Your Reference Committee recommends the following consent calendar for acceptance:

**RECOMMENDED FOR ADOPTION**

1. Resolution 04 – Movement Away from Employer-Sponsored Health Insurance
2. Resolution 15 – Drug Policy Reform
3. Resolution 16 – Medicare Coverage of Dental, Vision, and Hearing Services
4. Resolution 20 – Amending Policy on a Public Option to Maximize AMA Advocacy
5. Resolution 24 – Amending Policy H-155.955, Increasing Accessibility to
   Incontinence Products to Include Diaper Tax Exemption
6. Resolution 29 – AMA Study of Chemical Castration in Incarceration
7. Resolution 30 – Amend H-145.976, to Reimburse Physicians for Firearm Counseling
8. Resolution 46 – Reducing the Burden of Incarceration on Public Health
9. Resolution 50 – Encouraging Research of Testosterone and Pharmacological
   Therapies for Post-Menopausal Individuals with Decreased Libido
10. CME CBH CHIT Report A – Medical Student, Resident, and Fellow Suicide Reporting
11. Delegate Report A – Status of Pending MSS-Authored Resolution to HOD

**RECOMMENDED FOR ADOPTION AS AMENDED**

12. Resolution 05 – Advocating for Heat Exposure Protections for Outdoor Workers
13. Resolution 06 – Opposition to Immediate Separation of Infants from Incarcerated Pregnant Persons
14. Resolution 07 – Addressing Longitudinal Health Care Needs of Children in Foster Care
15. Resolution 08 – Re-evaluating the Food and Drug Administration’s Citizen Petition Process
16. Resolution 12 – Advocating for the Elimination of Hepatitis C Treatment Restrictions
17. Resolution 17 – Supporting and Funding Sobering Centers
18. Resolution 18 – Increasing Access to TBI Resources in Primary Care Settings
19. Resolution 19 – Universal Childcare and Pre-school
20. Resolution 28 – The Importance of Keeping HIT Advancements Age-Friendly
23. Resolution 37 – H-90.968, “Medical Care of Persons with Developmental Disabilities” Amendment
24. Resolution 38 – Supporting a Hybrid Residency and Fellowship Interview Process
25. Resolution 53 – Digitizing and Centralizing Access to Advance Care Planning Documents


27. Resolution 56 – Support Removal of BMI as a Standard Measure in Medicine

28. Resolution 61 – Support for the Creation of a Diagnostic Category for Climate-Associated Distress

29. Resolution 63 – Support for Democracy

30. CBH CEQM Report A – Opposing the Marketing of Pharmaceuticals to Parties Responsible for Captive Populations

31. CEQM CGPH Report A – Support of Research on Vision Screenings and Visual Aids for Adults Covered by Medicaid


33. CSI Report A – Amend H-150.927 and H-150.933, to Include Food Products with Added Sugar

34. WIM CHIT Report A – Reporting of Program-Level Demographic Data to FREIDA/Data Disclosure on Parenthood during Residency

RECOMMENDED FOR ADOPTION IN LIEU OF

35. Resolution 01 – Amending AMA Bylaw 2.12.2, Special Meetings of the HOD

36. Resolution 10 – Cultural Leave for American Indian Trainees

37. Resolution 13 – Providing Reduced or Waived Fees for Medical Students

38. Resolution 22 – Supporting Minimum Content Standards of LGBTQ+ Health Curriculum in Undergraduate Medical Education

39. Resolution 26 – Opposition to Debt Litigation Against Patients

40. COLA Report A – Support for Evidence-Based Policy

RECOMMENDED FOR REFERRAL

41. Resolution 03 – Elimination of Sobriety Requirements in Evaluation for Liver Transplant for Alcohol-Associated Liver Dysfunction

42. Resolution 21 – Addressing Health Insurance Coverage Disparity Among Latinx Children

43. Resolution 23 – Single Licensing Exam Series for Osteopathic and Allopathic Medical Students

44. Resolution 34 – Supporting the Further Study of Kratom

45. Resolution 35 – Amendment to Policy H-405.960, Policies for Parental, Family, and Medical Necessity Leave

46. Resolution 54 – Expansion of Medicaid Coverage of HPV Screening

47. Resolution 57 – Ensuring Competitive Pricing of Pharmaceutical Drugs

48. Resolution 60 – National Fertility Preservation Coverage Mandate

49. CEQM MIC Report A – Laying the First Steps towards a Transition to a Financial and Citizenship Need-Blind Model for Organ Procurement and Transplantation

50. WIM CEQM Report A – Amending H-420.978, “Access to Prenatal Care”, to Support the Practice of an Appropriate Reimbursement for Group Prenatal Care

RECOMMENDED FOR NOT ADOPTION

52. Resolution 09 – Microplastics
53. Resolution 25 – Supporting Sensitive Language Around Suicide
54. Resolution 32 – Amending H-160.903, Eradicating Homelessness, to Include Support for Street Medicine Programs
55. Resolution 39 – Redesigning the U.S. Immigration System
56. Resolution 41 – Support WHO Moratorium on COVID Booster Shots
57. Resolution 43 – Support of Increased Formal Training of Correctional Medicine Physicians
58. Resolution 47 – Overcoming Medical Misinformation through Utilizing Bots to Provide Accurate Medical Information
59. Resolution 49 – 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
60. Resolution 51 – Amending Policy H-50.973, to Support the Implementation of Health Care Referrals in Blood Donation Centers for Donors at Risk of HIV
61. Resolution 52 – Early Intervention and Treatment Programs for Adolescents with Substance Use Disorders
62. Resolution 62 – Expanding Access to Behavioral Therapy in Attention-Deficit Hyperactivity Disorder
63. Resolution 65 – Providing Pain Management Standards and Protocols for Outpatient Gynecologic Procedures
64. Resolution 67 – Additional Safeguards for Children Enrolled in Clinical Studies

