (ASHP) recently updated guidance that formulary decisions should include representative medical staff from the facility including practicing physicians and other providers, as well as other facility leaders, and patient or family stakeholders[19]. There is not currently enough transparency to suggest that these guidelines are being followed in the creation of formularies affecting incarcerated individuals. Once a formulary is established, the prison doctors can prescribe from this list without any additional approval.

Pharmaceutical companies may exert influence over these decision makers and even offer free samples or rebates to incentivize their products being preferred on formulary[22]. The incarcerated individuals have no say in the creation of these formularies, and best evidence-based medicine may not be employed. While some may advocate for accepting these reduced-cost drugs as a cost-saving measure, it can be a source of bias and compromises medical necessity being a driver of formulary creation[23]. There are other more accepted methods to secure rebates, including the 340B program utilized by sixteen state DOCs[20]. The greatest visibility into formulary decision-making comes from state budgets, but without centralized ordering, many state formularies differ between their DOCs and departments of Health and Human Services or Medicaid administrators. There is little visibility into how private contractors disclose their relative pharmaceutical spending due to bundling healthcare costs. In contract models, vendors paid comprehensively per patient have financial incentives to prescribe less expensive drugs while vendors given discretion over drug formulary have an incentive to prescribe unneeded medication.

Paying for Medications After they Are Prescribed

Counties and states are required by law to provide medical care to incarcerated individuals in their facilities. Since health insurance is tied to employment, incarcerated individuals often lose their health benefits when they are incarcerated and are not eligible for the private health insurance marketplace. Incarcerated individuals can apply for Medicaid while incarcerated but can not receive benefits until released. Incarcerated individuals with existing Medicaid or Tricare coverage prior to incarceration are excluded from receiving coverage while incarcerated, and depending on state law, coverage is either suspended until release or terminated[24]. Exceptions to this rule apply, and states that pass laws requiring all incarcerated people to repay medical expenses may technically allow medicare to cover certain costs[25].

To cover some cost and provide disincentives for overuse, 42 states currently charge incarcerated patients a copay. The use of co-pays in the prison healthcare system has resulted in decreased utilization, which comes at the expense of incarcerated individuals' health. However, incarcerated individuals who can not afford to pay their copay can not be denied care[25]. Unlike many insurance companies, state departments of corrections do not charge a higher co-payment for brand-name drugs over the generic.

Also contributing to higher costs are regulations that prohibit DOCs from qualifying for the Medicaid Drug Rebate Program (Section 1927 of the Social Security Act)[20]. The consequence

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of this is that DOCs pay higher costs for drugs than state medicaid agencies. This cost is then passed on to the state since they cover the DOCs' costs. If DOCs were eligible for the Medicaid Drug Rebate Program, costs would be lower and some paid for by the federal government.

When individuals are released, there is no standardized method for maintaining prescriptions that were given while incarcerated. Some states, such as Connecticut and Missouri, provide vouchers covering a month of medication for the released individual. This allows some time to establish care within the community[20]. Upon release, Connecticut and Massachusetts assist in completing Medicaid applications for released individuals[26].Other departments of corrections schedule appointments with community providers after release. Parole officers can also play an important role in ensuring individuals are continuing their medications and seeking community medical care.

Court-ordered Medications

Court-ordered medications and other treatments have differing authorities by state. Generally, treatments are ordered by the court for mental health and psychiatric patients. In *Sell v. United States*, the Supreme Court ruled the government has the ability to administer medically appropriate treatment for patients if there is evidence it may render them competent to stand trial[27]. Court-ordered assisted treatment is when a court of law deems that medication is necessary for an individual to stand trial or safely live in the community. Treatment may occur inpatient, or outpatient, with the mandate that medication be provided by the mental or behavioral health authority of the jurisdiction[28]. For court-ordered assisted treatment, involuntary commitment may be initiated by law enforcement, a concerned citizen, or a healthcare professional in most states[29]. Court-ordered medication is not required for acute stabilization of mania or psychosis, but for chronic treatment that may be in the best interest of a patient refusing treatment. The process for initiating treatment usually starts with a petition from the hospital or facility psychiatrist, and a treatment plan is established and approved by the court with an expectation for ongoing communication between court and treatment team on developments in the case[30]. Some states are more strict, such as Texas, which requires two physicians, one to prescribe and one to testify[31].

Court-assisted treatment evaluations are initiated at the request of a police officer, emergency health worker, physician, or person in charge of a correctional facility[29]. There are generally not situations where judges or the court make decisions on a specific agent or option without expert input. As mentioned, the treatment plan is usually proposed by a psychiatrist. The decision primarily rests in determining whether medical intervention is necessary at all based on the expert opinion of an individual's competence. Therefore, pharmaceutical advertising to judges is not of large concern, although it may be of concern if advertising to the experts occurs. These decisions are nevertheless unlikely to overrule a facility's formulary.

DISCUSSION

The AMA has extensive existing policy on the topics of incarcerated populations and pharmaceutical advertising. Regarding incarcerated populations, several AMA policies express support for the care of incarcerated individuals and the ethical treatment of their conditions. In D-430.997, the AMA supports the NCCHC and the improvement of the quality of care that incarcerated persons receive while in the correctional system, including mental health care. In H-100.955, the AMA expresses support for the use of drug courts at the state and local level to employ evidence-based models for treating non-violent crimes related to substance use disorders. While this policy does not pertain to incarcerated individuals and instead advocates for select individuals to avoid incarceration and instead undergo substance use treatment, the spirit of evidence based interventions for those with a medical disease is a bedrock principle that is again applied to those involved in the justice system.

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Aside from these directives and health policies, the AMA Code of Medical Ethics includes two key sections pertaining to prescribing treatments to an incarcerated individual. Item 9.7.2 speaks to the sensitivity of the power dynamic that exists within the justice system and the rights of those who are incarcerated. Specifically, it outlines that:
"(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. Issued: 2016."

These clauses delineate in no uncertain terms that, in the context of an incarcerated person, a physician should be at the center of medical decision making, that evidence-based treatment should be provided, and that no court or other party is fit to make medical treatment decisions. Within the MSS's own policy compendium, 100.014MSS uses similar language to assert the same.

Lastly, AMA policy opposes direct-to-consumer advertising of prescription drugs (H-105.988) and direct-to-prescriber advertising in EHRs (D-478.961). These principles can be considered breached in the creation of formularies based upon pharmaceutical company advertising or discounts. Additionally, in H-125.985, the AMA endorses the Principles of a Sound Drug Formulary System, which should be followed by jails and prisons[32].

CONCLUSION

Incarcerated individuals are a vulnerable population as they lack traditional autonomy, particularly in their healthcare. This population exhibits higher rates of physical and mental illness and demonstrates significant racial disparities, disproportionately impacting populations of color. Despite being promised a constitutional right to health care, overall health is routinely worse in these individuals than in the general American population. This also is true of detainees and immigrants being held in custody of ICE. These facilities are required to provide healthcare to detainees and poorly regulated across a vast variety of program structures. The individuals treated at such facilities are typically non-citizens without alternative options for healthcare and are therefore a particularly vulnerable population.

Little information is publicly available on how prisons' pharmaceutical formularies are developed. Cost-reduction tends to be a driving factor on which medications are included, as well as pharmaceutical companies' influence and purchasing options and availability. There is little to no regulation of formularies between different states, counties, and institutions, and discrepancies in payment makes room for undue influence from vendor contracts. The lack of transparency also allows for the possibility of unethical influences from marketing and financial benefit. The government is legally responsible for covering the cost of these medications while these individuals are incarcerated, however these same individuals are often left with little to no

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resources following release. In situations where a judge has ruled that an individual must take a certain medication, there typically must be expert opinion to make this decision.

The AMA has extensive policy supporting the health of incarcerated individuals and the use of evidence-based treatment related to the legal system. In particular, there is sufficient precedent in policy to suggest that physicians be at the center of medical decision making for incarcerated individuals as well as to support implementing only evidence-based treatments. Furthermore, the AMA opposes direct-to-consumer advertising and direct-to-prescriber advertising in EHR, both of which can unduly influence prescriptions.

RECOMMENDATIONS

Your Committee on Bioethics and Humanities and Committee on Economics and Quality in Medicine recommend that the following resolve clauses are adopted as amended and the remainder of this report is filed:

> RESOLVED, That our AMA will ~~actively~~ oppose the practice of pharmaceutical marketing towards those who make decisions for captive populations, including, but not limited to, doctors working in a correctional capacity, judges, wardens, sheriffs, correctional officers, Immigration and Customs Enforcement, and other detention administrators; and be it further
>
> RESOLVED, That our AMA will advocate for the inclusion of physicians in the selection ~~and negotiation~~ of which drugs are available to vulnerable populations such as ~~inmates~~ incarcerated individuals; and be it further
>
> RESOLVED, That our AMA will work with state legislatures and their respective Departments of Corrections to adopt transparency-increasing measures, including, but not limited to: (1) requiring those responsible for medical procurement to report gifts from pharmaceutical companies over a minimum amount; and (2) centralizing formulary choices to the extent they are not already, in a physician-led office, agency, or commission following the principles of a sound formulary.

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REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON ECONOMICS AND QUALITY IN MEDICINE AND COMMITTEE ON GLOBAL AND PUBLIC HEALTH

MSS CEQM CGPH Report A
(N-21)

Introduced by: MSS Committee on Economics and Quality in Medicine and Committee on Global and Public Health

Subject: Support of Research on Vision Screenings and Visual Aids for Adults Covered by Medicaid

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

INTRODUCTION

MSS Resolution 23 was originally referred to the Committee on Economics and Quality in Medicine (CEQM) following the 2020 November Meeting.

Resolution 23 recommends that our AMA encourage scientific research on the benefits of a comprehensive eye exam and the benefits of visual aids in Medicaid eligible individuals. Resolution 23 was previously not recommended for adoption by the MSS Reference Committee. The authors extracted the resolution during the Assembly meeting and recommended that the resolution be referred for study because there is a lack of research on why appropriate scientific bodies have not recommended comprehensive eye exams and visual aids be covered by Medicaid for eligible individuals.

Resolution 23 focuses on asking for increased research to determine the benefits of visual aids and screening for Medicaid patients. This ask differed from current AMA policy due to its focus on research and specification of Medicaid patients. Current AMA policy focuses on children and the elderly, including AMA policies Encouraging Vision Screening for Schoolchildren H-425.977 and Eye Exams for the Elderly H-25.990.

Resolution 23 was referred to the CEQM to discuss the potential benefits and consequences of adding comprehensive eye exams and the benefits of visual aids in adults eligible for Medicaid. The resolution reads:

> RESOLVED, That our AMA encourages appropriate scientific and medical research to determine the benefits of routine comprehensive eye exam and benefits of visual aids in adults eligible for Medicaid.

CEQM submitted a report at the 2021 June Meeting that was then re-referred to CEQM and the Committee on Global and Public Health (CGPH). The Reference Committee recommended reviewing this topic in more detail and providing more up-to-date references on the benefits of routine vision care. They also recommended discussion of the pros and cons of including

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routine vision care in Medicaid benefits. After expanding and editing the report, CEQM and CGPH are now bringing this report forward for consideration at the 2021 November Meeting.

BACKGROUND

Twelve million people 40 years of age and over in the United States have vision impairment (VI), per the Centers for Disease Control and Prevention (CDC) in June 2020.[1] Approximately 1 million are blind, 3 million have vision impairment after correction, and 8 million have vision impairment due to uncorrected refractive error. Of the estimated 93 million US adults at high risk for vision loss, only half visited an eye doctor in the past 12 months.[1] The number of those living with vision impairment are only projected to increase due to the prevalence of diabetes and chronic conditions in the aging US population, leading to the long-term importance of proper eye care. For example, by 2050, numbers are projected to increase to 2.01 million people who are blind, or having VI of 20/200 or worse, 6.95 million people with VI, and 16.4 million with VI due to uncorrected refractive error.[2]

Vision impairment has lasting social, economic, and medical consequences by causing disability, loss of productivity, and diminished quality of life due to the inability to read, write, and drive safely, among other daily activities. Furthermore, the costs of vision loss and eye disease prevalence will be expected to grow from $145 billion in 2014 to $247 billion in 2032, and reach $376 billion by 2050 (with costs being real costs expressed in constant 2014 dollars). Nominal expenditures, which include the impacts of inflation and represent actual dollars spent per year, will reach $385 billion by 2032 and $717 billion by 2050.[3]

Medicaid operates as a federal-state partnership by which states establish and administer their own programs with financial support from the federal government. As of April 2021, Medicaid provides insurance coverage to 74 million people in the U.S.[4] Federal law requires that each Medicaid program provide a minimum collection of benefits and allows them to provide additional optional benefits. For example, in terms of vision care, eyeglass coverage is an optional benefit, and thus coverage varies by state.[5]

Currently, there are no federal guidelines requiring Medicaid coverage of routine visual screening exams in adults 21 years and older, with most participating states providing vision screening coverage at 24 to 48-month intervals. Thirty-three states offer optional, limited Medicaid coverage of eyeglasses and other visual aids; six states only offer these benefits to children and those with severe eye conditions. Twenty-eight states have limitations on access to visual care, including but not limited to pre-existing conditions, number of visits allowed, or exclusively cover eyeglasses only.[6]

Research analyzing the lack of access to vision care and the benefits of visual screening in adult Medicaid patients has been limited. One study showed that Medicaid beneficiaries find it harder to obtain an eye care appointment compared to individuals with a private health insurance plan. Specifically, adults with Medicaid had significantly decreased odds of receiving an appointment compared with those with a private health insurance plan (odds ratio = 0.41), with rates of successfully obtaining appointments among callers 61.5% for adults with Medicaid and 79.3% for adults with a private health insurance plan.[7]

Another study showed that in open angle glaucoma (OAG), Medicaid beneficiaries were 234% more likely to not receive any glaucoma testing after initial testing in the 15 months following initial diagnosis. Specifically, the proportions of people with private health insurance with newly-

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diagnosed OAG who underwent visual field (VF) testing, fundus photography (FP), and other ocular imaging (OOI) were 63%, 22%, and 54%, respectively, while the proportions for Medicaid recipients were 35%, 19%, and 30%, respectively.[8]

DISCUSSION

There are a number of advantages to supporting research on vision exams for Medicaid beneficiaries, especially given the number of people in the U.S. under Medicaid coverage is large and increasing (74 million as of April 2021 and counting).[4] The lasting economic, health quality, and public health factors of vision screenings and vision aids are thus important to consider.

An Economic Perspective

In a study by the National Opinion Research Center (NORC) at the University of Chicago, the total economic burden of eye disorders and vision loss in the United States was $139 billion per annum, including $65 billion in direct medical costs, $48 billion in lost productivity, $2 billion in opportunity costs due to the need for informal care, $20 billion in long-term care for vision loss, and $1.7 billion for other direct costs, including special education, screening, government assistance programs, and low vision aids and devices.[9,10] These figures demonstrate the tremendous financial burden of eye disorders and vision loss and highlight the need for further research and healthcare investment within this area. The indirect costs of poor vision extend far beyond the healthcare sector, with far-reaching impacts in the form of reduced productivity and deadweight loss.

Multiple eye diseases, in particular macular degeneration, diabetic retinopathy, and glaucoma, benefit from early detection, prevention, and treatment.[11-13] In addition, the steadily increasing prevalence of diabetes mellitus within the U.S. is expected to lead to expansion of costs due to the adverse impact of the disease on vision.[14] A visual screening program in Sweden among children for amblyopia reduced the prevalence of amblyopia from 2% to 0.2%, representing a significant health benefit for relatively minimal cost.[15] Other studies in children in Holland and San Francisco have found similar results.[16,17] Furthermore, recent work using a decision-analytic Markov model demonstrated that screening for primary angle-closure glaucoma was cost-effective in China.[18]

The new and growing field of teleophthalmology is perfectly poised to extend the benefits of eye exams to more patients while controlling costs, as teleophthalmology visits are more accessible for patients, cheaper than in-person clinical exams, and effective at detecting eye disease.[19] For example, a teleretinal diabetic retinopathy screening program resulted in the elimination of the need for more than 14,000 visits to specialty care professionals.[20] Visual screenings therefore represent a potential avenue to improve clinical outcomes and reduce costs associated with eye disease.

The estimated costs of including vision screenings in Medicaid is limited in the literature. Per a 2020 report on the Center on Budget and Policy Priorities, “No official estimate of the cost of adding comprehensive dental, hearing, and vision benefits to Medicaid, in addition to Medicare, is available, but it might be half or less than that of adding this coverage to Medicare alone, depending in part on these design choices.”[21] For comparison, the Congressional Budget Office estimates that additional benefits of dental, vision, and hearing coverage would increase

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Medicare spending by $358 billion over the 2020-2029 period; of this total, $30 billion would be for vision care.[22]

Per the Center on Budget and Policy Priorities, the lower cost for Medicaid dental, hearing, and vision benefits compared to Medicare is for a number of reasons. First, fewer enrollees would get benefits under Medicaid than Medicare since the number of adult Medicaid beneficiaries that are not also eligible for Medicare is about half the number of Medicare Part B beneficiaries. Second, utilization of dental, hearing, and vision benefits is lower among working-age adults than seniors and persons with disabilities. Third, access to preventive care is associated with reduction in utilization of the emergency department, which may offset a proportion of the cost. Fourth, some states already cover some services and states would likely share some of the cost of the new Medicaid benefits. On the other hand, Medicaid has little or no cost-sharing, since enrollees are low-income, which could mean adding to the federal cost.[21]

Further studies are needed to elucidate the costs of vision care benefits for the population covered under Medicaid.

A Health Quality Perspective

As with many other chronic conditions, early detection and intervention are critical for slowing the progress of disease in ocular conditions. Being able to identify age-related macular degeneration, cataracts, or glaucoma early will allow for earlier intervention. In addition to increased cost-effectiveness as compared to intervention in later stages of chronic diseases, earlier detection is associated with increased vision preservation. This has especially been demonstrated in diabetic patients with risk of retinopathy.[23] With the aging population in the United States, the management and prevention of chronic diseases is as important as ever. The importance of supporting research to find the true value of comprehensive screening and benefits of visual aids in adults eligible for Medicaid is imperative to improving healthcare quality and lowering future healthcare costs.

Diabetic retinopathy is the leading cause of vision loss for working age adults, affecting 28.5% of adults with diabetes aged 40 and over in the United States.[24] Given that it is often asymptomatic even into an advanced stage and treatment with laser, anti-vascular endothelial growth factor (VEGF) agents, or intravenous (IV) corticosteroids have been shown to be effective, diabetic retinopathy is an ideal candidate for screening. And indeed, effective screening has been shown to slow disease progression and reduce incidence of blindness through timely surgical and medical treatments.[25-29] Despite this, only 60% of people in the US with diabetes are screened for retinopathy at the recommended annual interval.[24] Specifically when exploring a higher-risk Medicaid population, a previous study indicated that less than two-thirds of patients were completing annual diabetic eye exams.[30] In comparison, in the UK, where more than 80% of patients with diabetes are regularly screened, diabetic retinopathy is no longer the leading cause of blindness in working-age adults.[29]

Open angle glaucoma affects an estimated 2 to 3 million Americans and is the leading cause of blindness in African Americans.[31] While open angle glaucoma may ultimately result in irreversible blindness, it is typically asymptomatic until late in the disease course and early detection and treatment can prevent or slow vision loss.[32] This being said, there is unfortunately a vast difference in eye examination rates between Caucasian patients and racial or ethnic minority patients. Although some differences may be attributed to health insurance, disparities were still noted when patients were compared to others with similar insurance coverage.[33]

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The United States Preventive Services Task Force (USPSTF) have not updated their guidelines since 2013, at which time they reported insufficient evidence to recommend screening in all asymptomatic adults, noting both potential harms of false positives along with a gap of long-term follow up and randomized controlled trials.[34] However, screening has been shown to be effective and useful in higher risk patients, specifically those with positive family history or non-white race. In fact, Centers for Medicare & Medicaid Services (CMS) has covered these higher risk patients for older adults since 2002.[32,35,38] The American Academy of Ophthalmology (AAO) recommends baseline screening at the age of 40 in an effort to emphasize early intervention and preservation of vision. The AAO estimates that in less than 10 years, the prevalence of glaucoma will rise to 4.3 million individuals and 11.3 million with diabetic retinopathy. [37]

Though insurance coverage and financial concerns are perhaps the largest barrier to access vision screenings, a systematic review identified several others, including lack of transport, childcare, paid time off, patient knowledge and psychological factors, and provider communication and cultural competence.[28] In one prospective study of diabetic patients, only 30% adhered to specialist follow-up in the recommended time frame, despite reducing financial and transportation barriers. Interestingly, those who did were more likely to know their most recent HbA1c, suggesting that patient education may improve adherence to follow up.[38]

A Public Health Perspective

Quality of life is an important determinant of health in the United States, with vision being one of the greatest factors on quality of life.[39] An individual's vision is often their primary gateway to discovering and communicating with the world around them. However, its importance often remains undervalued as a chronic or preventable condition in public health measures.[40] Vision loss is associated with significantly lower self-reported quality of health scores compared to those of individuals with intact vision.[41] Additionally, this perceived decrease in health quality is associated with increased rates of depression and suicide.[42] Vision also adversely impacts an individual's abilities to navigate, drive, ambulate, communicate, engage socially, access educational and employment opportunities, and care for family members.[40, 43-51] Thus, preventing vision loss and ameliorating the burden of vision impairment through providing eyeglasses and visual aids is important from a public health and health equity standpoint.

Visual impairment disproportionately affects marginalized communities.[52,53] Individuals belonging to an ethnic or racial minority group, those with lower incomes, lower educational attainment, or working in manual labor jobs have a higher prevalence of vision loss or blindness compared to those who do not have these disadvantages. There are also discrepancies in access to vision screening and care for those living in rural locations compared to those living in urban or suburban areas.[50] In older adults, visual impairment is associated with a decreased ability in maintaining activities of daily living (ADLs) and instrumental ADLs (IADLs), which subsequently increases the risk for falls, long-term disabilities, and all-cause mortality.[54,55]

Despite the importance of vision and the burden of vision impairment, eye and vision health have been historically poorly represented in federal government programs overall. Notably, before 2016, chronic vision impairment was often absent from government priority chronic diseases lists, which meant that eye and vision health could be passively excluded from federal programs and initiatives that looked to reduce the burden of chronic disease.[40] However, possibly due to increased awareness of vision health, vision is now included in the Healthy People 2020 campaign led by the Office of Disease Prevention and Health Promotion, which

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focuses on “evidence-based interventions to preserve sight and prevent blindness.”[56] Given the recent focus on vision health at the federal level, vision screenings and vision aids should be an important part of the goal to “improve the visual health of the Nation through prevention, early detection, timely treatment, and rehabilitation.”[56]

Ultimately, creating policy that expands access to vision screenings and vision aids in populations that are disproportionately impacted by visual impairment, blindness, and decreased access to eye care may help mitigate the effects of disparities on individual and community health.

CONCLUSION

Based on our review of the economics, health quality, and public health perspectives of Medicaid vision coverage, we find vision screenings critical in preventing chronic disease for a relatively minimal cost, improving overall quality of care for individual patients, and expanding access to a population disproportionately impacted by visual impairments. Furthermore, the importance of visual aids follows from the importance of vision screenings as a way to further ameliorate the burden of vision impairment. It is thus imperative to fund further research regarding the cost-effectiveness and efficacy of providing comprehensive eye exams and visual aids to Medicaid recipients. This will allow the AMA to take the most effective and informed actions in ensuring a larger percentage of Americans have adequate vision health coverage.

RECOMMENDATIONS

Your Committee on Economics and Quality in Medicine and Committee on Global and Public Health recommends that the following recommendations be adopted in lieu of MSS Resolution 23 and the remainder of this report is filed:

> RESOLVED, That our AMA work with the Centers for Medicare and Medicaid Services (CMS) to evaluate the value and feasibility of incorporating routine comprehensive eye exams and visual aids into the minimum mandatory benefits for Medicaid beneficiaries.

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REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON ECONOMICS AND QUALITY IN MEDICINE AND COMMITTEE ON LEGISLATION AND ADVOCACY

MSS CEQM COLA Report A
(N-21)

Introduced by: MSS Committee on Economics and Quality in Medicine and Committee on Legislation & Advocacy

Subject: The Impact of COVID-19 on the Financial Viability of Various Healthcare Delivery Systems

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

INTRODUCTION

The COVID-19 (SARS-CoV-2) pandemic has disrupted economic systems and placed strains on the healthcare system. Economic opportunities, as in many other industries, are not distributed evenly throughout the healthcare system. This meant that certain methods of healthcare delivery were more or less capable of sustainably continuing their operations depending on the resources, surrounding population, and typical income sources.

This report was initiated following the J-20 meeting via a MSS Governing Council (GC) Action Item request from the Committee on Economics and Quality in Medicine for self-referral: “We intend for our report to research the financial challenges that healthcare delivery institutions face during the COVID-19 pandemic and how the size and location of these systems may influence the extent of their financial burden or the allocation of state and federal relief. Additionally, we intend to review all pertinent AMA and AMA-MSS policy, consider how this policy may lead the AMA to action, and evaluate if new policy should be recommended.” This request was approved by the GC, and the Committee on Legislation & Advocacy was requested to assist on the report, with a report due at I-21, now N-21.

This report focuses on various methods of healthcare delivery, from major academic hospitals to rural for-profit hospitals, and from private practice to urgent and long-term care centers. The report highlights which services and practices may have been most affected, and considers the federal government’s economic stimulus response and its adequacy. The relative financial stability of different insurance and payment models are also considered for their ability to assist healthcare delivery in weathering economic downturns. Further, sensitivities to the country’s disconnected healthcare delivery network are highlighted. In conclusion, we recommend a more comprehensive strategy for emergency fund distribution and adequate financial preparedness for essential healthcare services.

BACKGROUND

Factors affecting all healthcare delivery:

Not all systems of healthcare delivery have unique economic considerations. Indeed, during the COVID-19 pandemic, all had to contend with purchasing additional PPE, making operational changes, and losing revenue from elective procedures.

PPE:

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Every healthcare delivery method had to account for collecting and storing additional PPE to combat the coronavirus. This included masks, gowns, gloves, eye protection, and other materials.This was challenging as facilities ran out of their PPE supplies quickly, and needed to stockpile additional PPE. These, along with other non-treatment costs, were estimated to be $2.4 billion by the American Hospital Association (AHA) over the first four months of the pandemic.[1] As a result, hospitals were forced to be creative and implement strategies to find other sources of PPE or extend PPE shelf-life with sanitation and re-use.[2,3]

Operational Changes:

In the face of COVID, hospitals had to completely shift their daily operations, including moving staff to new jobs, implementing telehealth capacity and infection screening, even re-designing rooms. These changes were more easily implemented at the most resource-rich hospitals.[4] Resource-poor hospitals were less likely to adapt and had to reduce capacity rather than adapt in the early months.

Elective Procedure Cancellation:

The AHA estimated that lost revenue due to cancelled procedures totaled $161 billion over the course of four months.[1] However, other journal articles using data from the National Inpatient Sample (NIS) projected $30 - 65 billion in losses over the same four-month time period.[5,6] It is important to note that the AHA may be biased to overstate losses to secure government support while they may also have better insight into the current revenue of their members than national databases that lag behind by 2 - 10 years. The true number may be somewhere in-between these. The exact number may not be clear, but the losses are significant either way when considering that the revenues for resource-poor hospitals often go directly to paying staff and off-setting losses from less lucrative but equally important preventative and acute services. Elective procedures can account for up to two-thirds of the revenue of healthcare delivery institutions in our current fee-for-service-dominated system.[6,7] Despite their fiscal importance, one study of the VA healthcare system indicated that health outcomes were not significantly worsened by elective procedure cancellation.[8]

Unique Considerations for Different Facets of Healthcare Delivery:

Various systems of healthcare delivery in the United States rely upon distinct sources of funding and revenue to maintain their operations. Although it is not possible to entirely capture the subtleties of every mode of healthcare delivery in this report, we have summarized some common types of healthcare delivery below and how COVID-19 impacted their economics. We recognize that not every institution or facility will fit these molds perfectly, but these are some of the typical archetypes:

Total Hospitals in U.S. (2019):[9]	**6,090**
Community Hospitals:	**5,141**
| Not-for-profit:	2,946
| For-profit:	1,233
| State or Local Government:	962
| Urban Community:	1,805
| Rural Community:	3,336
Federal Government:	**208**
Psychiatric:	**625**
Other:	**116**
Urgent Care (2018):[10]	**8,774**
Primary Care Physicians (2010):[11]	**209.000**

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Long-term Care (2016):[12] **28,900**

I. Acute Care:

Non-profit (Teaching) Hospitals

Academic, non-profit teaching hospitals are considered the most influential and expert sources of healthcare delivery. They tend to treat the rarest cases (ones referred from primary or secondary care centers) and offer specialized services. The majority have more than 400 beds, medical and cardiac ICUs, are located in urban areas, and have a higher proportion of black patients compared to non-teaching hospitals.[13] The Medicaid-eligible proportion are similar between teaching and non-teaching hospitals (within 1 - 2%), but teaching hospitals may also attract a higher income population with private insurance coverage.

Academic hospitals' unique economic models made them less susceptible to economic challenges, such as those listed above. Unlike other institutions, academic hospitals can continue to rely on income from investments, bonds, education, research, and federal funding for residencies during times of economic stress. Estimates say that in 2017 non-profit hospitals issued $35 billion in bonds, and that number may only have increased since that year.[14] Some hospital systems did elect to not issue bonds during the pandemic due to concerns of an uncertain bond market.[15,16] Yet, despite widespread decreases in credit ratings in 2020, only 14 non-profit hospital systems received downgrades.[17] For years, academic institutions have had to contend with Medicare alone contributing to a negative 9% profit margin, and these additional funding sources helped to weather the first half of 2020.[18,19] Non-profit hospitals also receive a degree of tax exemption, and all these factors made them more resilient despite having incurred more loan debt for growth and development of new facilities and services.[19] One recent study demonstrated using linear regression that among 226 major teaching hospitals in 46 states, proportion of outpatient revenue has a significant effect on amount of cash on hand, though it can reduce long-term return on assets.[20] Long-term return on assets were significantly improved by metropolitan location, low unemployment in the catchment area, system membership, and the size of the hospital.[20]

Government intervention was able to address most barriers to economic stability for academic centers quickly during the early months of the pandemic, and these institutions have continued their important missions.[20] Despite large investment portfolios with little liquidity, non-profit hospitals used strategies such as furloughing or reducing wages for non-essential employees, cutting chief executive salaries, and cancelling non-essential contracts to bridge the timeframe to assets becoming liquid.[14,21] The stock market also recovered quickly meaning that these investments did not lose as much value as was expected. These institutions were also the primary beneficiaries of federal funding from The Coronavirus Aid, Relief, and Economic Security Act (CARES) act, and the government also quickly introduced a diagnostic-related group (DRG) for COVID-19.[19] Unlike the other types of institutions discussed below, no teaching centers were forced to close due to the economic constraints of the COVID-19 pandemic.

For-profit Hospitals

For-profit hospitals are owned by investors, and aim to create a profit for their shareholders. For-profit hospitals generally spend a larger portion of their budget on marketing and advertising initiatives and provide less uncompensated care; catering mainly to the wealthy, medical tourists, and those seeking elective care.[22]

For-profit hospitals had a wide-range of financial tolerance to the unique challenges presented by the COVID-19 pandemic. In general, for-profit hospitals had a much larger decrease in revenue, compared with other healthcare delivery models, because for-profit hospitals tend to rely on elective services for a larger portion of their revenue. Elective services comprise 60-80% of for-profit hospital revenue.[23] This had a significant impact on for-profit hospital financial

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health, as most elective services were suspended for much of the COVID-19 pandemic and even once elective services were reinstated, many patients were hesitant to pursue elective services.

For-profit hospitals shifted care to focus on COVID-19 patients during the pandemic, resulting in lower reimbursement revenue. This was compounded by some private insurers refusing or denying payments due to cancelation of insurance coverage, given widespread job-losses, as well as some private insurers refusing payment for add-ons like personal protective equipment (PPE) and oxygen.[23]

The relative success of for-profit hospitals during the COVID-19 pandemic depended largely on their portfolios. Those that relied most heavily on elective services faced the greatest losses in revenue.[24] As of 2021, some major for-profit corporations, such as HCA Healthcare, have seen admissions and same-facility outpatient surgeries rebound from 2020 levels and even surpass year-over-year levels from 2019, while ER visits and inpatient surgeries still lag behind 2019 levels.[25] Investor sentiment, reflected in stock prices, are at an all-time high for multiple for-profit systems.

Metropolitan and Rural Hospitals

Metropolitan hospitals, defined by their proximity to large urban centers and cities, are inherently different compared to their rural counterparts. Such hospitals tend to be affiliated with larger health systems, including those affiliated with non-profit teaching/academic hospitals. These centers generally have higher patient volumes, which correspondingly allow them to offer a more diverse catalog of lucrative procedures. Thus, in times of financial distress, as had occurred during the COVID-19 pandemic, these hospitals are less reliant on outpatient services and surgical procedures.[26] Therefore, they are more resilient to decreases in revenue. Furthermore, such centers tend to have higher liquid capital and cash reserves, and if they are associated with a teaching hospital, more endowments and grants, further amplifying their ability to handle decreased revenue streams as well as increased costs from COVID-19 related expenses.[26]

Prior to the COVID-19 pandemic, rural healthcare delivery centers were experiencing significant financial distress, in part as a result of their small size, lower occupancy rates, and lower margins. The median operating margin of all hospitals was 2.0%. Those in the 25th percentile, which were overwhelming rural and safety net hospitals, reported margins of -4.4% (Table 1).[26] Additionally, as a result of halting or severely decreasing elective procedures across the nation, rural centers experienced a much larger decrease in revenue as compared to their urban counterparts. Prior to the pandemic, rural and safety net hospitals relied more heavily on surgical procedures for revenue, with the upper 75th percentile of hospitals by operating margin attributing 76.9% of their outpatient revenue from surgical procedures alone. In comparison, the 25th percentile received 49.9% of outpatient revenue from surgical procedures.[26] Furthermore, demographic factors only exacerbated the healthcare divide between the two geographic areas. The patient population in rural areas tends to be older individuals with higher rates of comorbidities, such as obesity, diabetes, and hypertension, who are more likely to be underinsured or uninsured altogether.[27] As a result, patients in these areas are more susceptible to COVID-19 complications, further straining the already compromised finances of rural hospitals.

Initially, funding from the CARES Act was allocated to hospitals in proportion to their 2018 net patient revenue. Subsequently, rural areas were asymmetrically reimbursed less than their urban equivalents. Rural centers are more likely to serve a Medicare and Medicaid population.[28] On average, reimbursement for such state and federally-sponsored insurances average just 87 cents per dollar of care.[29] Thus, hospitals would lose money by treating such patients, causing the initial distribution of the CARES Act funds to be skewed in favor of urban centers. Thus, the

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financial distress of rural centers was only further exacerbated. This is reflected in the closure of 47 hospitals in 2019, most of which were small, rural, and located in Medicaid non-expansion states.[30] Projections indicate that the proportion of hospitals overall with a negative operating margin has increased due to the pandemic, and this is largely driven by rural hospitals being unable to recover their profitability (Table 2).

Federal Service Hospitals

The federal government operates around 200 hospitals in the U.S. that provide care for specific populations, such as active-duty military service members and their families (through TRICARE, run by the Department of Defense), veterans (run by the Veterans Health Administration), and American Indians and Alaska Natives (run by the Indian Health Service). There are about 2.56 million American Indians and Alaska Natives served by the Indian Health Service,[31] over 9 million veterans enrolled in Veterans Affairs (VA) healthcare services,[32] and about 9.6 million beneficiaries of TRICARE.[33]

In response to COVID-19, the recent American Rescue Plan (ARP) granted the VA $17 billion for fiscal year 2021, which has been allocated towards the department's programs providing healthcare to homeless populations, job retraining programs for veterans, financial relief (e.g., waiving copayments) for veterans affected by the pandemic, among other uses.[34] Overall, the financial challenges facing the VA during the pandemic do not seem specific to the pandemic itself but are rather a continuation of pre-existing issues, namely addressing the rapidly increasing budget while ensuring adequate care for major healthcare needs in the veteran community, especially disability-related and mental healthcare.[35]

The COVID-19 pandemic has disproportionately affected American Indian and Alaska Native populations in the U.S., who have experienced infection rates over 3.5 times higher than those of non-Hispanic Whites.[36] In response, the Indian Health Service (IHS) received over $9 billion in supplemental funding through the American Rescue Plan, CARES Act, and other programs, which have been used to increase vaccine accessibility, testing sites, and telehealth services during the pandemic.[37] On a per-beneficiary basis, the amount of emergency funding allocated to IHS is greater than that allocated to the VA.

In response to the pandemic, the Military Health System (MHS) waived copayments for and expanded access to telehealth, expanded coverage for investigational new drugs, allowed for greater provider flexibility, and implemented new data collection platforms, including a COVID-19 registry and Current Operation Dashboard.[38] Despite these changes, total expenditures decreased slightly from fiscal year 2020 to 2021, believed to be an impact of COVID-19 on preventative healthcare utilization. The percentage of TRICARE beneficiaries using MHS services decreased slightly from fiscal year 2018 to fiscal year 2020, with decreases in inpatient care, outpatient care, and prescription drug spending.[38]

Safety Net Hospitals

While the definition of safety net hospitals varies, safety net hospitals are broadly characterized as hospitals that care for all patients regardless of ability to pay or insurance coverage.[39] As a result, they care for a high proportion of patients on Medicaid or Medicare and patients without insurance, ultimately caring for our society's most vulnerable.[40] Because of lower levels of compensation for Medicaid and Medicare patients and their high level of uncompensated care, safety net hospitals generally operated on thin operating margins even before the COVID-19 pandemic.[41,42] The AEH calculates the aggregate national operating margins if its 300+ members at ~3%.[41] In 2017, this estimate was ~1.6%.[43] Safety net hospitals exist across all geographies and can include public hospitals, private hospitals, and academic medical centers.[44] The number of safety net hospitals varies widely depending on the definition, though membership in America's Essential Hospitals (AEH) estimates there are over 300.[42,45] Safety

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net hospitals provide a wide range of services from community programs to expensive, critical services like trauma care and psychiatric services.[45]

Like other healthcare centers, the COVID-19 pandemic slowed or shut down revenue sources for safety net hospitals, and patients delayed seeking out emergency care, arriving in higher acuity situations.[40] Even "revenue-generating" services like elective procedures are less profitable for safety net hospitals in a given year due to the lower rate of reimbursement with Medicaid and Medicare.[46] Unlike other healthcare systems, hospitals in the lower quartile of operating margins, where safety net hospitals are largely represented, had roughly a week's worth of cash on hand compared to other hospitals with healthier cash reserves to draw on.[26] In parallel, patients utilizing safety net hospitals - people of color, essential workers, people from low socioeconomic backgrounds, immigrants - were disproportionately affected by COVID-19; the COVID-19 Hospitalization Tracking Project estimated that AEHs treated more patients from August 2020-May 2021, with "10% more patients in beds than other hospitals" over that time.[41,47] As safety net hospitals treated a high proportion of patients, particularly vulnerable patients, they simultaneously had less financial reserves and revenue generating sources to rely on.

The lack of a standard definition for safety net hospitals exacerbated the lack of early governmental support during the pandemic.[39] The first CARES act allocation of ~$50 billion in April 2020 was distributed based on net patient revenue from all payers and so benefited wealthy hospitals.[46,47] Other allocations relied on the number of COVID cases.[48] It was not until the fourth allocation of CARES act funding in June 2020 that ~$10B in funds were specifically targeted to safety net hospitals and ~$15B for Medicaid and CHIP providers.[49] The safety net allocation initially relied upon three criteria as defined by HHS: Medicare Disproportionate Patient Percentage (DPP) of 20.2% or higher, Uncompensated Care (UCC) of at least $25,000 per bed, and a profit margin of 3% or less. As it became evident that certain safety net hospitals were missed, these criteria were expanded to annualize UCC and account for fluctuations in profit margins.[50] Despite these changes, as of September 2020, some safety net hospitals had yet to receive CARES act funding.[51]

The COVID-19 pandemic has both highlighted and exacerbated the ongoing trend for struggling safety net hospitals. In 2020, almost half of the rural hospitals that closed were safety net hospitals.[44] While the future of safety net hospitals is uncertain, safety net hospitals will undoubtedly have to manage their costs to make up for declining profit margins.[52] Safety net hospitals also utilize public funding as a substantial source of funding, which is in question given the rising debt of state governments as a result of the pandemic.[40] Some predict that many safety net hospitals will close and others may need to rely on private funding, raising important questions about the impact on patient care for the most vulnerable and the importance of ensuring equitable healthcare for all.[41]

II. Primary/Long-term Care:

Federally Qualified Health Centers

Federally Qualified Health Centers (FQHCs) are community-based healthcare providers that receive funding from the Health Resources & Services Administration (HRSA) to provide primary care services to underserved populations. There are many different types of FQHCs, including community health centers, migrant health centers, and healthcare for the homeless programs, but they are all similar in that they serve medically underserved areas and/or populations and charge for services on a sliding fee scale. In 2020, 90% of the patients served by FQHCs were at or below 200% of the federal poverty level (FPL), 63% were racial and/or ethnic minority patients, and over one-fifth were uninsured.[53] Consequently, FQHCs have been an important safety net for groups hit especially hard by the COVID-19 pandemic, providing

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crucial services such as COVID-19 testing (provided by about 90% of health centers) and virtual visits.[54]

FQHCs responded to the pandemic by increasing the number of telehealth visits, with almost half of visits now being conducted virtually or over the phone.[54] Despite this, they have faced sharp declines in patient visits since the pandemic started, as well as staffing shortages, with over a tenth of staff not working due to COVID-19 exposures, lack of PPE, site closures, and other COVID-19-related complications.[54] This has posed major financial challenges, since almost two-thirds of FQHC revenues come from patient visits.[54] FQHCs have received $5 billion in COVID-19 relief funding from the federal government as of December 2020.[55] Although an important source of relief for struggling FQHCs, these grants have not been enough to make up for the over $10 billion in estimated COVID-19 related expenses and lost revenue from the pandemic.[55] Furthermore, FQHCs had less of a financial buffer to begin with, with over 40% of health centers having negative operating margins in 2018.[56] In the short term, this has led to almost 2,000 temporary closures of health centers as of May 2020.[54] It is still unclear how many of these closures might become permanent and what long-lasting effects COVID-19 may have on the financial stability of FQHCs, since increasing operating costs and issues with workforce recruitment were already challenges facing these health centers before the pandemic began.[57]

Private Practice

Private practices, defined as practices that are owned by a physician or physician groups, serve different patient populations depending on the practice's specialty as well as its provided services. Group practices can include single or multiple specialties. As of 2020, only 14% of physicians were in solo practice, a decline from 18.4% in 2012. The largest share of physicians worked in single- (45.4%) and multi-specialty (26.2%) practices. About a third of physicians worked in smaller practices containing fewer than 5 physicians, and approximately half worked in practices with 10 or fewer physicians.[58]

The pre-pandemic decline in private practice can be attributed to multiple financial and environmental factors. Private practices have high and increasing operational costs as physicians pay for technology, malpractice insurance, supplies, and employees. A 2016 Medical Group Management Association Cost and Revenue Report found that healthcare IT costs increased by more than 40% per physician since 2009, for example.[59] These costs, combined with declining reimbursement, increased competition with hospital-owned practices and non-traditional primary care services (e.g. urgent care, minute clinics), and the physician shortage have dissuaded younger physicians from pursuing private practice.[60] This decline in private practice ownership has accelerated during the pandemic, with a decrease of almost 5 percentage points since 2018 compared to a 1 percentage point decrease from 2016-2018.[61]

COVID-19 furthered the decline of private practices as these medical practices almost all experienced revenue losses from increased PPE costs and a decreased patient volume.[62] Another survey, including mostly physicians in smaller and independent practices, found that practices reported a 55% revenue decrease and a 60% patient volume decrease on average since the pandemic's start.[63] Volume decreases hurt primary care providers as many of these practices rely on a fee-for-service method of payment.[62,64] Specialists also saw a decrease in visit volume as patients canceled non-emergent procedures and were reluctant to utilize specialty care.[65] Many practices were unable to continue operating with decreases in revenue. A Physicians Foundation Survey found that 8% of practices had closed due to the pandemic, with another 4% planning to close within the next year.[66]

When comparing the impact of COVID-19 on smaller private practices to larger physician practice groups, physician practice groups are thought to have stronger defenses against decreases in revenue and increases in costs. Larger groups often have larger patient bases, higher reimbursement rates, and access to larger savings or credit lines to help them survive

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disruptive market trends.[67,68] Furthermore, larger physician groups are more frequently able to implement alternative payment methods that help keep them afloat as patient volume decreases.

Private practices have utilized government financial assistance throughout the pandemic. However, a majority of CARES Act funds were distributed to those who participate in Medicare, supporting mostly larger hospitals and health systems.[69] Many practices also relied on PPP loans for financial assistance. Furthermore, the Centers for Medicare and Medicaid Services (CMS) facilitated increased reimbursement flexibility surrounding telehealth and used the Accelerated and Advance Payment Program to aid providers.[62] The AMA's Physician Practice Financial Impact Survey found that the vast majority of practice owners found these government financial assistance programs very or extremely helpful.[70]

Long-term Care

Long term care facilities, including nursing homes and assisted living facilities, provide medical care and assistance with activities of daily living for people who cannot live independently. There is tremendous variation in patient populations served, sources of revenue, and costs associated with different long term care models, as well as, presumably, the effects of COVID-19 on their financial viability. Since the majority of literature to date pertains to COVID-19's financial impact on nursing homes specifically, they will be the focus of this section of the report.

Nursing home spending faced slower growth than other U.S. healthcare sectors in the decade before the COVID-19 pandemic, partly due to a growing preference for home healthcare and a shift away from intensive end-of-life care.[71,72] The pandemic has only exacerbated this decline[72]: the widely publicized toll of COVID-19 on nursing home residents, with over 130,000 resident and over 2,000 staff deaths in nursing homes across the U.S. as of August 2021,[73] and fear of infection have contributed to a decrease in nursing home occupancy and decreased revenue, while the need for PPE, extra staffing, and COVID-19 testing has increased expenses.

In response, nursing homes have received a large amount of financial support from federal and state governments, including about $21 billion from the CARES Act and $5.7 billion in loan funds from the Paycheck Protection Program, Medicare accelerated funds, and Medicaid, among other sources.[74] The federal government has also provided nursing homes nationwide PPE,[75] tests and testing equipment,[76] and infection control training.[77] This large influx of resources seems to have offset the financial impact of COVID-19 on many nursing homes, with one study of publicly traded nursing home companies demonstrating that most of these facilities avoided "serious financial damage," including bankruptcies or insolvencies, in 2020.[74] The nursing home industry, however, claims that the long-term care industry is at risk of losing over $90 billion over the course of the pandemic, that more assistance is required, and that over 1,600 nursing homes could close in 2021 without additional aid.[78]

Although direct financial impacts of the pandemic on nursing homes seem to have been largely ameliorated by government aid, COVID-19 may spur some longer-term changes in the industry. Many facilities are shifting to predominantly private rather than shared rooms, and some are experimenting with hybrid home health/assisted living models.[79] Furthermore, the large amounts of government financial support to nursing homes during the pandemic has re-invigorated a call for greater transparency in nursing homes' financial reporting.[80-82]

III. Semi-acute:

Urgent Care

Urgent care centers are walk-in clinics serving non-life threatening medical concerns, bridging care between primary care physicians and emergency rooms. As of 2019, there were almost 10,000 urgent care clinics across the United States.[83] According to a 2016 study, most urgent

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care clinics are located in urban areas, in communities with high income levels and high proportions of private insurance, as well as communities with a high proportion of people of color.[84] For a given urgent care, over 50% of visits are covered by private insurance with a proportion covered by Medicare and Medicaid and a small proportion are paid out of pocket.[85] Unlike emergency rooms under EMTALA, Urgent Care sites are not mandated to care for patients regardless of ability to pay.[86]

At the beginning of the pandemic, urgent care clinics fared similarly to emergency rooms: one report demonstrated that many patients put off necessary and urgent or emergency care during the pandemic, affecting revenues.[87,88] This CDC report did not disaggregate between avoidance of urgent care clinics from avoidance of emergency rooms.[87] However, urgent care clinic utilization soon soared with "a 58% increase in visit volume during the pandemic" many of which were new patients to urgent care clinics.[89] Additionally, an increase in reimbursement amounts helped offset early losses for some clinics.[88] Part of the increase in visit volume was the role that urgent care clinics played: by May 2020, many urgent care clinics were providing on demand COVID tests and were able to fill a gap in the healthcare systems, advising patients on symptoms or when to present at an emergency department.[90] COVID tests, in particular, have become a large part of urgent care business; one report estimated that as much as 10% of COVID testing in the U.S. in October 2020 was conducted through urgent care clinics.[90] As the financial benefit of COVID testing bolstered healthcare institutions across the country, it was estimated that by October 2020, urgent care clinics had earned over $400M for COVID testing.[91,92]

While the demand for COVID testing increased patient volumes, the current reimbursement model does not favor the reliance on COVID testing for revenue generation given the high costs of COVID test kits and PPE.[90] Urgent care clinics were also not prioritized for PPE in some states.[93] However, it is clear that COVID testing will continue to be a crucial part of our daily lives, as individuals test to visit family or travel abroad, to attend events and gatherings, and to help combat the ongoing pandemic. Partnerships between urgent care clinics and airports have already begun to offer streamlined testing for travel, which promises to also create additional opportunities for urgent care clinics in the future.[94]

<u>Free-standing EDs:</u>
Free standing emergency departments (FSEDs) are licensed facilities that provide emergency care. These departments are physically distinct from hospitals. FSEDs owned and operated by a hospital system or medical system are called hospital outpatient departments (HOPD) or satellite emergency department while departments that are not associated with hospitals are known as independent freestanding emergency centers.[95] FSEDs have vastly increased in number through the United States. In 2016, the Medicare Payment Advisory Commission (MedPAC) reported that 11 percent of Emergency Departments nationwide were FSEDs[95] while in 2001, FSEDs only accounted for 1 percent of Emergency Departments. There has been pushback on FSED growth over the last few years due to concerns of higher prices for services compared to hospital-based ERs; MedPAC released a proposal to cut Medicare payment rates by 30 percent on some services in stand-alone facilities within a 6-mile radius of emergency rooms in a hospital.[96]

The onset of the pandemic and the increased need for testing only further raised concerns about potential price gouging, especially by FSEDs that were charging for drive-through testing. The Texas legislature introduced Senate Bill 2038 to address these concerns with the proposal that FSEDs would be prohibited from billing additional fees for drive-up services including testing and vaccinations.[97] Colorado's Department of Health Care Policy and Financing Director reported a state incentive payment program where hospitals could receive money to shut down their FSEDs.[98] During the pandemic, some hospitals have reported declines in patient numbers

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in both emergency departments as well as FSEDs. For instance, University Hospitals (UH) in Ohio documented a 50 percent decline in emergency departments and a 70 percent decline in their FSEDs over the course of the pandemic as care has shifted to phone or online virtual appointments for urgent care visits.[99] Similarly, patient volume has declined around 40 to 60 percent in the 200 FSEDs in Texas.[100] Additional data are needed to determine how many FSEDs were shut down due to financial losses from the pandemic.

Impact of billable telehealth

Several independent variables have been noted to affect the adoption of telehealth. Whether a clinic or hospital already employs an electronic clinical documentation system makes the adoption of telehealth delivery models more likely. Studies also show that larger hospitals (size based on total number of beds) are more likely to already have telehealth as part of their delivery model.[101] The ownership status of the healthcare center also plays a role in the incorporation of telehealth. Studies show that for-profit and investor-owned establishments are less likely to adopt telehealth while those that are affiliated with a hospital system, non-profit, major teaching, and micropolitan area establishments are more likely to adopt telehealth.[101]

One key factor in making the use of telehealth widespread is reimbursement. State telehealth reimbursement policies were variably adopted in 2018. Nearly all (98%) states provided reimbursement for interactive communication, 57% Store and Forward reimbursement (covers the sharing of medical information like digital images, documents, and video through secure online communication), and 45% remote patient monitoring. Most states legislated parity policies: 73% for commercial payers, 63% for Medicaid, and 86% for location.[101] Legislative characteristics were only significantly different for Remote Patient Monitoring. Reimbursement policies vary by state and typically dictate reimbursement for remote patient monitoring, storage and forward technology, commercial parity, Medicaid parity, and location-based parity. Studies showed a 150% increase in telehealth visits during the last week of March 2020, as compared to the same period in 2019, associated with expanded reimbursement policies.[101] There was a rebound in in-person visits as of May 2020 due to the temporary nature of telehealth reimbursement policies, many of which were implemented not as a permanent solution but as a support mechanism during the COVID-19 pandemic. Telehealth adoption has significant implications for rural healthcare systems. Geographic restrictions within reimbursement policies disproportionately affect rural areas and result in lower levels of telehealth adoption. Removing them may incentivize rural hospitals to adopt electronic health records (EHR). Increasing reimbursement rates for patient monitoring could also increase the monetary capital rural hospitals have to work with and would make telehealth implementation more likely.

Impact of the CARES Act and how it was distributed

Even before the COVID-19 pandemic, the U.S. had an enormous cost burden due to uncompensated care. Uncompensated care in the U.S. cost $42.4 billion between 2015 and 2017. Federal payments to offset costs of uninsured care totaled $33.6 billion in 2017; the greatest contributions came from the Veterans Health Administration & Medicaid budgets. Additionally, states and localities spent $9.9 billion caring for the uninsured. However, many of these public programs did not directly address individual provider compensation.[102]

The CARES Act was designed to specifically target the economic consequences of the COVID-19 pandemic. It served to support state Medicaid programs to support the cost of COVID-19 testing, and to provide immediate fiscal relief to localities to cover the negative economic effects of the pandemic.[103] However, it did not fully address the disparities among communities suffering the repercussions of the pandemic.

There is no doubt that COVID-19 has affected the entire U.S. population, with direct health consequences in addition to indirect economic and social consequences. However, minorities have been disproportionately affected by the pandemic for a variety of reasons. Many minorities

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are employed at jobs that were considered “essential,” and were thus at increased risk. Minorities additionally face barriers to accessing healthcare and receiving adequate care.[104]

The CARES Act was designed to allocate funds based on past revenue. Revenue, however, is an imperfect measure that does not address the medical comorbidities and demographic makeup of localities, to name just a few complicating factors. A Journal of the American Medical Association (JAMA) study found that in counties receiving equal amounts of funding from the CARES Act, counties with a higher Black population had higher COVID-19 burden, more comorbidities, and worse hospital finances.[105] The CARES Act relief algorithm also favors for-profit hospitals with private insurance since private insurers tend to reimburse at higher rates than Medicare and Medicaid. These hospitals with more market power are able to command higher reimbursement rates from private insurers, and thus receive greater funding according to the CARES Act formula.[69]

Through the CARES Act, $21 billion was allocated to nursing homes, and roughly $50 billion was allocated to hospitals.[106] The money allocated to hospitals and nursing homes did not come with spending restrictions. The Department of Health and Human Services specified that aid did not have to be “specific to providing care for possible or actual coronavirus patients” This led to funds occasionally being used for administrative purposes instead of directly for patient care.[107]

Impact of Insurance Program Participation on Financial Stability

The focus of this report is the financial impact of the pandemic on healthcare delivery. A fundamental source of healthcare reimbursement is health insurance, so the potential impact of insurance needs to be addressed. Medicare, Medicaid, TRICARE, and other government program reimbursement (its place and potential insufficiency) has been addressed substantially above. Here the focus is on private insurance models and risk sharing strategies (Preferred Provider Organizations, Health Maintenance Organizations, Accountable Care Organizations (ACO), Integrated Health Networks, etc.).

Overall, private insurance saw tremendous growth in revenue, largely due to decreased healthcare utilization during the pandemic. UnitedHealth Group saw its net income double from $3.4 billion to $6.7 billion; Anthem grew from $1.1 billion to $2.3 billion; Aetna and Humana also gained a $1-2 billion.[108] In contrast, ACOs were concerned about the impact of COVID-19 on their risk profiles since there were no actuarial models to account for potential consequences of hospitalization and care cost for these patients.[109,110] This contributed to the government ruling that COVID-19 costs could not be counted against them.[111] Nevertheless, over half of the risk-based Medicare ACOs are likely to leave the risk based program in response to concerns over financial losses in 2020.[109,110] This comes along with the disappointing evidence that ACOs have not contributed to meaningful healthcare savings since their inception under the guidance of the ACA.

Interestingly, another successful financial model for weathering the pandemic was demonstrated by Kaiser Permanente’s system in California. This Integrated Health Network is unique in operating both as the delivery of healthcare and its insurance/risk stratification simultaneously. Combining these two historically disparate components of the healthcare system in the United States may contribute to intangible benefits and evidence-based, adaptable healthcare spending and delivery. Indeed, unlike many other healthcare delivery systems, the network remained profitable after recovering from first-quarter losses.[112] It is not possible to understand the specifics that led to this result without proprietary financial information, but it speaks to the benefit of aligning the incentives of healthcare delivery and insurance.

Table 1: Historical Operating Margins

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	Hospital Operating Margins (2003)[113]	Hospital Operating Margins (2013)[113]
95th percentile	18%	18%
75th percentile	5%	5%
25th percentile	-12%	-9%
5th percentile	-18%	-28%

Table 2: Recent and Projected Proportion of Hospitals with Negative Operating Margins

Hospitals with Negative Operating Margins (2016) (%)[114]	Projected Hospitals with Negative Operating Margins (2021 Q4) (%)[115]*
30.6	35.2 - 49.1%

*Projections based on assumptions from real and proprietary revenue data for 900 hospitals.

DISCUSSION

Are health systems recovering or what services may never come back?

Our healthcare system experienced a stress test through the COVID-19 pandemic. Rather than exposing new issues, it has primarily highlighted the system's vulnerability to the trends of privatisation and business-influence in healthcare, hospital consolidation, fee-for-service billing, and high-cost care. These trends have served to put at risk essential healthcare services for underserved populations including most notably: rural hospitals, safety-net hospitals, private practice primary care physicians, and even FHQCs. These represent lost services that are unlikely to return in the near future, largely due to financial instability. The majority of closures were of rural hospitals, and protecting safety net hospitals will require government and public support and a wide array of policies aimed at investing in and bolstering this critical network of hospitals. FHQCs have experienced temporary closures, but the extent to which some may have become permanent is unknown. Long-term care closures may also be imminent due to trends in growth of at-home care and infection control concerns during the pandemic.

Although government financial assistance has helped both small private practices and larger physician groups, ultimately COVID-19 has undoubtedly accelerated the decline of private practice groups across the country. The effects of this ownership change cannot be understated as one of the major drivers of changes in the practice of medicine for the U.S. over the next decade. The final effects of COVID-19 will continue to play out as private practices face increasing headwinds while competing against other healthcare delivery systems.

FSEDs may also have closed, however these were confounded by government efforts to encourage their closure due to concerns for inferior and higher-cost care. As noted with FSEDs, these facilities are at risk of upcharging for services without increasing the benefits or the number of individuals served. Urgent care counterparts have largely maintained their business models through adaptation, but without comprehensive services or savings for patients.

In contrast, the healthcare delivery systems that fared best have the greatest cash reserves and investor management, but do not always address the underserved. Academic and non-profit hospitals were largely able to continue their operations and benefited disproportionately from

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government intervention and their large investment portfolios. Academic hospitals even returned $2.3 billion in COVID-19 aid.[116] In other more concerning cases, funding may actually have been allocated to administrative tasks rather than direct patient care. For-profit hospitals are likely to respond in the long-term with better engagement in collaborative disaster preparedness planning, re-focusing care to establish at least a larger percentage of revenue derived from life-saving/prolonging care, consolidation of smaller hospitals to focus only on three to four top earning departments and partner with other local facilities for other patient care, and ensure stronger investments for the ability to better weather the storm of any periods of reduced elective service offerings in the future.

High Risk of Closure (Known Closures due to Pandemic)	Rural Hospitals Safety Net Hospitals Private Practice Primary Care and Groups Long-term Care
Moderate Risk of Closure (Temporary or Suspected Closures)	Free-standing Emergency Departments Federally Qualified Health Centers
Low Risk of Closure (No Significant Closures Reported)	Non-profit Hospitals For-profit Hospitals Metropolitan Hospitals Urgent Care Centers

Impact of telehealth on finances

Overall, the extent to which telehealth was used during the COVID-19 pandemic and prior to the pandemic needs to be researched further. The information currently available regarding utilization and effectiveness of telehealth demonstrates that changes made to reimbursement policies during the COVID-19 pandemic should become permanent. However, they have not significantly decreased the extent to which healthcare delivery suffered financial instability.

Insurance coverage method may affect emergency preparedness

ACOs were most concerned about the pandemic affecting their bottom line. This implies an interesting question to consider, might not the impact on ACOs be a product of their relative size rather than an inherent flaw in their design? Private insurance (PPOs/HMOs) still accounts for a larger and healthier proportion of the population than do ACOs. Indeed, the financial boon to private insurance is not a good bellwether for quality healthcare, as it represents money not being spent to improve health. In contrast, the concern expressed by ACOs for COVID-19 indicates that the financial incentives were driving them to make decisions and priorities in line with supporting the health outcomes of their beneficiaries. If ACOs were larger, would they successfully spread risk and save costs in the face of COVID-19? What might this mean for a single-payer system?

What factors should go into calculations for emergency funding distribution?

The Coronavirus Aid, Relief, and Economic Security (CARES) Act and Paycheck Protection Program and Healthcare Enhancement Act allocated $175 billion worth of grants for healthcare providers. The costs can be used for treating COVID patients or reimbursements for lost revenue. Approximately 29 percent of the funds were available to providers who participate in Medicare based on total net patient revenue. According to a report by the Kaiser Family Foundation, the formula used to calculate about $50 billion in funding was more favorable for hospitals that had the highest share of private insurance revenues of their total net revenue.[69] Additionally, the hospitals that received the highest shares of funding also provided less uncompensated care (bad debt, charity care, unreimbursed Medicaid expenses) compared to the hospitals in which private insurance revenue was a smaller percentage of total revenue.

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The pandemic had a disproportionate impact on hospitals in rural areas and those serving underserved populations. In order for more equitable distribution of funding in the future, the formula for calculating funding should take into account the proportion of uninsured patients in a given hospital or health system. Uninsured patients are more likely to receive unreimbursed care that could devastate a hospital that is suffering losses during a situation such as the one faced during the pandemic. Other considerations should include financial risk for the facility and their likelihood to upcharge without benefiting patients. The financial needs such as equipment availability as well as provider:patient ratio must also be considered in funding. Hospitals that are at risk of going under due to strained finances and inability to afford additional equipment, supplies, or payment for employees must be considered first in emergency situations.

Proposed Principles of Equitable Emergency Funding Distribution:

1. **Accounts for uninsured, underinsured, and uncompensated care**
2. **Considers vulnerability and comorbidities of population served**
3. **Caters to the relative financial stability of the institution**
4. **Addresses the needs for new equipment or services to address the specific public health threat**

It is possible to envision what could happen had these principles been applied to previous public health emergencies. In the opiate epidemic there could have been increased funding to the rural hospitals and primary care physicians based on affected individuals in their catchment area. In Hurricane Katrina there could have been better allocation of generators, ventilators, and staff to address the lasting impact of hospital closures and patient needs. What we need to envision is a radical reassessment of how we monitor the financial, structural, and demographic needs of each method of healthcare delivery to ensure equitable outcomes.

Review of Current Relevant AMA policies

The AMA has prior policies relevant to this current issue. The AMA currently supports access to care (H-160.987), and measures to help offset costs of uncompensated care (H-160.923). These include “transitional redistribution” of funding to subsidize coverage for the uninsured and use “innovative federal or state-based projects that are not budget neutral” to support the care of the uninsured. These are examples of the principles of equitably distributing supplemental funding. Further, our AMA opposes monopolistic hospital consolidation and closure (H-215.960;D-383.980;D-225.995), as well as support for rural hospitals including capacity payments for minimum fixed costs and greater network coordination (D-465.998;H-465.989;H-240.970). Standards have also previously been introduced for for-profit and nonprofit hospitals (H-215.967;H-215.975). The AMA has also previously developed policies to study the ability of ACOs to generate savings (H-160.892), finance long-term care (H-280.991;H-290.982), promote telemedicine (H-480.969), ensure urgent care center quality and connection to PCPs (H-160.888; H-160.983), and sustain private practice (H-240,979).

CONCLUSION

The greatest concern for the financial viability of healthcare delivery in the U.S. is to maintain the best care possible for the patients that need it most. In the face of the pandemic, healthcare for the underserved was most likely to close and least likely to benefit from government funding. The largest healthcare institutions and insurance companies benefited the most financially during the pandemic. Rather than distributing funding during a public health emergency in a way that is convenient (i.e., based on revenue), other factors of need and ability to sustain operations must be accounted for. This will require advance planning before the next public health emergency and agreement on the core factors to consider, which are elucidated above. Furthermore, healthcare systems with the ability to manage and fund their own emergency preparedness should be encouraged to do so, and any funding provided must be directed

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towards patient care. Our healthcare system is too discontinuous and vulnerable to respond adequately without this form of intervention and planning.

RECOMMENDATIONS

The Committees on Economics and Quality in Medicine and Legislation and Advocacy of the AMA Medical Student Section submit the following resolve clauses for consideration by the assembly based on the findings of this report, and request that the remainder of the report be filed:

RESOLVED, Our AMA support distribution of funding based on proportion of uninsured, uncompensated, and vulnerable individuals treated and baseline institutional financial needs required to maintain essential patient care operations during a public health emergency in order to achieve equitable outcomes; and be it further,

RESOLVED, Our AMA recommend that hospitals, medical practices, and other healthcare delivery institutions have an adequate financial security plan and preparedness in the event of a public health emergency to maintain essential operations without producing undue burdens on medical staff that is sustained by:

1) The cash on hand and investments of the institution or
2) In the case that an institution is unable to maintain adequate reserves due to the payer mix or demographics of their population served, that public funding be made available.

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REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON ECONOMICS AND QUALITY IN MEDICINE AND MINORITY ISSUES COMMITTEE

MSS CEQM MIC Report A
(N-21)

Introduced by:	MSS Committee on Economics and Quality in Medicine and Minority Issues Committee
Subject:	Laying the First Steps towards a Transition to a Financial and Citizenship Need-Blind Model for Organ Procurement and Transplantation
Referred to:	MSS Reference Committee (Zachary Dunton and Neha Siddiqui, Chair)

INTRODUCTION

At the 2019 MSS Annual meeting, MSS Resolution 46 asked the AMA to support and advocate for federal laws that remove financial barriers to transplant recipients, a 2020 national taskforce for organ procurement that would be renewed every 20 years, to research a fiscal federal strategy that would cover annual transplant costs and to make amendments to 6.2.1. in the Code of Ethics and AMA existing policy H-370.982 that would alter statements to not regard immigration status. The A-19 Reference Committee referred MSS Resolution 46 for report. The MSS Assembly and Reference Committee specifically stated concerns over:

1) including criteria for having established a “physical presence” in the United States;
2) the resource intensive nature and feasibility of advocating and creating such a taskforce;
3) the limited feasibility of the AMA researching a fiscal federal strategy to cover annual transplantation costs given the AMA is not a body that commonly conducts such research; and
4) the fact that the HOD cannot amend the AMA Ethical Opinion, and would have to be referred to the Council on Ethical and Judicial Affairs (CEJA).

Both the Reference Committee and Assembly agreed that this is an important resolution that could be strengthened through an assigned report. Specifically, we take note of the potential fiscal and political capital that would come of the asks. This report was originally assigned at A-19 and was referred for further study at that meeting. The report was set to be presented at I-20, but it was not discussed due to time constraints. Per MSS Reference Committee recommendation, the report was re-referred and is slated to be discussed at I-21.

BACKGROUND

Of the 11 million undocumented immigrants residing within the United States, an estimated 6,500 have end-stage renal disease (ESRD) requiring chronic dialysis.[1] Many of these patients, however, are unable to access appropriate care, largely due to financial barriers. The average cost of chronic hemodialysis per patient is $90,000/year and most patients with ESRD who are citizens are able to afford this through the 1972 Public Law 92–603 amendment to the Social Security Act that provides financial coverage to those who qualify for Social Security benefits.[2,3] Unfortunately, undocumented immigrants are excluded from these benefits and must rely on emergent-only hemodialysis, and only after they develop life-threatening metabolic disturbances.[4] The annual costs of these treatments range from $285,000 to $400,000 per patient.[5] Undocumented immigrants are able to receive emergent hemodialysis because the 1986 Emergency Medical Treatment and Active Labor Act (EMTALA) mandates that all states

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must provide federally funded emergency medical treatment. However, no federal, state, or local funds – including Medicaid, Medicare, and the Children's Health Insurance Program are available for maintenance therapy for undocumented immigrants with ESRD, as dictated by the 1996 Personal Responsibility and Work Opportunity Reconciliation Act.[6,14,16]

The alternative treatment option for ESRD is kidney transplantation. Not only is this approach curative, it also has lower associated annual costs, averaging $39,939 per patient for HLA-compatible living donor transplantation.[7,8,17] Current ethical and legal guidelines dictate that medical need alone should determine how organs are allocated for transplant. However, only 1% of all kidney transplant recipients per year are non-citizens, which is grossly out of proportion to the 2-3% annual contribution to the donor organ pool made by this same population.[9] While organs may be allocated to undocumented immigrants, current policy excludes this patient population from receiving federal, state, and local funding to cover their transplantation and post-transplantation care.[10,11,14,20] This means that undocumented persons are not only unable to afford these potentially curative transplants, they are also unable to pay for costly post-transplant immunosuppressive medications, leading to graft failure over time. Consequently, thousands of patients with ESRD are forced to go without a potentially lifesaving transplant because of their legal status. These patients continue to receive costly dialysis treatment paid for by state emergency health care funds. It is evident, therefore, that there exists a glaring disparity in access to adequate long-term treatment options for undocumented persons with ESRD. Not only is there a moral imperative to advocate for the improved health outcomes of these persons, there is a financial benefit to improving access to kidney transplants. Since kidney transplantation is a curative and cost-effective long-term treatment option for ESRD, efforts should be made to facilitate access for undocumented persons.

Patients with other forms of organ failure have even fewer non-surgical treatment options in comparison with those who need a kidney transplant.[6,21] A recent study of liver transplant indicates that undocumented persons rarely have access to liver transplantation, and when they do, long wait times may negatively affect their outcomes.[22,23] An undocumented person's access to organ transplantation is further complicated by location. Access to transplantation varies by state, with almost a quarter of all liver transplants occurring at two transplant centers in California.[22, 23] Each transplant center gets to set their own rules for who can be added to the waiting list for an organ.[24] These rules, while also considering the patient's health and risk factors for transplant, also consider financial status; without insurance, an undocumented patient is less likely to be considered a good candidate and is therefore less likely to get access to an organ transplant.[25]

As the biggest barrier to organ transplantation in this population remains financial in nature, it is important to continue research into feasible federal fiscal strategies that would cover annual transplant costs for undocumented and uninsured patients.

DISCUSSION

Organ procurement is an issue that affects over 100,000 people each year, and equitable access is not available across all communities. Our AMA has already shown support through previous policy for equal access in receiving transplants, regardless of citizenship status.

With regard to the first resolve clause of MSS Resolution 46, while the spirit of the clause is certainly in the interest of ensuring equality for organ transplant recipients, the phrase "physical presence in the U.S. prior to needing the organ" is vague and raises questions about what "physical presence" means and how it is confirmed. While the intention of ensuring that non-citizens are not excluded from this process is clear and in line with previous AMA policy, such as H-370.990, there is concern that by keeping this phrase vague, "physical presence" is left open to interpretation and could possibly work against the overall goal of equal access. This

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phrase is repeated in resolve clause 4. In addition, in resolve clause 5, the language is not consistent with previous clauses, using the wording “as long as the person lives in the U.S.” and for clarity, having the same language here as was used in previous resolve clauses would be helpful. Overall, in order to ensure that non-citizens are considered viable recipients for organ transplants, there needs to be more specificity.

With regard to the second resolve clause, the intention of keeping policies regarding organ procurement up to date is reasonable given our changing demographics and technologies. However, the choice to renew the task force every 20 years is not backed by any evidence or reasoning. Ideally, renewing the task force every 10 years when the US census is conducted may better provide standardized updates on demographic information, characteristics of minority populations, and immigration trends. It is important to note that the AMA would not be the optimal body to establish this task force given the organization’s structure, but would be better off to support the establishment of this task force.

Similarly, regarding resolve clause 3, the AMA is not a body that routinely conducts primary research, and would be more equipped to support researching a federal fiscal strategy to cover the costs of organ transplantation and coverage of follow up care, including office visits and immunosuppressants.

Although the spirit and intention of the fourth resolve clause is in line with current AMA policy, it is similarly out of scope, as changes to the code of ethics must be referred to the Council of Ethical and Judicial Affairs. In addition, it would be redundant to the asks of the fifth resolve clause.

The Minority Issues Committee and the Committee on Economics and Quality in Medicine did consider the suggested amendment by addition to the Code of Ethics 6.2.1 to be appropriate for an amendment by addition in H.370.982 in resolve clause 5. As written, this amendment strengthens the current policy, clarifying that a citizenship blind approach to organ transplantation is ethical in accordance with legal precedent. On the other hand, we believe that attempts to clarify the physical presence of an individual in the US may work against the goal of the resolution as previously stated.

It is within the scope of the AMA and the AMA-MSS to support the removal of financial barriers to access organ transplantation as it:

1) Improves equitable access to a benefit to a marginalized population to reduce health disparities, where the major hurdle to receiving a transplant is financial cost.
2) Health care costs associated with emergent dialysis far outweigh the costs associated with routine hemodialysis and organ transplantation

RECOMMENDATIONS

Your Minority Issues Committee and Committee on Economics and Quality in Medicine recommend that the following recommendations be adopted and the remainder of the report be filed:

1) That the first resolve clause of MSS Resolution 46 be amended by addition and deletion as follows:

   RESOLVED, That our AMA support and advocate for federal ~~laws~~ mechanisms that ~~remove~~ decrease financial barriers to transplant recipients, such as provisions for expenses involved in the transplantation of organs incurred by the uninsured or those who do not qualify for health care coverage regardless of a legally defined United States

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Citizenship and Immigration Service (USCIS) status in the country as long as the person ~~can show physical presence~~ lives in the U.S. ~~prior to needing the organ~~; and

2) That the second resolve clause of MSS Resolution 46 be amended by deletion as follows:

~~RESOLVED, That our AMA support the creation of a 2020 national taskforce for organ procurement and transplant, that will be renewed every 10 years to assess the needs of the generation and account for changes in demographics and technology; and~~

3) That the third resolve clause of MSS Resolution 46 be amended by addition as follows:

RESOLVED, That our AMA support the research of a federal fiscal strategy to cover annual transplant costs in the U.S. for patients who ~~without or~~ are ineligible for the insurance distributions ~~distributed~~ among the ~~over~~ 200+ ~~transplant centers in the~~ U.S. transplant centers; and

4) That the fifth resolve clause of MSS Resolution 46 be amended by addition and deletion as follows:

RESOLVED, That our AMA amend H-370.982 ~~to also clarify its stance of not regarding immigration status as long as the person lives in the U.S. thereby keeping the overall equitability of the system for organ donation and receiving parties intact~~ by addition to read as follows:

Ethical Considerations in the Allocation of Organ and Other Scarce Medical Resources Among Patients, H-370.982

Our AMA has adopted the following guidelines as policy: (1) Decisions regarding the allocation of scarce medical resources among patients should consider only ethically appropriate criteria relating to medical need. (a) These criteria include likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in some cases, the amount of resources required for successful treatment without regard to a legally defined United States Citizenship and Immigration Service (USCIS). In general, only very substantial differences among patients are ethically relevant; the greater the disparities, the more justified the use of these criteria becomes. In making quality of life judgments, patients should first be prioritized so that death or extremely poor outcomes are avoided; then, patients should be prioritized according to change in quality of life, but only when there are very substantial differences among patients. (b) Research should be pursued to increase knowledge of outcomes and thereby improve the accuracy of these criteria. (c) Non-medical criteria, such as ability to pay, social worth, perceived obstacles to treatment, patient contribution to illness, or past use of resources should not be considered.
(2) Allocation decisions should respect the individuality of patients and the particulars of individual cases as much as possible. (a) All candidates for treatment must be fully considered according to ethically appropriate criteria relating to medical need, as defined in Guideline 1. (b) When very substantial differences do not exist among potential recipients of treatment on the basis of these criteria, a "first-come-first-served" approach or some other equal

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opportunity mechanism should be employed to make final allocation decisions. (c) Though there are several ethically acceptable strategies for implementing these criteria, no single strategy is ethically mandated. Acceptable approaches include a three-tiered system, a minimal threshold approach, and a weighted formula.

(3) Decision making mechanisms should be objective, flexible, and consistent to ensure that all patients are treated equally. The nature of the physician-patient relationship entails that physicians of patients competing for a scarce resource must remain advocates for their patients, and therefore should not make the actual allocation decisions.

(4) Patients must be informed by their physicians of allocation criteria and procedures, as well as their chances of receiving access to scarce resources. This information should be in addition to all the customary information regarding the risks, benefits, and alternatives to any medical procedure. Patients denied access to resources have the right to be informed of the reasoning behind the decision.

(5) The allocation procedures of institutions controlling scarce resources should be disclosed to the public as well as subject to regular peer review from the medical profession.

(6) Physicians should continue to look for innovative ways to increase the availability of and access to scarce medical resources so that, as much as possible, beneficial treatments can be provided to all who need them.

(7) Physicians should accept their responsibility to promote awareness of the importance of an increase in the organ donor pool using all available means.