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

65. Resolution 02 – A Response to Human Trafficking Amid a Public Health Emergency
66. Resolution 11 – Support Research and Development of Vaccines Against Neglected Tropical Diseases
67. Resolution 14 – Ensuring Quality of Medical Interpretation for Patients with Limited English Proficiency
68. Resolution 27 – Longitudinal Capacity Building to Address Climate Action and Justice
69. Resolution 33 – Increase Federal Funding towards Nutrition Research
70. Resolution 40 – 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
71. Resolution 42 – Amending H-345.981, to Address Increased Utilization of Mobile Health Technology for the Management of Mental Health Conditions
72. Resolution 44 – Access to Naloxone for Vulnerable and Underserved Populations
73. Resolution 45 – Screening for Suicide Risk in Transgender Patients
74. Resolution 48 – End Firearm Default Proceed Sales
75. Resolution 58 – Advocating for Breastfeeding Protections for Medical Students
76. Resolution 59 – Supporting Healthcare Worker Mental Health During Disasters
77. Resolution 64 – Protecting Clinical AI from Adversarial Attacks
78. Resolution 66 – Earmarking for More Research Targeted towards Preventive Medicine and Cardiology Care Using AI

79. Resolution 68 – Improving Care Coordination Among Patients, Primary Care Providers (PCPs), and Specialists
RECOMMENDED FOR ADOPTION

1
(1) RESOLUTION 04 – MOVEMENT AWAY FROM
EMPLOYER-SPONSORED HEALTH INSURANCE

RECOMMENDATION:

Resolution 04 be adopted.

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 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.
   bc. 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.
   ed. 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.
   de. The public option is financially self-sustaining and has uniform solvency requirements.
   ef. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.
   fg. 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.

VRC testimony was supportive of Resolution 04. Region 1, Region 2, Region 3, Region 7 and PsychSIGN supported the resolution. There were concerns raised by the MSS Section Delegates, the Committee on Economics and Quality in Medicine (CEQM), and the MSS Councilor on the AMA Council on Medical Service. We respectfully disagree with the suggestion on the VRC to combine this resolution with any other resolutions on Employer Sponsored Health Insurance reform. We believe that these issues have been thoughtfully divided due to their political delicacy and possible future flexibility when transmitting to the AMA House of Delegates. Your Reference Committee recommends Resolution 04 be adopted.
(2) RESOLUTION 15 – DRUG POLICY REFORM

RECOMMENDATION:

Resolution 15 be adopted.

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.

Resolution 15 was broadly supported on the VRC. Region 1, Region 2, Region 3, Region 4, Region 6, Region 7, PsychSIGN, the Committee on Legislation and Advocacy (COLA) and the Committee on Bioethics and Humanities (CBH) supported this resolution as written. The MSS Section Delegates supported making Resolution 15 internal.

Your Reference Committee recognizes that this is a complex issue, but we believe the authors presented a large body of evidence demonstrating the negative health effects of incarceration and the benefits of decriminalization. We also note that there is a forthcoming report from the AMA Council on Science and Public Health (CSAPH) on the expungement of cannabis records. We are concerned that if Resolution 15 is transmitted to the HOD at the same meeting the CSAPH report is presented, this resolution will be considered in conjunction with that report and some of the key points lost. While unconventional, we recommend that, if adopted, the MSS transmit Resolution 15 at a meeting later than the one in which the CSAPH report on cannabis expungement is presented. We recommend Resolution 15 be adopted as amended.

(3) RESOLUTION 16 – MEDICARE COVERAGE OF DENTAL, VISION, AND HEARING SERVICES

RECOMMENDATION:

Resolution 16 be adopted.

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.

VRC testimony broadly supported Resolution 16. There was support from Region 1, Region 2, Region 3, Region 4, Region 5, Region 6, Region 7, PsychSIGN, and the Student Osteopathic Medical Association (SOMA). The Committee on Legislation and Advocacy (COLA) and the Committee on Economics and Quality in Medicine (CEQM) recommended striking the clause to immediately forward this resolution to the AMA House of Delegates. We respectfully disagree. Your Reference Committee believes the justification for immediate forwarding was well-presented by the authors and we recommend Resolution 16 be adopted.

(4) RESOLUTION 20 – AMENDING POLICY ON A PUBLIC OPTION TO MAXIMIZE AMA ADVOCACY

RECOMMENDATION:
Resolution 20 be adopted.
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 public option to expand health insurance coverage must meet the following standards:
   a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.
   b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits.
   c. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.
   d. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option.
   e. The public option is financially self-sustaining and has uniform solvency requirements.
   f. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.
   g. The public option shall be made available to uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost.

2. Our AMA supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets the following standards:
   a. Individuals must provide consent to the applicable state and/or federal entities to share their health insurance status and tax data with the entity with the authority to make coverage determinations.
   b. Individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would, therefore, include individuals eligible for Medicaid/Children’s Health
Insurance Program (CHIP) or zero-premium marketplace coverage.

c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled.

d. Individuals should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto-enrollment.

e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values.

f. Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze and silver plans, to maximize the value of zero-premium plans to plan enrollees.

\textbf{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.

VRC testimony was mixed on Resolution 20. Region 3, Region 7, the Asian Pacific American Medical Student Association (APAMSA), and the Committee on Legislation and Advocacy (COLA) supported the resolution as written. The Association of Native American Medical Students (ANAMS) supported with amendments. The MSS Councilor on the AMA Council on Medical Service recommended referral. The Committee on Economics and Quality in Medicine (CEQM) opposed the resolution. Your Reference Committee found this resolution well-researched and the arguments well-presented.

We also appreciate the ANAMS effort to provide an amendment to the policy that would expand this policy to cover Indian Health Service (IHS) physicians regardless of which state they are licensed in. Though we support the goal of the amendment, we believe that it would be stronger if framed as a separate resolution and would provide an opportunity to address multiple asks specific to IHS physician practices in sum.