5) That the fourth resolve clause of MSS Resolution 46 be amended by deletion as follows:

~~RESOLVED, That our AMA amend 6.2.1 in the Code of Ethics to explicitly state that organs should be allocated to recipients on the basis of ethically sound criteria without regard to a legally defined United States Citizenship and Immigration Service (USCIS) status as long as the recipient can show physical presence in the U.S. prior to needing the organ, thereby keeping the overall equitability of the system for donating and receiving parties intact:~~

~~**Guidelines for Organ Transplantation from Deceased Donors, 6.2.1 AMA code of**~~
~~**Medical Ethics, 6.2.1 AMA code of Medical Ethics**~~

~~6.2.1 in the Code of Ethics states "Physicians who participate in transplantation of~~
~~organs from deceased donors should: … (e) Except in situations of directed donation, ensure that organs for transplantation are allocated to recipients on the basis of ethically sound criteria, including but not limited to likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in certain cases, amount of resources required for successful treatment~~ ~~without regard to a legally defined United States Citizenship and Immigration Service (USCIS) status.; and let it be further~~

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REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON MEDICAL EDUCATION AND COMMITTEE ON BIOETHICS AND HUMANITIES

MSS CME CBH CHIT Report A
(N-21)

Introduced by: MSS Committee on Medical Education, Committee on Bioethics and Humanities and Committee on Health Information Technology

Subject: Medical Student, Resident, and Fellow Suicide Reporting

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

INTRODUCTION

At the June 2021 AMA-MSS Meeting, MSS Resolution 42 asked the AMA to support a resolution amending D-345.983, regarding the study of medical student, resident, and physician suicide, to develop a standardized reporting process for suicide information stratified by institution. The J-21 Reference Committee recommended that MSS Resolution 42 not be adopted. Although the resolution was extracted for discussion during the Assembly Meeting, testimony focused on whether the amendment provided would address the primary concerns raised. The AMA-MSS Assembly recognized the merits of this resolution, namely that it would hold institutions accountable for reporting suicides that would inform efforts to address mental health. However, the largest concern brought forth by the Reference Committee and other stakeholders was loss of individual privacy and anonymity with the report and subsequent accessibility of suicide data. Especially in the context of smaller residency and fellowship programs, suicide reports would be easily discernible and break confidentiality. While a 5 year reporting period was discussed, confidentiality was still a concern. Additionally, public data on suicide statistics at different institutions may be misinterpreted without additional context, and accordingly, the accessibility of data posed another concern. The MSS body voted to refer resolution 42 for study to avoid unintended consequences of adopting this resolution without close study.

Your Committee on Medical Education (CME), Committee on Bioethics & Humanities (CBH), and Committee on Health and Information Technology (CHIT) researched the current climate of suicide in the medical field and contacted stakeholders to determine the viability of a standardized suicide reporting mechanism that protects confidentiality of trainees.

BACKGROUND

Existing studies of medical trainees have shown high rates of depression and anxiety, both of which are known risk factors for suicide[1,2,3,4]. In one meta-analysis, the prevalence of depression or depressive symptoms among medical students was 27%, with only 16% of those who screened positive seeking psychiatric treatment[3]. The prevalence of suicidal ideation among students in that same study was a surprising 11%[3]. Rates of anxiety symptoms and generalized anxiety disorder follow similar trends - one smaller scale study revealed that medical students screen positive for GAD at a rate eight times higher than age-matched controls[6]. In a retrospective study of residents spanning multiple decades and countries, 21% to 43% of residents reported depression or depressive symptoms, the prevalence of which has only increased over time[5]. For both trainee groups, transitional years have been found to be critical

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periods for worsening mental health. Matriculating medical students start off at lower rates of depression and burnout, a trend that quickly reverses when they begin medical school[26,27]. The first year of residency is similarly associated with a 16% increase in depressive symptoms, highlighting a need for additional support during that transition[5]. Lastly, rates of burnout - a contributor to depression, relationship problems, and substance use - are higher in all medical trainees compared to the general population[6,15].

Surprisingly, the suicide rates in medical students and residents are lower than those of their same-age contemporaries[7,8]. This may in part be due to cohort-wide protective factors against suicide, including educational attainment and overall high socioeconomic status[22,23]. Suicide rates are also difficult to estimate due to lack of high-quality data, particularly in the medical student population[8,27]. For residents, an Association of American Medical Colleges (AAMC) study on causes of death among residents revealed suicide to still be the second leading cause (second only to cancer), and the leading cause of death for male residents[7]. An uptick in suicides corresponded with the early years of residency and the 1st and 3rd quarters of the academic year, underscoring increased stress around those times of year and the impact of depressive symptoms as mentioned above[7].

There is limited data on depression, anxiety, and suicide in post-graduate physicians, much of which comes from older data and small scale studies[29]. An estimated 19.5% of female physicians report depression (as of 2000), with somewhat lower rates of depression in male physicians[30]. One often cited abstract from the 2018 APA conference estimates that 300-400 physicians die every year by suicide, but the study has not been published in any peer-reviewed journal, as of the writing of this report[10]. An older 2004 meta-analysis reveals suicide rates in physicians that are higher compared to the general population (40% higher for men and 130% higher for women)[9]. A 2020 meta-analysis subsequently found that suicide remains a leading cause of mortality for physicians when compared to other causes (ie. cardiovascular disease, cancer), despite a general decrease in physician suicide rates since 1980[24,25]. Given the continued stigma surrounding mental health and lack of formal reporting mechanisms, the Medscape Physician Burnout and Suicide Report has become a powerful tool to track mental health trends anonymously within our profession in real time[11,29].

Overall, there are limited robust studies about medical student, resident, and physician suicide. JAMA published a viewpoint in 2015 calling for a national response regarding studies of depression and suicide in medical trainees[31]. In 2019, the AMA House of Delegates began exploring the viability of confidentially recording causes of death in the AMA Physician Masterfile as well as calling upon leading medical education organizations to track medical trainee suicide (D-345.983), however there are no stipulations for this data to become publicly available [12,13]. In light of increasing professional demands and worsening burnout related to the COVID-19 pandemic, it is all the more imperative to collect accurate, real-time data on our profession's mental health to inform efforts on mitigating risks and preventing suicide[28].

DISCUSSION

Resolution 42 identifies important issues regarding the reporting and accessibility of medical student suicide and resident/fellow suicide. Currently, the most consistent report is through Medscape's annual survey, but it only tracks physicians who have experienced suicidal ideation and not those who have attempted or completed suicide. The AMA is currently exploring the fesiability of a study with medical trainee and physician suicide using the the National Death Index and the AMA physician masterfile. Resolution 42 has three asks:

1.) Work with appropriate stakeholders to explore the viability of developing a standardized reporting mechanism for the confidential collection of pertinent suicide information of trainees in medical schools, residency, and fellowship programs

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Multiple organizations routinely collect data on resident suicide. Data collected by the ACGME and National Death Index (NDI) has an established suicide as the second leading cause of death among residents, preceded only by neoplastic disease[7]. In 2019, the AMA adopted a report that stated they would partner with an unspecified leading medical education body to collect data on the manner of death from the NDI on a subset of the Masterfile population[13].

However, there are no such databases for reporting suicide in medical students. Consistently collecting data through a standardized reporting mechanism can improve studies focused on the efficacy of suicide prevention efforts in medical schools and improve the study of trends in suicide rates among medical students over several years. Collecting this information is important as medical students are three times more likely to commit suicide compared to the general population in their age range according to the AMA Council on Medical Education. However, there are concerns over collecting this information from individual schools without conglomerating the data[14]. Such concerns include student and trainee privacy and undue comparison between programs[4]. Additionally, the cost-effectiveness of collecting this information must also be taken into consideration. It would cost approximately $30,000 per year to obtain data from the National Death Index on a yearly basis based on a report by the AMA Council on Medical Education.

In 2018, the AMA called upon the LCME to collect such data, which was ultimately rejected in 2019 as they deemed it out of their purview. The LCME has previously stated that they will not collect such data as doing so may pressure institutions to “feel as though there is a direct correlation in any kind of unfortunate student outcome and the medical education program itself, when there are so many other factors involved.[1,4]

2.) Work with appropriate stakeholders to explore the viability of developing a standardized reporting mechanism for the confidential collection of current wellness initiatives that institutions have in place, to inform and promote meaningful mental health and wellness interventions in these populations.

Medical schools and residency programs are required to have wellness programs. For allopathic medical school accreditation, the LCME requires that institutions “include programs that promote student wellbeing.” For osteopathic medical school accreditation, COCA requires that the institution “must develop and implement policies and procedures as well as provide the human and physical resources required to support and promote health and wellness.” For residency, ACGME requires “Institution, must ensure healthy and safe learning and working environments that promote resident well-being.”

Collecting information on wellness initiatives at each medical school and residency has clear benefits of informing and promoting mental health and wellness interventions. Additionally, collecting such information is not subject to the same need of confidentiality compared to suicide reporting. Having the information publicly available can encourage other institutions to adopt certain wellness initiatives, along with getting contact information for how to best implement these programs. However, the wellness initiative should not be used as a metric to compare institutions. Some institutions may have more resources to enable more extensive wellness initiatives than other institutions. Certain institutions may also implement fewer wellness initiatives, but these initiatives may be more effective for their student body overall. Different medical students may also respond differently to the wellness initiatives that are offered by an institution.

3.) Create a publicly accessible database that stratifies medical institutions based on relative rate of trainee suicide over a period of time, in order to raise awareness and promote the implementation of initiatives to prevent medical trainee suicide.

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There were several concerns brought about this ask. The first is finding an organization to confidentially collect information regarding medical trainee suicide. As mentioned earlier, the AMA has already discussed with LCME about collecting this data, but LCME declined participation. The LCME was concerned about singling out institutions that have had suicides since a lot of the factors for suicide are outside of the institution's control. While we agree that evaluating data based on individual schools may help identify underlying factors that contribute to suicide, getting institutional involvement and organization involvement would be a major barrier.

The other concern is confidentiality. Having a publicly available database based on medical institutions, particularly smaller residency and fellowship programs, makes it difficult to maintain confidentiality. A 2017 study using an ACGME database of resident names and the national death index was able to provide insightful information about resident suicide based on age, gender, and year in training[7]. However, the article was careful not to separate it out based on specialty and institution.

Our committee brainstormed the following methods to address confidentiality:

- Hybrid database, with one portion public and one portion private. The public portion would show total medical student deaths from suicide in aggregate in total or by region, with no dividing amongst schools. It could show the percentage of medical student deaths that are due to suicide as well. As for the private database, this would have data split by schools, and would have access restricted to only those who have a role directly tied to the use of such data (eg. researchers and schools that may want to evaluate their own performance).
- Obfuscating data that could be used to identify individuals who have died from suicide. Ways to obfuscate would be to equilibrate data between schools with no deaths from suicide and schools who had a certain number of deaths from suicide. For example, all schools who have had 2 or less deaths (including no deaths) from suicide within a certain timeframe could have their data point listed as "<2" in a dataset. This would make it very difficult to ascertain whether an individual died from suicide, as there would now be no way to tell if a particular school had a student or resident die by suicide or not."

Overall, while these mechanisms would address the concerns regarding confidentiality, it would require institutional and organizational support. The data is sensitive and the organizations posed to collect the data like LCME and AAMC are reluctant to collect the information. AMA is working to connect NDI data with the AMA physician masterfile, but is against stratifying the database and making it publicly available.

CONCLUSION

The asks of Resolution 42 identify pressing issues important to both student and physician training. The intention of these asks is that instituting a standardized reporting body for student, resident, and fellow suicide would put needed pressure on institutions to hold them accountable. Some of these issues, such as maintaining confidentiality and the cost-effectiveness of such data collection, are currently being addressed by partnering with NDI and utilizing the AMA Physician Masterfile.

However, there are significant concerns regarding the creation of such a database. Trainee suicide is a multifaceted issue, of which the AMA, LCME, and individual institutions are not able to fully address. There is concern that such standardized reporting may penalize institutions for suicides, when there are many factors that are outside of programs' controls. In fact, it is because of this reason in particular that the LCME has declined involvement. There are also a

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number of worrisome unintended consequences regarding this ask. Opponents fear that such pressure would result in institutions screening out students with prior mental health issues. Other fears include public misinterpretation of the data that may unduly hurt programs and concerns over which people or organizations would have access to this data.

With this being said, it is viable to have a public database of wellness initiatives of each medical school and residency. Such a database would allow programs to display their own initiatives as well as gather ideas and contact information to implement new ones. However, such information should not be used to compare programs as some schools may have resources making options possible that may not be viable for other programs.

Proposed alternatives to a public database include a hybrid database and reporting schools without deaths by suicide as "<2." A hybrid database would include a public and private version, which would avoid influencing public opinion but still stratify information by institution. However, these alternatives would require the support of institutions, such as the AMA and LCME, who have already made statements against the explicit collection of such data. Without this fundamental support, this ask would be difficult to accomplish. The NDI and AMA Masterfile already collect data on manner of death in physicians, and it would not be viable for the AMA to develop a better standardized reporting mechanism at this time.

RECOMMENDATIONS

Your Committee on Medical Education, Committee on Health Information Technology, and Committee on Bioethics and Humanities recommends that Resolution 42 be adopted as amended, and the remainder of this report is filed:

> D-345.983 – STUDY OF MEDICAL STUDENT, RESIDENT, AND PHYSICIAN SUICIDE
> 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, the American Association of Colleges of Osteopathic Medicine, 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~~.~~; and (5) work with appropriate stakeholders to explore the viability of developing a standardized reporting mechanism for the ~~confidential~~ collection of ~~pertinent suicide information of trainees in medical schools, residency, and fellowship programs, and~~ current wellness initiatives that institutions have in place, to inform and promote meaningful mental health and wellness

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interventions in these populations.~~; and (6) create a publicly accessible database that stratifies medical institutions based on relative rate of trainee suicide over a period of time, in order to raise awareness and promote the implementation of initiatives to prevent medical trainee suicide.~~

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REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON LEGISLATION AND ADVOCACY

MSS COLA Report A
(N-21)

Introduced by: MSS Committee on Legislation and Advocacy

Subject: Support for Evidence-Based Policy

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

INTRODUCTION

At the November 2020 MSS meeting, MSS Resolution 074 asked the AMA to support evidence-based policy when determining MSS positions on HOD resolutions for which the MSS did not have related existing policy. This resolution was brought forth in response to the inability of MSS delegates to provide testimony on contentious policy issues addressed at meetings of the AMA HOD. Specifically, this policy served as a reaction to MSS inaction regarding the AMA stance on vaping during the November 2019 Interim Meeting (H-495.972, H-490.913, H-490.907, D-495.992, D-495.992, H-70.911, H-495.986) and the use of hydroxychloroquine for COVID-19 treatment at the November 2020 Special Meeting.

Debate in the Virtual Reference Committee (VRC) regarding this resolution yielded opposing views on the resolution's utility. Proponents of MSS Resolution 074 claimed that it would allow MSS delegates to provide testimony in areas where the MSS does not have explicitly stated policy, as long as the policy in question was "evidence-based." This freedom to critically assess policy would theoretically allow MSS delegates the leeway to make intelligent policy decisions based on the evidence presented in HOD testimony.

Conversely, opponents of MSS Resolution 074 argued that this policy may place MSS delegates in the precarious position of blindly supporting policies that are ethically complicated or contravene existing MSS policy so long as they are "evidence-based." Additionally, concerns regarding the threshold for quantity and quality of data to be considered as "evidence-based" were also presented in VRC testimony.

Considering the VRC testimony, the Reference Committee referred this resolution to the Committee on Legislation and Advocacy (COLA) and Committee on Scientific Issues (CSI) for study. This report serves to address the Reference Committee's concerns with the resolution, specifically:

(1) How to quantify what constitutes the necessary threshold of evidence for a policy to be "evidence-based"
(2) How policy that is "evidence-based" but in opposition to existing MSS policy or ethically complex will be handled by MSS delegates
(3) Whether the evidentiary threshold will still be required to support policy that addresses exigent circumstances or policy gaps
(4) Whether an evidentiary threshold could prevent the passage of policy that is more amorphous or qualitative in nature
(5) Whether additional evidentiary requirements in excess of the standing MSS review processes will dilute and/or delay MSS participation in timely advocacy

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BACKGROUND

To fully dissect the proposed resolution, we must first set an agreed upon definition of "evidence-based policy". The phrase "evidence-based policy" has different meanings that are dependent on the context with which it is being used. Even within the high standards of healthcare, this term has led to many discussions on what is considered "evidence", what type of evidence is appropriate to use, how providers should search, identify and evaluate studies. Furthermore, even though something may have strong supporting evidence doesn't mean it is logistically or ethically implementable. One of the most common definitions of "evidence-based" describes it as a "conscientious, explicit and judicious use of current best evidence in making decisions about the care of individuals".[7] The key emphasis is often put on the evidence itself, and requires proactive research and comparison to find what evidence should be the impetus for action.

Finding the best evidence is not an easy task and subject to significant intraobserver variability. Several key steps to arriving at an evidence-based conclusion include "formulating an answerable practice question; searching for the best research-based evidence; critically appraising the research for its validity and applicability; implementing a practice decision after integrating the evidence with client characteristics, preferences, and values; and evaluating the outcome".[5] This cited process does not fully account for research that is constantly updating and may differ from dogmatic evidence-based policy. When determining "evidence-based policy" in any context, it is important to remain up-to-date when searching for different conclusions and may be virtually impossible on divisive or quickly evolving topics. These questions regarding the definition of "evidence-based policy" do not even begin to address the broader debates of who are the authority figures that make these decisions and who decides what person(s) have this authority?

While evidence-based practice involves using the best information available at the moment, the criteria for "best information" varies based upon clinical questions.[8] Systematic reviews, meta-analysis, and evidence-based guidelines all allow for clinicians to practice evidence-based medicine without analyzing all data individually themselves.

As discussed above, evidence-based medicine and policy is difficult to define, which means that its applications can take various forms. In medical literature, generally the most accepted sources are those that are replicable, peer-reviewed, and in journals with established reputations. Defined levels of evidence help differentiate the generalizability of findings and guide indications for applying findings to medical practice and policy. There are different levels of evidence depending on type of study: prognostic studies (I-IV) vs. therapeutic studies (1A-5).[3] Aligned with these levels of evidence are also grade practice recommendations (Grade A, B, C, D, etc), which provide varying implications for practice. Many third-party bodies issue these recommendations when evaluating new evidence. Such bodies include USPSTF and Cochrane. Different specialities have their own bodies that issue relevant guidelines which can add to levels of variability in conclusions.[4]

Beyond evaluation of evidence is the creation of actionable and implementable evidence-based health policy. Creating policy involves defining specific items that are backed by evidence that the policy effects would provide benefit to the relevant constituents.[1] The vetting process of passing health policy often has a wide grey zone where one must balance ethics and evidence. Baicker and Chandra (2017) describe this conundrum eloquently: "In health policy — as in any other realm — it is often necessary to act on the basis of the best evidence on hand, even when that evidence is not strong. Doing so requires weighing the costs of acting when you shouldn't against those of not acting when you should".[1] One concerning input into this fine balance is the values and anecdotal/personal experiences of policymakers. These experiences and ideologies can lead policymakers to weigh research evidence as less important, and still not be outside the bounds

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of what is considered "evidence-based".[2] In response to this, it is vitally important for medical professionals to propose evidence-based medicine practices in policy discussions, especially in cases where other factors are influencing policymaker decisions.

Currently, our AMA-MSS allows for delegates to vote on issues that have no guiding policy within the MSS through a ⅔ caucus vote; however, there are no guidelines on what delegates should be considering when voting on these issues. While our delegates are chosen based on their experiences and policy knowledge, our MSS gives no indication as to the criteria and level of established research they should consider when determining their votes. This in of itself calls into question what we as the AMA-MSS establish as "evidence-based policy" and the dangers of broad statements without clear meaning and intent.

DISCUSSION

The intent of this resolution is to give more support to delegates to provide informed testimony on policy during HOD meetings when the MSS does not have policy to support or oppose certain resolutions, per this committee's discussion with the resolution's authors. For example, during the 2019 Interim meeting, there were multiple policies introduced by other societies on the topic of vaping, for which the MSS did not have any policy. At the meeting, the MSS delegates were unable to provide testimony in support of resolutions backed by reputable, robust evidence and therefore were unable to contribute to much of the meeting's discussion. This resolution seeks to change this by allowing delegates to provide testimony in support of resolutions which are evidence-based, and in opposition to resolutions which do not have robust evidentiary support.

However, there are some concerns. The first concern is defining what evidence-based policy is without being too prescriptive in order to give our delegates more freedom; the intent of this resolution. Our review committee recognizes that the definition of evidence-based is subjective and evolves over time. We do not want to set arbitrary guidelines for delegates to be held to as this would be more restrictive than the authors intended. We do not want to set a threshold for what "evidence-based policy" would be defined as, because different topics require different levels of evidence and different types of evidence and research. To address this, our committee developed a definition of evidence-based that can be considered by delegates in the context of each resolution presented in the House of Delegates.

Additionally, there is concern for instances when MSS policy is contradicted by the presented evidence, due to the natural evolution of research over time. However, with our report, we do not want to restrict the delegates into having to choose between supporting MSS policy or supporting current evidence-based policy. This was a large reason for why we chose not to adopt the third Resolve in the original resolution, which states "RESOLVED, That the~~ AMA-MSS opposes policy proposals that are contradicted by evidence~~." Per our recommendations in this report, Section 9.2.6 of the IOP shall stand as is, and the MSS Caucus shall support use current evidence to guide positions of the MSS in the case where the MSS does not have MSS policy pertaining to the resolution being discussed.

There are also instances where primary evidence is lacking due to the nature of the topic. For instance, quality improvement and systems management research is not as robust as double-blind randomized controlled trials. There was a question on how to ensure our delegates recognize the differences in the types of evidence required for different topics. Our committee discussed this matter and determined that our delegates are elected because the MSS trusts their collective judgement. The MSS Caucus may determine whether to offer testimony in support of policy that is appropriately supported by existing literature, based on the given definition of evidence-based policy.

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Sometimes policies are written on the topic of ethical considerations for which the scientific evidence is contradicting or there is little scientific evidentiary support. There was a question on how our delegates would decide when it is appropriate to provide testimony when there is existing evidence that conflicts with ethical considerations. As was discussed in the preceding paragraph, the MSS elects our delegates because we trust their collective judgement. If our delegates recognize significant ethical considerations that contradict available evidence, they may choose to refrain from providing testimony.

Another concern is when there is a topic for which the majority of evidence in the existing literature is largely contradictory to the resolution, but there is new, less plentiful evidence which refutes the majority of the older existing literature. For example, with emerging research on marijuana the existing older research may show that it is harmful to use in all settings, but newer research may show that it can be beneficial when used in certain clinical settings. This would be a situation where the evidence largely does not support the resolution and the delegates may have to provide testimony in opposition to the resolution or not contribute to the discussion, again leading to restriction of our delegates by this policy. Our committee has addressed this by creating a definition of evidence-based policy that delegates may interpret according to each resolution.

Lastly, a concern brought before the Reference Committee in review of this resolution was that the MSS procedures for resolution review are already very rigorous and the addition of this policy may dilute or delay MSS participation in timely advocacy. This concern will be addressed by creating more specific language in the added language to denote that this policy is not to be used for internal review of policy, but instead for policy on topics for which the MSS does not have any existing policy which are discussed in the House of Delegates.

With all of these concerns in mind, our committee discussed many options for this resolution, including creating a stepwise process for policy which would move all policy to ideally be evidence-based, amending the IOP 9.2 to include “evidence-based” and the definition of ideal evidence-based policy, and amending the resolution’s language to be more clear for its intended purpose. In the end, this committee, in consultation with the authors and members of the Governing Council, recommends amending this policy by insertion and deletion to provide a definition of “evidence-based policy.” Additionally, this committee recommends amending section 9.2 of the AMA-MSS IOP by insertion to include language that would allow our delegates to speak on manners for which the MSS Caucus does not have policy and is not able to convene to vote to obtain a ⅔ majority.

RECOMMENDATIONS

Your Committee on Legislation and Advocacy recommends that MSS Resolution 074 (N-20) be adopted as amended by deletion and insertion and the remainder of the report is filed:

1) RESOLVED, That the AMA-MSS defines “evidence-based policy” as policy ~~based on rigorous, objective, replicable research, especially randomized control trials~~ composed in the context of societal, ethical, and implementable considerations and based on current rigorous, objective, reproducible research; and be it further

2) RESOLVED, That the AMA-MSS supports policy proposals that are evidence-based and align with our goals as outlined in the MSS Policy Digest; and be it further

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3) RESOLVED, That the AMA-MSS amend the AMA-MSS Internal Operating Procedures (IOP) Section 9.2.5 by insertion as follows: "In situations where the MSS Caucus is not able to meet to determine a policy position via a Caucus vote, individual delegates may speak and vote on the resolution if they are able to provide evidence to support their stance," and this language is approved by the AMA-MSS IOP Task Force.

~~3) RESOLVED, That the AMA-MSS opposes policy proposals that are contradicted by evidence; and be it further~~

~~4) RESOLVED, That the AMA-MSS, in cases where insufficient evidence exists to indicate a proper course of action, supports studies to acquire the necessary data to make an evidence-based decision; and be it further~~

~~5) RESOLVED, That the AMA-MSS will not allow the process of ensuring evidence-based analysis to interfere with policy decision making in exigent circumstances that can not await further study.~~

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REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON SCIENTIFIC ISSUES

MSS CSI Report A
(N-21)

Introduced by: MSS Committee on Scientific Issues

Subject: Amend H-150.927 and H-150.933, to Include Food Products with Added Sugar

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

INTRODUCTION

At the 2020 MSS November Meeting, the AMA-MSS referred for initial study MSS Resolution 119 "Amend H-150.927 and H-150.933, to Include Food Products with Added Sugar." There were some initial concerns that increased taxation would negatively affect people of low socioeconomic status (SES). Therefore the resolution was referred for study directly from the MSS Reference Committee without extraction at the general assembly.

The report has since been re-referred by the MSS Reference Committee for further clarification regarding the strategies for addressing added sugar consumption with a focus on delineating the boundary between previously approved AMA support for Sugar Sweetened Beverage (SSB) taxes and our current recommendation against an added sugar tax. The amended resolve clauses were as follows:

> RESOLVED, That our AMA amend H-150.927, "Strategies to Reduce the Consumption of Beverages with Added Sweeteners" by addition to read as follows:
>
> **Strategies to Reduce the Consumption of Beverages with Added Sweeteners, H-150.927**
> Our AMA: (1) acknowledges the adverse health impacts of sugar-sweetened beverage (SSB) consumption and food products with added sugars, and support evidence-based strategies to reduce the consumption of SSBs and food products with added sugars, including but not limited to, excise taxes on SSBs and food products with added sugars, removing options to purchase SSBs and food products with added sugars in primary and secondary schools, the use of warning labels to inform consumers about the health consequences of SSB consumption and food products with added sugars, and the use of plain packaging; (2) encourages continued research into strategies that may be effective in limiting SSB consumption and food products with added sugars, such as controlling portion sizes; limiting options to purchase or access SSBs and food products with added sugars in early childcare settings, workplaces, and public venues; restrictions on marketing SSBs and food products with added sugars to children; and changes to the agricultural subsidies system; (3) encourages

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hospitals and medical facilities to offer healthier beverages, such as water, unflavored milk, coffee, and unsweetened tea, for purchase in place of SSBs and apply calorie counts for beverages in vending machines to be visible next to the price; and (4) encourages physicians to (a) counsel their patients about the health consequences of SSB consumption and food products with added sugars and replacing SSBs and food products with added sugars with healthier beverage and food choices, as recommended by professional society clinical guidelines; and (b) work with local school districts to promote healthy beverage and food choices for students.

; and be it further

RESOLVED, That our AMA amend H-150.933, "Taxes on Beverages with Added Sweeteners" by addition to read as follows:

Strategies to Reduce the Consumption of Beverages with Added Sweeteners, H-150.933

1. Our AMA recognizes the complexity of factors contributing to the obesity epidemic and the need for a multifaceted approach to reduce the prevalence of obesity and improve public health. A key component of such a multifaceted approach is improved consumer education on the adverse health effects of excessive consumption of beverages and food products containing added sweeteners. Taxes on beverages and food products with added sweeteners are one means by which consumer education campaigns and other obesity-related programs could be financed in a stepwise approach to addressing the obesity epidemic.

2. Where taxes on beverages and food products with added sweeteners are implemented, the revenue should be used primarily for programs to prevent and/or treat obesity and related conditions, such as educational ad campaigns and improved access to potable drinking water, particularly in schools and communities disproportionately affected by obesity and related conditions, as well as on research into population health outcomes that may be affected by such taxes.

3. Our AMA will advocate for continued research into the potentially adverse effects of long-term consumption of non-caloric sweeteners in beverages and food products, particularly in children and adolescents.

4. Our AMA will: (a) encourage state and local medical societies to support the adoption of state and local excise taxes on sugar-sweetened beverages and food products, with the investment of the resulting revenue in public health programs to combat obesity; and (b) assist state and local medical societies in advocating for excise taxes on sugar-sweetened beverages and food products as requested.

Here we will explore the current literature regarding the legal landscape of added sugars, efficacy of taxation on consumption habits for sugar products, and alternative methodologies for promoting healthy consumption habits.

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BACKGROUND

"Added sugar" refers to any sugars added to a food product during processing and/or packaging such as artificial sweeteners, syrup, honey, or concentrated fruit and vegetable juices that are not naturally occurring.[1,2] They can be found most often in sugar-sweetened beverages (SSBs), but also in desserts, sweets, and baked goods including cookies, brownies, cakes, ice cream, and pastries.[1] The United States Food and Drug Administration (FDA) already includes added sugars on the Nutrition Facts label for foods.

The health impact of excessive consumption of sugar has been well documented over the last 20 years, with numerous studies showing that overconsumption is linked to obesity, cardiovascular disease, and diabetes.[3] The impact of these chronic diseases is large and contributes significantly to the global healthcare burden.

Sugar consumption varies widely by race, socioeconomic status, and age group. In 2017-2018, the average intake of added sugars for adults 20 and older was 17 teaspoons; by race and ethnicity, the average intake was 19 teaspoons for non-Hispanic Black adults, 17 teaspoons for non-Hispanic White adults, 16 teaspoons for Hispanic adults, and 10 teaspoons for non-Hispanic Asian adults.[4] For children, the average daily intake was similar at 17 teaspoons for children and young adults 2 to 19 years old. Among 12- to 19-year-olds, the average intake was 20 teaspoons for non-Hispanic Black young people, 20 teaspoons for non-Hispanic White young people, 15 teaspoons for Hispanic young people and 14 teaspoons for non-Hispanic Asian young people.[4] One study showed that older adults obtained a significantly higher proportion of added sugars from grocery stores than younger adults, as did lower-income adults when compared to higher-income adults.[5]

The relative cost of healthy and unhealthy food in a country may play a role in the country's obesity prevalence. For example, higher relative cost of SSBs has been associated with lower obesity rates in countries worldwide.[6] However, more research is needed as the relative prices of healthy/unhealthy foods have been widely implicated in the obesity epidemic, but never extensively quantified across countries or empirically linked to undernutrition.[6] One study noted that food deserts have been strongly associated with obesity, diabetes, and cardiovascular disease, but the strength of the association cannot be completely resolved by the availability of food retailers.[7] In urban food deserts, a great variety of food choice may exist, but oftentimes few of these choices are healthy. Therefore, both price and availability of food choices impact food consumption by a population.[8]

Although the consumption of sugary food has been clearly linked to obesity, food manufacturers have been known to fund studies that argue the contrary.[9] This practice directly harms under-represented communities. Heavily processed foods tend to be easier to mass produce while maintaining quality, have longer shelf lives, and are easier to distribute,often making them more viable options in low income areas. Additionally, it is easier to market unhealthy options to groups with lower health literacy. This can be seen in the way that processed foods are disproportionately marketed towards lower income communities and communities of color.[10]

Other countries may provide examples of taxation being used to limit the sale of sugary substances and to support healthy food initiatives in the target communities. Programs in Hungary and Mexico expanded laws for taxes on items with unhealthy levels of sodium and sugar or unhealthy saturated fats and generally non-essential items. In Mexico, within one year there was a 12% reduction in purchases of taxed products, with the reduction reaching as high as 17% in lower socioeconomic brackets.[11] The results were sustained over time, decreasing by the largest margin in the lowest socioeconomic group, particularly for taxed beverage products.[12] In Hungary, a 27% reduction in affected products was observed after implementation of a sales tax, and a

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follow-up systematic review determined that mean consumption of taxed food products with added sugars decreased by 4%.[12, 13]

In March 2015, Berkeley, California became the first US jurisdiction to implement a tax on sugar sweetened beverages (SSB), as determined by the city regulations. The tax was $0.01/oz. The tax found a decrease in SSB consumption of 21%, while neighboring cities without the tax saw an increase of 4%. Additionally, Berkeley saw a rise in water consumption of 68%, suggesting that, when a tax is implemented on an unhealthy choice, individuals will shift to the healthy choice instead.[14] Notably, the taxation in Berkeley was not just a punitive measure, as the majority of the funds raised were used to support gardening and healthy eating initiatives in community schools. While there is a dearth of studies on this subject, this natural experiment suggests that taxes will incentivize healthier behaviours to a reasonable extent if the tax results in making said items more expensive than healthy options.

The AMA has adopted a few different policies meant to address the impact of sugar products, as well as obesity in general. In 2018, the AMA voiced support for the labeling of added sugars on nutrition labels as well as an FDA review into a recommended daily value for inclusion on such labeling (D-150.974). To date, a daily value is not listed on added sugar products. Additionally, the AMA has advocated for limiting and eventually removing SSB eligibility from Supplemental Nutrition Assistance Program (SNAP) recipients, as well as providing more educational material on SSBs to SNAP recipients (D-150.975). In this case, the policy in question targets SSB consumption in a specific demographic (SNAP recipients).

Similar policy related to the proposed resolution has been previously introduced into the U.S. Congress. The Sugar Drinks Tax Act of 2021 (SWEET Act) was introduced into the U.S. House of Representatives on April 21st, 2021. This bill supports the adoption of an excise tax on the sale of sugary drink products, which would be paid by the manufacturer or importer of the product. The revenue would be used to support the School Breakfast Program, which is administered by the U.S. Department of Agriculture to support state-run breakfast programs in schools and residential childcare institutions. Currently, the bill has been assigned to two house committees for further evaluation.[15] This act was initially introduced into the U.S. Congress in 2015, but was referred to house committees where no further progress was made.[16]

DISCUSSION

The most sensitive questions regarding added sugars involve determining whether levying excise taxes 1) is effective at reducing sugar consumption in high risk demographics and 2) will not inappropriately impact underrepresented demographics.

Studies on the Berkeley California SSB tax show that the cheaper untaxed products increased in consumption while taxed SSB consumption decreased. However, overall consumer spending per visit did not.[17] This would suggest that consumers will shift to the cheaper goods, and if they are healthy, this will bring benefits. Additionally, the first year of implementation yielded over $1.4M in tax revenue that was able to be allocated for child nutrition and community health programs, which is an alternative that further benefits spending. It is important to note that the categorization of artificially sweetened products (Both SSB and added sugar foods) rarely include essential food products. This can be seen in the shift of consumer habits following the tax. However, no studies have determined whether or not this effort had any impact on actual obesity levels.

Interestingly, studies stratifying SSBs by sugar content yields some granular details regarding consumption habits. For one, decreased consumption of medium sugar drinks (5-8g sugar/100mL) via excise taxes can decrease consumption of alcoholic drinks.[18] However, in the same study, increased prices on low and high sugar drinks prompted an *increase* in alcohol

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consumption. It seems that a simple categorical method for grouping SSBs (and by extension added sugar foods) fails to address the wide scope and the intent of these products.

There are numerous examples of national attempts at taxation on unprocessed sugar and sugar-added foods that have benefited the population. In addition to the aforementioned programs in Hungary and Mexico, programs with similar intentions exist in Norway, Denmark, Bermuda, Dominica, St. Vincent and the Grenadines, and within the Navajo Nation in the United States.[13] However, a Cochrane systematic review of these programs determined that the evidence base for their benefits was of low quality because they exhibited significant heterogeneity as far as taxation rates, items taxed, and the designs for studies looking at their results.[13]

A number of U.S. cities have implemented their own taxes on sugar-sweetened beverages (SSB) and leveraged the revenues to support public health initiatives for the benefit of city residents. For instance, Philadelphia passed a tax on SSB in January 2017 with the goal of funding universal pre-kindergarten for city residents. As of June 2017, the tax funded preschool for 2,000 children and community school support for 4,500 students.[19] Another example includes a SSB tax adopted in Boulder, Colorado in July 2017. The revenue from this tax established a health equity fund that is set to support health, wellness, and chronic disease programs within the city.[20] Finally, Seattle is another city that implemented a tax on SSB starting January 2018. The majority of the revenue from this tax is used for a range of public health endeavors, such as healthy food initiatives and programs geared towards health inequalities.[21]

In the hopes of pushing manufacturers to reformulate products, some countries have implemented tiered tax systems, taxing SSBs based on the amount of sugar added to the products.[22] While this did see a reduction in consumption of higher tiered sugar products directly, the importance in pushing manufacturers to reformulate these products is more likely to have lasting impact on sugar consumption by modifying supply.

Ethically, excise taxes can often be seen as regressive as they disproportionately target lower SES populations, as people with greater means can afford the extra tax without trouble. It is important to note that taxes on SSBs and other added sugar products are generally structured to minimize categorization of essential goods. With this in mind, these taxes hardly make goods prohibitively expensive while still modifying consumption habits, in fact some would argue that the health and social benefits of such taxes (especially those with taxes allocated towards health programs) far outweigh the slight impedance in purchasing habits.[23]

CONCLUSION

Sugar taxes are fairly novel, with most being implemented within the last 10 years. Thus, the research on the unintended consequences and possibility of disproportionate impact on lower SES populations is limited. However, there is an increasing interest in the implementation of such excise taxes and the push to allocate this money towards health programs has merit. Though preliminary data is very promising, conclusive data regarding the efficacy of these taxes will be demonstrated in the coming years. With the focus on socioeconomic inequality as it is, a push towards taxation that may or may not be regressive would be a difficult stance for the AMA to take without incontrovertible evidence.

RECOMMENDATIONS

Your Committee on Scientific Issues recommends that the following resolution is adopted in lieu of MSS Resolution 119 , and the remainder of the report is filed:

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RESOLVED, That our AMA amend H-150.927, "Strategies to Reduce the Consumption of Beverages with Added Sweeteners" by addition to read as follows:

Strategies to Reduce the Consumption of Food and Beverages with Added Sweeteners, H-150.927

Our AMA: (1) acknowledges the adverse health impacts of sugar-sweetened beverage (SSB) consumption and food products with added sugars, and support evidence-based strategies to reduce the consumption of SSBs and food products with added sugars, including but not limited to, excise taxes on SSBs ~~and food products with added sugars~~, removing options to purchase SSBs and food products with added sugars in primary and secondary schools, the use of warning labels to inform consumers about the health consequences of SSB consumption and food products with added sugars, and the use of plain packaging; (2) encourages continued research into strategies that may be effective in limiting SSB consumption and food products with added sugars, such as controlling portion sizes; limiting options to purchase or access SSBs and food products with added sugars in early childcare settings, workplaces, and public venues; restrictions on marketing SSBs and food products with added sugars to children; and changes to the agricultural subsidies system; (3) encourages hospitals and medical facilities to offer healthier beverages, such as water, unflavored milk, coffee, and unsweetened tea, for purchase in place of SSBs and apply calorie counts for beverages in vending machines to be visible next to the price; and (4) encourages physicians to (a) counsel their patients about the health consequences of SSB consumption and food products with added sugars and replacing SSBs and food products with added sugars with healthier beverage and food choices, as recommended by professional society clinical guidelines; and (b) work with local school districts to promote healthy beverage and food choices for students.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Delegate Report A
(N-21)

Introduced by: Anna Heffron, Section Delegate, and Tristan Mackey, Alternate Section Delegate

Subject: Delegate Report A: Status of Pending MSS-Authored Resolutions to the House of Delegates

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

INTRODUCTION

The AMA Medical Student Section serves to provide "meaningful input into the decision and policy-making process of the AMA," (IOP 2.1) "promote membership and activity within organized medicine on the local, state, and national levels,"(IOP 2.7) and "work cooperatively with other student groups and AMA Sections to meet [stated] objectives." (IOP 2.8) One of the ways in which the MSS achieves this purpose is by participating in the AMA House of Delegates (HOD) through the submission of MSS-authored resolutions. To be considered by the HOD, MSS-authored resolutions must first be submitted to the MSS Assembly by MSS member(s) and adopted at a national meeting of the MSS Assembly.