While we recognize that strategically the issue of a public option may present an uphill battle at HOD, we believe this resolution has the strength to get us there and have a meaningful debate. Your Reference Committee recommends Resolution 20 be adopted.
(5) RESOLUTION 24 – AMENDING H-155.955, INCREASING ACCESSIBILITY TO INCONTINENCE PRODUCTS TO INCLUDE DIAPER TAX EXEMPTION

RECOMMENDATION:

Resolution 24 be adopted.

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, including single-use and reusable diapers, and the inclusion of child diapers as qualified medical expenses for HSAs, HRAs, and FSAs.

VRC testimony was supportive of Resolution 24. Region 1, Region 2, Region 3, the Committee on Legislation and Advocacy (COLA), and the Massachusetts delegation expressed support on the VRC. This resolution was well-researched and presents novel amendments to existing policy. Your Reference Committee recommends Resolution 24 be adopted.

(6) RESOLUTION 29 – AMA STUDY OF CHEMICAL CASTRATION IN INCARCERATION

RECOMMENDATION:

Resolution 29 be adopted.

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.

VRC testimony was supportive of Resolution 29. Region 2, Region 3, the Committee on Scientific Issues (CSI), and PsychSIGN supported the resolution as written. Your Reference Committee found Resolution 29 to be well-written and well-argued, especially on such a sensitive topic. There were questions raised during debate, but we believe that since this resolution is asking for a study of chemical castration in incarcerated individuals, those concerns will be handled in the forthcoming report. We specifically mention the variation in the definition of sex crimes in different states, the fact that aggregated crime data tends to be unreliable, and that causative factors are not easy to identify as some of our main concerns we’d like to see addressed. We recommend Resolution 29 be adopted.
(7) RESOLUTION 30 – AMEND H-145.976 TO REIMBURSE FOR FIREARM COUNSELING

RECOMMENDATION:

Resolution 30 be adopted.

RESOLVED, That our AMA amend Policy H-145.976, Firearm Safety Counseling in Physician-Led Health Care Teams by addition to read as follows:


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.

VRC testimony on Resolution 30 was mixed. Region 2, the Committee on Economics and Quality in Medicine (CEQM), and PsychSIGN supported the resolution as written. Region 6 recommended that this resolution be referred for study. The AMA already has policy for adequate reimbursement of primary care (H-200.949) and also has policy that encourages physicians to educate patients on firearms. This resolution brings those two ideas together to ensure that primary care physicians – who are usually responsible for firearm counseling – are reimbursed for time spent educating patients on this topic. The amendment proposed in this resolution strengthens existing AMA policy.

We also note that reimbursement for other preventative health counseling has separate ICD codes. There was criticism that evidence was needed to support the use of this counseling, but your Reference Committee disagrees. We think it would be difficult to see
if an sICD-10 code reimbursing firearm counseling works until the practice is actually implemented. For these reasons, we recommend Resolution 30 be adopted.

(8) RESOLUTION 46 – REDUCING THE BURDEN OF INCARCERATION ON PUBLIC HEALTH

RECOMMENDATION:

Resolution 46 be adopted.

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;

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.

Resolution 46 was generally well-supported on the VRC. Region 1, Region 3, Region 4, and the Massachusetts delegation supported the resolution as written. Your MSS Section Delegates recommended this be referred for further study. Your Reference Committee believed this resolution was well-written and very thoroughly researched. It focuses on improving the plight of incarcerated individuals and the barriers they experience in their health care. The evidence presented in the Whereas clauses is well-supported and we think this would result in a meaningful advancement in advocacy work on this topic. Your Reference Committee recommends Resolution 46 be adopted.
RESOLUTION 50 – ENCOURAGING RESEARCH OF TESTOSTERONE AND PHARMACOLOGICAL THERAPIES FOR POST-MENOPAUSAL INDIVIDUALS WITH DECREASED LIBIDO

RECOMMENDATION:

Resolution 50 be adopted.

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.

VRC testimony was generally supportive of Resolution 50. Region 2, Region 4, the Committee on Scientific Issues (CSI), and PsychSIGN supported the resolution as written. Region 6 and the Massachusetts delegation supported the resolution with amendments.

This resolution was well-written and well-supported. We did not find the suggested amendment from Region 6 to remove “testosterone” compelling. We believe it is important to keep “testosterone” in the resolution because there is already so much happening in this space and the Whereas clauses specifically support research on testosterone users. The amendments proposed by both Region 6 and the Massachusetts delegation are too broad to be covered by the existing Whereas clauses. Your Reference Committee recommends Resolution 50 be adopted.

CME CBH CHIT REPORT A – MEDICAL STUDENT, RESIDENT, AND FELLOW SUICIDE REPORTING

RECOMMENDATION A:

The Recommendations in CME CBH CHIT Report A be adopted and the remainder of the report be filed.

RECOMMENDATION B:

The title of this report be changed to “Standardized Wellness Initiative Reporting.”

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 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.

VRC testimony on CME CBH CHIT Report A was limited. We believe the recommendations address the problematic aspects of the original resolution. We also note that these recommendations no longer fit under the original title, and found the MSS Councilor on the AMA Council of Medical Education’s testimony on changing the title compelling. We recommend a change in title and recommend the recommendations in CME CBH CHIT Report A be adopted and the remainder of the report be filed.

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

RECOMMENDATION:

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

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

1. 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

There was no VRC testimony on Delegate Report A. As always, your Reference Committee thanks the MSS Section Delegates for their hard work and leadership through the transmittal process. We recommend the recommendations in Delegate Report A be adopted and the remainder of the report be filed.
RECOMMENDED FOR ADOPTION AS AMENDED

(12) RESOLUTION 05 – ADVOCATING FOR HEAT EXPOSURE PROTECTIONS FOR OUTDOOR WORKERS

RECOMMENDATION A:

The first Resolve clause of Resolution 05 be amended by addition and deletion:

RESOLVED, That our AMA-MSS support advocating 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

RECOMMENDATION B:

The second Resolve clause of Resolution 05 be amended by addition:

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

RECOMMENDATION C:

The third Resolve clause of Resolution 05 be amended by addition:

RESOLVED, That our AMA-MSS support working 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 further

RECOMMENDATION D:

The fourth Resolve clause of Resolution 05 be deleted:

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

Resolution 05 be adopted as amended.

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.

VRC testimony was overwhelmingly supportive of Resolution 05. Region 1, Region 2, Region 4, Region 6, the Committee on Legislation and Advocacy (COLA), the Minority Issues Committee (MIC), and the Massachusetts delegation supported Resolution 05 as written. It was noted that this resolution is identical to a resolution submitted by the Washington State Medical Association and recommended that this be made internal so the MSS can support the Washington resolution in the House of Delegates. Your Reference Committee offers minor amendments to the first three resolve clauses so they are feasible as an internal resolution and recommends striking the immediate forwarding clause as it is no longer needed. The authors supported these amendments on the VRC.

We recommend Resolution 05 be adopted as amended.

(13) RESOLUTION 06 – OPPOSITION TO IMMEDIATE SEPARATION OF INFANTS FROM INCARCERATED PREGNANT PERSONS

RECOMMENDATION A:

The first Resolve clause of Resolution 06 be amended by deletion:

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

RECOMMENDATION B:

The second Resolve clause of Resolution 06 be amended by deletion:
RESOLVED, That our AMA-MSS support solutions, such as community-based programs, which allow infants and incarcerated postpartum individuals to remain together.

RECOMMENDATION C:

Resolution 06 be adopted as amended.

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

Resolution 06 was universally supported on the VRC. Region 2, Region 3, Region 4, Region 6, the Committee on Bioethics and Humanities (CBH), and the Women in Medicine Committee (WIM) supported Resolution 06 as written. Your Reference Committee recognizes that not only is this ethically the right thing to do, but it is also well-supported by evidence. We offer amendments to make Resolution 06 external and additionally suggest this be added to the pending transmittal titled “Protections for Incarcerated Mothers in the Perinatal Period.” We do acknowledge that this resolution has already been submitted to the HOD for discussion at the N-21 meeting, and if it is accepted as business, we would recommend proffering these resolve clauses as amendments during HOD Reference Committee sessions. If the aforementioned transmittal is not accepted for business at N-21, we recommend appending these resolve clauses prior to re-submitting at a later meeting. This will help to strengthen both resolutions and streamline MSS transmittals. Your Reference Committee recommends Resolution 06 be adopted as amended.

(14) RESOLUTION 07 – ADDRESSING LONGITUDINAL HEALTH CARE NEEDS OF CHILDREN IN FOSTER CARE

RECOMMENDATION A:

The first Resolve clause of Resolution 07 be amended by deletion:

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
RECOMMENDATION B:

The second Resolve clause of Resolution 07 be deleted:

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

RECOMMENDATION C:

The third Resolve clause of Resolution 07 be amended by deletion:

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

RECOMMENDATION D:

The fourth Resolve clause of Resolution 07 be deleted:

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

RECOMMENDATION E:

The fifth Resolve clause of Resolution 07 be referred.

RECOMMENDATION F:

The remainder of Resolution 07 be adopted as amended.

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.

VRC testimony was mixed on Resolution 07. There were several amendments proposed. We found the suggestion to strike the second and fourth clauses compelling. The second resolve clause is covered by existing policy H-160.918 and the fourth resolve clause is not supported by the evidence presented in the Whereas clauses. The fourth resolve clause was specifically opposed by Region 6, the Massachusetts delegation and the MSS delegate to the American Academy of Pediatrics (AAP). We present clarifying amendments to the first and third resolve clauses.

There was extensive debate on the fifth resolve clause. Your Reference Committee recommends that instead of citing the Indian Child Welfare Act specifically this resolution should explicitly state which parts of the Act are supported. In the event the Indian Child Welfare Act is changed, the MSS stance will be codified. An attempt to capture this language during Reference Committee hearings was not successful and we ultimately believe this would be best done by the appropriate MSS Standing Committee(s). We recommend the fifth resolve of Resolution 07 be referred and the remainder of Resolution 07 be adopted as amended.

(15) RESOLUTION 08 – RE-EVALUATING THE FOOD AND DRUG ADMINISTRATION’S CITIZEN PETITION PROCESS

RECOMMENDATION A:

The first Resolve clause of Resolution 08 be deleted:

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
RECOMMENDATION B:

The second Resolve clause of Resolution 08 be amended by addition and deletion:

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

RECOMMENDATION C:

Resolution 08 be adopted as amended.

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.

VRC testimony supported the spirit of Resolution 08. Region 2, Region 3, and Region 4 supported Resolution 08 as written, while Region 1, the Committee on Economics and Quality in Medicine (CEQM), the Committee on Legislation and Advocacy (COLA), and the Massachusetts delegation supported the resolution with amendments. We found the amendments from CEQM compelling and present those here. We recognize that this research is already occurring and therefore do not find the first resolve to be necessary. We offer clarifying amendments to the second resolve clause and recommend Resolution 08 be adopted as amended.

(16) RESOLUTION 12 – ADVOCATING FOR THE ELIMINATION OF HEPATITIS C TREATMENT RESTRICTIONS

RECOMMENDATION A:

The second Resolve clause of Resolution 12 be amended by addition and deletion:

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:
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; (45) 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; (465) support programs aimed at training providers in the treatment and management of patients infected with HCV; (576) 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; (687) recognize correctional physicians, and physicians in other public health settings, as key stakeholders in the development of HCV treatment guidelines; (798) encourage equitable reimbursement for those providing treatment; (409) encourage the allocation of targeted funding to increase HCV treatment access at Indian Health Service facilities, especially for IHS patients insured by plans subject to HCV treatment restrictions.