In accordance with IOP 10.4.5, the purpose of the MSS Assembly is "to adopt resolutions for MSS Policy and for submission to the House of Delegates of the AMA." If the resolution secures a simple majority vote for adoption by the Assembly, it can be incorporated into the MSS Digest of Policy Actions ("internal resolution") and/or forwarded for consideration by the AMA HOD as an MSS-authored resolution ("external resolution"). Notably, IOP 10.8.8 decrees that external resolutions "shall be submitted to the AMA House of Delegates at the next appropriate meeting." Resolutions to be transmitted to the HOD shall be referred to as "transmittals" for the duration of this report.

AMA SPECIAL MEETINGS AND THE MSS PRIORITIZATION PROCESS

Due to the COVID-19 pandemic, the AMA Annual 2020 Meeting was cancelled. In its place, the AMA convened a Special Meeting, in which no policy deliberation had taken place. At the time of that announcement, our MSS had 41 transmittals in our queue—predominantly resolutions adopted at the Interim 2019 MSS Assembly—none of which could be submitted for consideration.

Given the ongoing pandemic, our AMA also convened a Special November 2020 Meeting of the HOD and a Special June 2021 Meeting of the HOD. Both Special HOD Meetings incorporated limited policy-making processes, with new meeting procedures released by our AMA Speakers, including specific requests asking all delegations to limit the number of items for House consideration and the use of a special resolutions committee.

With this in mind and the volume of transmittals in queue (including any potential resolutions requesting immediate forwarding), the 2020-2021 Section Delegates executed a prioritization

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process for the November 2020 and June 2021 Special Meetings in accordance with MSS Policy 945.023 – Medical Student Section Policy Making Procedures:

> "(2) When deemed necessary by the MSS Delegate and Alternate Delegate, AMA-MSS will employ a ranking/prioritization process for MSS resolutions intended to be forwarded to the AMA House of Delegates".

This process took place from August 14th through October 1st, 2020 for the November 2020 Special HOD and again from February 21st through April 25th, 2021 for the June 2021 Special HOD. It involved our MSS Caucus, which is comprised of the AMA Delegate and Alternate Delegate, the Regional Delegates and Alternate Regional Delegates, and any MSS member serving on any HOD delegation (IOP 9.1.1.), as well as our House Coordination Committee. The prioritization process involved 4 major stages:

1. Determination of our Section's focus priorities
2. An open comment period for Caucus members, authors, and Section members
3. Evaluation (scoring) of all transmittals
4. Caucus discussion of a resultant transmittal consent calendar

At the conclusion of the November 2020 prioritization process, our MSS transmitted 9 resolutions to the HOD, of which 5 were accepted by the House as business. The remaining transmittals, along with the external resolutions adopted by our November 2020 MSS Assembly, led to a total of 101 transmittals in queue at the start of the June 2021 policy cycle. Throughout the June 2021 transmittal prioritization process, our MSS Caucus re-evaluated the issue of our Section's growing transmittal backlog. After numerous extensive discussions and engagement with other stakeholders, the Caucus ultimately voted to transmit 40 resolutions at the June 2021 Special HOD, the largest volume in our Section's history.

Following the precedence of actions taken at the previous two special meetings and recognizing that the November 2021 meeting may have special procedures regarding prioritization, the 2021-2022 Section Delegates anticipated a need to decide which resolutions to transmit at the 2021 November Meeting and began working with the Caucus on this process on August 10, 2021. The Speakers named the November 2021 Meeting a Special Meeting on August 27, 2021. Following this announcement, they also informed the House that there would be a prioritization process involving a resolutions committee, similar to the ones which had been used at the prior two meetings. Given this, your section delegates found merit in developing a transmittal process for the upcoming meeting that was based on previous transmittal plans and the wants of our MSS Caucus. On August 26, 2021, your section delegates held a town hall regarding the section's transmittal process where we heard the following concerns and desires for a transmittal process:

1. Regional Delegates asked for increased guidance from Section Delegates. Specifically, it was requested that the Section Delegates offer more direct recommendations and guidance regarding how to handle individual transmittals.
2. There is an inherent amount of subjectivity that can be introduced through a scoring system when not everyone scores every resolution. This can lead to a less valid measure of what is actually a top priority item for our section.
3. The volume of work associated with the previous transmittal processes has been significant and often cumbersome at times for our regional delegates.
4. The criteria for prioritizing transmittals must consider urgency, both in terms of timeliness (or what is going to happen if we do/don't have this policy in place in the next 6-12

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months) and in terms of MSS priorities (or what are the things we are jumping to have passed, today if possible), and considerations of things specific to medical students. Additionally, there were requests to better account for the amount of time that a resolution had been in the transmittal queue.

5. Involvement from our caucus and section members must remain a priority for any transmittal process but should focus on gathering valuable input about transmittals. Specific suggestions on how to accomplish this including allowing for individuals to provide comments on items that related to each of the considerations listed in point 4.
6. Equity must remain a focus of any transmittal process and should be priority in not only the theme of the resolutions we decide to transmit, but also within the process itself. Specifically, requests were made to solicit input from equity-focused NMSOs and similar groups within our Section, and that input is heavily weighed.
7. The resolutions committee and its processes have been concerning for our section members and caucus, which raised various questions about the number of items we should transmit. There were many suggestions that we should transmit our entire transmittal queue, while others felt the need to only transmit a select number of items in order to maintain political capital within the House. Ultimately, the majority of voices heard felt that we should increase the number of transmittals that we send to the House as compared to previous meetings.

With these concerns in mind, your 2021-2022 Section Delegates developed a transmittal plan with the following stages (the full details are available here):

1. Step 1: Spreadsheets for comments on each resolution were made available to Caucus members, resolution authors, and the Section. Comments were solicited in terms of a) the urgency and timeliness of the issue, b) particular relevance to medical students, and c) MSS priority.
2. Step 2: The Section Delegates assigned different overarching “themes” (for example, gender equity, public assistance, disability rights, etc) to each resolution. A list of 28 themes was extracted from the 105 transmittals in this way. Caucus members were then asked to vote on the order in which these themes should be considered priority.
3. Step 3: Once the themes were ranked, the Section Delegates ordered the transmittals by their highest ranking themes. The Delegates then rearranged this ordering using the comments on the comment spreadsheets from Step 1 and released this preliminary transmittal ranking to the Caucus. The comment spreadsheets remained open, and comments on further rearrangement were encouraged.
4. Step 4: The Caucus held a meeting in which to decide upon the final transmittal list. Any member was able to extract an item and suggest its movement up or down in the transmittal list. At the end of this meeting, 50 resolutions were ordered for preparation to be transmitted to the House of Delegates.

Your 2021-2022 executed this transmittal plan according to the November 2021 Transmittal Calendar (Appendix 1). On September 30, 2021, your section delegates submitted 50 resolutions and priority statements for consideration to the House. This represents the largest volume of resolutions that our section has transmitted to the House. A detailed list of resolutions transmitted to the House at the November 2021 Special Meeting, including our priority rankings for items, can be found in Appendix 3.

CONCERNS WITH A GROWING TRANSMITTAL QUEUE

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The MSS Governing Council (GC) welcomes the increased interest in our MSS policy process and Assembly, and encourages students to submit resolutions advocating on issues which are important to them. However, several stakeholders have raised concerns about the growing transmittal queue. These concerns include:

- Insufficient time for adequate discussion of resolutions in the House of Delegates, including the bandwidth to garner external support for each resolution and potential dilution of MSS capital
- Timeliness of resolutions once they are transmitted, especially if left in queue beyond the standard 6-month period between national meetings.
- Increasing impact on student leadership (including sectional and regional delegates as well as the House Coordinating Committee) in regard to reviewing business items, preparing testimony, and defending MSS-authored resolutions, most of which cannot increase in size due to our bylaws
- Impact on AMA staff (including MSS staff, legal review, and advocacy review), who offer their feedback while concurrently preparing for the HOD and maintaining advocacy responsibilities

Table 1 shows the trend in MSS-authored resolutions discussed at each House of Delegates, and the ratio of MSS-authored to total number of HOD resolutions. (*Note that the idea of limiting the number or imposing additional thresholds for external resolutions has been considered by the 2018 MSS Resolutions Task Force, but was ultimately not recommended due to concerns on restricting the democratic process, and because the MSS has tried restricting resolutions considered by a Resolutions Committee in the past and found that the exercise did not ultimately reduce the amount of time or effort required for the resolutions process.)*

Meeting	Total No. of MSS Authored Resolutions	Total No. of HOD Resolutions	Ratio of MSS/HOD
A-06	13	-	-
I-06	4	-	-
A-07	12	254	4.72%
I-07	8	90	8.89%
A-08	13	239	5.44%
I-08	5	99	5.05%
A-09	10	224	4.46%
I-09	10	90	11.11%
A-10	14	198	7.07%
I-10	17	98	17.35%
A-11	23	189	12.17%
I-11	21	108	19.44%
A-12	29	216	13.43%
I-12	12	76	15.79%

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A-13	17	179	9.50%
I-13	6	88	6.82%
A-14	13	200	6.50%
I-14	17	110	15.45%
A-15	16	199	8.04%
I-15	13	93	13.98%
A-16	17	185	9.19%
I-16	20	103	19.42%
A-17	19	197	9.64%
I-17	14	102	13.73%
A-18	31	200	15.5%
I-18	12	98	12.2%
A-19	23	232	9.9%
I-19	30	98	30.6%
A-20 **No policy discussion	(41 in queue)	N/A	-
I-20 **Special Meeting	9 submitted, 5 considered	36 considered	13.9% of resolutions considered
A-21 **Special Meeting	(started with 101 in queue) 40 transmitted,16 considered	66	24.2% of resolutions considered
I-21 **Special Meeting	(started with 105 in queue) 50 transmitted (49 remain in queue)	TBD	TBD
MSS Average			**12.27%** (18.16% within the past 5 meetings)

TIMELINESS OF QUEUED TRANSMITTALS

Your Section Delegates and MSS Governing Council recognize the importance of finding a democratic solution that allows our Section to contribute meaningfully to the policy-making process of the AMA, and the capacity of our MSS Caucus to adequately defend each policy proposal brought forth to the HOD.

Appendix 2 of this report outlines the remaining transmittals along with a recommendation supporting rationale where appropriate. Specifically, your Section Delegates sought to clarify whether the ask (1) remains timely and (2) has otherwise been carried out by the organization. If it was determined that a resolution's proposed policy has been accomplished elsewhere within the AMA, then your Section Delegates interpret transmission to the House of Delegates to be unnecessary as there would be no future "appropriate meeting" where such policy be considered timely, novel, or necessary to guide the AMA's operations or advocacy. In those

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resolutions, detailed justifications will be provided for the Assembly's consideration. **Appendix 3** of this report lists the resolutions to be transmitted to the House of Delegates at the November 2021 meeting.

Regardless of transmittal status, all policies shall be retained in the AMA-MSS Digest of Actions until sunset review. Individuals or organizations seeking support for a particular issue will have this available to reference.

RECOMMENDATIONS

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

1. Amending H-515.952, Adverse Childhood Experiences and Trauma-Informed Care, to Encourage ACE and TIC Training in Undergraduate and Graduate Medical Education
2. Federal Health Insurance Funding and Co-Payments for People Experiencing Incarceration / Federal Health Insurance Funding for People Experiencing Incarceration
3. Medical Honor Society Inequities and Reform
4. Improving Access to Telehealth for those with Disabilities
5. Support for Universal Internet Access

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

1. Environmental Contributors to Disease and Advocating for Environmental Justice / Environmental Sustainability of AMA National Meetings
2. Improving Research Standards, Approval Processes, and Post-Market Surveillance Standards for Medical Devices / Improving Standards for Medical Devices
3. Increasing Access to Feminine Hygiene/Menstrual Products
4. Medicaid and CHIP Coverage of Continuous Glucose Monitoring Devices for Patients with Insulin-Dependent Diabetes / Increasing Access to Innovative Glucose Monitoring for All Patients with Diabetes
5. Protections for Incarcerated Mothers to Breastfeed and/or Breast Pump / Advocating for the Delivery of Standardized Perinatal Care and Monitoring of Healthcare Outcomes for Incarcerated Pregnant Individuals
6. Requiring Blinded Review of Medical Student Performance / Research the Ability of Two-Interval Grading of Clinical Clerkships to Minimize Racial Bias in Medical Education

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

1. Encouraging Collaboration between Physicians and Industry in AI Development
2. Establishing Comprehensive Dental Benefits Under State Medicaid Programs
3. Study a need-based scholarship to encourage medical student participation in the AMA

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Appendix 1: Transmittal Calendars

November 2020 Meeting

Dates	Event
Aug. 14th (Fri)	Release I-2020 Transmittal Calendar to MSS Caucus.
Aug.19th (Wed)	I-2020 Transmittal Focus Priorities submission deadline @ 11:59pm CT.
Aug. 21st (Fri)	Release summarized list of potential themes for Caucus to vote.
Aug. 25th (Tue)	Deadline to vote for I-2020 Transmittal Focus Priorities @ 11:59pm CT.
Aug. 26th (Wed)	I-2020 Transmittal Focus Priorities released to MSS Caucus.
Aug. 28th (Fri)	Announce Transmittal Focus Priorities to I-2020 Transmittal Authors. Release Google Form for authors and MSS Caucus to submit comments in support of any transmittal candidates, and how that resolution aligns with Focus Priorities, timeliness, impact (300 characters max).
Sept. 5th (Sat)	Deadline for transmittal authors and MSS Caucus to comment on resolutions @ 11:59pm CT.
Sept 6th (Sun)	Transmittal Scoring Assignments released to MSS Caucus. Submitted comments will be included for reviewers to consider while scoring/tiering.
Sept 18th (Fri)	Transmittal Scoring Deadline @ 11:59pm CT.
Sept 21st (Mon)	Release list of I-2020 Final Resolutions asking for immediate forwarding to Caucus for review.
Sept 24th (Thu)	MSS Caucus Town Hall to discuss the I-2020 Resolutions @ 8pm CT.
Sept 25th (Fri)	Release “consent calendar” of transmittals, after incorporating potential immediately forwarded resolutions, for Caucus review in preparation for town hall. Notify transmittal authors of decision.
Sept 30th (Wed)	MSS Caucus Town Hall to discuss transmittals list @ 7pm CT. If planning to extract, please complete this form 24hrs before the Town Hall.
Oct. 1st (Thu)	Submit I-2020 Transmittals to the House of Delegates

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June 2021 Meeting

Dates	Event
Feb 21 (Sun)	MSS Caucus meeting to brainstorm transmittal process, including any potential changes.
Mar 13th (Sat)	Transmittal Focus Priorities submission deadline @ 11:59pm CT.
Mar 14th (Sun)	Release summarized list of potential themes for Caucus to vote.
Mar 18th (Thu)	Deadline to vote for J-2021 Transmittal Focus Priorities @ 11:59pm CT.
Mar 19th (Fri)	Announce Transmittal Focus Priorities to J-2021 Transmittal Authors. Open Comment Period all MSS members to submit comments in support of any transmittal candidates, and how that resolution aligns with Focus Priorities, timeliness, impact (1000 characters max). Send resolutions for preliminary advocacy feedback.
Mar 28th (Sun)	Open Comment Period on MSS Transmittals closes @ 11:59pm CT.
Mar 29th (Mon)	Transmittal Scoring Assignments released to MSS Caucus. Submitted comments will be included for reviewers to consider while scoring/tiering.
Apr 10th (Sat)	Transmittal Scoring Deadline/Voting @ 11:59pm CT.
Apr 13th (Tue)	Release list of J-2021 Final Resolutions asking for immediate forwarding to Caucus for review.
Apr 23rd (Fri)	Release preliminary “consent calendar” of transmittals, after incorporating potential immediately forwarded resolutions, for Caucus review in preparation for town hall.
Apr 25th (Sun)	MSS Caucus Town Hall to discuss transmittals list (MANDATORY) @ 3pm CT. Transmittal Calendar finalized following MSS Caucus Town Hall.
May 12th (Wed)	Deadline to submit J-2021 Transmittals (batch #1) to the House of Delegates

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N-2021 Transmittal Calendar

Dates	Event
Aug. 10 (Tues)	First email to Caucus regarding transmittal process for upcoming meeting.
Aug. 26th (Thurs)	Section Delegates solicit feedback on previous transmittal processes and input on proposed ideas from Caucus.
Aug. 29th (Sun)	Release N-2021 Transmittal Calendar and Process to MSS Caucus. The N-2021 Transmittal Comments sheet was released and would remain open for the entirety of this process.
Sept. 5th (Sun)	Section Delegates release N-2021 Transmittal Themes for voting by MSS Caucus.
Sept. 7th (Tues)	MSS Town Hall to discuss N-2021 Transmittal Process. The event was open to all MSS members, recorded, and posted online.
Sept. 10th (Fri)	Deadline for MSS Caucus to vote on prioritization of N-2021 Transmittal Themes.
Sept. 16th (Thurs)	Section Delegates release Transmittal List, which included the preliminary N-21 Delegate Report plan, to the Caucus.
Sept 20-26th (Mon-Thu)	Extractions for changing the Transmittal list are open to the Caucus and due by 12 pm CT the day of the meeting.
Sept 26th (Sun)	MSS Caucus meeting to discuss the N-2021 Transmittal Consent Calendar.
Sept 27th (Mon)	Section Delegates release approved N-2021 Transmittal Consent Calendar
Sept. 30th (Thurs)	Deadline to submit N-2021 Transmittals to the House of Delegates

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Appendix 2 – Recommendations for Pending MSS Transmittals to the House of Delegates

links to full individual resolutions can be found here.

Transmittal (Alphabetical by Title)	Recommendation
Abolishment of the Resolution Committee RESOLVED, That our AMA 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.~~	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**
Addressing Adverse Effects of Active Shooter Drills on Children's Health RESOLVED, That our AMA support that all school systems conduct evidence-based active shooter drills in a trauma-informed manner that (a) is cognizant of children's physical and mental wellness; (b) considers prior experiences that might affect children's	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA

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response to a simulation; (c) avoids creating additional traumatic experiences for children; and (d) provides support for students who may be adversely affected; and be it further RESOLVED, That our AMA work with relevant stakeholders to raise awareness of ways to conduct active shooter drills that are safe for children and age appropriate.	
Addressing Healthcare Accessibility for Current and Aged-Out Youth in the Foster Care System RESOLVED, That our AMA amend H-60.910, by addition and deletion to read as follows: ADDRESSING HEALTHCARE NEEDS OF <u>YOUTH</u> ~~CHILDREN~~ IN FOSTER CARE, H-60.910 <u>1.</u> Our AMA advocates for comprehensive and evidence-based care that addresses the specific health care needs of ~~children~~ <u>youth</u> in foster care. <u>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.</u>	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**
Addressing Informal Milk Sharing RESOLVED, That our AMA discourage the practice of informal milk sharing when said practice does not rise to health and safety standards comparable to those of milk banks, including but not limited to screening of donors and/or milk pasteurization; and be it further RESOLVED, That our AMA encourage breast milk donation to regulated human milk banks instead of via informal means; and be it further RESOLVED, That our AMA support further research into the status of milk donation in the U.S. and how rates of donation for regulated human milk banks may be improved.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Addressing the Need for Firearm Safety in Medical School Curricula RESOLVED, That our AMA support the inclusion of gun violence epidemiology and evidence-based firearm-related injury prevention education in medical school curricula.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Advancing the Role of Outdoor Recreation in Public Health RESOLVED, That our AMA encourages federal, state and local governments to create new and maintain existing public lands and outdoor	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA

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spaces for the purposes of outdoor recreation; and be it further RESOLVED, That our AMA work with the Centers for Disease Control and Prevention, National Institute of Environmental Health Science, National Recreation and Park Association, and other relevant stakeholders to encourage continued research on the clinical uses of outdoor recreation therapy.	
Advocating for the Amendment of Chronic Nuisance Ordinances RESOLVED, That our AMA advocate for amendments to chronic nuisance ordinances that ensure calls made for safety or emergency services, are not counted towards nuisance designations; 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.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**
AMA Funding of Political Candidates who Oppose Research-Backed Firearm Regulations RESOLVED, That our AMA amend policy G-640.020 as follows: G-640.020 – POLITICAL ACTION COMMITTEES AND CONTRIBUTIONS Our AMA: […] ~~and~~ (8) Calls upon all candidates for public office to refuse contributions from tobacco companies and their subsidiaries; and (9) Calls upon all candidates for public office to refuse contributions from any organization that opposes public health measures to reduce firearm violence.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Enhancing Harm Reduction for People Who Use Drugs RESOLVED, That our AMA-MSS will ask the AMA to amend policy D-95.987 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	**Combine similar resolutions** into a single resolution on harm reduction for people who use drugs: • Amend D-95.987, to Support Exempting Fentanyl Test Strips and Other Drug Checking Technologies from Paraphernalia Laws • Amend H-95.958, to Decriminalize IDPE in Safe Syringe Programs The Resolved clauses for these original resolutions were combined by the J-21 Reference Committee. Your section delegates felt that these two items were similar enough that it would be advantageous for our section to combine these items. This will hopefully increase their likelihood of being considered and adopted by the House. Otherwise, **retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA

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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.	**This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**
Amending D-440.985, Health Care Payment for Undocumented Persons, to Study Methods to Increase Health Care Access for Undocumented Immigrants RESOLVED, That our AMA amend D-440.985, Health Care Payment for Undocumented Persons by addition as follows: D-440.985 – HEALTH CARE PAYMENT FOR UNDOCUMENTED PERSONS Our AMA: (1) shall assist states on the issue of the lack of reimbursement for care given to undocumented	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**

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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.	
Amending G-630.140, Lodging, Meeting Venues, and Social Functions RESOLVED, That our AMA amend AMA policy G-630.140 Lodging, Meeting Venues, and Social Functions be amended by addition as follows: LODGING, MEETING VENUES, AND SOCIAL FUNCTIONS, G-630.140 1. Our AMA supports choosing hotels for its meetings, conferences, and conventions based on size, service, location, cost, and similar factors. 2. Our AMA shall attempt, when allocating meeting space, to locate the Section Assembly Meetings in the House of Delegates Meeting hotel or in a hotel in close proximity. 3. All meetings and conferences organized and/or primarily sponsored by our AMA will be held in a town, city, county, or state that has enacted comprehensive legislation requiring smoke-free worksites and public places (including restaurants and bars), unless intended or existing contracts or special circumstances justify an exception to this policy, and our AMA encourages state and local medical societies, national medical specialty societies, and other health organizations to adopt a similar policy. 4. It is the policy of our AMA not to hold national meetings organized and/or primarily sponsored by our AMA, in cities, counties, or states, or pay member, officer or employee dues in any club, restaurant, or other institution, that has exclusionary policies, including, but not limited to, policies based on, race, color, religion, national origin, ethnic origin, language, creed, sex, sexual orientation, gender, gender identity and gender expression, disability, or age unless intended or existing contracts or special circumstances justify an exception to this policy.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA

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5. Our AMA staff will work with facilities where AMA meetings are held to designate an area for breastfeeding and breast pumping.	
Amending H-515.952, Adverse Childhood Experiences and Trauma-Informed Care, to Encourage ACE and TIC Training in Undergraduate and Graduate Medical Education RESOLVED, That our AMA encourage a deeper understanding of Adverse Childhood Experiences and Trauma-Informed Care amongst future physicians by amending H-515.952, Adverse Childhood Experiences and Trauma-Informed Care, as follows: H-515.952 – ADVERSE CHILDHOOD EXPERIENCES AND TRAUMA-INFORMED CARE […] 3. Our AMA supports the inclusion of ACEs and trauma-informed care into undergraduate and graduate medical education curricula.	**Discharge from transmittal queue.** Your MSS Caucus saw fit to add this resolution verbatim (as clause 3) to CSAPH report 3 at J-21. This was adopted without any further amendments. The newly amended policy can be viewed below: **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; 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. Given that the actions that would be accomplished by transmitting this item to the House have been done by other means, your section delegates feel that this item no longer needs to be sent to the House and it will be discharged from our queue.
Amendment to Truth and Transparency in Pregnancy Counseling Centers RESOLVED, That our AMA amend policy H-420.954, Truth and Transparency in Pregnancy Counseling Centers by insertion and deletion 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:	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**

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H-420.954 – TRUTH AND TRANSPARENCY IN PREGNANCY COUNSELING CENTERS 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.	
Anti-Harassment Training RESOLVED, That our AMA require all members elected and appointed to national and regional AMA leadership positions to complete AMA Code of Conduct and anti-harassment training, with continuous evaluation of the training for effectiveness in reducing harassment within the AMA; and be it further RESOLVED, That our AMA work with Women Physician Section, American Medical Women's Association, GLMA: Health Professionals Advancing LGBTQ Equality, and other stakeholders to identify an appropriate, evidence-based anti-harassment and sexual harassment prevention training to administer to leadership.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA

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Authority to Grant Vaccine Exemptions RESOLVED, That our AMA opposes medical vaccine exemptions by non-physicians by amending H-440.970 Nonmedical Exemptions from Immunizations as follows: H-440.970 – NON-MEDICAL EXEMPTIONS FROM IMMUNIZATIONS 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 (a) eliminate non-medical exemptions from mandated pediatric immunizations and (b) limit medical vaccine exemption authority to only licensed physicians.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA Of note, the title for this resolution has been updated to reflect the updated Resolved, which was changed by the MSS Reference Committee. The original title was “Investigation of Naturopathic Vaccine Exemptions”. **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**
Banning LGBTQ+ Panic Defenses RESOLVED, That our AMA advocate for legislation that would ban the use of LGBTQ+ “panic” defenses in court.	**Retain in transmittal queue** – Cosponsor similar resolution brought forth by New York. The resolution below was submitted by MSSNY at J-21 and will be resubmitted at N-21. MSS will plan to cosponsor it.

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	Resolution "Banning LGBTQ+ Panic Defenses" was preliminary ranked #44 by your MSS Caucus, and did not meet the threshold for transmittal at the June 2021 Meeting. Your Section Delegates have been informed that Medical State Society of New York (MSSNY) will be submitting an extremely similar resolution entitled, "Ban the Gay/Trans (LGBTQ+) Panic Defense," which contains the following resolved clauses: RESOLVED, Our AMA will seek a federal law banning the use of the so-called "gay or trans (LGBTQ+) panic" defense in homicide, manslaughter, physical or sexual assault cases, and be it further RESOLVED, Our AMA will publish an issue brief and talking points on the topic of so called "gay or trans (LGBTQ+) panic" defense, that can be used by the 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 or trans (LGBTQ+) panic" defense to mitigate personal responsibility for violent crimes such as assault, rape, manslaughter, or homicide. Given these similarities, your Section Delegates and Caucus plan to co-sponsor the MSSNY resolution, while our own resolution remains in queue. If New York's resolution is accepted as House business, then "Banning LGBTQ+ Panic Defenses" may be subject to further review on the appropriateness of its retention in the transmittal queue.
Banning the Practice of Virginity Testing RESOLVED, That our AMA advocate for the elimination of the practice of virginity testing exams, physical examinations purported to assess virginity; 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; 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.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**
Caps on Insulin Co-Payments for Patients with Insurance RESOLVED, That our AMA amend existing AMA policy H-110.984, Insulin Affordability, by addition and deletion to read: 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	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**

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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.	
Combating Natural Hair and Cultural Headwear Discrimination RESOLVED, That our AMA recognize that discrimination against natural hair/hairstyles and cultural headwear is a form of racial/ethnic and/or religious discrimination; and be it further RESOLVED, That our AMA oppose discrimination against individuals based on their hair or cultural headwear in health care settings; 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; 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.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**
Coverage of Pregnancy-Associated Healthcare for 12 Months Postpartum for Uninsured Patients who are Ineligible for Medicaid RESOLVED, That our AMA amend policy D-290.974, Extending Medicaid Coverage for One Year Postpartum, by addition as follows: D-290.974 – EXTENDING MEDICAID COVERAGE FOR PREGNANCY AND ONE YEAR POSTPARTUM 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. RESOLVED, That our AMA amend policy H-165.828, Health Insurance Affordability, by addition as follows: H-165.828 – HEALTH INSURANCE AFFORDABILITY	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**

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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.	
Decreasing Youth Access to E-Cigarettes RESOLVED, That AMA policy H-495.986 be amended by insertion as follows:	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA

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TOBACCO PRODUCT SALES AND DISTRIBUTION, H-495.986 Our AMA: […] (11) supports measures that prevent retailers from opening new tobacco specialty stores in proximity to elementary schools, middle schools, and high schools; and (12) supports measures that decrease the overall density of tobacco specialty stores.	
Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers RESOLVED, That AMA policy H-430.983 be amended by addition and deletion as follows: ~~REDUCING~~ OPPOSING THE USE OF RESTRICTIVE HOUSING ~~IN~~ FOR PRISONERS ~~WITH MENTAL ILLNESS~~ 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~~.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**
Development and Implementation of Recommendations for Responsible Media Coverage of Drug Overdoses (CBH REPORT A) RESOLVED, That our AMA encourages the Centers for Disease Control and Prevention, in collaboration with other public and private organizations, to develop recommendations or best practices for media coverage and portrayal of Opioid Drug overdoses.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA

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Disaggregation of Race Data for Individuals of Middle Eastern and North African (MENA) Descent RESOLVED, That our AMA add "Middle Eastern/North African (MENA)" as a separate race category on all AMA demographics forms; 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; 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 schools and residency demographics forms.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**
Increase Awareness Among Residency, Fellowship, and Academic Programs on the United States-Puerto Rico Relationship Status RESOLVED, That our AMA will 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), American Association of Medical Colleges (AAMC), and Middle States Commission on Higher Education (MSCHE) accredited, and their medical students are not considered international medical graduates; and be it further RESOLVED, That our AMA will 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.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA Note that the original title was "Education Residency, Fellowship, and Academic Programs on the United States-Puerto Rico Relationship Status" but was updated following Caucus concerns about sounding like the AMA was lecturing residency programs. **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**
Encouraging Brain and Other Tissue Donation for Research and Educational Purposes RESOLVED, That our AMA support the production and distribution of educational materials regarding the importance of postmortem tissue donation for the purposes of medical research and education; and be it further RESOLVED, That our AMA encourage the inclusion of additional information and consent	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA

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options for brain and other tissue donation for research purposes on appropriate donor documents; and be it further RESOLVED, That our AMA encourage all persons to consider consenting to tissue donation including brain tissue for research purposes; and be it further RESOLVED, That our AMA encourage efforts to facilitate recovery of postmortem tissue	
Encouraging Collaboration between Physicians and Industry in AI Development RESOLVED, That our AMA augment the existing Physician Innovation Network (PIN) through the creation of advisors to specifically link physician members of AMA and its associated specialty societies with companies or individuals working on augmented intelligence (AI) research and development, focusing on: (1) Expanding recruitment among AMA physician members, (2) Advising AMA physician members who are interested in healthcare innovation/AI without knowledge of proper channels to pursue their ideas, (3) Increasing outreach from AMA to industry leaders and companies to both further promote the PIN and to understand the needs of specific companies, (4) Facilitating communication between companies and physicians with similar interests, (5) Matching physicians to projects early in their design and testing stages, (6) Decreasing the time and workload spent by individual physicians on finding projects themselves, (7) Above all, boosting physician-centered innovation in the field of AI research and development; and be it further RESOLVED, That our AMA supports selection of PIN advisors through an application process where candidates are screened by PIN leadership for interpersonal skills, problem solving, networking abilities, objective decision making, and familiarity with industry.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA **Hold in queue for the current meeting** – given that CSAPH is currently working on a number of reports on AI, and this may overlap.
Ending Tax Subsidies for Advertisements Promoting Food and Drink of Poor Nutritional Quality Among Children RESOLVED, That our AMA advocate for the end of tax subsidies for advertisements that promote among children the consumption of food and drink of poor nutritional quality, as defined by appropriate nutritional guiding principles.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA

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Mitigating Environmental Contributors to Disease and Sustainability of AMA National Meetings 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, and report annually on the AMA's progress towards implementation; and be it further RESOLVED, That our AMA work with appropriate stakeholders to 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, including by creating educational materials; and be it further RESOLVED, That our AMA evaluate the feasibility of purchasing carbon offsets for member travel to and from Annual and Interim meetings and report back to the House of Delegates; and be it further RESOLVED, That our AMA evaluate the feasibility of holding future Annual and Interim meetings at Leadership in Energy and Environmental Design- certified or sustainable conference centers and report back to the House of Delegates; and be it further RESOLVED, That our AMA amend Policy D-135.997, "Research into the Environmental Contributors to Disease," by addition and deletion to read as follows: D-135.997 – ~~RESEARCH INTO THE~~ ENVIRONMENTAL CONTRIBUTORS TO DISEASE AND ADVOCATING FOR ENVIRONMENTAL JUSTICE Our AMA will (1) advocate for the greater public and private funding for research into the environment 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	**Combine similar resolutions** into a single resolution on environmental contributor to disease and sustainability: ● Combined Environmental Contributors to Disease ● Advocating for Environmental Justice with Environmental Sustainability of AMA National Meetings Your section delegates felt that these two items were similar enough that it would be advantageous for our section to combine these items. This will hopefully increase their likelihood of being considered and adopted by the House. Otherwise, **retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**

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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.	
Equal Access to Adoption for the LGBTQ Community RESOLVED, That our AMA advocate for equal access to adoption services for LGBTQ individuals who meet federal criteria for adoption regardless of gender identity or sexual orientation; 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.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**
Equitable Reporting of USMLE Step 1 Scores RESOLVED, That our AMA works with appropriate stakeholders to release guidance for residency and fellowship program directors on equitably comparing students who received 3-digit USMLE Step 1 or COMLEX Level 1 scores and students who received Pass/Fail scores.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**
Establishing Comprehensive Dental Benefits Under State Medicaid Programs RESOLVED, That our AMA amend H-330.872, "Medicare Coverage for Dental Services" by addition and deletion as follows: H-330.872 - MEDICARE, MEDICAID, AND OTHER PUBLIC HEALTH INSURANCE COVERAGE FOR DENTAL SERVICES 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, ~~and~~ Medicaid, and other public health insurance program beneficiaries; and (2) initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease among ~~in both~~ Medicare, and Medicaid, ~~and~~ other public health insurance program beneficiaries ~~populations~~, the optimal dental benefit plan designs to cost-effectively improve health and prevent	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA **Hold in queue for the current meeting** – given that current efforts nationally are directed toward Medicare expansions, making Medicare-related policy a higher priority currently. Additionally, there is currently a resolution that will be considered at our N-21 MSS Assembly relating to this topic that would strengthen this transmittal if accepted.