RECOMMENDATION B:

Resolution 12 be adopted as amended.

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

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; (46) support programs aimed at training
providers in the treatment and management of patients
infected with HCV; (57) 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; (68) recognize correctional
physicians, and physicians in other public health settings,
as key stakeholders in the development of HCV treatment
guidelines; (79) encourage equitable reimbursement for
those providing treatment; (10) encourage the allocation of
targeted funding to increase HCV treatment access at
Indian Health Service facilities.

Resolution 12 was broadly supported on the VRC. Region 1, Region 2, Region 4, Region
5, Region 6, Region 7, the Association of Native American Medical Students (ANAMS),
GLMA, the Asian Pacific American Medical Student Association (APAMSA), PsychSIGN,
the Committee on Global and Public Health (CGPH), and the Minority Issues Committee
(MIC) supported Resolution 12 as written. The Massachusetts delegation supported this resolution with amendments. Your Reference Committee recommends striking proposed clause (4) in the second resolve clause, as we believe that this point is more clearly and effectively made in the newly proposed clause (5). Additionally we offer a clarifying amendment to the authors proposed clause (10). We recommend that Resolution 12 be adopted as amended.

(17) RESOLUTION 17 – SUPPORTING AND FUNDING SOBERING CENTERS

RECOMMENDATION A:

The first Resolve clause of Resolution 17 be deleted:

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

RECOMMENDATION B:

The second Resolve clause of Resolution 17 be deleted:

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

RECOMMENDATION C:

The third Resolve clause of Resolution 17 be deleted:

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

RECOMMENDATION D:

The fourth Resolve clause of Resolution 17 be amended by addition and deletion:

RESOLVED, That our American Medical Association support the use of local, state, and national funding for the development and maintenance of sobering centers to serve as an alternative to emergency departments, hospitalization, or incarceration.

RECOMMENDATION E:

Resolution 17 be adopted as amended.
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.

VRC testimony was supportive of Resolution 17. This resolution was well-written and well-researched, although your Reference Committee believes the first three resolve clauses overlap with D-95.962, Enhanced Funding for and Access to Outpatient Addiction Rehabilitation. The fourth resolve clause provides an opportunity for more guided advocacy, so we offer amendments to increase the novelty and specificity of Resolution 17 and recommend this resolution be adopted as amended.

(18) RESOLUTION 18 – INCREASING ACCESS TO TRAUMATIC BRAIN INJURY RESOURCES IN PRIMARY CARE SETTINGS

RECOMMENDATION A:

The second Resolve clause of Resolution 18 be amended by addition and deletion:

RESOLVED, That our AMA supports increased access to traumatic brain injury resources in primary care settings, such as CDC Heads Up training programs and information packets about post-injury care and referral services for acute TBI rehabilitation, which advocate for early intervention, encourage follow-up retention of patients for post-injury rehabilitation, and demonstrate improved patient quality of life.

RECOMMENDATION B:

Resolution 18 be adopted as amended.

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 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.
VRC testimony was supportive of Resolution 18. Region 1, Region 4, Region 6, the Committee on Scientific Issues (CSI), and PsychSIGN supported the resolution as written. Region 2 suggested this would be better as an amendment to existing policy H-470.954 and should also include domestic violence abuse victims and minority patients who may suffer from TBIs. The authors clarified that this resolution was written to specifically address TBIs outside of sports, such as those experienced by domestic violence abuse victims or minority patients, whereas current policy H-470.954 is narrowly focused on sport-related injuries and wanted to make this distinction clear by submitting this as a standalone policy (not amending existing policy). There were several amendments proposed on the VRC which were supported by the authors. We present those here and recommend Resolution 18 be adopted as amended.

(19) RESOLUTION 19 – UNIVERSAL CHILDCARE & PRESCHOOL

RECOMMENDATION A:
Resolution 19 be amended by addition of a new Resolve clause:
RESOLVED, That our AMA-MSS immediately forward this resolution to the House of Delegates at the November 2021 meeting.

RECOMMENDATION B:
Resolution 19 be adopted as amended.

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

VRC testimony was overwhelmingly supportive of Resolution 19. Region 1, Region 2, Region 3, Region 4, Region 6, the Committee on Global and Public Health (CGPH), the Committee on Legislation and Advocacy (COLA), and PsychSIGN were in support. This resolution was well-written and well-researched. The Whereas clauses are extensively supported by recent literature and clearly make the case for the ask in the resolve clause. Your Reference Committee found the suggestion to add an immediate forward clause compelling, especially considering upcoming legislation in Congress, and have made that amendment. We recommend Resolution 19 be adopted as amended.
(20) RESOLUTION 28 – THE IMPORTANCE OF KEEPING HEALTH INFORMATION TECHNOLOGY (HIT) ADVANCEMENTS AGE-FRIENDLY

RECOMMENDATION A:

The first Resolve clause of Resolution 28 be amended by addition and deletion as follows:

RESOLVED, That our AMA support the development of work with the appropriate stakeholders to develop a standardized definition for “age-friendliness” in health information technology (HIT) advancements; and be it further

RECOMMENDATION B:

The second Resolve clause of Resolution 28 be amended by addition and deletion as follows:

RESOLVED, That our AMA encourage the appropriate stakeholders to identify current best practices to set expectations of HIT developers to ensure that they create devices and technology applicable to and easily accessible by older adults that are age-friendly by default.

RECOMMENDATION C:

Resolution 28 be adopted as amended.

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.

VRC testimony was limited and mixed on Resolution 28. Region 3 and the Committee on Health Information Technology (CHIT) supported the resolution as written. The Massachusetts delegation supported the resolution with amendments, specifically to strike the second resolve clause. The Section Delegates raised concerns about some of the language used in the resolve clauses as written. Your Reference Committee found those concerns compelling and have updated the language of Resolution 28 to address this. The authors responded to the amendments on the VRC and seemed amenable to these changes. Your Reference Committee recommends Resolution 28 be adopted as amended.
(21) RESOLUTION 31 – EVALUATING CLINICAL OUTCOMES OF MOBILE HEALTH TECHNOLOGIES

RECOMMENDATION A:

Resolution 31 be amended by addition and deletion as follows:

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 monitor and report on 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; (23) Our AMA will continue to engage with stakeholders to identify relevant guiding principles to promote a vibrant, useful and trustworthy mHealth market; (34) 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; (45) Our AMA will develop and publicly disseminate a list of best practices guiding the development and use of mobile medical applications; (56) 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; (67) 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; (78) 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; (89) 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.

RECOMMENDATION B:

Resolution 31 be adopted as amended.

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; (23) Our AMA will continue to engage with stakeholders to identify relevant guiding principles to promote a vibrant, useful and trustworthy mHealth market; (34) 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; (45) Our AMA will develop and publicly disseminate a list of best practices guiding the development and use of mobile medical applications; (56) 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; (67) 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; (78) 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; (89) 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.

VRC testimony was limited, but supportive of Resolution 31. Region 1, Region 3, Region 7, and the Massachusetts delegation supported this resolution as written. The Integrated Practice Physician Section (IPPS) reviewed this resolution and recommended an amendment to change the verb in clause (2) from “study” to “monitor and report” so the process remains ongoing. We found this amendment from the IPPS delegates compelling and have made this change. Your Reference Committee recommends Resolution 31 be adopted as amended.

(22) RESOLUTION 36 – PHARMACEUTICAL DRUG PRICING:
PARAMETERS AROUND NEGOTIATION AND
GOVERNMENT MANUFACTURING OF GENERIC
DRUGS

RECOMMENDATION A:
The first Resolve clause of Resolution 36 be amended by substitution:

RESOLVED, That our AMA-MSS supports the use of international drug price indices and averages, which may include data from countries regardless of structure of healthcare system or any price controls used, in determining the price of and payment for drugs.

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;
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;
ba. 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;
bc. The use of any international drug price index or average should preserve patient access to necessary medications;
bd. The use of any international drug price index or average should limit burdens on physician practices; and
ed. 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
RECOMMENDATION B:

The second Resolve clause of Resolution 36 be amended by addition and deletion:

RESOLVED, That our AMA support the formation of a governmental or non-profit pharmaceutical government manufacturers of pharmaceuticals to produce small-market generic drugs to address market failures, including the existence of small markets for generics, the absence of generics in the market after expiration of patents and exclusivity, and shortages of necessary medications.

RECOMMENDATION C:

Resolution 36 be adopted as amended.

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;
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;
   ba. 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;
   cb. The use of any international drug price index or average should preserve patient access to necessary medications;
   dc. The use of any international drug price index or average should limit burdens on physician practices; and
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 manufacturer of pharmaceuticals to produce small-market generic drugs.

VRC testimony on Resolution 36 was mixed. Region 1, the Massachusetts delegation, and PsychSIGN supported the resolution as written. The Committee on Economics and Quality in Medicine (CEQM) recommended striking “government” as it would tie the AMA efforts specifically to governmental non-profits and they believed it would be better to urge action directly with the federal government.

Your Reference Committee appreciates the spirit of this request, although we believe we need to include the phrase “governmental” to ensure this resolution is appropriately interpreted by the AMA Board of Trustees and AMA Advocacy staff. We offer a small grammatical change to make “manufacturers” plural to allow flexibility in choosing to support publicly funded or private non-profit ventures that may arise, without support for one necessarily being dependent on the other.

Additionally, we note that the California Medical Association has submitted a resolution to the N-21 House of Delegates meeting that is similar to the first resolve clause. For this reason, we recommend amending the first resolve to make it internal, which will then allow the MSS Caucus to support the California resolution without duplicating efforts. We offer clarifying amendments to the second resolve clause and recommend Resolution 36 be adopted as amended.
RESOLUTION 37 – H-90.968 “MEDICAL CARE OF PERSONS WITH DEVELOPMENTAL DISABILITIES”

AMENDMENT

RECOMMENDATION A:

Resolution 37 be amended by addition and deletion as follows:

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 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 Disabilities; (cd) the education of physicians on how to provide and/or advocate for quality, developmentally appropriate, and accessible medical, social and living supports for patients with developmental disabilities so as to improve health outcomes; (de) 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 intellectually disabled individuals with disabilities, 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 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/objective 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. 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. 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.
789. 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.

8910. Our AMA will advocate that the Health Resources and Services Administration include persons with intellectual and developmental disabilities (IDD) as a medically underserved population.

9102. Specific to people with developmental and intellectual disabilities, a uniquely underserved population, our AMA encourages (a1c) 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 and intellectual disabilities, to improve quality in clinical care; (b1f) 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 individuals with developmental and intellectual disabilities, the developmentally disabled; and (c1g) cooperation among physicians, health & human services professionals, and a wide variety of adults with intellectual and developmental disabilities to implement priorities and quality improvements for the care of persons with intellectual and developmental disabilities.

10115. Our AMA recognizes the importance of managing the health of children and adults with developmental and intellectual disabilities as a part of overall patient care for the entire community.

11126. Our AMA supports efforts to educate physicians on health management of children and adults with developmental and intellectual disabilities, as well as the consequences of poor health management on mental and physical health for people with developmental and intellectual disabilities.

RECOMMENDATION B:

Resolution 37 be adopted as amended.

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
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 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 Disabilities; (c) 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) 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 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/objective 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. 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. 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. 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. 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. Specific to people with developmental and intellectual disabilities, a uniquely underserved population, our AMA encourages (a) 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; (b) 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) 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.

115. 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.

126. 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.

VRC testimony was supportive of Resolution 37. Several comments noted that there were disabilities excluded from this policy and here we offer amendments to rectify this. We also amended all clauses to person-first language. This resolution was well-written and well-supported and we offer several clarifying amendments supported by the authorship team and testimony on the VRC to further strengthen this resolution. Your Reference Committee recommends Resolution 37 be adopted as amended.