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disease ~~in both~~ among Medicare~~, and~~ Medicaid, and other public health insurance program beneficiaries ~~populations~~, and the impact of expanded dental coverage on health care costs and utilization.	
Evaluating Scientific Journal Articles for Racial and Ethnic Bias RESOLVED, That our AMA support major journal publishers issuing guidelines for interpreting previous research which define race and ethnicity by outdated means; and be it further RESOLVED, That our AMA support major journal publishers implementing a screening method for future research submissions concerning the incorrect use of race and ethnicity.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**
Exclusion of Race and Ethnicity in the First Sentence of Case Reports RESOLVED, That our AMA encourages curriculum and clinical practice that omits race and/or ethnicity from the first sentence of case reports and other medical documentation; 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.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**
Expanding Medicaid Transportation to Include Healthy Grocery Destinations RESOLVED, That our AMA (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.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**
Expanding the Definition of Iatrogenic Infertility to Include Gender-Affirming Interventions RESOLVED, That our AMA amend policy H-185.990 by addition 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	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**

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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; 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. RESOLVED, That our AMA amend policy H-185.950 by addition as follows: REMOVING FINANCIAL BARRIERS TO CARE FOR TRANSGENDER PATIENTS, H-185.950 Our AMA supports public and private health insurance coverage for medically necessary treatment of gender dysphoria as recommended by the patient's physician, including gender-affirming hormone therapy and gender-affirming surgery.	
Expansion of Epinephrine Entity Stocking Legislation RESOLVED, That our AMA support the adoption of laws that allow state-authorized entities to permit the storage of auto-injectable epinephrine for use in case of an emergency.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Expansion on Comprehensive Sexual Health Education RESOLVED, That our AMA amend H-170.968 by addition and deletion 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	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**

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	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; (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;	

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(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.	
Federal Health Insurance Funding and Co-Payments for People Experiencing Incarceration (Combination with 75. Federal Health Insurance Funding for People Experiencing Incarceration) RESOLVED, That our AMA advocate for the continuation of federal funding for health insurance benefits, including Medicaid,	**Discharge from transmittal queue.** The ask of this resolution was accomplished at the J-21 meeting. Health Care While Incarcerated H-430.986 now reads as follows: **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

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Medicare, and the Children's Health Insurance Program, for otherwise eligible individuals in pre-trial detention; and be it further RESOLVED, That our AMA advocate for the prohibition of the use of co-payments to access healthcare services in correctional facilities; and be it further RESOLVED, That our AMA amend policy H-430.986 by addition and deletion as follows: 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. That our AMA advocate for the repeal of the Medicaid Inmate Exclusion Policy. ~~5~~6. Our AMA encourages states not 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~~7. 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~~8. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of incarcerated	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 advocates and requires a smooth transition including partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system. 3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated. 4. Our AMA encourages 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 advocates for states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal legal system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community. 6. Our AMA advocates for Congress to repeal the "inmate exclusion" of the 1965 Social Security Act that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons. 7. Our AMA advocates for Congress and the Centers for Medicare & Medicaid Services (CMS) to revise the Medicare statute and rescind related regulations that prevent payment for medical care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the services are delivered. 8. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of women and adolescent females who are incarcerated, including gynecological care and obstetrics care for individuals who are pregnant or postpartum. 9. Our AMA will collaborate with state medical societies, relevant medical specialty societies, and federal regulators to emphasize the importance of hygiene and health literacy information sessions, as well as information sessions on the science of addiction, evidence-based addiction treatment including medications, and related stigma reduction, for both individuals who are incarcerated and staff in correctional facilities. 10. 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 use disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; and (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community. 11. Our AMA advocates for the continuation of federal funding for health insurance benefits, including Medicaid, Medicare, and the Children's Health Insurance Program, for otherwise eligible individuals in pre-trial detention. 12. Our AMA advocates for the prohibition of the use of co-payments to access healthcare services in correctional facilities. Additionally, the AMA sent a letter to Congress on August 30, 2021that includes a bullet point on Medicaid coverage for incarcerated individuals to be included in budget reconciliation: https://searchlf.ama-

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women and adolescent females, including gynecological care and obstetrics care for pregnant and postpartum women. ~~8~~9. 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~~10. 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.	assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-8-30-Letter-to-Congressional-Leadership-re-Budget-Reconciliation-Bill-v9.pdf Given that the actions that would be accomplished by transmitting this item to the House have been done by other means, your section delegates feel that this item no longer needs to be sent to the House and it will be discharged from our queue.
Formal Transitional Care Program for Children and Youth with Special Healthcare Needs RESOLVED, That our AMA amend policy H-60.974, Children and Youth with Disabilities, by addition and deletion as follows, to strengthen our AMA policy and to include 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;	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**

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(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.	
Gender Neutral Language in AMA Policy RESOLVED, That our AMA (1) revise all relevant policies to utilize gender-neutral pronouns and other non-gendered language in place of gendered language where such text inappropriately appears; (2) utilize gender-neutral pronouns and other non-gendered language in future policies where gendered language does not specifically need to be used.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Guidelines on Chaperones for Sensitive Exams RESOLVED, That our AMA ask the Council on Ethical and Judicial Affairs to consider amending E-1.2.4, "Use of Chaperones " in the 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; d) asking patients' consent regarding the gender of the chaperones and attempting to accommodate that preference as able.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA Of note, given that this resolution ultimately asks for a study, your 2020-2021 Section Delegates brought the issue directly to the AMA Board of Trustees for consideration. To date, this has resulted in no significant action that we have been notified of and we will therefore be retaining this item in our transmittal queue. **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**
Hospital Bans on TOLAC RESOLVED, That our AMA encourage hospitals that can provide basic maternal care as defined by American College of Obstetrics and Gynecology not to prohibit trial of labor after cesarean (TOLAC); and be it further RESOLVED, That our AMA encourage hospitals that do not have resources to perform trial of labor after cesarean (TOLAC) to assist in the transfer of care of patients who desire TOLAC to a hospital that is equipped to perform TOLAC.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Improving Access to Telehealth for those with Disabilities RESOLVED, That our AMA utilize virtual platforms that are accessible to all members, including those with hearing or visual impairment, by using resources such as closed-captioning, magnification, and screen readers; and be it further	**Discharge from transmittal queue.** The first resolved clause has been accomplished by changes made at the J-21 meeting, in which accessible technologies were used for the virtual meeting. The second and third resolved clauses have been accomplished by the adoption of CMS Report 7 at J-21, which is now policy: **Addressing Equity in Telehealth H-480.937** Our AMA: (1) recognizes access to broadband internet as a social determinant of health;

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RESOLVED, That AMA amend Preserving Protections of the Americans with Disabilities Act of 1990 D-90.992 by addition as follows: Preserving Protections of the Americans with Disabilities Act of 1990, D-90.992 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 and institutions make their offices and telemedicine platforms more accessible to persons with disabilities, consistent with the Americans With Disabilities Act as well as any applicable state laws. and be it further RESOLVED, That AMA amend Enhancing Accommodations for People with Disabilities H-90.971 by addition as follows: H-90.971 – ENHANCING ACCOMMODATIONS FOR PEOPLE WITH DISABILITIES Our AMA encourages physicians to make their offices both physically and virtually accessible to patients with disabilities, consistent with the Americans with Disabilities Act (ADA) guidelines.	(2) encourages initiatives to measure and strengthen digital literacy, with an emphasis on programs designed with and for historically marginalized and minoritized populations; (3) encourages telehealth solution and service providers to implement design functionality, content, user interface, and service access best practices with and for historically minoritized and marginalized communities, including addressing culture, language, technology accessibility, and digital literacy within these populations; (4) supports efforts to design telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology, such as older adults, individuals with vision impairment and individuals with disabilities; (5) encourages hospitals, health systems and health plans to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and non-physician provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth; (6) supports expanding physician practice eligibility for programs that assist qualifying health care entities, including physician practices, in purchasing necessary services and equipment in order to provide telehealth services to augment the broadband infrastructure for, and increase connected device use among historically marginalized, minoritized and underserved populations; (7) supports efforts to ensure payers allow all contracted physicians to provide care via telehealth; (8) opposes efforts by health plans to use cost-sharing as a means to incentivize or require the use of telehealth or in-person care or incentivize care from a separate or preferred telehealth network over the patient's current physicians; and (9) will advocate that physician payments should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person. Given that the actions that would be accomplished by transmitting this item to the House have been done by other means, your section delegates feel that this item no longer needs to be sent to the House and it will be discharged from our queue.
Improving Research Standards, Approval Processes, and Post-Market Surveillance Standards for Medical Devices RESOLVED, That our AMA support improvements to the Food and Drug Administration 510(k) exception to ensure the safety and efficacy of medical devices to: (a) make more stringent guidelines for which devices can qualify for the 510(k) exceptions; (b) mandate all 510(k) devices demonstrate equivalent or improved safety and effectiveness compared to market devices for the same clinical purpose; and be it further RESOLVED, That our AMA support stronger post-market surveillance requirements of medical devices, including but not limited to (a): conditional approval of devices until sufficient post-market surveillance data determining	**Combine similar resolutions** into a single resolutions on improving standards for medical devices: • Improving Research Standards, Approval Processes, and Post-Market Surveillance Standards for Medical Devices • Improving Standards for Medical Devices Your section delegates felt that these two items were similar enough that it would be advantageous for our section to combine these items. This will hopefully increase their likelihood of being considered and adopted by the House. Otherwise **retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA

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device safety can be collected, followed by confirmatory trials, and (b) a publicly available summary of medical devices approved under expedited programs along with associated clinical trial data and list of reported adverse events; and be it further RESOLVED, That our AMA amend policy H-100.992 to include medical devices by addition as follows: FDA, H-100.992 1. Our AMA reaffirms its support for the principles that: (a) an FDA decision to approve a new drug or medical device, to withdraw a drug or medical device's approval, or to change the indications for use of a drug or medical device must be based on sound scientific and medical evidence derived from controlled trials, real-world data (RWD) fit for regulatory purpose, and/or postmarket incident reports as provided by statute; (b) this evidence should be evaluated by the FDA, in consultation with its Advisory Committees and expert extramural advisory bodies; and (c) any risk/benefit analysis or relative safety or efficacy judgments should not be grounds for limiting access to or indications for use of a drug or medical device unless the weight of the evidence from clinical trials, RWD fit for regulatory purpose, and post market reports shows that the drug or medical device is unsafe and/or ineffective for its labeled indications.	
Improving Support and Access for Medical Students with Disabilities RESOLVED, That our AMA amend D-295.929 by addition as follows: D-295.929 – A STUDY TO EVALUATE BARRIERS TO MEDICAL EDUCATION FOR TRAINEES WITH DISABILITIES Our AMA will work with relevant stakeholders to study available data on: (1) medical trainees and students with disabilities and consider revision of technical standards for medical education programs; and (2) medical graduates and students with disabilities and challenges to employment after training and medical education; and 3) work with relative stakeholders to encourage medical education institutions to make their	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA

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policies for inquiring about and obtaining accommodations related to disability transparent and easily accessible through multiple avenues including, but not limited to, online platforms. RESOLVED, That our AMA amend D-90.991 by addition and deletion as follows: D-90.991 – ADVOCACY FOR PHYSICIANS WITH DISABILITIES 1. Our AMA will study and report back on eliminating stigmatization and enhancing inclusion of physicians and medical students with disabilities including but not limited to: (a) enhancing representation of physicians and medical students with disabilities within the AMA, and (b) examining support groups, education, legal resources and any other means to increase the inclusion of physicians and medical students 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 and medical students 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, and medical student education programs about legal rights related to accommodation and freedom from discrimination for physicians, patients, and employees with disabilities. RESOLVED, That our AMA collaborate with the Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine (AACOM), and other relevant stakeholders to encourage the incorporation of closed captioning to all relevant medical school communications, including, but not limited to lecture recordings, videos, webinars, and audio recordings, that may prohibit any students from accessing information.	
Improving the Health and Safety of Sex Workers	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA

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RESOLVED, That our AMA recognize the adverse health outcomes of criminalizing consensual sex work; and be it further RESOLVED, That our AMA: 1) Supports legislation that decriminalizes individuals who offer sex in return for money or goods; 2) Opposes legislation that decriminalizes sex buying and brothel keeping; and 3) Supports the expungement of criminal records of those previously convicted of sex work, including trafficking survivors; and be it further RESOLVED, That our AMA supports research on the long-term health, including mental health, impacts of decriminalization of the sex trade.	**This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**
Incorporating the Evidence-Based Concepts of the Choosing Wisely Program into Undergraduate and Graduate Medical Education RESOLVED, That our American Medical Association amend D-155.988, Support for the concepts of the "Choosing Wisely" Program by insertion as follows: SUPPORT FOR THE CONCEPTS OF THE "CHOOSING WISELY" PROGRAM, D-155.988 1. Our AMA supports the concepts of the American Board of Internal Medicine Foundation's Choosing Wisely program. 2. Our AMA supports the inclusion of the evidence-based concepts of the American Board of Internal Medicine Foundation's Choosing Wisely program in undergraduate and graduate medical education.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Increase Employment Services Funding to People with Disabilities RESOLVED, That our AMA support increased resources for employment services to reduce health disparities for people with disabilities.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Increased Recognition and Treatment of Eating Disorders in Minority Populations RESOLVED, That our AMA amend policy H-150.965, by insertion 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	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**

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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, binge-eating, dieting, and weight restrictive behaviors in adolescents and to offer education and appropriate referral of adolescents and their families for culturally-informed interventional counseling; and (4) participates in this effort by consulting with appropriate and culturally-informed educational and counseling materials pertaining to unhealthy eating, binge-eating, dieting, and weight restrictive behaviors.	
Increasing Access to Feminine Hygiene/Menstrual Products RESOLVED, That our AMA recognize the adverse physical and mental health consequences of limited access to menstrual products for school-aged individuals; and be it further RESOLVED, That our AMA will 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; 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; 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; and be it further RESOLVED, That our AMA amend H-525.974, "Considering Feminine Hygiene Products as Medical Necessities", 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. (3) encourage the American National Standards Institute, the Occupational Safety and Health Administration, and other relevant	**Combine similar resolutions** into a single resolution on increasing access to feminine hygiene products: ● Increasing Access to Menstrual Hygiene Products in School Settings ● Providing Widespread Access to Feminine Hygiene/Menstrual Products ● Inclusion of Hygiene Products in Supplemental Nutrition Programs Your section delegates felt that these two items were similar enough that it would be advantageous for our section to combine these items. This will hopefully increase their likelihood of being considered and adopted by the House. The original resolved clauses of these resolutions were: **Increasing Access to Menstrual Hygiene Products in School Settings / Providing Widespread Access to Feminine Hygiene/Menstrual Products** RESOLVED, That our AMA recognize the adverse physical and mental health consequences of limited access to menstrual products for school-aged individuals; and be it further RESOLVED, That our AMA support the distribution of menstrual products and inclusion of menstrual product disposal systems in education institutions. RESOLVED, That our AMA encourage public and private institutions as well as places of work to provide free, readily available menstrual care products to workers and patrons; and be it further RESOLVED, That our AMA amend H-525.974, "Considering Feminine Hygiene Products as Medical Necessities", 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

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stakeholders to establish and enforce a standard of practice for providing free, readily available menstrual care products to meet the needs of workers.	products including tampons for their needs. (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. **Inclusion of Hygiene Products in Supplemental Nutrition Programs** RESOLVED, That our AMA will 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; and be it further RESOLVED, That our AMA advocate for federal legislation that increases access to menstrual hygiene products, especially for recipients of public assistance; and be it further RESOLVED, That our AMA work with state medical societies to advocate for state legislation that increases access to menstrual hygiene products, especially for recipients of public assistance. Otherwise, **retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**
Medicaid and CHIP Coverage of Glucose Monitoring Devices for Patients with Diabetes RESOLVED, That our AMA advocate for broadening the classification criteria of Durable Medical Equipment to include all clinically effective and cost-saving diabetic glucose monitors; and be it further RESOLVED, That our AMA amend Resolution H-330.885 to include the following: ~~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.	**Combine similar resolutions** into a single resolution on public insurance coverage of diabetes-related supplies: ● Medicaid and CHIP Coverage of Continuous Glucose Monitoring Devices for Patients with Insulin- Dependent Diabetes ● Increasing Access to Innovative Glucose Monitoring for All Patients with Diabetes Your section delegates felt that these two items were similar enough that it would be advantageous for our section to combine these items. This will hopefully increase their likelihood of being considered and adopted by the House. The original resolved clauses of these resolutions were: **Medicaid and CHIP Coverage of Continuous Glucose Monitoring Devices for Patients with Insulin-Dependent Diabetes** RESOLVED, That our AMA amend Policy H-330.885, to include the following: 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, Medicaid, and Children's Health Insurance Program (CHIP)~~ coverage of continuous glucose monitoring systems for patients with insulin-dependent diabetes by all public insurance programs.

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	Increasing Access to Innovative Glucose Monitoring for All Patients with Diabetes RESOLVED, That our AMA advocate for broadening the classification criteria of Durable Medical Equipment to include all clinically effective and cost-saving diabetic glucose monitors; and be it further RESOLVED, That our AMA amend policy H-330.885 by addition and deletion as follows: H-330.885 – ~~MEDICARE~~ PUBLIC INSURANCE COVERAGE OF CONTINUOUS GLUCOSE MONITORING DEVICES FOR PATIENTS WITH INSULIN-DEPENDENT DIABETES Our AMA supports efforts to achieve Medicare coverage of continuous and flash glucose monitoring systems for all ~~diabetic~~ patients with diabetes ~~with insulin-dependent diabetes~~ by all public insurance programs. Otherwise, **retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**
Medical Honor Society Inequities and Reform RESOLVED, That our AMA recognize that demographic and socioeconomic inequities exist in medical student membership in medical honor societies; and be it further RESOLVED, That our AMA study reforms to mitigate demographic and socioeconomic inequities in the selection of medical students for medical honor societies, including Alpha Omega Alpha and the Gold Humanism Honor Society, as well as the implications of ending the selection of medical students to these societies on equity in the residency application process and report back by the November 2021 HOD meeting	**Discharge from transmittal queue.** This ask was added onto CME Report 5 at J-21. This CME Report resulted in amendment of Continued Support for Diversity in Medical Education D-295.963, with final form: **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.

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	The study requested has not yet been initiated, but it is in CME's queue. Due to the action of this transmittal being directly accomplished through an amendment offered by our MSS Caucus, we no longer need to transmit this item and this it will be discharged from the queue.
Medical Student, Resident/Fellow, and Physician Voting in Federal, State and Local Elections RESOLVED, That our AMA will work with appropriate stakeholders to guarantee a full day off on Election Days at medical schools; and be it further RESOLVED, That our AMA study the rate of voter turnout in physicians, residents, fellows, and medical students in federal, state, and local elections without regard to political party affiliation or voting record, as a step towards understanding political participation in the medical community.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Mental Health First Aid Training RESOLVED, That our AMA encourage appropriate stakeholders including physicians, medical societies, physician specialty organizations, federation of state medical societies, and state medical boards to provide access to evidence-based mental illness rescue training programs as accredited Continuing Medical Education (CME) commensurate with their responsibilities in emergent mental illness crises, both in the clinical setting and community.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Modifying Eligibility Criteria for the Association of American Medical Colleges' Financial Assistance Program RESOLVED, That our AMA encourage the Association of American Medical Colleges' (AAMC) to conduct a study of the financial impact of the current Fee Assistance Program (FAP) policy to medical school applicants.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA Of note, given that this resolution ultimately asks for a study, your 2020-2021 Section Delegates brought the issue directly to the AMA Board of Trustees for consideration. To date, this has resulted in no significant action that we have been notified of and we will therefore be retaining this item in our transmittal queue. **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**
Non-Cervical HPV-Associated Cancer Prevention RESOLVED, That our AMA amend policy H-440.872 "HPV Vaccine and Cervical Cancer Prevention Worldwide" by insertion and deletion as follows: HPV VACCINE AND ~~CERVICAL~~ CANCER PREVENTION WORLDWIDE, H-440.872 1. Our AMA (a) urges physicians to educate themselves and their patients about HPV	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA

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and associated diseases, HPV vaccination, as well as routine ~~cervical~~ cancer screening for those at risk; 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, in both sexes such as, but not limited to, cervical cancer, head and neck cancer, anal cancer, and penile cancer, the availability and efficacy of HPV vaccinations, and the need for routine cervical cancer screening in the general public. 3. Our AMA 1. encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits ~~for adolescents and young adults~~, 2. 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, 3. recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination. 4. Our AMA encourage appropriate stakeholders to investigate means to increase HPV vaccination rates by: 1. facilitating administration of HPV vaccinations in community-based settings including school settings, and 2. supporting state mandates for HPV vaccination for school attendance, and be it further RESOLVED, That our AMA support legislation and funding for research aimed towards discovering screening methodology and early detection methods for other non-cervical HPV associated cancers.	
Online Medical School Interview Option RESOLVED, That our AMA work with relevant stakeholders to study the advantages and disadvantages of an online medical school interview option for future medical school applicants, including but not limited to financial implications and potential solutions, long term	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA

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success, and well-being of students and residents.	
Opposition to Alcoholic Industry Marketing Self-Regulation RESOLVED, That our AMA amend policy H-30.940, Labeling Advertising, and Promotion of Alcoholic Beverages, by addition and deletion as follows: H-30.940, LABELING, ADVERTISING, AND PROMOTION OF ALCOHOLIC BEVERAGES […] (3.) Actively supports and will work for a total statutory prohibition of advertising of all alcoholic beverages except for inside retail or wholesale outlets. Pursuant to that goal, our AMA (a) Supports federal and/or state oversight for all forms of alcohol advertising ~~in lieu of the alcohol industry's current practice of self-regulated advertising and marketing (a)~~(b) supports continued research, educational, and promotional activities dealing with issues of alcohol advertising and health education to provide more definitive evidence on whether, and in what manner, advertising contributes to alcohol abuse; ~~(b)~~(c) opposes the use of ~~the radio and television~~ any form of advertising which links alcoholic products to agents of socialization in order to promote drinking; ~~(c)~~(d) will work with state and local medical societies to support the elimination of advertising of alcoholic beverages from all mass transit systems; ~~(d)~~(e) urges college and university authorities to bar alcoholic beverage companies from sponsoring athletic events, music concerts, cultural events, and parties on school campuses, and from advertising their products or their logo in school publications; and ~~(e)~~(f) urges its constituent state associations to support state legislation to bar the promotion of alcoholic beverage consumption on school campuses and in advertising in school publications. (4.) (a) Urges producers and distributors of alcoholic beverages to discontinue all advertising directed toward youth, including such as promotions on high school and college campuses; (b) urges advertisers and broadcasters to cooperate in eliminating television program content that depicts the irresponsible use of alcohol without showing its adverse consequences (examples of such use include driving after drinking, drinking while pregnant, or drinking to enhance performance or win social acceptance); (e) supports continued warnings against the irresponsible use of alcohol and challenges the liquor, beer, and wine trade groups to include in their advertising specific warnings against driving	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA

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after drinking; and (f) commends those automobile and alcoholic beverage companies that have advertised against driving while under the influence of alcohol.	
Opposition to Sobriety Requirement for Hepatitis C Treatment RESOLVED, That our AMA amend policy H-440.845, Advocacy for Hepatitis C Virus Education, Prevention, Screening and Treatment, by addition and deletion as follows: H-440.845 – ADVOCACY FOR HEPATITIS C VIRUS EDUCATION, PREVENTION, SCREENING, AND TREATMENT Our AMA will: (1) encourage the adoption of birth year-based screening practices for hepatitis C, in alignment with Centers for Disease Control and Prevention (CDC) recommendations; (2) encourage the CDC and state Departments of Public Health to develop and coordinate Hepatitis C Virus infection educational and prevention efforts; (3) support hepatitis C virus (HCV) prevention, screening, and treatment programs that are targeted toward maximum public health benefit; (4) support removal of sobriety requirements as a barrier to HCV treatment; (5) work with state medical societies to remove sobriety requirements for HCV treatment; (~~4~~6) support programs aimed at training providers in the treatment and management of patients infected with HCV; (~~5~~7) support adequate funding by, and negotiation for affordable pricing for HCV antiviral treatments between the government, insurance companies, and other third party payers, so that all Americans for whom HCV treatment would have a substantial proven benefit will be able to receive this treatment; (~~6~~8) recognize correctional physicians, and physicians in other public health settings, as key stakeholders in the development of HCV treatment guidelines; (~~7~~9) encourage equitable reimbursement for those providing treatment.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**
Patient Education and Security Risks Involving Direct-to-Consumer Genetic Testing RESOLVED, That our AMA address direct-to-consumer genetic testing by amending H-460.908, Genomic-Based Personalized Medicine, by insertion and deletion as follows: H-460.908 – GENOMIC-BASED PERSONALIZED MEDICINE Our AMA: […](4) will support efforts to create and disseminate guidelines for best practice standards concerning counseling and data security for genetic test results in medical settings and in direct-to-consumer contexts	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA

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; and be it further RESOLVED, That our AMA amend D-480.987, Direct-to-Consumer Marketing and Availability of Genetic Testing, by insertion and deletion as follows: D-480.987 – DIRECT-TO-CONSUMER MARKETING AND AVAILABILITY OF GENETIC TESTING […] (5) will work to educate and inform physicians and patients regarding the types, benefits, and risks of genetic tests that are available directly to consumers, including, but not limited to information about the lack of scientific validity associated with some direct-to-consumer genetic tests, privacy violations and company ownership of patient data ~~so that patients can be appropriately counseled on the potential harms~~ ; and be it further RESOLVED, That our AMA support legislation regarding comprehensive security protection regarding direct-to-consumer genetic testing results to ensure patient privacy.	
Poverty-Level Wages and Health RESOLVED, That our AMA 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.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**
Promoting Oral Anticancer Drug Parity RESOLVED, That our AMA amend H-55.986, Home Chemotherapy and Antibiotic Infusions by addition and deletion as follows: H-55.986 – HOME CHEMOTHERAPY AND ANTIBIOTIC INFUSIONS Our AMA: (1) endorses the use of home medications to include those orally-administered, injections and/or infusions of FDA approved drugs and group C drugs (including chemotherapy and/or antibiotic therapy) for appropriate patients under physicians' recommendation and supervision; (2) only considers extension of the use of home infusions for biologic agents, immune modulating therapy, and anti-cancer therapy as allowed under the public health emergency when circumstances are present such that the benefits to the patient outweigh the potential risks; (3) encourages CMS and/or other insurers to provide adequate reimbursement and liability protections for such treatment; (4) supports educating legislators and administrators about the risks and benefits of such home infused antibiotics and supportive	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA

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care treatments in terms of cost saving, increased quality of life and decreased morbidity, and about the need to ensure patient and provider safety when considering home infusions for such treatment as biologic, immune modulating, and anti-cancer therapy; (5) advocates for appropriate reimbursement policies for home infusions; and (6) opposes any requirement by insurers for home administration of drugs, if in the treating physician's clinical judgment it is not appropriate, or the precautions necessary to protect medical staff, patients and caregivers from adverse events associated with drug infusion and disposal are not in place; this includes withholding of payment or prior authorization requirements for other settings.; and (7) advocates for patient cost-sharing parity between office- and home-administered anticancer drugs.	
Promoting the Use of Multi-Use Devices and Sustainable Practices in the Operating Room RESOLVED, That our AMA advocate for research into and development of intended multi-use operating room equipment and attire over devices, equipment and attire labeled for "single-use" with verified similar safety and efficacy profiles.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Protecting Medical Student Access to Abortion Education and Training RESOLVED, That our AMA amend policy H-295.923, Medical Training and Termination of Pregnancy by insertion as follows: H-295.923 – MEDICAL TRAINING AND TERMINATION OF PREGNANCY […] 2. Although observation of, attendance at, or any direct or indirect participation in 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. 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.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**

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Protections for Incarcerated Mothers in the Perinatal Period RESOLVED, That our AMA encourage research efforts to characterize the health needs for pregnant inmates, including efforts that utilize data acquisition directly from pregnant inmates; and be it further RESOLVED, That our AMA support legislation requiring all correctional facilities, including those that are privately-owned, to collect and publicly report pregnancy-related healthcare statistics with transparency in the data collection process; 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. However, since there are established benefits of breast milk for infants and breast milk expression for mothers, the AMA supports policy and legislation that extends the right to breastfeed and/or pump and store breast milk to include incarcerated mothers. 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 and breastfeeding/breast pumping 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.	**Combine similar resolutions** into a single resolution on protections for incarcerated mothers in the perinatal period: ● Combined Protections for Incarcerated Mothers to Breastfeed and/or Breast Pump ● Advocating for the Delivery of Standardized Perinatal Care and Monitoring of Healthcare Outcomes for Incarcerated Pregnant Individuals The exact clauses of the original resolutions are shown in the left column. Your section delegates felt that these two items were similar enough that it would be advantageous for our section to combine these items. This will hopefully increase their likelihood of being considered and adopted by the House. Otherwise, **retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**
Providing Reduced Parking Fees for Patients RESOLVED, That our AMA works with relevant stakeholders to recognize parking fees as a burden of care for patients and encourage mechanisms for reducing parking costs.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**
Recognizing LGBTQ+ Individuals as Underrepresented in Medicine	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA

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RESOLVED, That our AMA advocate for the creation of targeted efforts to recruit sexual and gender minority students in efforts to increase medical student, resident and provider diversity; and be it further RESOLVED, That our AMA encourage the inclusion of sexual orientation and gender identity data in all surveys as part of standard demographic variables, including but not limited to governmental, AMA, and the Association of American Medical Colleges surveys, given respondent confidentiality and response security can be ensured; and be it further RESOLVED, That our AMA work with the Association of American Medical Colleges to disaggregate data of LGBTQ+ individuals in medicine to better understand the representation of the unique experiences within the LGBTQ+ communities and their overlap with other identities.	
Recognizing Loneliness as a Public Health Issue RESOLVED, Our AMA will release a statement identifying loneliness as a public health issue with consequences for physical and mental health; and RESOLVED, Our AMA supports evidence-based efforts to combat loneliness	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Reducing Complexity in the Public Service Loan Forgiveness RESOLVED, That our AMA amend H-305.925 by insertion and deletion 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: […] 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; <u>(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</u>	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**

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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.	
Reducing Costs of CMS Limited Data Sets for Academic Use RESOLVED, That our AMA encourage the Centers for Medicare and Medicaid Services to adjust the pricing of limited data sets in order to increase access for academic use.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Reducing Disparities in HIV Incidence through Pre-Exposure Prophylaxis (PrEP) for HIV RESOLVED, That our AMA amend AMA Policy H-20.895 “Pre-Exposure Prophylaxis (PrEP) for HIV” by insertion 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. […]	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**

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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.	
Reducing the Prevalence of Sexual Assault by Testing Sexual Assault Evidence Kits RESOLVED, That our AMA amend policy H-80.999, Sexual Assault Survivors, by insertion: H-80.999 – SEXUAL ASSAULT SURVIVORS […] 5. 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.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**
Regulation of Phthalates in Adult Personal Sexual Products RESOLVED, That AMA H-135.945 be amended by addition and deletion as follows: H-135.945 – ENCOURAGING ALTERNATIVES TO PVC/PHTHALATE ~~DEHP~~ PRODUCTS IN HEALTH Our AMA: 1. Encourages hospitals and physicians to reduce and phase out polyvinyl chloride (PVC) ~~medical device~~ products, especially those containing phthalates such as Di(2-ethylhexyl)phthalate (DEHP), and urge adoption of safe, cost-effective, alternative products where available; and 2. Urges expanded manufacturer development of safe, cost-effective alternative products to PVC ~~medical device~~ products, especially those containing phthalates such as DEHP~~.~~; and 3. Encourages the U.S. Consumer Product Safety Commission to conduct a risk assessment of adult personal consumer products, including adult personal sexual products, as a source of phthalates; and 4. Supports consumer education about the potential for exposure to toxic substances in adult personal sexual products.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Reimbursement of School-Based Health Centers	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA

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RESOLVED, That the AMA promotes the implementation, use, and maintenance of SBHCs by amending H-60.921 School-Based and School-Linked Health Centers 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 SBHCs 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.	**This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**
Representation of Dermatological Pathologies in Varying Skin Tones RESOLVED, That our AMA encourage the inclusion of a diverse range of skin tones in preclinical and clinical dermatologic medical education materials and evaluation; 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; and be it further RESOLVED, That our AMA support the overrepresentation of darker skin tones in dermatologic medical education materials.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**
Decreasing Bias in Evaluations of Medical Student Performance RESOLVED, That our AMA work with appropriate stakeholders, such as the Liaison Committee on Medical Education (LCME) and the Commission on Osteopathic College Accreditation (COCA), to support: 1) increased diversity and implementation of implicit bias	**Combine similar resolutions** into a single resolution on decreasing bias in medical student performance evaluations: ● Requiring Blinded Review of Medical Student Performance ● Research the Ability of Two-Interval Grading of Clinical Clerkships to Minimize Racial Bias in Medical Education The exact clauses of the original resolutions are shown in the column to the left. Your section delegates felt that these two items

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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; and be it further RESOLVED, That our AMA will study the impact of two-interval clinical clerkship grading systems on residency application outcomes and clinical performance during residency.	were similar enough that it would be advantageous for our section to combine these items. This will hopefully increase their likelihood of being considered and adopted by the House. Otherwise, **retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**
Sexual Harassment accreditation Standards for Medical Training Programs RESOLVED, That our AMA encourage the LCME and ACGME to create a standard for accreditation that addresses sexual harassment training, policies, and repercussions for sexual harassment in undergraduate and graduate medical programs; and be it further RESOLVED, That our AMA encourage the LCME and ACGME to assess 1) medical trainees' perception of institutional culture regarding sexual harassment and preventative trainings, and 2) sexual harassment prevalence, reporting, investigation of allegations, and Title IX resource utilization in order to recommend best practices.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Student-Centered Approaches for Reforming School Disciplinary Procedures RESOLVED, That our AMA support evidence-based frameworks in K-12 schools that focus on school-wide prevention and intervention strategies for student misbehavior; and be it further RESOLVED, That our AMA support the inclusion of school-based mental health professionals in the student discipline process.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**
Study a need-based scholarship to encourage medical student participation in the AMA RESOLVED, That our AMA-MSS will ask the AMA to explore mechanisms to mitigate costs associated with medical student participation at national, in-person AMA conferences	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA **Hold in queue for the current meeting** – given that there is significant movement on this issue among the MSS GC and the larger AMA at this time.
Support for Institutional Policies for Personal Days for Undergraduate Medical Students RESOLVED, That our AMA encourage medical schools to accept flexible uses for excused	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**

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absences from clinical clerkships; 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.	
Support for Mental Health Courts RESOLVED, That AMA Policy H-100.955, Support for Drug Courts, be amended by addition and deletion 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 ~~addictive disease who are convicted of nonviolent crimes~~ mental illness involved in the justice system within a comprehensive system of community-based services and supports; (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.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**
Support for Pediatric Siblings of Chronically Ill Children RESOLVED, That our AMA support programs and resources that improve the mental health, physical health, and social support of pediatric siblings of chronically ill pediatric patients.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Support for Standardized Interpreter Training RESOLVED, That our AMA 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; and be it further 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	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**

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AAMC "Guidelines for Use of Medical Interpreter Services; and be it further RESOLVED, That our AMA work with the Commission for Medical Interpreter Education, National Hispanic Medical Association, National Council of Asian Pacific Islander Physicians, National Medical Association, Association of American Indian Physicians, National Association of the Deaf, and other relevant stakeholders to develop educational resources, such as through the AMA Ed Hub, for physicians to effectively and appropriately use interpreter services to ensure optimal patient care.	
Support for Universal Internet Access RESOLVED, That our AMA amend policy H-478.980, Increasing Access to Broadband Internet to Reduce Health Disparities, by addition and deletion as follows: INCREASING ACCESS TO BROADBAND INTERNET TO REDUCE HEALTH DISPARITIES, H-478.980 1. Our AMA recognizes internet access as a social determinant of health and will advocate for universal and affordable access to ~~the expansion of~~ broadband and high-speed wireless internet and voice connectivity, especially in ~~to all~~ rural and underserved areas of the United States 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. 2. Our AMA advocate for federal, state and local policies to support infrastructure that reduces the cost of broadband and wireless connectivity and covers multiple devices and streams per household.	**Discharge from transmittal queue.** Your MSS Caucus was able to advocate that these aims be added to several policies being considered by the House at the N-20 and J-21 meetings. The resultant policy is as follows: **Addressing Equity in Telehealth H-480.937** Our AMA: (1) recognizes access to broadband internet as a social determinant of health; (2) encourages initiatives to measure and strengthen digital literacy, with an emphasis on programs designed with and for historically marginalized and minoritized populations; (3) encourages telehealth solution and service providers to implement design functionality, content, user interface, and service access best practices with and for historically minoritized and marginalized communities, including addressing culture, language, technology accessibility, and digital literacy within these populations; (4) supports efforts to design telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology, such as older adults, individuals with vision impairment and individuals with disabilities; (5) encourages hospitals, health systems and health plans to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and non-physician provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth; (6) supports expanding physician practice eligibility for programs that assist qualifying health care entities, including physician practices, in purchasing necessary services and equipment in order to provide telehealth services to augment the broadband infrastructure for, and increase connected device use among historically marginalized, minoritized and underserved populations; (7) supports efforts to ensure payers allow all contracted physicians to provide care via telehealth; (8) opposes efforts by health plans to use cost-sharing as a means to incentivize or require the use of telehealth or in-person care or incentivize care from a separate or preferred telehealth network over the patient's current physicians; and (9) will advocate that physician payments should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person.

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	COVID-19 Emergency and Expanded Telemedicine Regulations D-480.963 Our AMA: (1) will continue to advocate for the widespread adoption of telehealth services in the practice of medicine for physicians and physician-led teams post SARS-COV-2; (2) will advocate that the Federal government, including the Centers for Medicare & Medicaid Services (CMS) and other agencies, state governments and state agencies, and the health insurance industry, adopt clear and uniform laws, rules, regulations, and policies relating to telehealth services that: (a) provide equitable coverage that allows patients to access telehealth services wherever they are located, and (b) provide for the use of accessible devices and technologies, with appropriate privacy and security protections, for connecting physicians and patients; (3) will advocate for equitable access to telehealth services, especially for at-risk and under-resourced patient populations and communities, including but not limited to supporting increased funding and planning for telehealth infrastructure such as broadband and internet-connected devices for both physician practices and patients; and (4) supports the use of telehealth to reduce health disparities and promote access to health care. **Increasing Access to Broadband Internet to Reduce Health Disparities H-478.980** Our AMA will advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States 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. Given that the actions that would be accomplished by transmitting this item to the House have been done by other means, your section delegates feel that this item no longer needs to be sent to the House and it will be discharged from our queue.
Support for Vote-by-Mail RESOLVED, That our AMA support measures to reduce crowding at polling locations and facilitate equitable access to voting for all voters, including: (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; and (e) adequate resourcing of the United States Postal Service and election operational procedures; and be it further RESOLVED, That our AMA oppose requirements for voters to stipulate a reason in order to receive a ballot by mail and other constraints for eligible voters to vote-by-mail.	**Retain in transmittal queue** – Cosponsor “Support for Safe and Equitable Access to Voting” with the Resident & Fellows Section (RFS) Resolution “Support for Vote-by-Mail” was adopted by the MSS Assembly and immediately forwarded to the House of Delegates at the Special November 2020 Meeting. Unfortunately, it was not considered for business due to urgency/priority constraints. When the MSS Caucus re-evaluated all transmittals for the June 2021 policy cycle, “Support for Vote-by-Mail” received a preliminary ranking of #37. Your Section Delegates have been informed that the RFS will be submitting an extremely similar resolution at the upcoming June 2021 Special House of Delegate, and that they would be prioritizing that resolution. Given that the Special Resolutions Committee may consider ranking in their evaluations, your MSS Caucus determined that it would be more strategic to co-sponsor the RFS resolution. The RFS resolutions asks: RESOLVED, That our American Medical Association support measures to facilitate safe and equitable access to voting as a harm-reduction strategy to safeguard public health and mitigate

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	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 [emphasis ours]; and be it further RESOLVED, That our AMA oppose requirements for voters to stipulate a reason in order to receive a ballot by mail and other constraints for eligible voters to vote-by-mail. Given these similarities, your Section Delegates recommends co-sponsoring the RFS resolution, and to retain "Support for Vote-by-Mail" in the transmittal queue in the event that the RFS resolution not be considered for business. If the RFS resolution is accepted as House business, our MSS resolution may be subject to further review on the appropriateness of its retention in the transmittal queue.
Support for Warning Labels on Firearm Ammunition Packaging RESOLVED, That our AMA supports legislation requiring that packaging for any firearm ammunition produced in, sold in, or exported from the United States carry a legible, boxed warning that includes, at a minimum, (a) text based statistics and/or graphic picture-based warning labels related to the risks, harms, and mortality associated with firearm ownership and use, and (b) explicit recommendations that ammunition be stored securely and separately from	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Support Harm Reduction Efforts through Decriminalization of Possessing of Non-Prescribed Buprenorphine RESOLVED, That our AMA advocate for the removal of buprenorphine from the misdemeanor crime of possession of a narcotic; and be it further RESOLVED, That our AMA support any efforts to decriminalize the possession of non-prescribed buprenorphine.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Supporting Collection of Data on Medical Repatriation RESOLVED, That our AMA 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; and be it further RESOLVED, That our AMA denounce the practice of forced medical repatriation.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**

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Supporting Daylight Saving Time as the New, Permanent Standard Time RESOLVED, That our AMA recognize the adverse health effects of biannual time changes and support the elimination of biannual time changing; and be it further RESOLVED, That our AMA recognize the positive health effects of daylight savings time and support daylight savings time as the permanent standard time.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Supporting the Availability of Closed Captioning in Medical Education RESOLVED, That our AMA collaborate with the Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine (AACOM), and other relevant stakeholders to encourage the incorporation of closed captioning to all relevant medical school communications, including but not limited to, lecture recordings, videos, webinars, and audio recordings, that may prohibit any students from accessing information.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Supporting the Study of Reparations as a Means to Reduce Racial Inequalities RESOLVED, That our AMA study potential mechanisms of national economic reparations that could improve inequities associated with institutionalized, systemic racism and report back to the House of Delegates; 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; and be it further RESOLVED, That our AMA support federal legislation that facilitates the study of reparations.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Teaching and Assessing Osteopathic Manipulative Treatment and Osteopathic Principles and Practice to Resident Physicians in the Context of ACGME Single System Accreditation **(COLRP CME REPORT B)** RESOLVED, That our AMA collaborate with the Accreditation Council on Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), and any other relevant stakeholders to investigate the need for graduate medical education faculty development in the supervision of Osteopathic Manipulative Treatment across ACGME accredited	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA

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residency programs.	
TV Broadcast and Online Streaming of LGBTQ+ Inclusive Sexual Encounters and Public Health Awareness on Social Media Platforms RESOLVED, That our AMA amend policy H-485.994, "Television Broadcast of Sexual Encounters and Public Health Awareness" by addition and deletion, to read as follows: TELEVISION BROADCAST AND ONLINE STREAMING OF SEXUAL ENCOUNTERS AND PUBLIC HEALTH AWARENESS ON SOCIAL MEDIA PLATFORMS, H-485.994 The AMA urges television broadcasters and online streaming services, producers, ~~and~~ sponsors, and any associated social media outlets to encourage education about heterosexual and LGBTQ+ inclusive safe sexual practices, including but not limited to condom use and abstinence, in television or online programming of sexual encounters, and to accurately represent the consequences of unsafe sex.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
University Land Grant Status in Medical School Admissions RESOLVED, That our AMA work with the Association of American Medical Colleges (AAMC), Liaison Committee on Medical Education (LCME), Association of American Indian Physicians, and the Association of Native American Medical Students to design and promulgate medical school's admissions recommendations in line with the federal trust responsibility; and be it further RESOLVED, That our AMA amend H-350.981 by addition to read as follows: H-350.981 – AMA SUPPORT OF AMERICAN INDIAN HEALTH CAREER OPPORTUNITIES 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. These	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**

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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. (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 stronger clinical exposure and a greater number of 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. (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. (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.	
Updating Policy on Immigration Laws, Rules, Legislation, and Health Disparities to Better Address National Crises RESOLVED, That our AMA, in order to prioritize the unique health needs of immigrants, asylees, refugees, and migrant workers during national crises, such as a pandemic: 1. opposes the slowing or halting of the release of individuals and families that are currently part of the immigration process; and	**Retain in transmittal queue as a combined item** on immigration law reform: ● 7. Amending H-350.957, Immigrant Health Disparities ● 50. Status of Immigration Laws, Rules, and Legislation during National Crises The exact clauses of these resolutions are shown in the column to the left. This resolution was combined by your 2020-21 Section Delegates and is now considered a single item. **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).**

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2. opposes 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. supports 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. opposes utilizing public health concerns to deny or significantly hinder eligibility for asylum status to immigrants, refugees, or migrant workers without a viable, medically sound alternative solution; and be it further RESOLVED, That our AMA amend H-350.957, Addressing Immigrant Health Disparities by addition as follows: H-350.957 – ADDRESSING IMMIGRANT <u>AND REFUGEE</u> HEALTH DISPARITIES 1. Our American Medical Association recognizes the unique health needs of <u>immigrants and</u> refugees and encourages the exploration of issues related to <u>immigrant and</u> 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 immigration 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 of 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. <u>4. Our AMA opposes any rule, regulation, or policy that would worsen health disparities among refugee or immigrant populations by forcing them</u>	

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to choose between health care or future lawful residency status.	
Use of Social Media for Product Promotion and Compensation RESOLVED, That our AMA study the ethical issue of medical students, residents, fellows, and physicians endorsing non-health related products through social and mainstream media for personal or financial gain.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA Of note, given that this resolution ultimately asks for a study, the 2020-2021 Section Delegates brought the issue directly to the AMA Board of Trustees for consideration prior to the J-21 meeting. To date, this has resulted in no significant action of which we have been notified and we will therefore be retaining this item in our transmittal queue.
Using X-Ray and Dental Records for Assessing Immigrant Age RESOLVED, That our AMA support discontinuation of the use of non-medically necessary dental and bone forensics to assess an immigrant's age.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA **This item will be transmitted as a priority item by our section to the November 2021 Special meeting of the AMA House of Delegates (please see Appendix 3).** H-65.958 was adopted by HoD at A-19, this policy was adopted by MSS at I-19. Your Section Delegates note some concern that the current resolution may be considered covered by existing policy in the House (see below), but the resolution will be retained in our queue. **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.