(24) RESOLUTION 38 – SUPPORTING A HYBRID RESIDENCY AND FELLOWSHIP INTERVIEW PROCESS

RECOMMENDATION A:

The first Resolve clause of Resolution 38 be deleted:

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

RECOMMENDATION B:

The second Resolve clause of Resolution 38 be amended by addition and deletion as follows:

RESOLVED, That our AMA will work with encourage appropriate stakeholders, such as the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education, to study the feasibility and utility of videoconferencing for graduate medical education (GME) interviews and examine interviewee and program perspectives on incorporating videoconferencing as an adjunct to GME residency and fellowship interviews, in order to guide the development of equitable protocols for expansion of hybrid GME residency and fellowship interviews.
RECOMMENDATION C:

Resolution 38 be **adopted as amended**.

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.

VRC testimony was mixed on Resolution 38. Region 1 and Region 2 supported the resolution as written, the Committee on Long Range Planning (COLRP) supported with amendments, and the Massachusetts delegation opposed this resolution due to lack of research. Your Reference Committee found the concerns regarding the lack of research to support the first resolve compelling. We do not believe there is enough evidence on virtual interviews to take a stance at this time. We also incorporated suggestions from the Resident and Fellow Section (RFS) to address their concerns that this applies broadly to GME and not specifically mentioning “residency and fellowship” interviews. We also question the unintended consequences and potential inequities that may be the result of expanding virtual or hybrid interviews. We have made amendments to address these concerns and recommend Resolution 38 be adopted as amended.

(25) RESOLUTION 53 – DIGITIZING AND CENTRALIZING ACCESS TO ADVANCE CARE PLANNING DOCUMENTS

RECOMMENDATION A:

Policies H-85.968 and D-140.953 be reaffirmed in lieu of the first and second Resolve clauses of Resolution 53.

RECOMMENDATION B:

The third Resolve clause of Resolution 53 be amended by addition and deletion:

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 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.

RECOMMENDATION C:

Resolution 53 be adopted as amended.

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 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.

VRC testimony on Resolution 53 was mixed. Region 1 and Region 3 supported the resolution with amendments. The Massachusetts delegation opposed the resolution noting that they were not sure why we are focusing on this subset of problems when there are lots of interoperability issues with EHRs. The MSS Section Delegates recommended reaffirmation of existing policy. The MSS House Coordination Committee (HCC) placed the second resolve on the reaffirmation consent calendar. We concur with HCC and also believe the first resolve is covered by existing policy, specifically D-140.953.

We found the third resolve to be novel and offer a clarifying amendment here. It is actually the EHR provider that would be providing standardized, easily accessible storage space for advance care paperwork (not the EHR itself), so this amended language reflects that. We recommend H-85.968 and D-140.953 be reaffirmed in lieu of the first and second resolve clause and the remainder of Resolution 53 be adopted as amended.

H-85.968 – PATIENT SELF DETERMINATION ACT
The AMA will: (1) lend its administrative, legislative, and public relations support to assuring that the specific wishes of the individual patient as specified in his or her advance directive be strictly honored in or out of the hospital setting; (2) encourage all physicians and their patients to execute an advance directive prior to the time of severe acute or terminal illness; and (3) promote efforts to develop a national system to assist emergency medical personnel to rapidly ascertain a person’s wishes with regard to resuscitation, regardless of his or her state of location.

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.

(26) RESOLUTION 55 – RESIDENCY APPLICATION
SUPPORT FOR STUDENTS OF LOW-INCOME BACKGROUNDS

RECOMMENDATION A:

Resolution 55 be amended by addition and deletion:

RESOLVED, That our AMA advocate to relevant stakeholders for supports 1) The creation of a Fee Assistance or Fee Waiver Program for ERAS and or funding opportunities to support for students from 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.

RECOMMENDATION B:

Resolution 55 be adopted as amended.

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.

VRC testimony was generally supportive of Resolution 55. There was concern raised about the prescriptiveness of the resolution and this was addressed by amendments from the MSS Councilor on the AMA Council on Medical Education. We agree that this resolution would be best if the language is left broad. Your Reference Committee found the proposed amendments compelling and recommend Resolution 55 be adopted as amended.
(27) RESOLUTION 56 – SUPPORT REMOVAL OF BODY MASS INDEX (BMI) AS A STANDARD MEASURE IN MEDICINE

RECOMMENDATION A:

The third Resolve clause of Resolution 56 be deleted.

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

RECOMMENDATION B:

The fourth Resolve clause of Resolution 56 be deleted.

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

RECOMMENDATION C:

The fifth Resolve clause of Resolution 56 be amended by deletion:

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 sustainable health goals regardless of their intentions to alter their weight.

RECOMMENDATION D:

Resolution 56 be adopted as amended.

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 sustainable health goals regardless of their intentions to alter their weight.

VRC testimony on Resolution 56 was mixed. Region 1 and Region 4 supported the resolution as written; Region 2 and the Massachusetts delegation opposed the resolution and the Committee on Scientific Issues (CSI) recommended referral. Your Reference Committee found Region 2’s testimony compelling and agree that “this resolution does not adequately plan for an alternative that will effectively replace BMI for dosages or diagnosis of metabolic diseases, while evading the stigma that is associated with BMI and preventing it for being added to this potential new metric.” We also agree with CSI who noted that several of the Whereas clauses are factually inaccurate or based on opinion. In some of the sources cited alternative methods showed improvements over BMI, some sources showed that outcomes were the same, while others showed that alternatives were actually inferior to BMI. We offer amendments here to strike the third and fourth resolve clauses, as they are redundant, and strike the addition of clause (4) in H-440.866. We recommend Resolution 56 be adopted as amended.