Appendix 3 - Transmittals (in order of priority) to the November 2021 Special Meeting of the House of Delegates

1. Disaggregation of Race Data for Individuals of Middle Eastern and North African (MENA) Descent
2. Supporting the Study of Reparations as a Means to Reduce Racial Inequalities
3. Equitable Reporting of USMLE Step 1 Scores
4. Poverty-Level Wages and Health
5. Abolishment of the Resolution Committee
6. Combating Natural Hair and Cultural Headwear Discrimination
7. University Land Grant Status in Medical School Admissions
8. Decreasing Bias in Evaluations of Medical Student Performance (combination of 124. Research the Ability of Two-Interval Grading of Clinical Clerkships to Minimize Racial Bias in Medical Education/ 40. Requiring Blinded Review of Medical Student Performance)
9. Supporting Collection of Data on Medical Repatriation
10. Evaluating Scientific Journal Articles for Racial and Ethnic Bias
11. Exclusion of Race and Ethnicity in the First Sentence of Case Reports

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12. Mitigating Environmental Contributors to Disease and Sustainability of AMA National Meetings (combination of 110. Environmental Contributors to Disease and Advocating for Environmental Justice/ 73. Environmental Sustainability of AMA National Meeting [Res. 062/ Res. 075 Nov. 2020])
13. Representation of Dermatological Pathologies in Varying Skin Tones
14. Reducing Prevalence of Sexual Assault by Testing Kits
15. Amendment to Truth and Transparency in Pregnancy Counseling Centers
16. Reducing Complexity in the Public Service Loan Forgiveness
17. Increase Awareness Among Residency, Fellowship, and Academic Programs on the United States-Puerto Rico Relationship Status (original title was Educate Residency, Fellowship, and Academic Programs on the United States-Puerto Rico Relationship Status)
18. Updating Policy on Immigration Laws, Rules, Legislation, and Health Disparities to Better Address National Crises (combination of 7. Amending H-350.957, Immigrant Health Disparities / 50. Status of Immigration Laws, Rules, and Legislation during National Crises)
19. Authority to Grant Vaccine Exemptions (original title was Investigation of Naturopathic Vaccine Exemptions)
20. Protections for Incarcerated Mothers in the Perinatal Period (combination of 117. Advocating for the Delivery of Standardized Perinatal Care and Monitoring of Healthcare Outcomes for Incarcerated Pregnant Individuals/ 66. Protections for Incarcerated Mothers to Breast Feed and/or Breast Pump)
21. Increasing Access to Feminine Hygiene/Menstrual Products (combination of 116. Inclusion of Hygiene Products in Supplemental Nutrition Programs/ 23. Increasing Access to Menstrual Hygiene Products in School Settings / 87. Providing Widespread Access to Feminine Hygiene/Menstrual Products)
22. Coverage of Pregnancy-Associated Healthcare for 12 Months Postpartum for Uninsured Patients who are Ineligible for Medicaid
23. Banning the Practice of Virginity Testing
24. Improving the Health and Safety of Sex Workers
25. Expanding the Definition of Iatrogenic Infertility to Include Gender-Affirming Interventions
26. Increased Recognition and Treatment of Eating Disorders in Minority Populations
27. Expansion on Comprehensive Sexual Health Education
28. Equal Access to Adoption for the LGBTQ+ Community
29. Reimbursement of School-Based Health Centers
30. Expanding Medicaid Transportation to Include Healthy Grocery Destinations
31. Medicaid and CHIP Coverage of Glucose Monitoring Devices for Patients with Diabetes (combination of 113. Increasing Access to Innovative Glucose Monitoring for All Patients with Diabetes/ 51. Medicaid and CHIP Coverage of Continuous Glucose Monitoring Devices for Patients with Insulin-Dependent Diabetes)
32. Amending D-440.985, Health Care Payment for Undocumented Persons, to Study Methods to Increase Health Care Access for Undocumented Immigrants
33. Caps on Insulin Co-Payments for Patients with Insurance
34. Addressing Healthcare Accessibility for Current and Aged-Out Youth in the Foster Care System
35. Support for Standardized Interpreter Training [Res. 123/CME MIC Rep. A Nov 2020]
36. Reducing Disparities in HIV Incidence through PREP for HIV
37. Support for Institutional Policies for Personal Days for Undergraduate Medical Students [Res 001- Nov. 2020/COLRP CME Rep. A Nov. 2020]
38. Modifying Eligibility Criteria for AAMC Financial Assistance

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39. Using X-Ray and Dental Records for Assessing Immigrant Age
40. Student-Centered Approaches for Reforming School Disciplinary Procedures
41. Advocating for the Amendment of Chronic Nuisance Ordinances
42. Providing Reduced Parking Fees for Patients
43. Increase Employment Services Funding to People with Disabilities
44. Formal Transitional Care Program for Children and Youth with Special Healthcare Needs
45. Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers
46. Support for Mental Health Courts
47. Enhancing Harm Reduction for People Who Use Drugs (Amend D-95.987, to Support Exempting Fentanyl Test Strips and Other Drug Checking Technologies from Paraphernalia Laws/Amend H-95.958, to Decriminalize IDPE in Safe Syringe Programs)
48. Opposition to Sobriety Requirement for Hepatitis C Treatment
49. Protecting Medical Student Access to Abortion Education and Training
50. Guidelines on Chaperones for Sensitive Exams

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REPORT OF THE MEDICAL STUDENT SECTION
GOVERNING COUNCIL

GC Report A
(N-21)

Introduced by: Haidn Foster, Chair

Subject: Policy Sunset Report for AMA-MSS Policies

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

INTRODUCTION

At the 1995 National Medical Student Interim Meeting, a sunset mechanism for MSS policy was established per MSS COLRP Report B-I-95 and reaffirmed by MSS GC Report C-A-00. Consequently, MSS policies automatically expire after 5 years unless action is taken by the Assembly to retain them.

The sunset mechanism for MSS policy was established for several reasons, including:

- To facilitate the analysis of policy for internal consistency and relevancy to the changing environment;
- To assist in the identification of areas where additional policy is needed;
- To help identify and remove outmoded, duplicative, or inconsistent policies;
- To promote efficiency in Assembly deliberations; and
- To simplify the resolution-writing process by monitoring the body of policy to be researched.

The policy sunset mechanism conforms to the following procedures codified in MSS policy 630.044MSS:

> (1) Review of policies will be the ultimate responsibility of the GC; (2) policy recommendations will be reported to the MSS Assembly at each Interim Meeting on the five or five and one-half year anniversary of a policy's adoption; (3) a consent calendar format will be used by the Assembly in considering the policies encompassed within the report; and (4) a vote will not be necessary on policies recommended for rescission as they will automatically expire under the auspices of the sunset mechanism.

MSS POLICY REVIEW

The MSS GC and MSS Standing Committees conducted a review of policies adopted or reaffirmed by the MSS Assembly in 2016. Appendix 1 of this report contains a listing of the 295 total policies adopted or reaffirmed in 2016, the recommendation for retention or

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rescission, and a brief supporting rationale for that recommendation, where needed. Some of these policies call for a specific finite action, such as preparing a letter, amending a policy, creating a product, or conducting a study. Other policies have been superseded by relevant AMA or MSS policy. The remaining policies contain general statements of policy that are still relevant, at least in part, and can be referenced by organizations or individuals seeking support for a particular issue. Of the 295 presented for consideration in this report, 248 of them will be either fully or partially retained as a part of the MSS policy compendium.

RECOMMENDATIONS

Your AMA-MSS Governing Council recommends that the following be adopted and the remainder of the report by filed:

1. That the policies specified for retention in Appendix 1 of this report be retained as official, active policies of the AMA-MSS.
2. That the AMA-MSS Governing Council review the AMA-MSS Digest of Policy Actions every five years for redundant and outdated statement of support.

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APPENDIX 1 – Policy Sunset Report Recommendations for AMA-MSS Policies

Policy #	Title	Policy	Recommendation
5.003MSS	Patient Confidentiality and Reproductive Health	AMA-MSS condemns the attempts of the Department of Justice to subpoena medical records in cases involving abortion.	Retain
10.001MSS	Prevention of Scald Burns in Children	AMA-MSS will ask the AMA to encourage physicians to educate all parents by disseminating scald prevention information.	Sunset; AAP already includes information regarding scald burn prevention through their healthy children initiative
10.012MSS	Helmet Safety	AMA-MSS will ask the AMA to amend H-470.974 by insertion and deletion as follows: H-470.974 Athletic Helmets Our AMA urges the Consumer Product Safety Commission to establish standards that athletic and recreational helmets, including but not limited to football, baseball, hockey, horseback riding, bicycle and motorcycle riding, lacrosse, and skiing, produced or sold in the United States provide protection against head injury; and that the AMA advocate the use of appropriate and safe clear face guards as a permanent installation on the current bilateral ear protective batter's helmet to be worn by all baseball and softball players as required safety equipment in all organized baseball and softball for those children from 5 to ~~14~~ 18 years of age; that the AMA encourage the use of protective helmets and face shields to be worn by all baseball and softball pitchers in organized leagues from 5 to 18	Retain

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		years of age. 2. Our AMA: (a) supports legislation requiring the use of helmets by children ages 17 and younger while engaged in potentially dangerous athletic activities, including but not limited to sledding, snow skiing, ~~or~~ and snowboarding; (b) encourages the use of helmets in adults while engaged in potentially dangerous athletic activities, including but not limited to sledding, snow skiing ~~or~~ and snowboarding; (c) encourages physicians to educate their patients about the importance of helmet use while engaged in potentially dangerous athletic activities, including but not limited to sledding, skiing and snowboarding; and (d) encourages the availability of rental helmets at all commercial sledding, skiing and snowboarding areas.	
15.008MSS	Advocacy of a Highway-Rail Crossing Safety Program	AMA-MSS supports programs set forth by the United States Department of Transportation – Federal Railroad Administration to ensure the safety at highway – rail crossings.	Sunset; policy was passed at A-99 AMA and then possibly sunset but no longer on AMA Policy Finder
15.009MSS	Seatbelt Use in Young Drivers and Passengers	AMA-MSS will ask the AMA to urge physicians to take an active stance with their young patients on the importance of safety in motor vehicles through routine questioning regarding passenger seat belt use during every history and physical exam.	Retain
20.001MSS	Look Back Programs	AMA-MSS will ask the AMA to support the concept of blood bank “look-back" programs as a means of protecting patients and reducing the possible spread of infection.	Sunset; this is now mandated by FDA and USPSTF

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20.012MSS	Policy Regarding HIV Infected Medical Students	AMA-MSS will ask the AMA to take the stand that a medical student who becomes infected with human immunodeficiency virus (HIV) and other blood-borne infectious diseases should not be prevented from completing his or her course of study and receiving their MD/DO degree based solely on their HIV seropositivity.	Retain
20.013MSS	Compulsory Discharge of HIV Infected Military Personnel	AMA-MSS will ask the AMA to oppose any measure that would mandate the compulsory discharge of members of the armed services who have HIV and are otherwise in compliance with present Pentagon regulations.	Sunset
20.014MSS	Promotion of Rapid HIV Test	AMA-MSS will ask the AMA to work with any and all local and state medical societies, and other interested U.S. and international organizations to increase access to and utilization of FDA approved rapid HIV testing by personnel appropriately trained in test administration and results counseling.	Sunset
20.018MSS	Averting Antiretroviral Treatment Rationing in the United States – Strengthening the AIDS Drug Assistance Program	AMA-MSS will ask the AMA to lobby the United States Congress to expand funding to ensure coverage for all current and future qualified individuals for the AIDS Drug Assistance Program.	Retain
25.001MSS	Geriatric Delirium Screening	AMA-MSS will ask the AMA to support efforts to educate physicians regarding the importance of delirium screening for clinically relevant patients 65 years of age or older, using an evidence-based and validated delirium detection tool.	Retain

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30.007MSS	Drunk Driving Prevention through Designated Driver Use Promotion	AMA-MSS urges businesses that serve alcohol to offer incentives such as free admission, reduced food prices, and free non-alcoholic beverages to patrons who elect to be designated drivers.	Retain
30.008MSS	Support for Medical Amnesty Policies for Underage Alcohol Intoxication	AMA-MSS will ask the AMA to support efforts among universities, hospitals, and legislators to establish medical amnesty policies that protect underage drinkers from punishment when seeking emergency medical attention for themselves or others.	Retain
50.004MSS	Blood Donor Deferral Criteria Revisions	AMA-MSS will ask that our AMA (1) amend policy H-50.973 by addition and deletion to read as follows: Blood Donor Deferral Criteria H-50.973 AMA: (1) supports the use of rational, scientifically-based blood and tissue donation deferral periods that are fairly and consistently applied to donors according to their ~~level of~~ individual risk; ~~and~~ (2) opposes ~~the current lifetime~~ a deferral on blood and tissue donations from men who have sex with men not based in science; and (3) supports research into Individual Risk Assessment criteria for blood donation. ; and (2) advocate for the elimination of current deferral policy and ask the Food and Drug Administration to develop recommendations for Individual Risk Assessment during the public commentary period.	Retain

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55.006MSS	9/11 Early Responder Health Coverage of Cancer	AMA-MSS will ask the AMA to encourage further study of the association between post-September 11, 2001 World Trade Center attack exposure and cancer incidence.	Sunset
60.001MSS	Medical Family History in Adoptions	AMA-MSS stands in favor of a change in adoption procedures that would require adoption agencies to obtain a complete family medical history and permit the adoptee to have access to this information while still maintaining confidentiality.	Retain
60.012MSS	Teen and Young Adult Suicide in the United States	AMA-MSS will ask the AMA to recognize teen and young-adult suicide as a serious health concern in the United States and compile resources to reduce teen and young adult suicide, including but not limited to CME classes, patient education programs and other appropriate educational and interventional programs for health care providers, and Rep Back at A-05.	Sunset; this was Adopted by the AMA
60.016MSS	Ensuring Best Care for Children with Diabetes in School	AMA-MSS will ask the AMA to recognize teen and young-adult suicide as a serious health concern in the United States and compile resources to reduce teen and young adult suicide, including but not limited to CME classes, patient education programs and other appropriate educational and interventional programs for health care providers, and Rep Back at A-05.	Sunset; more recent policy covers ask Youth and Young Adult Suicide in the United States H-60.937
60.020MSS	Reduction of Online Bullying	AMA-MSS will ask the AMA to urge social networking platforms to adopt Terms of Service that define and prohibit cyber-bullying and cyber-hate.	Retain
65.002MSS	Nondiscrimination Based on Sexual Orientation	AMA-MSS continues to support its positions that	Retain

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		nondiscrimination policies are a means for protecting the rights of those that suffer from prejudice.	
65.005MSS	Disseminating Information to Combat Ethnic Retaliation and Racism	AMA-MSS will work to raise awareness about incidents of ethnic retaliation and racism with the goal of reducing the occurrence of such incidents in the future.	Retain
65.016MSS	Elimination of Health Care Disparities Resulting from Insurance Status	AMA-MSS (1) supports the elimination of health care disparities caused by differential treatment based on insurance status of Americans; (2) encourages the Commission to End Health Care Disparities to specifically address in its mission, advocacy and actions, the contribution of differences in insurance status to health care disparities; and (3) supports efforts by the Agency for Healthcare Research and Quality to specifically investigate the impact of insurance-based segregation of Medicaid patients in different settings on racial and ethnic health care disparities and make appropriate evidence-based recommendations.	Retain
65.018MSS	Preventing Discrimination against Patients by Medical Students	AMA-MSS will ask the AMA to oppose the refusal by medical students to treat patients on the basis of the patient's race, ethnicity, age, religion, ability, marital status, sexual orientation, sex, or gender identity.	Sunset
65.021MSS	Addressing Patient Spirituality in Medicine	AMA-MSS will ask (1) That our AMA support inquiry into, as well as discussion and consideration of, individual patient spirituality as an important component of health; and (2) That our AMA	Retain

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		encourage expanded patient access to spiritual care services and resources beyond trained healthcare professionals.	
75.003MSS	Contraceptive Programming in the Media	AMA-MSS will ask the AMA to urge print and broadcast media to permit advertising and public service announcements regarding contraception and safe sexual practices as a matter of public health awareness.	Retain
75.011MSS	Informed Consent with Regards to Advertising and Prescribing Contraceptives	AMA-MSS: (1) supports continued research that explores alternative mechanisms of contraceptives; and (2) supports the concept of providing accurate and balanced information on the effectiveness, safety and risks/benefits of contraception in all public media and urges that such advertisements include appropriate information on the effectiveness, safety and risk/benefits of various methods with the addition of information regarding possible secondary mechanisms of contraceptive methods when conclusive and quantitative data is available.	Retain
95.004MSS	Support for Drug Courts	AMA-MSS will ask the AMA to (1) support the establishment of drug courts as an alternative to incarceration and as a more effective means of overcoming drug addiction for drug-abusing individuals convicted of nonviolent crimes; and (2) encourage legislators to establish drug courts at the state and local level in the United States.	Sunset; adopted by AMA
95.005MSS	Recognition of Addiction as Pathology, Not Criminality	AMA-MSS supports encouraging government agencies to re-examine the enforcement-based approach to illicit drug issues and to prioritize and	Retain

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		implement policies that treat drug abuse as a public health threat and drug addiction as a preventable and treatable disease.	
95.010MSS	Eliminating "Fail First" Policy in Addiction Treatment	AMA-MSS will ask that our AMA advocate for the elimination of the "fail first" policy implemented by insurance companies for addiction treatment.	Retain
100.001MSS	Ethical Concerns and Development of New Medications	AMA-MSS will ask the AMA to support the position that research, development, and submission for the Food and Drug Administration consideration of antiprogestins and other new medications be based predominantly on scientific evidence.	Retain
100.010MSS	Promoting Prevention of Fatal Opioid Overdose	AMA-MSS will ask the AMA to (1) encourage the establishment of new pilot programs directed towards heroin overdose treatment with naloxone; and (2) advocate for encourage the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities.	Retain
100.016MSS	Educating Physicians and Young Adults on Synthetic Drugs	AMA-MSS will ask the AMA to amend AMA policy H-95.940 to read as follows: Our AMA: (1) supports ongoing efforts of the National Institute on Drug Abuse, the Drug Enforcement Administration, and poison control centers to assess and monitor energy trends in illicit <u>and legal synthetic</u> drug use, and to develop and disseminate fact sheets and other educational materials; (2) encourages the development of continuing	Sunset; SAMHSA has a national survey on drug use trends, including legal drug use. https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health

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		medical education on emerging trends in illicit and legal synthetic drug use; and (3) supports efforts by the federal government to identify new drugs of abuse and to institute the necessary administrative or legislative actions to deem such drugs illegal in an expedited manner.	
105.003MSS	Opposing Tax Deductions for Direct-to-Consumer Advertising	AMA-MSS opposes allowing costs for direct-to-consumer advertising of prescription medications, medical devices, and controlled drugs to be considered deductible business expenses for tax purposes.	Retain
120.006MSS	Antidepressant Usage Among Children, Adolescents and Young Adults	AMA-MSS supports working in conjunction with all appropriate specialty societies to prepare an independent, comprehensive review of the scientific data currently available pertaining to the safety and efficacy of the use of Selective Serotonin Reuptake Inhibitor (SSRI) antidepressants in the treatment of child and adolescent psychiatric disorders.	Retain
120.009MSS	Restrictions on Use of Physician Prescribing Data for Commercial Purposes	AMA-MSS (1) supports limiting the use of physician prescribing data from any and all sources for commercial purposes, including its use by pharmaceutical companies; and (2) supports the availability of physician prescribing data to organizations using it for public health research, law enforcement, adverse effects reporting, and all other noncommercial purposes.	Retain
120.013MSS	Expanding Access to Buprenorphine for the Treatment of Opioid Use Disorder	Our AMA-MSS will ask the AMA to study solutions to overcome the barriers preventing appropriately trained physicians	Retain

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		from prescribing buprenorphine for treatment of Opioid Use Disorder.	
135.003MSS	Recycling in the Medical Community	AMA-MSS will ask the AMA to encourage the medical community to 1) initiate programs to recycle paper, aluminum cans, and bottles to show their commitment to improving the environment; and 2) use recyclable products in lieu of substances shown to be deleterious to the environment.	Retain
135.011MSS	Providing Safety-Type Needles for Use in Health Care Settings	AMA-MSS (1) supports efforts to require all health care settings to provide safety-type needles (such as re-sheathable winged steel needles, bluntable needles, retractable needles, or needles with hinged recapping sheaths) as viable alternatives to conventional hypodermic needles for the use of staff and students and (2) recommends that all health care institutions educate and encourage injured persons to report their needle stick injuries to the proper sources so that they might receive appropriate diagnostic and therapeutic care.	Retain with Amendments
135.012MSS	Toward Environmental Responsibility	AMA-MSS will ask the AMA to recognize the negative impact of climate change on global human health, particularly in the areas of infectious disease, the direct effects of heat, severe storms, food and water availability, and biodiversity.	Retain
140.007MSS	AMA-MSS Support of Advance Directives	(1) AMA-MSS affirms the need for advance directives for all patients, including young adults, and will provide its members with information about advance directives, and recommends medical students complete their	Retain

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		own; (2) AMA-MSS will ask the AMA to encourage physicians to discuss advance directives and organ donation with all patients, including young adults, as a part of the ongoing doctor-patient relationship; (3) AMA-MSS will ask the AMA to (a) recommend that advance directives completed by a patient be placed in a prominent area of the patient's medical record; and (b) recommend the inclusion of information on and eligibility requirements pertaining to organ and tissue donation in any advanced directive; (4) AMA-MSS will ask the AMA to support policies and legislation mandating physician reimbursement for time spent discussing advance directives with patients.	
140.024MSS	Encouraging Standardized Advance Directives forms within States	AMA-MSS will ask the AMA to encourage state societies to develop a standardized form of advance directives for use by physicians and other health care providers as a template to discuss end-of-life care with their patients.	Retain
140.025MSS	Regulations on the Patenting of Endogenous Human DNA	AMA-MSS will ask the AMA to oppose the patenting of endogenously occurring human DNA or RNA sequences, including specific alleles of such sequences found anywhere within the human population, or DNA and RNA products derived from these sequences.	Retain; could be potentially worth writing another resolution because the opposite of this policy is happening with CRISPR patents.
140.032MSS	Study of the Current Uses and Ethical Implications of Expanded Access Programs	AMA-MSS will ask (1) that our AMA study the implementation of expanded access programs, accelerated approval mechanisms, and payment reform models meant to	Retain

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		increase access of experimental therapies; and (2) that our AMA study the ethics of expanded access programs, accelerated approval mechanisms, and payment reform models meant to increase access of experimental therapies.	
140.033MSS	Addressing the Importance of Advance Directive Planning and Education for Medical Students	Our AMA-MSS supports undergraduate medical education on end-of-life care, including teaching advance directive planning as a clinical skill through simulation and skills practice, in addition to established didactic modalities.	Retain
140.034MSS	Physician Aid-in-Dying	AMA-MSS (1) supports protections for physicians who participate in physician aid-in-dying in states where physician aid-in-dying is legal and (2) encourages use of the term "physician aid-in-dying" instead of "physician-assisted suicide."	Retain
145.004MSS	Prevention of Unintentional Firearm Accidents in Children	AMA-MSS will ask the AMA to increase efforts to reduce pediatric firearm morbidity and mortality by encouraging its members: (1) to inquire as to the presence of household firearms as a part of childproofing the home; (2) to educate patients to the dangers of firearms to children; (3) to encourage patients to educate their children and neighbors as to the dangers of firearms; and (4) to routinely remind patients to obtain firearm safety locks and store firearms under lock and key; and that the AMA encourage state medical societies to work with other organizations to increase public education about firearm safety.	Retain

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150.015MSS	Increasing Customer Awareness of Nutrition Information and Ingredient Lists in Restaurants and Schools	AMA-MSS will ask the AMA to (1) support the adoption of regulations by the U.S. Food and Drug Administration requiring restaurants with menu items that are standard to multiple locations provide standard nutrition labels for all applicable items, available to their customers on request and (2) support the adoption of regulations by the U.S. Food and Drug Administration requiring all restaurants, school, and work cafeterias to have ingredient lists and nutritional information, including total fat, trans fat, sugar content, and sodium, for all menu items, available to their customers on request.	Retain; note that the first clause is included in AMA policy H-150.948, but second clause is not
150.016MSS	Folic Acid Fortification of Grain Products	AMA-MSS will ask the AMA to: (1) urge the Food and Drug Administration to recommend the folic acid fortification of all grains marketed for human consumption, including grains not carrying the "enriched" label; and (2) write letters to domestic and international producers of corn grain products, including masa, nixtamal, maize, and pozole, to advocate for folic acid fortification of such products.	Sunset; policy was passed at HOD and is currently in AMA Policy Finder verbatim
150.017MSS	Addition of Alternatives to Soft Drinks in Public Schools	AMA-MSS will ask the AMA to seek to promote the consumption and availability of low calorie, low sugar drinks as a healthy alternative in public schools instead of beverages such as carbonated sodas.	Retain
150.018MSS	Food Stamp Incentive Program	AMA-MSS will ask the AMA to support legislation to provide a meaningful increase in the value of food stamps when used to purchase fruits and vegetables.	Sunset; verbatim in AMA policy: D-150.983

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150.031MSS	Standardizing the Use of Expiration Dates on Food	AMA-MSS supports the principle that food dating labels be directed towards consumers in addition to retailers.	Retain
160.002MSS	Uncompensated Care for the Medically Indigent	AMA-MSS will ask the AMA to support policies that reimburse hospitals for treating patients unable to pay and promote further legislation that establishes such policies.	Retain
160.003MSS	Health Care for the Uninsured	AMA-MSS will ask the AMA to continue to advocate, refine, and seek implementation of its proposals for improving health expense protection for the uninsured.	Retain
160.019MSS	Improved Adequacy of Translation Services in Hospital and Pharmacy Settings	AMA-MSS will ask the AMA to amend policy H-215.982 by deletion and insertion as follows: H-215.982 Translator Services ~~in Hospitals~~ Our AMA encourages ~~hospitals~~ <u>health care institutions, including but not limited to hospitals and pharmacies</u>, that serve populations with a significant number of non-English speaking patients to provide trained translator services.	Retain
160.021MSS	Support of Multilingual Digital Assessment Tools for Medical Professionals	AMA-MSS will ask our AMA to encourage the publication and validation of standard patient assessment tools in multiple languages.	Retain
160.022MSS	Reducing Barriers to Preventive Health Care Delivery and Compensation	AMA-MSS will ask the AMA to support both the reduction of financial barriers to the delivery of cost-effective preventive health care services, and the implementation of financial incentives for cost-effective preventive medical care.	Retain

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160.024MSS	Transportation and Accessibility to Free Medical Clinics	AMA-MSS will ask the AMA to encourage initiatives that address transportation as a barrier to utilization of those institutions addressing the healthcare needs of the underserved in local communities.	Retain
160.032MSS	Feminine Hygiene Products	Our AMA-MSS supports the distribution of readily available feminine hygiene products in publicly funded institutions, including but not limited to schools, correctional facilities and shelters.	Retain
160.033MSS	Expanding Access to Screening Tools for Social Determinants of Health	AMA-MSS will ask that our AMA (1) provide access to evidence-based screening tools for evaluating and addressing social determinants of health in their physician resources; (2) support the continued integration of evidence-based screening tools evaluating social determinants of health into the electronic medical record and electronic health record; and (3) support fair compensation for the use of evidence-based social determinants of health screening tools and interventions in clinical settings.	Retain
160.034MSS	Improving Language Access for Limited English Proficiency Patients	AMA-MSS supports initiatives to educate physicians and medical students on the appropriate use of medical interpreters.	Retain
160.035MSS	Implementation of Standardized HIPAA Training	Our AMA-MSS supports a standardized HIPAA training curriculum for medical professionals that is transferable between healthcare entities and defines an appropriate time interval for recertification.	Retain
165.004MSS	Health Insurance Premium Subsidies for	AMA-MSS will ask the AMA to expand health system reform efforts to integrate other	Sunset; this is very specific and not actionable,

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	Affordable Universal Coverage	federal health insurance premium subsidies in addition to refundable health insurance tax credits for attaining affordable universal access to health care.	especially compared to more recent MSS policy on universal healthcare
165.006MSS	Medical Student Participation in Statewide Movements for Expanding Health Coverage	AMA-MSS encourages its members to participate in statewide movements that seek to expand health coverage to the uninsured and underinsured.	Retain; many states still have not passed Medicaid expansion, so this is still relevant and does not seem to be redundant with other policies
165.009MSS	Evaluation of the Principles of the Health Care Access Resolution	(1) AMA-MSS supports efforts to make health care more cost-effective by reducing administrative burdens, but only to such a degree that quality of care is not compromised; (2) AMA-MSS supports means of including both long-term care and prescription drug benefits into the guidelines for seeking affordable universal health care access and coverage; (3) AMA-MSS encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality of health care; and that our AMA-MSS supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons; (4) AMA-MSS will adopt policy to promote outcomes research as an effective mechanism to improve the quality of medical care for all persons and urge that the results of such research be used only for educational purposes and for improving practice parameters; (5) AMA-	Retain

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		MSS will adopt policy to address the need to increase numbers of qualified health care professionals, practitioners, and providers in underserved areas to increase timely access to quality care; (6) AMA-MSS supports the inclusion of adequate and timely payments to physicians and other providers into any plan calling for affordable universal health care access; (7) AMA-MSS supports the inclusion of the principles of continuity of health insurance coverage and continuity of medical care into any plan calling for affordable universal health care access; (8)AMA-MSS supports the inclusion of the principle of consumer choice of healthcare providers and practitioners into any plan calling for affordable universal health care access; (9) AMA-MSS supports the inclusion of reducing health care administrative cost and burden into any plan calling for affordable universal health care access.	
165.010MSS	Development and Support of Prospective Personalized Health Planning	AMA-MSS will ask the AMA to: (1) continue to recognize the need for possible adaptation of the United States' health care system to prospectively prevent the development of disease by ethically using genomics, proteomics, metabolomics, imaging and other advanced diagnostics, along with standardized informatics tools to develop individual risk assessments and personal health plans; (2) support studies aimed at determining the viability of prospective care	Retain

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		models, and measures that will assist in creating a stronger focus on prospective care in the United States' health care system; and (3) support research and discussion regarding the multidimensional ethical issues related to prospective care models, such as genetic testing.	
165.015MSS	Maintaining Insurance Coverage and Empowering State Choice	AMA-MSS (1) supports an individual mandate for health insurance coverage; and (2) supports proposals for state-choice in federal health insurance reform only if they maintain the standards of insurance quality and reach set forward under the 2010 Patients Protection and Affordable Care Act.	Retain
165.019MSS	Protecting Patient Access to Health Insurance and Affordable Care	AMA-MSS will ask that our AMA advocate that any health care reform legislation considered by Congress ensures continued improvement in patient access to care and patient health insurance coverage by maintaining: (a) Guaranteed insurability, including those with pre-existing conditions, without medical underwriting, (b) Income-dependent tax credits to subsidize private health insurance for eligible patients, (c) Federal funding for the expansion of Medicaid to <u>at least</u> 138% of the federal poverty level in states willing to accept expansion~~, as per current AMA policy (D-290.979)~~, (d) Maintaining dependents on family insurance plans until the age of 26, (e) Coverage for preventive health services, (f) Medical loss ratios set at no less than 85% to protect patients	Retain with Amendments

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		from excessive insurance costs; and (g) Coverage for mental health and substance use disorder services at parity with medical and surgical benefits.	
170.007MSS	Teaching Preventive Self Examinations to High School Students	AMA-MSS will ask the AMA to support the development of programs to teach self-breast examinations to female high school students and testicular self-examinations to male high school students and encourage county medical societies to assist local high schools in implementing such programs.	Retain
170.009MSS	Teaching Sexual Education to Disabled Youth in School	AMA-MSS will ask the AMA to encourage the Department of Education to ensure mentally and/or physically disabled youth receive more effective and comprehensive sexual education and encourage the Department of Education to offer sexual education counseling targeted to mentally and/or physically disabled youth.	Sunset
180.003MSS	Equitable Reimbursement for Physicians' Cognitive Services	AMA-MSS supports the concept that third-party payors should provide more equitable reimbursement for physicians' cognitive services.	Retain
180.010MSS	Parity in Health Care for Domestic Partnerships	AMA-MSS will ask the AMA to: (1) encourage the development of domestic partner health care benefits in the public and private sector; (2) support parity of pre-tax health care benefits for domestic partnerships; and (3) support legal recognition of domestic partners for hospital visitation rights and as the primary medical care decision-maker in the Uniform Probate Code in the absence of an alternative health care proxy designee.	Retain

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180.013MSS	Value Based Insurance Design	AMA-MSS will ask the AMA to recommend to the AMA Insurance Agency that value-based insurance design for Medicare Advantage be studied for potential future inclusion in Agency health insurance products.	Retain with Amendments
180.017MSS	Increasing Access to Medical Devices for Insulin-Depending Diabetics	AMA-MSS will ask that our AMA work with relevant stakeholders to encourage the development of plans for inclusion in the Medicare Advantage Value Based Insurance Design Model that reduce copayments/coinsurance for diabetes prevention, medication, supplies, and equipment including pumps and continuous glucose monitors, while adhering to existing AMA policies ~~the principles established in H-185.939~~.	Retain with Amendments
180.018MSS	Support for Equal Healthcare Access for Eating Disorders	Our AMA-MSS supports parity of coverage for all psychiatric disorders.	Retain; eating disorders qualify as a psychiatric disorder and should be equally as accessible as other mental health conditions
200.014MSS	Residency Position Considerations	AMA-MSS supports priority consideration of graduates of US LCME- and AOA-accredited medical schools for US residency positions in the event that limits are placed on the number of entry level residency positions.	Retain
215.005MSS	Prevention of Newborn Falls in Hospitals	Our AMA-MSS will ask that our AMA support implementation of newborn fall prevention plans and post-fall procedures through clinically proven, high-	Sunset; already adopted by AMA. See below: H-245.967

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		quality, and cost-effective approaches.	"Our AMA supports implementation of newborn fall prevention plans and post-fall procedures through clinically proven, high-quality, and cost-effective approaches."
245.014MSS	National Minimum Newborn Screening Recommendations	AMA-MSS will ask the AMA to: (1) support and recognize a need for uniform minimum newborn screening (NBS) recommendations; (2) encourage continued research on the benefits of NBS for certain diseases and the development of new NBS technology; and (3) recommend the adoption of a national minimum uniform screening panel for newborns by establishment of model state legislation and encouragement of legislation for adoption by Congress, pending completion and a review of the evaluation by the Advisory Committee on Heritable Disorders and Genetic Diseases in Newborns and Children.	Sunset; this was adopted by the AMA
245.016MSS	Doctors Defending Breastfeeding	AMA-MSS will ask the AMA to: (1) support and recognize a need for uniform minimum newborn screening (NBS) recommendations; (2) encourage continued research on the benefits of NBS for certain diseases and the development of new NBS technology; and (3) recommend the adoption of a national minimum uniform screening panel for newborns by establishment of model state legislation and encouragement	Retain

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		of legislation for adoption by Congress, pending completion and a review of the evaluation by the Advisory Committee on Heritable Disorders and Genetic Diseases in Newborns and Children.	
250.011MSS	Low-Cost Drugs to Poor Countries During Times of Pandemic Health Crisis	AMA-MSS will ask the AMA to: (1) support increased availability of anti-retroviral drugs and drugs to prevent active TB infection to countries where HIV/AIDS is pandemic; (2) encourage pharmaceutical companies to provide low cost medications to countries during times of pandemic health crises; and (3) work with the World Health Organization, UNAID, and similar organizations that provide comprehensive assistance, including health care, to poor countries in an effort to improve public health and national stability.	Retain
250.013MSS	Support of Medical and Surgical Supply Recycling Programs	AMA-MSS promotes organizations that provide medical and surgical supplies to underserved areas through recycling programs and encourages AMA-MSS chapters to participate in medical and surgical supply recycling programs.	Retain
250.027MSS	Emphasizing Training in the Treatment of Refugees	AMA-MSS (1) will ask the AMA to support state, local, and community programs that remove language barriers and promote education about low-cost health-care plans, and to minimize gaps in health-care for refugees, and (2) supports the efforts of federal and state government agencies to facilitate enrollment, or re-enrollment, of eligible refugees	Retain

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		into Medicaid, CHIP or Refugee Assistance insurance plans.	
255.006MSS	Support Equal Standards for Foreign Medical Schools Seeking Title IV Funding	AMA-MSS will ask that our AMA support the application of the existing requirements for foreign medical schools seeking Title IV Funding to those schools which are currently exempt from these requirements, thus creating equal standards for all foreign medical schools seeking Title IV Funding.	Sunset
270.003MSS	Broadening Access to Paid Family Leave to Improve Health Outcomes and Health Disparities	AMA-MSS supports the preference of paid leave and job security, over unpaid, for persons who must forsake work responsibilities for family or medical reasons, including parental leave.	Retain
270.009MSS	Protection for Physicians who Prescribe Pain Medication	AMA-MSS will ask the AMA to: (1) support the idea that physicians who prescribe pain medication to relieve chronic pain of both malignant and non-malignant origins should be freed from the burden of excessive regulatory scrutiny and censure; and (2) seek to implement legislation protecting physicians who treat chronic pain of malignant and non-malignant origins.	Sunset; this was adopted by AMA
270.010MSS	Support of Health Care to Legal Immigrants	AMA-MSS will ask the AMA to establish as policy its opposition to Federal and state legislation denying or restricting legal immigrants Medicaid and immunizations.	Retain
270.011MSS	Support of Patient Protections	AMA-MSS strongly supports and will promote AMA patient advocacy activities including efforts to ensure patient	Retain

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		protections in health benefit plans.	
270.017MSS	Support for Legislation for Businesses to Provide Breastfeeding Employees Time, Facilities, and Equipment for Breastfeeding	AMA-MSS will ask the AMA to support legislation encouraging and promoting breast feeding, such as tax credits for businesses that provide facilities and equipment for employed breastfeeding mothers to breastfeed or express milk on business premises.	Retain
270.023MSS	Requiring Placement of Automated External Defibrillators in All Nursing Homes	AMA-MSS will ask the AMA to support state legislation that mandates Automated External Defibrillator placement in all nursing homes as a condition of licensure.	Retain
270.024MSS	Addressing Safety and Regulation in Medical Spas	AMA-MSS will ask the AMA to (1) advocate for state regulation over medical spas to include a classification system of traditional salon treatments and medical procedures, with recommendations as to who may perform procedures based on the level of risk to the patient and requirements for practitioners to be licensed by an appropriate Board of Registration; (2) advocate that botulinum toxin injections be considered the practice of medicine; and (3) take steps to increase the public awareness about the dangers of medical spas by encouraging the creation of formal complaint procedures and accountability measures within the Department of Health and Human Services in order to increase transparency.	Sunset; adopted by AMA in D-35.983 "Our AMA will: (1) advocate for state regulation to ensure that cosmetic medical procedures, whether performed in medical spas or in more traditional medical settings, have the same safeguards as "medically necessary" procedures, including those which require appropriate training, supervision and oversight; (2) advocate that cosmetic medical procedures, such as botulinum toxin injections, dermal filler injections, and laser and intense pulsed light procedures, be

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			considered the practice of medicine; (3) take steps to increase the public awareness about the dangers of those medical spas which do not adhere to patient safety standards by encouraging the creation of formal complaint procedures and accountability measures in order to increase transparency; and (4) continue to evaluate the evolving issues related to medical spas, in conjunction with interested state and medical specialty societies.“
270.030MSS	Advocacy and Studies on ACA Section 1332 (State Innovation Waivers) to Improve States’ Abilities to Innovate and Improve Healthcare Benefits, Access and Affordability	Our AMA-MSS will ask (1) that our AMA advocate that the “deficit-neutrality” component of the current HHS rule for Section 1332 waiver qualification be considered only on long-term, aggregate cost savings of states’ innovations as opposed to having costs during any particular year, including in initial “investment” years of a program, reduce the ultimate likelihood of waiver approval; and (2) that our AMA study reforms that can be introduced under Section 1332 of the ACA in isolation and/or in combination with other federal waivers to improve healthcare benefits, access and affordability for the benefit of	Retain

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		patients, healthcare providers and states, and encourages state societies to do the same.	
270.031MSS	Addressing the Exploitation of Restricted Distribution Systems by Pharmaceutical Manufacturers	AMA-MSS will ask (1) that our AMA advocate with interested parties for legislative or regulatory measures that require prescription drug manufacturers to seek Federal Drug Administration and Federal Trade Commission approval before establishing a restricted distribution system; (2) that our AMA support the mandatory provision of samples of approved out-of-patent drugs upon request to generic manufacturers seeking to perform bioequivalence assays; and (3) that our AMA advocate with interested parties for legislative or regulatory measures that expedite the FDA approval process for generic drugs, including but not limited to application review deadlines and generic priority review voucher programs.	Retain
270.032MSS	Paid Parental Leave	Our AMA-MSS (1) supports policy that extends the length of universal paid parental leave, recommending especially a period of 14 weeks or longer; and (2) supports policies that equally encourage parents of all genders to take parental leave.	Retain
270.033MSS	Increased Oversight of Suicide Prevention Training for Correctional Facility Staff	AMA-MSS will ask that our AMA (1) strongly encourage all state and local correctional facilities to develop a suicide prevention plan that meets current National Commission on Correctional Health Care guidelines; and (2) strongly encourage all state and local correctional facility officers to	Retain; this policy is specific to correctional facility officers and staff and this issue is not represented anywhere else in AMA-MSS policy

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		undergo suicide prevention training annually.	
270.034MSS	Accountability of 911 Emergency Services Funding	AMA-MSS will ask that our AMA encourage federal guidelines and state legislation that protects against reallocation of 911 funding to unrelated services.	Sunset; this was adopted by AMA
275.011MSS	Transfer of Jurisdiction Over Required Clinical Skills Examinations to LCME-Accredited and COCA-Accredited Medical Schools	The AMA-MSS will (1) ask our AMA, working with the state medical societies, to advocate for the Federation of State Medical Boards (FSMB) and state medical boards to eliminate the United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) and the Comprehensive Osteopathic Licensing Examination (COMLEX) Level 2-Performance Examination (PE) as a requirement for Liaison Committee on Medical Education (LCME)-accredited and Committee on Osteopathic College Accreditation (COCA)-accredited medical school graduates who have passed a school administered, clinical skills examination; (2) ask the AMA to amend D-295.998 by insertion and deletion as follows: <u>Required</u> Clinical Skills Assessment During Medical School D-295.988 Our AMA will encourage its representatives to the Liaison Committee on Medical Education (LCME) to ask the LCME to <u>1)</u> determine and disseminate to medical schools a description of what constitutes appropriate compliance with the accreditation standard that	Sunset

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		schools should "develop a system of assessment" to assure that students have acquired and can demonstrate core clinical skills~~.~~, and 2) require that medical students attending LCME-accredited institutions pass a school-administered clinical skills examination to graduate from medical school.; and (3) ask that our AMA advocate for medical schools and medical licensure stakeholders to create guidelines standardizing the clinical skills examination that would be administered at each LCME-accredited and COCA-accredited medical school in lieu of USMLE Step 2 CS and COMLEX Level 2-PE and would be a substitute prerequisite for future licensure exams.	
275.012MSS	Support a Study on the Minimum Competencies and Scope of Medical Scribe Utilization	AMA-MSS will ask that our AMA partner with The Joint Commission and other stakeholders to study the minimum skills and competencies required of a medical scribe regarding documentation performance and clinical boundaries of medical scribe utilization.	Retain
285.002MSS	Managed Care Organizations' Responsibility to Contribute to Medical Education	AMA-MSS will ask the AMA to: (1) recognize the need for managed care organizations to work cooperatively with medical schools and residency programs in developing medical education programs; and (2) support the training and	Retain

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		evaluation of medical students and residents in their sites.	
290.001MSS	State Coverage of Medical Formula for Uninsured People Suffering from Phenylketonuria (PKU) Regardless of Age or Gender	(1) AMA-MSS will promote awareness among health professionals and medical students of Medicaid coverage as it pertains to all PKU patients, regardless of age and gender. (2) AMA-MSS will ask the AMA to encourage state medical societies to support legislation within their jurisdictions that would provide Medicaid funding and coverage of medical formula and foods for Medicaid patients suffering from PKU, regardless of age or gender.	Sunset; this was adopted by AMA as D-290.994 which was itself sunset in 2012 as the ask was accomplished in 2002 according to A-12 report compilation
290.002MSS	Interstate Medicaid Cooperation	AMA-MSS will ask the AMA to (1) support and advocate for legislation allowing out-of-state providers in close proximity to the border to be enrolled as in-state providers in those states that do not currently allow it, using Oregon's Medicaid system as a model; and (2) support and advocate for legislation that would streamline the provider enrollment process in order to encourage more physicians to become providers for border communities.	Retain
295.008MSS	Teaching Clinical Medical Ethics	AMA-MSS will ask the AMA to support required medical ethics instruction in medical schools by encouraging medical schools to make medical ethics a part of the required curriculum.	Sunset
295.013MSS	Proposed Alteration in Fourth Year Curriculum	AMA-MSS adamantly opposes any changes restricting the freedom of medical students to choose their fourth-year curriculum.	Sunset
295.018MSS	Addition of Instruction on Organ and Tissue Procurement to the	AMA-MSS will ask the AMA to encourage the Liaison Committee on Medical Education (LCME) to	Retain

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	Medical Student Curriculum	recommend incorporation into medical schools' curricula content focusing on organ and tissue procurement.	
295.022MSS	Health Promotion and Disease Prevention Education	AMA-MSS supports improvements in health promotion/disease prevention curricula in medical schools, residency programs, and CME programs.	Retain
295.069MSS	Fairness in the National Resident Matching Program	AMA-MSS will ask the AMA to remain committed to ensuring a fair residency selection process that works to accommodate students' best interests.	Retain
295.072MSS	Emergency Child Care	AMA-MSS encourages chapters to develop, in conjunction with the medical school, child care network projects or lists of local resources for emergency child care to support medical students with children.	Retain
295.073MSS	Inclusion of Lactation Management Education in Medical School Curricula	AMA-MSS encourages medical schools to incorporate lactation management education into the medical school curriculum where appropriate.	Retain
295.074MSS	Dissemination of Disability Insurance Information	AMA-MSS encourages medical schools to widely disseminate information to medical students regarding disability insurance and available policy options.	Retain
295.075MSS	Preserving Our Investment in the Face of Medical School Class Size Reduction	AMA-MSS (1) supports protections for medical students and accordant AMA action to ensure proper placement of displaced students in the event of medical school closures or class size reductions that do not allow for natural attrition of those currently enrolled; and (2) supports encouraging the Liaison Committee on Medical Education to develop guidelines for institutions to follow in the event of medical school closure	Sunset

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		or immediate class size reductions that provide for adequate notification and placement assistance for the affected medical students.	
295.077MSS	Medical Student Education on Termination of Pregnancy Issues	AMA-MSS believes that education on termination of pregnancy issues be included in the medical school curriculum so that medical students receive a satisfactory knowledge of the medical, ethical, legal, and psychological principles associated with termination of pregnancy, although performance of the actual procedure should not be required.	Retain
295.078MSS	Teaching Domestic Violence Screening	AMA-MSS will ask the AMA to encourage editors and publishers of medical training literature to include (1) domestic violence screening questions in recommendations and guidelines for conducting a comprehensive medical history and (2) domestic violence intervention and documentation protocols.	Retain
295.079MSS	Education of Medical Students about Domestic Violence Histories	AMA-MSS will ask the AMA to continue its support for the education of medical students on domestic violence by advocating that medical schools and post-graduate medical programs immediately begin training students and resident physicians to sensitively inquire about family abuse with all patients regardless of chief complaint or risk.	Sunset
295.081MSS	Promoting Culturally Competent Health Care	AMA-MSS will ask the AMA to encourage medical schools to offer electives in culturally competent health care with the goal of increasing awareness and acceptance of cultural	Retain

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		differences between patient and provider.	
295.082MSS	Respect for Individual Student's Beliefs	AMA-MSS will ask the AMA to encourage medical schools to adopt a policy whereby medical students would be allowed, without penalty, to withdraw from participating in medical procedures that may be violative of personally held moral principles or religious beliefs, provided that the students receive a satisfactory knowledge of the principles associated with the procedure and that the medical schools establish their own guidelines concerning specific procedures and situations in order to avoid the potential of abuse.	Retain
295.083MSS	Cardiopulmonary Resuscitation and Basic Life Support Training for First Year Medical Students	AMA-MSS will ask the AMA to strongly encourage training of cardiopulmonary resuscitation and basic life support to first-year medical students, preferably during the first term.	Retain
295.107MSS	HIV Post-Exposure Prophylaxis for Medical Students during Electives Abroad	AMA-MSS will ask the AMA to: (1) recommend that U.S. medical schools ensure that medical students who engage in clinical rotations abroad have immediate access to HIV post-exposure prophylaxis, and that the schools assume financial responsibility for providing or obtaining PEP when not otherwise covered; and (2) encourages medical schools to provide information to medical students regarding the potential health risks of completing a medical rotation abroad, and on the appropriate precautions to take to minimize such risks.	Sunset; this was adopted by AMA in D-295.970 "Our AMA: (1) recommends that US medical schools ensure that medical students who engage in clinical rotations abroad have immediate access to HIV prophylaxis; and (2) encourages medical schools to provide information to medical students regarding the potential health risks of completing a medical rotation

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			abroad, and on the appropriate precautions to take to minimize such risks."
295.110MSS	US Medical Student Match Fees	AMA-MSS strongly encourages the NRMP staff to continue ~~develop and implement~~ an equitable NRMP Match fee structure for both U.S. Medical Students and Independent Applicants that appropriately reflects actual costs for each group.	Retain with Amendment
295.119MSS	State Support of Public Medical School Education	AMA-MSS will ask the AMA to oppose any legislation that would compel graduates of public medical schools to agree to practice in a particular locale upon completion of medical training, including a medical residency, as a condition of matriculation.	Retain
295.123MSS	Teaching and Evaluating Professionalism in Medical Schools	AMA-MSS will ask the AMA to: (1) strongly urge the Liaison Committee on Medical Education to promptly create and enforce uniform accreditation standards that require all LCME- accredited medical schools to evaluate professional behavior regularly as part of medical education; (2) strongly urge the Liaison Committee on Medical Education to develop competencies for professional behavior and a mechanism for outcome assessment at least every four years in the accreditation process, examining teaching and evaluation of the competencies at LCME-accredited medical schools; (3) recognize that evaluation of professionalism is best performed by medical	Retain

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		schools and should not be used in evaluation for licensure of graduates of LCME-accredited medical schools; continue its efforts to teach and evaluate professionalism during medical education; and (4) actively oppose, by all available means, any attempt by the NBME and/or FSMB to add separate, fee-based examinations of behaviors of professionalism to the United States Licensing Examinations.	
295.129MSS	Improving Sexual Education in the Medical School Curriculum	AMA-MSS will ask the AMA to: (1) encourage all medical schools to train medical students to be able to take a thorough and non-judgmental sexual history in a manner that is sensitive to the personal attitudes and behaviors of patients in order to decrease anxiety and personal difficulty with sexual aspects of health care; and (2) issue a public service announcement that encourages patients to discuss concerns related to sexual health with their physician and reinforces the AMA's commitment to helping patients maintain sexual health and well-being	Retain
295.130MSS	Educating Medical Students about the Pharmaceutical Industry	AMA-MSS will ask the AMA to: (1) strongly encourage medical schools to include unbiased curricula concerning the impact of direct-to-consumer marketing practice employed by the pharmaceutical industry, as they relate to the physician-patient relationship; and (2) strongly encourage medical schools to include unbiased information in their curricula concerning the pharmaceutical	Retain

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		industry regarding (a) the cost of research and development for new medications, (b) the cost of promoting and advertising new medications, and (c) the proportion of (a) and (b) in comparison to their overall expenditures, and (d) the basic principles in the decision-making process involved in prescribing medications specifically using evidence-based medicine to compare outcomes and cost effectiveness of generic versus proprietary medications of the same class.	
295.138MSS	Medical Spanish Electives in Medical School Curriculum	AMA-MSS will ask the AMA to strongly encourage all accredited U.S. medical schools to offer medical second languages, especially medical Spanish, to their students as an elective.	Retain
295.139MSS	Standardization of Medical Student Background Checks	AMA-MSS (1) will collaborate with the appropriate organizations to ensure the standardization of medical student criminal background checks throughout all LCME and AOA accredited medical schools; and (2) will work with the appropriate organizations to ensure that medical student criminal background checks are structured to maintain the student's confidentiality, as well as avoid excessive frequency, cost, and duplicity as students rotate through clinical sites.	Retain
295.140MSS	Written Maternity Policies: A New LCME Accreditation Standard	AMA-MSS will urge the Liaison Committee on Medical Education to add maternity, paternity, and adoption leave policies as an accreditation standard or annotation.	Retain

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295.157MSS	Encouraging Medical Student Professionalism: Affirming Institutional Financial Disclosure Policies during Undergraduate Medical Education	AMA-MSS will ask the AMA to (1) work with the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medicine to encourage the Liaison Committee on Medical Education and the American Osteopathic Association Commission on Osteopathic College Accreditation to require all medical schools to make known to students the existence of the physician-industry financial disclosure database(s) that exist as required by the Patient Protection and Affordable Care Act (H.R. 3590 Section 6002); and (2) work with the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medicine to encourage all medical school faculty to model professional behavior to students by disclosing the existence of financial ties with industry, in accordance with existing disclosure policies at each respective medical school.	Retain
295.158MSS	Access to Vaccinations for Student and Healthcare Workers	AMA-MSS recommends (1) That all medical schools provide all institutionally required vaccinations to health professions students, with implementation costs to be part of student fees, unless medically contraindicated; and (2) That hospitals provide necessary access to vaccinations for their healthcare personnel.	Retain
295.161MSS	Transition from "Scramble" to Supplemental Offer and Acceptance Program	AMA-MSS will ask the AMA to encourage the National Resident Matching Program to study the effects of	Sunset

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		implementation of the Supplemental Offer and Acceptance Program on the number of residency spots not filled through the Main Residency Match and to include stratified analysis by specialty and other relevant areas.	
295.162MSS	Transparency in the NRMP Match Agreement	AMA-MSS will ask the AMA to (1) ask the National Resident Matching Program to publish all statistics on waivers and violations with subsequent consequences for both programs and applicants, thereby encouraging match integrity and in violation repercussions; and (2) advocate for the word "training" in section 7.2.1 of the NRMP match agreement be changed to "residency training," and specifically state that NRMP cannot prevent an applicant from maintaining their education through rotating, researching, teaching, or otherwise working in positions other than resident training at NRMP affiliated programs.	Sunset
295.164MSS	Medical Student Access to Comprehensive Mental Health and Substance Abuse Treatment	AMA-MSS strongly encourages the Association of American Medical Colleges and the Liaison Committee on Medical Education to conduct research into the number of US medical students with mental health and/or substance abuse concerns who either: 1. do not seek treatment due to the cost involved, or 2. have sought treatment, but do not feel that it has been adequate due to yearly visit and dollar limits placed on their care by their insurance plan.	Retain

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295.165MSS	Securing Quality Clinical Education Sites for U.S. Accredited Schools	AMA-MSS will ask the AMA to oppose extraordinary payments by any medical school for access to clinical rotations.	Retain
295.187MSS	Promoting and Reaffirming Domestic Medical School Clerkship Education	AMA-MSS will ask (1) that our AMA pursue avenues that promote the regulation of the financial compensation which medical schools can provide for clerkship positions in order to facilitate fair competition amongst medical schools and prevent unnecessary increases in domestically-trained medical student debt; (2) that our AMA support the expansion of partnerships of foreign medical schools with hospitals in regions which lack local medical schools in order to maximize the cumulative clerkship experience for all students; and (3) that our AMA reaffirm policies D-295.320, D-295.931, and D-295.937.	Retain
295.188MSS	Future of the United States Medical Licensing Examination (USMLE): Examining Multi-Step Structure and Score Usage	AMA-MSS will ask that our AMA (1) work with the appropriate stakeholders to investigate the advantages, disadvantages, and practicality of combining the United States Medical Licensing Examination (USMLE) Step 1 and Step 2 Clinical Knowledge (CK) exams into a single licensure exam measuring both foundational science and clinical knowledge competencies, and (2) work with the appropriate stakeholders to study alternate means of scoring United States Medical Licensing Examination (USMLE) exams.	Retain
295.189MSS	Encouraging Lifestyle Medicine in Undergraduate Medical Education	AMA-MSS supports the teaching of Lifestyle Medicine in undergraduate medical education.	Sunset

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305.039MS	A Voucher-Based Mechanism for Residency Position Funding	(1) AMA-MSS supports the establishment of a voucher system to provide entry eligibility for residents into graduate medical education programs and concurrently provide funding eligibility for the training program at the site where training occurs. (2) AMA-MSS supports the voucher system for funding of graduate medical education training positions for all graduates of US LCME and AOA-accredited medical schools with additional vouchers provided on a competitive basis to International Medical Graduates in a number determined by a public/ private sector workforce planning group.	Retain
305.072MSS	Financial Aid Dependency Status of Medical Students	AMA-MSS will (1) encourage medical schools to institute an appeals procedure that allows individual students with extenuating familial circumstances to apply for institutional financial aid without parental tax information taken into consideration, such as students whose non-custodial parent's whereabouts are unknown or students who have an established history of non-support from their parents; and ~~(2) work to ensure adequate dissemination of information on educational funding sources available to medical students.~~	Retain with Amendment
310.001MSS	The Residency Match Process	The AMA-MSS recognizes the significant time, energy, and resources that are allocated to the residency match process and hereby supports to following principles to help improve the residency match	Retain

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		process: 1. That the AMA-MSS will continue to work with other student, resident, and physician organizations to research and promote changes in the structure and/or the rules governing the Match so as to maximize the advantage to medical students and residents. 2. That the AMA-MSS supports efforts to encourage residency and fellowship programs to incorporate in their interview dates increased flexibility, whenever possible, to accommodate applicants' schedules. 3. That the AMA-MSS supports efforts to encourage the ACGME, the AOA, 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. 4. That the AMA-MSS supports a change in the NBME policy to report examination scores as "pass-fail" only. 5. That the AMA-MSS encourages individual chapters to maintain a roster of students willing to host residency applicants when they visit their institution. 6. That the AMA-MSS will ask the AMA to work with the NRMP to keep transaction costs of the Match to reasonable levels, and ensure that fees charged for each program a medical student applies to be capped at a reasonable level that takes into	

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		account medical students' budgeting constraints. 7. That the AMA-MSS will ask the AMA to support students, residents, and all appropriate organizations who work to ensure that any suspected violation of NRMP policy is addressed, publicized, and proper redress achieved, including the active promotion of NRMP complaint forms and other existing channels. 8. That the AMA-MSS will ask the AMA to urge the NRMP to allow students to opt out of the Match without penalty when there are extenuating circumstances, including but not limited to: unforeseen family emergencies such as illness that would require the individual to care for a family member; unforeseen physical or mental health problems that would impede the individual's ability to participate in residency training and required military or foreign service duty. 9. That the AMA-MSS will ask the AMA to support the concept that programs should retain the ability to extend applicants positions outside the Match. 10. That the AMA-MSS will ask the AMA to support improvements to the structure of the Match program for efficient placement of unmatched students, as long as such alterations do not result in postponement of the traditional "Match Day" date in mid-March.	
310.003MSS	MSS Graduate Medical Education Financing	1. The AMA-MSS joins the AMA in its strong opposition to the reduction of Medicare Funding of graduate medical education	Retain

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		and will advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions. 2. The AMA-MSS joins the AMA in its position that all payers for health care, including the federal government, the states, and private payers, benefit from graduate medical education and should directly contribute to its funding through, for example, expansion of government grant opportunities. 3. The AMA-MSS will ask the AMA to work together with other stakeholders to actively lobby Congress for legislation requiring all payers to contribute towards graduate medical education, while simultaneously continuing to lobby to protect Medicare and Medicaid graduate medical education payments. 4. The AMA-MSS urges the AMA to work toward the removal of caps on residency programs funded by the Center for Medicare and Medicaid Services (CMS), and encourage the CMS to adjust Graduate Medical Education funding to account for the need of an expanded workforce . 5. The AMA-MSS supports the AMA (a) with consultation of interested stakeholders, developing a comprehensive framework for a sustainable graduate medical education financing plan that addresses the physician workforce shortage and could be implemented at both the state and federal levels; (b)	

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		advocating for pilot projects supported through state and /or federal funding in medically underserved areas that foster resident training programs and offer loan repayment as a means to address the physician workforce shortage; and (c) working with our state medical societies for the drafting and implementation of model legislation to enact a comprehensive plan for graduate medical education reform once such a plan is developed. 6. The AMA-MSS supports combining Indirect Graduate Medical Education into the Direct Graduate Medical Education payments into a single, transparent funding stream. 7. The AMA-MSS support that Medicare's Graduate Medical Education funding be a per-resident federal allocation that is adjusted according to solely geographic measures, such as cost-of-living. 8. The AMA-MSS will advocate for transparency in how graduate medical education funds are allocated to residency programs and for how those programs use the allotted funding. 9. The AMA-MSS support that the payment of Graduate Medical Education funding being directed to the designated residency GME Office, in lieu of the hospital system, to be allocated across the department(s), sites and other specialties to provide comprehensive training. 10. The AMA-MSS will publicize in an appropriate manner, to all medical students, the potential	

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		for the elimination or reduction of Medicare Funding of graduate medical education and the consequential development of uncompensated residency positions. 11. The AMA-MSS opposes further expansion of graduate medical education funding to non-physician "residencies" at the expense of Accreditation Council for Graduate Medical Education- or AOA Commission on Osteopathic College Accreditation-accredited residency programs. 12. The AMA-MSS supports legislation regarding new funding for primary care graduate medical education designated for Accreditation Council for Graduate Medical Education- or AOA Commission on Osteopathic College Accreditation-accredited residency programs. 13. The AMA-MSS supports direct graduate medical education funding that allows each resident an initial residency period of five years, regardless of specialty choice or minimum years to attain board certification, in order to ensure flexibility of career choice.	
310.006MSS	The Influence of Residency Training on Quality of Patient Care in Teaching Hospitals	AMA-MSS supports the following principles: (1) There is a relationship between the structure and environment of residency training programs and the quality of patient care. (2) Quality of care is maximized in an intense training environment which recognizes human limitations inherent in all physicians and provides supportive mechanisms. (3)	Retain

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		Compassion is an essential component to the provision of effective patient care. (4) To the extent that the residency training environment affects patient care, the medical profession should promote those components which facilitate desirable clinical outcomes.	
310.027MSS	Resident Work Hours	(1) AMA-MSS will work with the AMA-RFS to make the improvement of hospital working conditions, including resident/fellow work hours, a top priority for the AMA. (2) AMA-MSS supports the concept of pursuing avenues in addition to working with the ACGME to alleviate resident work hour concerns.	Sunset
310.029MSS	Resident Work Hours	AMA-MSS will ask the AMA to: (1) draft original, modify existing, or oppose legislation and pursue regulatory or administrative strategies when dealing with resident work hours and conditions; (2) continue to work with organizations like the Accreditation Council on Graduate Medical Education (ACGME) and the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) toward finding solutions to the problem of work hours and conditions which would strengthen current work hours enforcement mechanisms; and (3) encourage the Agency for Healthcare Research and Quality (AHRQ) to examine the link between resident work hours and patients safety and to explore possible solutions to the	Retain

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		problem of work hours and conditions.	
310.033MSS	Eliminating Religious Discrimination from Residency Programs	AMA-MSS will ask the AMA to: (1) encourage the adoption of residency requirements that allow individuals to honor their religious beliefs and practices; (2) encourage the Accreditation Council for Graduate Medical Education and the American Osteopathic Association to extend its current policies regarding religious exceptions to include the observance of religious holidays and observances; (3) encourage the Accreditation Council for Graduate Medical Education to require that all residency programs become aware of and make an effort to ensure that residents be allowed to practice in a manner that does not interfere with their religious convictions, including observance of religious holidays and observances.	Retain
310.034MSS	Compensation for Resident/Fellow Physicians	The AMA-MSS recognizes the tremendous value of GME for patients and supports systems wherein adequate compensation is provided during GME training and supports the following principles regarding resident/fellow compensation: 1. The AMA-MSS supports reforming the current system of determining residents' salaries so that a resident's level of training, cost of living, whether or not they work in an underserved area, and other factors relevant to appropriate compensation of residents are taken into account. 2. The AMA-MSS asks that our AMA (a)	Retain with Amendments

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		work with the Accreditation Council for Graduate Medical Education and other appropriate agencies to assure that the terms of employment for resident physicians reflect the unique and extensive amount of education and experience acquired by physicians; (b) study the use of collective bargaining and unions with residency programs participating in the Accreditation Council for Graduate Medical Education to ensure fair and equitable terms of employment for resident physicians; (c) study the creation of a body that would establish and monitor criteria for fair and equitable terms of employment for resident physicians.	
310.046MSS	Investigating Adverse Public Health Outcomes Relating to Chronic GME Funding Shortages	AMA-MSS will ask the AMA to act to encourage appropriate stakeholder organizations to study and quantify the public health impacts of cuts to GME funding sources, including the effects on, but not limited to, the physician shortage, spending on public health initiatives, and availability and quality of care.	Sunset; this was accomplished through regular amendments to D-305.967 "...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..."
345.004MSS	Stigmatization of Mental Health Disorders within the Medical Profession	AMA-MSS will ask the AMA to address the stigmatization of mental health disorders in medical professionals by medical professionals by taking an active role in activities such as developing and/or	Retain

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		encouraging programming to promote awareness about and reduce this stigmatization.	
345.006MSS	Reduced Incarceration and Improved Treatment of Individuals with Mental Illness or Illicit Drug Dependence	AMA-MSS will ask the AMA to amend policy H-430.989 by insertion and deletion as follows: H-430.989 Disease Prevention and Health Promotion in Correctional Institutions Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public health systems toward 1. the prevention and control of HIV/AIDS, substance ~~abuse~~ use disorder, tuberculosis and hepatitis, 2. The management and treatment of psychiatric disorders such as ~~drug dependence~~ substance use disorder, and 3. A reduction in reincarceration rates related to ~~drug abuse~~ substance use disorders and psychiatric disorders. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers, ~~and~~ drug treatment center staff, and psychiatric care center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase in direct referral by correctional systems of parolees with a history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment	Retain with Amendments; change any mention of "substance abuse", "drug dependence", and "drug abuse" to "substance use disorder". The APA transitioned to using "substance use disorder" as opposed to dependence or abuse as an umbrella term, avoiding the challenges with defining where on the spectrum individuals may fall. In addition, this avoids any stigmatization associated with the word "abuse".

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		programs, as well as inpatient or outpatient psychiatric treatment programs, as a sentence or in connection with sentencing."	
345.010MSS	Support for the Decriminalization and Treatment of Suicide Attempts amongst Military Personnel	AMA-MSS will ask (1) that our AMA support efforts to decriminalize suicide attempts in the military and (2) that our AMA support efforts to provide treatment for survivors of suicide attempt in lieu of punishment in the military.	Retain
345.011MSS	Improving Mental Health at Colleges and Universities for Undergraduates	AMA-MSS will ask (1) that our AMA support accessibility and de-stigmatization as strategies in mental health measures implemented by colleges and universities, in order to improve the provision of care and increase its use by those in need; (2) that our AMA support colleges and universities in publicizing the importance of mental health resources, with an emphasis on the availability and efficacy of such resources; and (3) that our AMA support collaborations of university mental health specialists and local health centers in order to provide a larger pool of resources, such that any student be able to access care in a timely and affordable manner.	Retain
345.012MSS	Addressing Medical Student Mental Health through Data Collection and Screening	AMA-MSS will ask that our AMA (1) encourage study of medical student mental health, including but not limited to rates and risk factors of	Retain

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		depression and suicide; and (2) encourage medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students.	
345.013MSS	Studying the Effectiveness of Telemental Health in Schools	AMA-MSS supports research by appropriate stakeholders assessing the effectiveness of telemental health programs in comparison to standard mental health services offered by elementary, middle, and secondary educational institutions.	Retain
350.012MSS	Opposing Legislation to Cut Funding to the HRSA Health Careers Opportunity Program and the HRSA Centers of Excellence Program	AMA-MSS will ask the AMA to: (1) publicly oppose any reduction or elimination of funding for the Health Careers Opportunity Program and the Centers of Excellence Program; and (2) work with other interested organizations to seek increased public and private sector funding for the Health Careers Opportunity Program and the Centers of Excellence Program.	Retain
365.002MSS	Confidentiality, Counseling and Treatment in the Tuberculosis Screening of Health Care Workers	AMA-MSS will ask the AMA to: (1) encourage OSHA to adopt industry-wide standards which guarantee a health care worker's right to confidentiality, appropriate counseling, and treatment following the positive conversion of a tuberculosis ~~PPD skin~~ test; and (2) encourage OSHA to adopt industry-wide standards that guarantee that all prospective health care workers have a right to confidentiality,	Retain with Amendments; so this is not limited to "PPD skin tests" only and instead apply to "tuberculosis tests" as a whole- both skin and blood.

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		appropriate counseling, and treatment referral following a positive tuberculosis ~~PPD skin~~ test, which was obtained as a result of a pre-employment physical examination.	
365.003MSS	On-Site Employer Medical Clinics	AMA-MSS will ask the AMA to develop guidelines for the operation of on-site employer-sponsored medical clinics, ensuring that employee privacy, safety, and access to preventive health are not compromised.	Sunset; see H-160.910, Worksite Health Clinics
365.004MSS	Hospital Workplace and Patient Safety and Weapons	1) AMA-MSS supports policies which restrict guns and Tasers in civilian healthcare delivery settings and (2) AMA-MSS supports comprehensive training of security personnel that focus on patient safety and empathy.	Retain
370.010MSS	Increasing Organ Donation Discussions through Medical Education	Our AMA-MSS will (1) encourage the Accreditation Council for Graduate Medical Education, the Association of American Medical Colleges, and the Liaison Committee on Medical Education to include training on organ donation discussions in undergraduate and graduate medical education; (2) ask the AMA to compile current materials into a comprehensive resource and make them available for the development of a Continuing Medical Education Activity educating physicians on how to conduct organ donation discussions with patients; and (3) ask the AMA to support the development of billing codes for	Retain

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		physician-patient organ donation discussions.	
370.017MSS	Living Organ Donation at the Time of Imminent Death	AMA-MSS will ask (1) that our AMA study the implications of the removal of barriers to living organ donation at the time of imminent death.	Retain
385.001MSS	Most Favored Nation Clauses	AMA-MSS will ask the AMA to prepare model legislation to eliminate the use of "most favored nation" clauses in payor-provider ~~insurance~~ contracts as barriers to offering affordable medical care.	Retain with Amendments
390.005MSS	Opposing Medicare Reimbursement Based Off of Patient Satisfaction Score	Our AMA-MSS will ask that our AMA study the potential healthcare disparities caused by Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) in Medicare reimbursement.	Retain
405.002MSS	National Service Project	(1) AMA-MSS recognizes the value of associating the AMA-MSS with a community service project at each medical school. (2) AMA-MSS will make available a national service project that may be implemented at each medical school.	Retain
420.002MSS	Substance Abuse during Pregnancy	AMA-MSS will ask the AMA to: (1) continue its ongoing efforts to educate the general public, especially adolescents, about the effects of alcohol use disorder ~~alcohol abuse~~ on prenatal and postnatal development and expand these efforts to target all substance use disorders ~~abuse of other substances~~; and (2) encourage intensified research into the physical and	Retain with Amendments; "alcohol abuse" and "substance abuse" are outdated and slightly pejorative terminology that have been phased out of medical practice and have been replaced with alcohol or substance "use disorder(s)". As such, our AMA policy should reflect this change in practice. The

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		psychosocial aspects of maternal substance use ~~abuse~~ as well as the development of efficacious prevention and treatment modalities.	content of the policy remains extremely important and relevant.
420.004MSS	Improving Mental Health Services for Pregnant and Post-Partum Mothers	AMA-MSS will ask the AMA to (1) support improvements in current mental health services for women during pregnancy and postpartum; (2) support advocacy for inclusive insurance coverage of mental health services during gestation, and extension of postpartum mental health services coverage from 6 weeks to 1 year postpartum; and (3) support appropriate organizations working to improve awareness and education among patients, families, and providers of the risks of mental illness during gestation and postpartum.	Sunset; already adopted by AMA, see H-420.953
420.009MSS	Opposition to Government Funding of Crisis Pregnancy Centers	AMA-MSS opposes federal, state, and local funding for crisis pregnancy centers that distribute information that is contradictory to current published medical information.	Sunset; this has been incorporated into/forwarded to HOD by/superseded by 420.013MSS Amendment to Truth and Transparency in Pregnancy Counseling Centers, which is a pending transmittal.
435.007MSS	U.S. Medical Liability Crisis and the Impact on Clinical Medical Education	AMA-MSS will ask the AMA to: (1) recognize that undergraduate and graduate	Retain

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		medical education are impacted by the medical liability crisis; and (2) oppose medical liability insurance premiums based solely on preceptor or volunteer faculty status.	
440.003MSS	Childhood Immunization	AMA-MSS will ask the AMA to: (1) support legislation to assure a safe and adequate supply of childhood vaccines; and (2) impress upon Congress the urgency of the effects of decreasing numbers of vaccine manufacturers on the public health of the nation's children.	Retain
440.011MSS	Nosocomial Transmission of Disease via Stethoscope	AMA-MSS will ask the AMA to advocate that health care providers frequently clean their stethoscopes and take all reasonable precautions with their other hand-held instruments in order to minimize the potential risk of nosocomial infection.	Sunset; this was adopted by AMA, see H-440.908
440.021MSS	Promoting Fitness and Healthy Lifestyles	AMA-MSS encourage all physicians and health professionals to set an example by (1) striving to maintain a healthy weight and engaging in physical activity as recommended by scientific literature and expert panels; (2) maintaining a healthy and nutritious diet as recommended by scientific literature and expert panels; and (3) getting enough sleep to avoid the known short and long term adverse effects of sleep deprivation as recommended by scientific literature and expert panels.	Retain
440.022MSS	U.S. Government Involvement in	AMA-MSS will encourage the U.S. government to create a long-term solution to change	Retain

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	Preventing Future Vaccine Shortages	the infrastructure of the vaccine industry to prevent future problems such as shortages.	
440.023MSS	Support for a National Center on Pain Research	AMA-MSS will ask the AMA to support the development of a Center or Institute for Pain Research that would assist in the distribution of funding toward more clinical and basic science research regarding the treatment as well as the biology of pain and support efforts to create public awareness on responsible pain management, symptom management, and palliative care.	Sunset; this already has been accomplished: https://www.painconsortium.nih.gov
440.024MSS	Advertising for Herbal Supplements	AMA-MSS will and will ask the AMA to: (1) strongly encourage the naming of herbal supplements in a manner so that they cannot be confused with prescription drugs; (2) strongly discourage the advertising of herbal supplements in a way that resembles prescription drug advertisements; (3) work with the appropriate agencies to strengthen regulations regarding the advertising and distribution of herbal supplements and work with appropriate agencies to improve public awareness of regulations and distribution practices associated with herbal supplements, including but not limited to purity, safety, and pregnancy risk.	Retain
440.028MSS	HPV Vaccine in Cervical Cancer Prevention Worldwide	AMA-MSS will ask the AMA to: (a) urge physicians to educate themselves and their patients about HPV vaccination; (b) encourage the development and	Sunset; more recent policy covers this ask, see H-440.872

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		funding of programs targeted at reducing HPV transmission and screening for infection and precancerous cervical changes in developing countries; (c) intensify efforts to improve awareness and understanding about the availability and efficacy of HPV vaccinations in the general public; (d) encourage the integration of HPV vaccination into reproductive health care settings, including but not limited to routine reproductive health care visits for adults and adolescents; and (e) support the availability of the HPV vaccine to patient groups that benefit most from preventative measures, including but not limited to low-income and pre-sexually active populations.	
440.029MSS	Usage of Alcohol Based Hand Sanitizers in Institutional Settings	AMA-MSS: (1) recognizes alcohol-based hand sanitizers with alcohol concentrations of greater than 60% as an effective adjunct to hand washing in reducing microbial contamination and spread; and (2) urges the placement of alcohol-based hand sanitizer dispensers in institutional settings and highly trafficked public areas.	Retain
440.036MSS	Support for Establishment of Minimum Requirements for Training of Personnel	AMA-MSS will ask the AMA to support efforts to establish minimum standards for personnel	Retain

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	Administering Medical Radiation	performing medical procedures using ionizing radiation to be appropriately educated and trained in order to avoid patient over-radiation.	
440.037MSS	AMA-MSS Support for FDA Efforts to Reduce Computed Tomography Radiation in Children	AMA-MSS (1) supports the current US Food and Drug Administration policy including; promoting the safe use of medical imaging devices, supporting informed clinical decision making and increasing patient awareness; (2) supports working with all relevant parties to advocate for inclusion of an individual registry containing the patient's historical (test and procedure-based) cumulative radiation dose, as well as research the fiscal impact such a registry would incur; (3) encourages the continued development and use of standardized electronic medical record systems that will help physicians track the number of imaging procedures a patient is receiving and that will help physicians discuss the potential dangers of high level of radiation exposure with patients; and (4) supports initiatives to increase awareness of ionizing radiation exposure from medical imaging and practices that lower	Retain

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		radiation exposure from medical imaging.	
440.038MSS	HPV Vaccination Access for Minors	AMA-MSS will ask the AMA to develop and support model legislation allowing HPV vaccination consent by an unemancipated minor, independent of parental involvement.	Retain
440.057MSS	Improving Detection, Awareness, and Prevention of Lead Contamination in Water	(1) Our AMA-MSS supports future research to improve water sampling techniques and protocols to better detect human exposure to lead at the point of consumption; (2) Our AMA-MSS supports improved open public access to testing data on health hazardous substance levels in public commodities, such as water; and (3) Our AMA-MSS supports legislation and efforts to reduce or eliminate lead from public and private water infrastructure.	Retain; this is useful internal policy guiding environmental health
440.058MSS	Importance of Oral Health in Medical Practice	AMA-MSS (1) recognizes the importance of managing oral health as a part of overall patient care; (2) supports efforts to educate physicians on oral condition screening and management, as well as the consequences of poor oral hygiene on mental and physical health; (3) supports closer collaboration of physicians with dental providers to provide comprehensive medical care; and (4) support	Retain; closer collaboration of physicians with dental providers is not captured in more recent resolutions intended to expand dental coverage and dental access

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		efforts to increase access to oral health services.	
440.059MSS	Improving Access to Direct Acting Antivirals for Hepatitis C-Infected Individuals	The AMA-MSS (1) supports hepatitis C virus (HCV) treatment programs aimed at reducing the public health burden of the HCV epidemic; (2) will ask that our AMA support educational programs aimed at training primary care providers in the treatment and management of patients infected with HCV, particularly those providers serving rural or otherwise underserved populations; and (3) will ask that our AMA amend current policy H-440.845 by addition to read as follows: **Advocacy for Hepatitis C Virus Education, Prevention, Screening and Treatment H-440.845** Our AMA will: (1) encourage the adoption of birth year-based screening practices for hepatitis C, in alignment with Centers for Disease Control and Prevention (CDC) recommendations; (2) encourage the CDC and state Departments of Public Health to develop and coordinate Hepatitis C Virus infection educational and prevention efforts; (3) support hepatitis C virus (HCV) prevention, screening, and treatment programs that are targeted toward	Retain

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		maximum public health benefit; (4) support educational programs aimed at training primary care providers in the treatment and management of patients infected with HCV ~~(4)~~ (5) support adequate funding by, and negotiation for affordable pricing for HCV antiviral treatments between, the government, insurance companies and other third party payers, so that all Americans for whom HCV treatment would have a substantial proven benefit will be able to receive this treatment; and ~~(5)~~ (6) recognize correctional physicians, and physicians in other public health settings, as key stakeholders in the development of HCV treatment guidelines.	
440.060MSS	Housing Provision and Social Support to Immediately Alleviate Chronic Homelessness in the United States	AMA-MSS will ask that our AMA amend policy H-160.903 by addition and deletion to read as follows: **Eradicating Homelessness H-160.903** Our American Medical Association: (1) supports improving the health outcomes and decreasing the health care costs of treating the	Retain

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		chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services; (2) will work with state medical societies to advocate for legislation implementing stable, affordable housing and appropriate voluntary social services as a first priority in the treatment of chronically-homeless individuals, without mandated therapy or services compliance and (3) supports the appropriate organizations in developing an effective national plan to eradicate homelessness.	
445.001MSS	Public Image of Physicians	(1) AMA-MSS: (a) will help develop community service and public education programs that serve to inform the public of health care issues and improve the public image of the AMA and the medical profession; and (b) will investigate possible advantages of involving medical students in AMA efforts to improve the public image of physicians and to assure the public that the primary role of physicians today continues to be that of advocates for their patient's health.	Retain
460.007MSS	AMA Support for Manned Space Exploration of the	AMA-MSS will ask the AMA to publicly support a commitment	Retain

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	Moon, and Mars that will Promote Medical Research and Enhance Patient Care	for manned space exploration of the moon, Mars, and other celestial bodies for the benefits to medicine and advances in patient care.	
460.014MSS	Creation of a National Registry for Healthy Subjects in Phase I Clinical Trials	AMA-MSS will ask the AMA to encourage the development and implementation of a national registry, with minimally identifiable information, for healthy subjects in phase I trials by the US Food and Drug Administration or other appropriate organizations to promote subject safety, research quality, and document previous trial participation.	Retain
460.015MSS	Understanding Medical School Support for Student Participation in Year-Out Research Programs	AMA-MSS will work with the AMA Academic Physicians Section, the AMA Council on Medical Education, and other appropriate groups to encourage medical schools to facilitate student participation in year-out research programs.	Retain
460.018MSS	Removing Restrictions on Federal Public Health Crisis Research	AMA-MSS will ask (1) that our AMA recognize the importance of timely research and open discourse in combatting public health crises; and (2) That our AMA oppose efforts to restrict funding or suppress the findings of biomedical and public health research for the purpose of influencing political discourse.	Sunset; this was incorporated via amendment into D-440.997
460.019MSS	Removing Restrictions on Federal Funding for Firearm Research	AMA-MSS will ask that our AMA provide an informational report on recent and current organizational actions taken on our existing AMA policies (e.g. H-145.997) regarding removing the restrictions on federal funding for firearms violence research, with additional	Sunset; report completed, task accomplished

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		recommendations on any ongoing or proposed upcoming actions.	
470.001MSS	Pre-Participation Sports Examinations	AMA-MSS will ask the AMA to support and encourage state medical societies to support implementation of the guidelines established by the American Academy of Pediatrics for pre-participation sports physical examinations.	Retain
470.006MSS	Bicycle Sharing Programs	AMA-MSS (1) supports city governments in their investigation of the feasibility and economic sustainability of bicycle sharing programs; and (2) supports implementation of a bicycle sharing program in cities where the feasibility, economic viability, and potential health impacts are favorable.	Retain
480.004MSS	Ultrasound Imaging	AMA-MSS (a) affirms that ultrasound imaging is within the scope of practice of appropriately trained physicians ~~specialists~~; (b) acknowledges that broad and diverse use and application of ultrasound imaging technologies exists in medical practice; (c) affirms that privileging of the physician to perform ultrasound imaging procedures in a hospital setting should be a function of hospital medical staff and should be specifically delineated	Retain with amendment; "appropriately trained physician specialists" is unclear and not well defined.

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		on the Department's Delineation of Privileges form; and (d) believes that each hospital medical staff should review and approve criteria for granting ultrasound privileges based upon background and training for the use of ultrasound technology and ensure that these criteria are in accordance with recommended training and education standards developed by each physician's respective specialty society.	
480.005MSS	"Keepsake" Fetal Ultrasonography	AMA-MSS will ask the AMA lobby the federal government to enforce the current FDA position, which views "keepsake" fetal videos as an unapproved use of a medical device, on non-medical use of ultrasonic fetal imaging.	Sunset; this was Adopted by the AMA
480.007MSS	Novel Technologies in Biometrics and Medical ID Bracelets Used to Enhance Security and Quality of Care	AMA-MSS will ask the AMA to (~~1) encourage the use of biometric technologies, such as, but not limited to fingerprint and palm scanners, in hospitals and clinics 1. for patient identification to reduce health insurance fraud and 2. for providers to streamline and secure user authentication processes and better protect patient privacy; and(2) to~~ amend H-130.987 by insertion and deletion as follows:	Retain with amendment - delete (1), retain (2); the increased utilization and prevalence of two-factor authentication in health technology as well as iPhone Apple Face ID for sensitive apps may have made adoption of this technology non-essential.

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		H-130.987 Emergency Medical Identification Aids The AMA (1) urges worldwide use of the Emergency Medical Identification Symbol (Symbol); (2) urges that persons with special health problems wear a readily evident durable metal or plastic alerting device and that all persons carry a universal medical information card identifying family, friends and personal physicians; (3) urges that the Symbol be imprinted on alerting devices, on medical identification cards, and on emergency medical care educational material; ~~and~~(4) encourages physicians to work individually with their patients in selecting an appropriate signal device and identification card; and (5) encourages health insurance providers to offer enrollment in a virtual medical ID bracelet identification alert system as an optional health service, which can offer emergency responders immediate access to pertinent health information and family contact information.	
480.009MSS	Safe, Effective Smartphone Applications	AMA-MSS supports ongoing research on the safety and efficacy of	Retain

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		medical apps used in clinical settings in terms of patient outcomes and physician performance and efficiency.	
480.017MSS	Secure Text Messaging Between Healthcare Providers	AMA-MSS supports usage of mobile devices messaging within clinical settings that is in compliance with the HIPAA Security Rule and minimally burdensome to healthcare providers.	Retain
480.018MSS	Exploring Applications of Wearable Technology in Clinical Medicine and Medical Research	AMA-MSS will ask that our AMA study the safety, efficacy, and potential uses of wearable devices within clinical medicine and clinical research.	Retain
485.002MSS	Support for Increased Educational Children's Television Programming	AMA-MSS will ask the AMA to encourage independent television stations and network affiliates throughout the U.S. to broadcast at least one hour per day, during regular viewing hours, of educational programming for children.	Retain
490.007MSS	Medical School Tobacco Stock Holdings	AMA-MSS will ask the AMA to support the divestiture of tobacco stocks held by medical schools and universities.	Retain
490.008MSS	Regulation of Tobacco Products by the Food and Drug Administration	AMA-MSS will ask the AMA to support the regulation of tobacco products by the Food and Drug Administration.	Sunset; this was Adopted by the AMA
490.021MSS	Providing Full Coverage for Smoking Cessation Treatments	AMA-MSS (1) supports working with state and local medical societies to formally request that state lawmakers allocate at least the Centers for Disease Control and Prevention-recommended minimum	Retain with change in policy number; This has the same policy number as "Defining the Physical Boundaries and General Scope

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		amount of the state's Tobacco Settlement Fund award annually to tobacco cessation programs; and (2) recommends that third-party payers and government agencies involved in medical care offer full coverage for smoking cessation products to smokers seeking counseling for quitting.	of Smoke-Free Policies on Medical Campuses and Other Institutions of Higher Education." This will be re-numbered as 490.027MSS, which is the next available policy number in the Digest – no changes will be made to the content of this policy.
500.005MSS	International Ban on Tobacco Advertising	AMA-MSS supports the AMA in a national and international ban within constitutional protections on tobacco advertising and in encouraging the U.S. government to include a ban on tobacco advertising in the international treaty on tobacco controls.	Sunset; this was adopted by the AMA
505.005MSS	Elimination of Smoking in Public Places and Businesses	AMA-MSS will ask the AMA to pursue legislation for states and counties to eliminate smoking in public places and businesses.	Sunset; this was adopted by the AMA
525.001MSS	Inclusion of Women in Clinical Trials	AMA-MSS encourages the inclusion of women, including pregnant women, in all research on human subjects, except in those cases for which it would be scientifically irrational, in numbers sufficient to ensure that results of such research will benefit both men and women.	Retain
525.002MSS	Surgical Modification of Female Genitalia	AMA-MSS will ask the AMA to: (1) encourage the appropriate obstetric/gynecologic and urologic societies in the United States to develop educational programs addressing medically unnecessary surgical modification of female genitalia, the many complications, and possible corrective surgical procedures; and (2) oppose all	Retain

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		forms of medically unnecessary surgical modification of female genitalia.	
525.004MSS	Discrimination of Women Physicians in Hospital Locker Facilities	AMA-MSS will ask the AMA to, request that the appropriate organizations require: (1) that male and female physicians have equitable locker facilities including equal equipment, similar luxuries, and equal access to uniforms; and (2) that if physical changes must be made to the hospital's locker facilities to comply with these requirements, that they must be budgeted and implemented within a period of five years of the adoption of these requirements.	Retain
525.005MSS	Cancer Screening and Sexually Transmitted Infection (STI) Risk in Women who have Sex Exclusively with Women	AMA-MSS will ask the AMA to (1) educate physicians regarding the need for women who have sex exclusively with women for regular cancer and sexually transmitted infection screenings due to their comparable or elevated risk for these conditions; and (2) support its partner medical organizations in educating women who have sex exclusively with women on the need for regular cancer screening exams, the risk for sexually transmitted infections, and the appropriate safe sex techniques to avoid that risk.	Retain
525.006MSS	Supporting the Inclusion of Pregnant Women in Research	AMA-MSS (1) supports the update of federal, including FDA, regulations on human subject research with a proactive and inclusive approach to pregnant women in clinical research; and (2) supports the prioritization and advancement of research on medications' effect on pregnancy and breastfeeding.	Retain with Amendments

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530.016MSS	Creation of Additional Dues Structure for Resident & Fellow Section	AMA-MSS will ask the AMA to create appropriate discounted multi-year dues options for residents in any length of residency.	Retain
530.017MSS	Creation of a National Labor Organization for Physicians	AMA-MSS (1) supports the development and implementation by the AMA of a national bargaining unit under the National Labor Relations Act, consistent with our AMA Principles of Medical Ethics (Opinion 9.025), for employed physicians in professional practice, in order to retain the physician's role as the patient advocate, (2) vigorously supports national and state antitrust relief that permits collective bargaining between self-employed physicians and health plans/insurers/hospitals and others under the National Labor Relations Act, and (3) supports the development and implementation by the AMA of a national labor organization under the National Labor Relations Act consistent with our AMA Principles of Medical Ethics (Opinion 9.025) specifically for resident and fellow physicians.	Retain
530.020MSS	Establishing an AMA International Health Consortium	AMA-MSS will ask the AMA to establish an "international health consortium" of physicians, residents, and medical students interested in promoting international health issues	Retain
530.023MSS	Equal Opportunity in Professional Affiliations for Physicians	AMA-MSS will ask the AMA to: (1) urge its state medical associations and constituent societies to oppose policy that directly or indirectly restricts or	Retain

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		restrains any individual member's freedom of choice with respect to professional societies for which they are eligible; (2) urge state medical associations to review and study membership provisions of their bylaws to maintain fair membership standards for equal access for all physicians and medical students; and (3) urge state medical associations to provide all medical students equal access to funding and opportunity within the realm of their society.	
530.025MSS	Sexual Orientation and Gender Identity Demographic Collection by the AMA and Other Medical Organizations	Our AMA-MSS will ask that our AMA develop a plan with input from the LGBTQ+ advisory committee to expand the demographics we collect about our members to include both sexual orientation and gender identity information, which will be given voluntarily by members and handled in a confidential manner.	Retain
540.002MSS	Council Elections and Visibility	AMA-MSS will retain the appointment process as a means of selecting the student representatives to the AMA Councils with an increased focus on visibility and communication as incontestable components of the Council positions.	Retain
565.003MSS	Building AMA-MSS Membership through Promotion of AMPAC and State Medical PACs	(1) AMA-MSS urges all regional delegates to annually recruit for AMPAC and state PAC membership among all medical students from their respective regions; (2) AMA-MSS will ask the AMA to urge all delegates to annually recruit for AMPAC and state PAC membership among all medical student members that they are in contact with; (3) Where state laws permit, AMA-	Retain

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		MSS will encourage and will ask the AMA to encourage all medical students (regardless of AMA membership) to join state medical society PACs; (4) AMA-MSS will recognize and will ask the AMA to recognize the state and the medical student region with the highest percentage membership in AMPAC and/or state PACs at each annual meeting.	
630.008MSS	Referencing Data in Resolutions	It is the policy of the AMA-MSS that all data in resolutions which contain hard facts, figures, and quotes be referenced accordingly, or the resolution be returned to the author for additional information.	Retain
630.037MSS	Reaffirmation Calendar	AMA-MSS will implement and use a reaffirmation consent calendar akin to that used by the AMA-HOD and set forth in AMA Policy 545.979 and 545.974, to expedite the business of the Assembly on resolutions seeking reaffirmation of existing AMA-MSS policy. The Reaffirmation Calendar will provide "statements of support" for existing AMA policy for those resolutions deemed identical or nearly identical to existing AMA policy.	Retain
630.041MSS	Inclusion of AOA-Accredited Schools in Policy Language	It is the policy of the AMA-MSS that resolutions and internal policies specifically recognize osteopathic students whenever appropriate.	Retain
630.042MSS	Improving AMA-MSS Communication	AMA-MSS supports the production of a newsletter for student members in electronic formats.	Retain

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630.063MSS	Creation of International Health Policy Regional Chairs	AMA-MSS suggests that each region elect or appoint an International Health Policy Committee Regional Chair.	Sunset; if Regions wanted to incorporate this position in their GCs, they would have done so at this point
630.073MSS	Voting Rights of MSS Speaker and Vice Speaker	Our AMA-MSS (1) will amend its Internal Operating Procedures IV.A by deletion as follows: A. Designations. The officers of the MSS shall be the eight Governing Council members: Chair, Vice Chair, AMA Delegate, Alternate AMA Delegate, At-Large Officer, Chair-elect/Immediate Past Chair, Speaker, and Vice Speaker. The Chair-elect/Immediate Past Chair shall be a non-voting member of the Governing Council. The officers of the Assembly for the purpose of business meetings will be the Speaker and Vice Speaker. ~~The Speaker and Vice Speaker shall be non-voting members of the Governing Council.~~; and (2) amend its Internal Operating Procedures IV.E by addition and deletion as follows: <u>1.</u> The Chair-elect/Chair/Immediate Past Chair of the Governing Council shall serve a two-year term. His or her term as Chair-elect will begin at the conclusion of the	Retain

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		Interim Meeting at which he or she is elected. He or she will take office as Chair at the conclusion of the following Annual Meeting, and one year later will become Immediate Past Chair. He or she will serve as Immediate Past Chair until the conclusion of the following Interim Meeting. 2. The other Governing Council members shall serve one-year terms, beginning at the conclusion of the Annual Meeting at which they are elected and ending at the conclusion of the next Annual Meeting of the AMA House of Delegates. 3. Maximum tenure for members of the MSS Governing Council will be two years in any combination of voting ~~or non-voting~~ positions. ~~The periods of service as Chair- elect and Immediate Past Chair shall not count toward the maximum tenure of two years in any combination of voting or non-voting positions.~~	
640.001MSS	MSS Task Force on Long Range Planning	It is the policy of the AMA-MSS that the Committee on Long Range Planning should be a Committee, appointed by the Governing Council, to study issues referred by the Governing Council as well as structure, function, and strategic planning issues relating to the future of the MSS.	Retain
640.011MSS	Region Chair Elections	AMA-MSS will modify its policy on the Region Chairs to allow for direct election of the Region Chairs by the sections, according to the following guideline: New chairs must be selected before Saturday	Retain

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		morning of the annual meeting, and the new chair must be present at the annual meeting.	
645.015MSS	Non-Voter Participation during the Assembly Portion of the AMA-MSS Annual and Interim Meetings	(1) AMA-MSS will continue to sponsor a Community Service project during Business Meetings of Medical Student Section. (2) The AMA-MSS Governing Council will: (a) continue to investigate and implement alternative activities for non-voting participants including but not limited to residency fairs, workshops, and lectures; (b) establish a separate convention committee to organize and implement NSP activities during the meetings; and (c) investigate ways to further promote and expand the activities of the sectional meetings.	Retain
645.016MSS	Student Academy of the American Academy of Physicians Assistants Official Observer	The AMA-MSS will invite the Student Academy of the American Academy of Physician Assistants to send a non-voting Official Observer to all meetings of the AMA-MSS Assembly.	Retain
645.023MSS	Medical Student Section Policy Making Process	(1) As part of its annual review of MSS policies set to sunset at each Interim meeting, the MSS Governing Council will undertake policy consolidation for at least one issue; (2) When deemed necessary by the MSS Delegate and Alternate Delegate, AMA-MSS will employ a ranking/prioritization process for MSS resolutions intended to be forwarded to the AMA House of Delegates; (3) The MSS Governing Council will provide the MSS with updates on actions taken on resolutions and report recommendations adopted by the MSS Assembly, similar in format to the HOD's	Retain

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		"Implementation of Resolutions and Report Recommendations" documents, and that these updates be archived as an historical record of GC actions; (4) AMA-MSS will continue to use a Reaffirmation Consent Calendar, modeling it in the style of the House of Delegates Reaffirmation Consent Calendar; (5) The MSS Governing Council will educate the Section, specifically representatives to the MSS Assembly, on the purpose and functioning of the MSS Reaffirmation Consent Calendar; (6) AMA-MSS will continue to use and enforce the mandatory MSS Resolution Checklist; (7) When MSS policy comes up for sunsetting, the MSS Delegate and Alternate Delegate will, at their discretion, consider re-forwarding to the House of Delegates MSS policy that was previously forwarded but not adopted.	
650.002MSS	Improved Communications between MSS and RFS and between RFS and YPS	AMA-MSS will report regularly on communications and shared initiatives with the other AMA Sections.	Retain
655.004MSS	Medical Student Membership Benefits	AMA-MSS will ask the AMA to: (1) acknowledge all new student applications within two weeks of receipt of applications and that this acknowledgment contain the name and a phone number, which may be dialed collect, of an AMA staff member responsible for benefit inquiries and grievances; (2) ensure the distribution of journals to new members within 8 weeks of receipt of applications; and (3) provide benefits, free of charge,	Retain

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		to new members processed before January until official membership begins in January according to the AMA calendar.	
655.005MSS	Recruitment Information in AMA and MSS Pamphlets	(1) It is the policy of the AMA-MSS that recruitment literature distributed to students by the AMA and/or MSS clarify that AMA membership does not automatically imply membership in state or county/local medical societies. (2) AMA-MSS recruitment literature will stress the benefits of membership on the national, state, and county/local levels.	Retain
655.017MSS	Multi-Year Membership Benefit	AMA-MSS will ask the AMA to support medical student recruitment efforts by providing a tangible membership benefit linked to the multi-year membership option on a continual annual basis.	Retain
655.031MSS	Re-evaluating AMA-MSS Membership Benefits	AMA-MSS will ask the AMA to continue to provide tangible membership benefits for medical students that are both useful and encourage participation in our professional society.	Sunset
655.033MSS	Establishing a Joint MSS and RFS Approach for Recruitment Initiatives for Incoming MSS Members to the RFS	AMA-MSS will: (1) work with the AMA-RFS to focus membership strategies to retain student members and recruit new resident members; and (2) work with medical school deans to find better means to recruit 4th year medical students to the AMA-RFS including increased presence at match day and graduation events.	Retain
665.001MSS	Strengthening of Regional Internal Operating Procedures (IOPs), Creation of Regional Coordinating Committees, and	AMA-MSS will: (1) work with the AMA-RFS to focus membership strategies to retain student members and recruit new resident members; and (2) work with medical school deans	Retain

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	Creation of Membership/Recruitment Chair for Each Region	to find better means to recruit 4th year medical students to the AMA-RFS including increased presence at match day and graduation events	
665.014MSS	Evaluating the Value of Region Restructuring (Follow Up)	(1) The existing AMA-MSS region structure will remain unchanged and (2) the AMA-MSS assess each region's membership numbers and degree of engagement with the AMA-MSS at least every 5 years.	Retain

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REPORT OF THE MEDICAL STUDENT SECTION
WOMEN IN MEDICINE COMMITTEE AND COMMITTEE ON ECONOMICS AND QUALITY IN MEDICINE

MSS WIM CEQM Report A
(N-21)

Introduced by: MSS Women in Medicine Committee and Committee on Economics and Quality in Medicine

Subject: Amending H-420.978, Access to Prenatal Care, to Support the Practice of an Appropriate Reimbursement for Group Prenatal Care

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

INTRODUCTION

At the June 2021 MSS Assembly meeting, MSS Resolution 038 proposed that the AMA support amending H-420.978, Access to Prenatal Care, to Support the Practice of and Appropriate Reimbursement for Group Prenatal Care, with the following language:

> RESOLVED That our AMA amend H-420.978, Access to Prenatal Care by addition and deletion as follows:
>
> H-420.978 – ACCESS TO INDIVIDUAL AND GROUP PRENATAL CARE
> (1) ~~The~~ Our AMA supports development of legislation or other appropriate means to provide for access to and equitable reimbursement for individual and group 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; and (2) Our AMA will work with appropriate stakeholders and state medical associations to draft model legislation to ensure equitable Medicaid reimbursements for individual and group prenatal care in all states; and (3~~2~~) In developing such legislation, ~~the~~ our AMA urges that the effect of medical liability in restricting access to prenatal and or natal care be taken into account.

The J-21 MSS Reference Committee received testimony in support of the spirit of this resolution, but also heard concerns that sufficient evidence is not available to support equitable reimbursement for group prenatal care. MSS Resolution 038 was referred to the AMA-MSS Women in Medicine Committee (WIM) and the Committee on Economics & Quality in Medicine (CEQM) for a report to be completed prior to the AMA-MSS A-22 meeting. Accordingly, WIM and CEQM prepared this report, which details existent legislation ensuring equitable reimbursement for group prenatal care.

BACKGROUND

Group prenatal care is defined as a care model that brings patients with similar needs together for health care encounters in order to increase the time available for the educational component of the encounter, increase social support, improve efficiency, and reduce repetition, while maintaining some components of individual prenatal care.[14]

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A recent study on the benefits of CenteringPregnancy, a model of group prenatal care, found that participation in the program reduced the risk of premature birth by 36% and the risk of a NICU stay by 28%,[1] Group prenatal care models have also been found to promote maternal stress reduction and appropriate gestational weight gain and loss.[1,16-22] Women who participated in the group prenatal care programs demonstrated increased attendance at prenatal and postpartum care visits, as well as increased postpartum contraception initiation, versus their individual prenatal care counterparts.[18,23,24] Though some studies have identified that group prenatal care has increased breastfeeding initiation and patient satisfaction, other evidence has suggested that women who participate in group care have similar rates of preterm birth, neonatal intensive care unit admission, and breastfeeding.[2,13,15,18,21,25] Other studies have reported that individual and group prenatal care had no difference in patient outcomes including preterm birth, low birth weight, and NICU admissions.[2,3]

Beyond these comparable and improved clinical outcomes, group prenatal care programs offer the potential to significantly increase Medicaid savings in practice. In a pilot study, a $14,875 investment into the establishment of a CenteringPregnancy group prenatal care program led to approximately $67,293 in net savings from NICU costs.[26] Given that 20-71% of births in states were financed by Medicaid, group prenatal care programs have the potential to offer states vast savings.[27] Medicaid reimbursement of one group prenatal care model, CenteringPregnancy, in South Carolina was able to offer the state $2.3 million in Medicaid savings.[1]

To date, twelve states have encouraged the practice of group prenatal care or recognized its effectiveness. Ten states (California, Georgia, Louisiana, Michigan, Montana, New Jersey, New York, South Carolina, Texas, and Utah) have offered enhanced reimbursements for group prenatal care.[4] These enhanced reimbursements have taken several forms, including greater Medicaid reimbursements in eight states and grant funding in two states. Fifteen states have adopted alternative payment methods that offer value-based payment for group prenatal care services.[4] Some states, such as Illinois, have broadly expressed support for more evidence-based prenatal care services, though have made no explicit commentary on its stance on group prenatal care.[4] Fourteen health plans have followed suit with South Carolina and established payment strategies with CenteringPregnancy, one of the largest group prenatal care programs.[5]

South Carolina and New Jersey have updated their Medicaid policies to allow coverage of Centering Pregnancy.[6,7] Both states offer coverage of up to ten group clinical visits, which must last at least 1.5 hours and have a minimum of two clients and a maximum of 20 clients.[6,7] Only providers who are certified by the Centering Healthcare Institute to offer CenteringPregnancy programs, and who are either operating at a site that is either accredited by the Centering Healthcare Institute or working towards accreditation, qualify for reimbursement.[6,7] Providers must submit claims for management of pregnancy, a modifier TH for obstetrical treatments and services, and a pregnancy diagnosis code for the same date of service as the established patient visit.[6,7]

Programs launched in support of group prenatal care have not had a uniform design. For instance, the State of Maryland's Health Services Cost Review Commission (HSCRC) has committed an additional $8 million annually to Maryland Medicaid to support maternal and child healthcare programs, including CenteringPregnancy.[8] New York State has also established a 2-year CenteringPregnancy pilot program in areas known to have poor birth outcomes in support of its First 1,000 Days on Medicaid Initiative.[9] The first phase of the pilot offered enhanced reimbursement payments per patient visit at clinics with an existing CenteringPregnancy program to evaluate the impact of enhanced reimbursements on quality of care and patient outcomes, beginning in August 2019.[9,10] In the second phase of the pilot, New York State planned to completely finance training and start-up fees for 12 clinics who wished to establish CenteringPregnancy groups in one of the predetermined target regions that was identified to have poor birth outcomes.[9] These clinics must be approved by both the New York State

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Department of Health and the Centering Healthcare Institute, and consent to collecting and reporting data to the pilot team.[10] Though the second phase was intended to start January 1, 2020, the effect of the COVID-19 pandemic upon the status of this pilot program remains unclear.[9,10]

Establishing equitable or enhanced Medicaid reimbursements for group prenatal care, versus individual prenatal care, could serve as a catalyst for the large-scale adoption of group prenatal care, as Medicaid is the United States' largest single payer for maternity care.[11] However, addressing Medicaid reimbursements for group prenatal care is not enough to promote solvency of group prenatal care centers. CenteringPregnancy noted that financial sustainability requires up-front investment in training materials and spaces, which has historically been obtained from grant funding, as well as buy-in from commercial payers.[11] However, philanthropic organizations and payors have expressed some reluctance towards investing in group prenatal care programs given the emergence of some mixed evidence on the benefits of these programs versus traditional prenatal care models.[10,14] In accordance with this, the American College of Obstetricians and Gynecologists broadly acknowledged that group prenatal care should be recognized as an alternative option to traditional prenatal care, but advised additional study into the difference in outcomes between individual and group prenatal care.[12]

DISCUSSION

The vast Medicaid savings seen in South Carolina following Medicaid coverage of services by one of the leading group prenatal care companies in the country indicates the potential of group prenatal care to improve the cost and outcomes of prenatal services in the United States.[1] However, literature to date have failed to firmly establish that group prenatal care programs have improved outcomes versus individual prenatal care programs. Studies to date have reported some conflicting evidence on the effects of group prenatal care on clinical outcomes, though group prenatal care was more broadly found to offer neutral to positive outcomes versus traditional individual prenatal care. Further research is necessary to clarify the benefits of group prenatal care over individual prenatal care.

In spite of this neutral to positive evidence on the efficacy of group prenatal care programs, most states have expressed support for group prenatal care and the principles underlying it, with many also fiscally backing these programs. States that have offered equitable or enhanced Medicaid reimbursement for group prenatal care programs have done so in several different ways, including changing Medicaid reimbursement policies directly, investing in these programs through state commissions, and creating pilot programs. This reflects the unique fiscal climate within each state, which must be accounted for if the AMA prepares model draft legislation advocating for equitable Medicaid reimbursements for individual and group prenatal, as requested by the proposed amendment to H-420.978. However, a commonality to all existent state programs is their creation of a partnership with the Centering Healthcare Institute to certify group prenatal care programs. This partnership indirectly offers reimbursement of group prenatal care services exclusively to providers affiliated with CenteringPregnancy. Since it is not within the scope of practice of the AMA and AMA-MSS to endorse and aid in the monetary endeavors of private-sector organizations, there is no existent legislation free from conflicts of interest that the AMA could refer to when drafting model legislation ensuring equitable Medicaid reimbursements for individual and group prenatal care, as proposed by MSS Resolution 038.

CONCLUSION

Our committees recognize that government support and Medicare and Medicaid coverage of group prenatal care has the potential to offer notable financial relief to states and the nation. Though there was some conflicting evidence in the studies of clinical outcomes associated with group prenatal care, group prenatal care had neutral or positive clinical outcomes relative to

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individual prenatal care overall. Accordingly, our committees recommend that legislation is developed to encourage equitable reimbursement of both individual and group prenatal care, in accordance with the original resolution, and that our AMA supports research endeavors further clarifying the clinical benefits and financial barriers associated with group prenatal care.

RECOMMENDATION

Your Women in Medicine Committee (WIM) and Committee on Economics and Quality in Medicine (CEQM) recommend that the following resolve clauses be adopted in lieu of MSS Resolution 038 and the remainder of this report is filed:

> RESOLVED, That our AMA support development of legislation or other appropriate means to provide for access to and equitable reimbursement for individual and group 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; and be it further
>
> RESOLVED, That our AMA support further research endeavors into the clinical benefits of group prenatal care and the financial barriers associated with expanded implementation in the United States.

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REPORT OF THE MEDICAL STUDENT SECTION
WOMEN IN MEDICINE COMMITTEE AND COMMITTEE ON HEALTH INFORMATION TECHNOLOGY

MSS WIM CHIT Report A
(N-21)

Introduced by: MSS Women in Medicine Committee and Committee on Health Information Technology

Subject: Reporting of Program-Level Demographic Data to FREIDA/Data Disclosure on Parenthood during Residency

Referred to: MSS Reference Committee
(Zachary Dunton and Neha Siddiqui, Chair)

INTRODUCTION

At the June 2021 Meeting, MSS Resolutions 041 and 054 respectively asked the AMA to support publication of FREIDA demographic data, as well as the collection and distribution of data on family planning and parental leave policies in residency by residency programs, the Accreditation Council for Graduate Medical Education, and other relevant stakeholders.

MSS Resolutions 041 and 054 have since been referred to the AMA-MSS Committees on Women in Medicine (WIM) and Health Information Technology (CHIT) for a report to be completed prior to the AMA-MSS A-22 meeting.

The resolve clause of MSS Resolution 041 was as follows:

> RESOLVED, Our AMA will encourage residency programs to annually publish and share with FREIDA demographic data, including but not limited to age, gender identity, URM status, and LGBTQIA+ status of their programs from over the last 5 years.

The resolve clauses of MSS Resolution 054 were as follows:

> RESOLVED, That our AMA encourage the Accreditation Council for Graduate Medical Education and other relevant stakeholders to annually collect data on pregnancy, childbirth, and parenthood (disaggregated by gender identity and specialty) from all accredited US residency programs in their current and all future resident cohorts; and be it further,
>
> RESOLVED, That our AMA encourage all accredited US residency programs to annually publish data on their individual parental leave policies and the number of residents who have utilized this leave in the past 5 years on the official websites for individual programs in a manner that respects the privacy of individual residents.

BACKGROUND

While organizations, including the American Medical Association (AMA), Association of American Medical Colleges (AAMC), National Resident Matching Program (NRMP), and Accreditation Council for Graduate Medical Education (ACGME), have gathered data on current residents and residency applicants, this information typically captures very little demographic information and no family planning or parental leave data. The AMA's Fellowship and Residency

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Electronic Interactive Database (FREIDA) offers information on academic background of residents (United States MD, United States DO, International Medical Graduate) and the Male to Female ratio, but largely focuses on the academic and professional experiences of residents.[1] FREIDA's data is derived from the ACGME's annual survey of all residents, which captures little additional demographic and familial data.[2] AAMC gathers this information, as well as a residency applicant's self identification, via its Electronic Residency Application Service (ERAS).[3] ERAS makes it possible for the AAMC to sort this data by specialty, which is of particular importance because of the limited number of professional medical societies that have developed surveys to capture this information.[3,4,5] The National Resident Matching Program (NRMP) stated their intention to capture demographic data following the 2022 Main Residency Match, but has primarily gathered information on residents' attitudes towards the graduate medical education experience to date.[6,7] Studies on diversity and inclusion in graduate medical education have largely relied upon the little demographic data published by these national surveys.[8,9]

To date, endeavors to gather information on trends in pregnancy, childbirth, and parenthood among residents have been restricted to academic studies, which typically maintain a limited regional focus.[10,11] A recent study of the residency programs affiliated with *US News & World Report*'s top 50 medical schools made some information on national family leave policies available.[12] Forty-two percent of the study's residency programs offered unpaid leave in accordance with the Family Medical Leave Act (FMLA), which ensures employees of a company or institution for at least 1 year, with 1250 hours of service, qualify for up to 12 weeks of unpaid job protection for family and medical reasons.[12,13] Forty-two percent of the studied residency programs offered paid parental leave in some capacity.[12] Twenty-two percent of the study's programs referred residents to state-funded paid family leave programs.[12] No mention was made of adherence to the additional parental leave guidelines imposed by professional specialty societies.[14] It is of note that these family leave policies were not necessarily published on each program's website. The authors of this study conducted a web search to find publicly available information, then contacted schools directly for this data.[12] Even after these efforts, there was one school that did not publish family leave information on their website and did not respond to inquiries, indicating this information may not be readily accessible to prospective residency applicants and current residents.[12]

In addition to gathering and publishing information on the items identified in Resolutions 041 and 054, FREIDA, ACGME surveys, and internal residency program surveys should consider collecting information on ability, religion, and immigration status to identify additional resources necessary to support current residents.[15]

DISCUSSION

The data currently gathered on current residents and resident applicants through existing surveys illustrates a significant scarcity of information relating to demographics, family planning and parental-leave among residents. This data is critical to assessing the diversity and inclusion of graduate medical education. Gathering data on these metrics is the first step to identifying the needs of current residents. Steps that can be taken to better identify and address the needs of current residents include expanding surveys from FREIDA, ACGME, and internal residency programs to collect and publish information on a broader array of demographic, family planning, and parental leave characteristics, as proposed by MSS resolutions 041 and 054.

CONCLUSION

To date, there is a scarcity of information on the demographic and parenthood of residents. Existing surveys from FREIDA, ACGME, and internal residency programs could be used to

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gather this information, as well as data on factors such as incoming and current residents' ability, religion, and immigration status. Gathering this robust array of data on the background of residents has the potential to elucidate the path to equity, diversity, and inclusion in medicine.

RECOMMENDATION

The Committee on Women in Medicine (WIM) and Committee on Health Information Technology (CHIT) recommend that Resolution 041 and Resolution 054 be adopted and that the remainder of this report be filed.

RESOLVED, That our AMA will encourage residency programs to annually publish and share with FREIDA demographic data, including but not limited to age, gender identity, URM status, and LGBTQIA+ status of their programs from over the last 5 years; and be it further

RESOLVED, That our AMA encourage the Accreditation Council for Graduate Medical Education and other relevant stakeholders to annually collect data on pregnancy, childbirth, and parenthood (disaggregated by gender identity and specialty) from all accredited US residency programs in their current and all future resident cohorts; and be it further

RESOLVED, That our AMA encourage all accredited US residency programs to annually publish data on their individual parental leave policies and the number of residents who have utilized this leave in the past 5 years on the official websites for individual programs in a manner that respects the privacy of individual residents.

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