(28) RESOLUTION 61 – SUPPORT FOR CREATION OF DIAGNOSTIC CATEGORY FOR CLIMATE-ASSOCIATED DISTRESS

RECOMMENDATION A:

Resolution 61 be amended by addition and deletion:

RESOLVED, That our AMA work with relevant stakeholders such as the American Psychiatric Association (APA) to support the creation of an SDOH-related ICD Z code International Classification of Disease (ICD) code to denote problems related to for distress caused by climate change.
RECOMMENDATION B:

Resolution 61 be adopted as amended.

RECOMMENDATION C:

The title of Resolution be changed to “SDOH-Related ICD Z Code for Problems Related to Climate Change”

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.

VRC testimony was supportive of the spirit of Resolution 61. Region 3, Region 4, Region 5, and PsychSIGN supported the resolution as written. Region 7 supported the resolution with amendments. The Committee on Economics and Quality in Medicine (CEQM), the Minority Issues Committee (MIC), and your MSS Section Delegates opposed the resolution as written. Both CEQM and MIC suggested this would be more appropriate coming from the American Psychiatric Association (APA). The Section Delegates were concerned with both the evidence presented and the AMA and APA alone would not be sufficient to achieve this change due to ICD codes being issued by the World Health Organization (WHO).

Your Reference Committee appreciates the robust testimony on this resolution, but believe that this idea is novel and the language just needed further refinement to increase feasibility and actionability. We present these amendments and recommend Resolution 61 be adopted as amended.

(29) RESOLUTION 63 – SUPPORT FOR DEMOCRACY

RECOMMENDATION A:

Policies G-640.020 and G-605.035 be reaffirmed in lieu of the first, second, and third Resolve clauses of Resolution 63.

RECOMMENDATION B:

The fourth Resolve clause of Resolution 63 be amended by substitution:

RESOLVED, That our AMA-MSS oppose political endorsements of and donations to candidates who attempt to subvert democratic election results.
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.

RECOMMENDATION C:

Resolution 63 be adopted as amended.

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

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.

Resolution 63 was widely opposed on the VRC. The MSS Councilor on the AMA Council of Constitution and Bylaws, the MSS Councilor on the AMA Council on Legislation, Region 1, the Committee on Legislation and Advocacy (COLA), and the Section Delegates opposed this resolution. Your MSS House Coordination Committee (HCC) placed the first three resolve clauses on the reaffirmation calendar. We concur.

This left the fourth resolve clause for your Reference Committee’s consideration. We had extensive debate on this clause but ultimately found it problematic as written. We note that AMPAC is organizationally and legally separate from the AMA, and there is existing policy that asks the AMA not to have a “litmus test” on who AMPAC can and cannot support. We also share that AMPAC already released a statement following the January 6th insurrection. Given this, we are not sure that the fourth resolve clause would be feasible, but more importantly it is out of scope. The authors were advised in the draft resolution stage that this language needed to be changed to be more in line with health and healthcare and those changes were not made. We offer amendments to make the fourth resolve clause internal and encourage the MSS Governing Council to liaise with the MSS representative on the AMPAC Board to see if additional feedback and guidance can be provided. We recommend G-640.020 and G-605.035 be reaffirmed in lieu of the first, second, and third resolve clauses and the remainder of Resolution 63 be adopted as amended.
G-640.020 – POLITICAL ACTION COMMITTEES AND CONTRIBUTIONS

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.

G-605.035 – ENDORSEMENTS FOR PUBLIC OFFICE

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.

(30) CBH CEQM REPORT A – OPPOSING THE MARKETING OF PHARMACEUTICALS TO PARTIES RESPONSIBLE FOR CAPTIVE POPULATIONS

RECOMMENDATION A:

The first Recommendation in CBH CEQM Report A be amended by addition and deletion:

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
RECOMMENDATION B:

The second Recommendation in CBH CEQM Report A be amended by addition and deletion:

RESOLVED, That our AMA will advocate for the inclusion of physicians in the selection and negotiation of which drugs are medications available to vulnerable populations such as incarcerated individuals; and be it further

RECOMMENDATION C:

The third Recommendation in CBH CEQM Report A be amended by addition and deletion:

RESOLVED, That our AMA support and will work with state medical societies legislatures and their respective Departments of Corrections to support adoption of transparency increasing measures to increase transparency in medication procurement, 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.

RECOMMENDATION D:

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

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 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.

VRC testimony was limited on CBH CEQM Report A. There were clarifying amendments proposed to the recommendations to make the ask feasible and we found those compelling. We thank CBH and CEQM for a well-written report and recommend the recommendations in CBH CEQM Report A be adopted as amended and the remainder of the report be filed.

(31) CEQM CGPH REPORT A – SUPPORT OF RESEARCH ON VISION SCREENINGS AND VISUAL AIDS FOR ADULTS COVERED BY MEDICAID

RECOMMENDATION A:

CEQM CGPH Report A be amended by addition of a new Recommendation:

RESOLVED, That our AMA-MSS support the incorporation of routine comprehensive eye exams, and visual aids, including eyeglasses and contact lenses, into the minimum mandatory benefits for Medicaid beneficiaries.

RECOMMENDATION B:

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

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.

VRC testimony on CEQM CGPH Report A was limited and mixed. The MSS Councilor on the AMA Council of Medical Service supported the report as written, Region 3 opposed the report and the MSS Section Delegates proposed an amendment. Your Reference Committee found this to be a much-improved report from what was submitted at previous Assembly meetings. Your Reference Committee recommends the addition of a new recommendation to codify the MSS stance on Medicaid coverage of eye exams and visual aids. We recommend the recommendations in CEQM CGPH Report A be adopted as amended and the remainder of the report be filed.
(32) CEQM COLA REPORT A – THE IMPACT OF COVID-19
ON THE FINANCIAL VIABILITY OF VARIOUS
HEALTHCARE DELIVERY SYSTEMS

RECOMMENDATION A:

The first Recommendation in CEQM COLA Report A be amended by addition:

RESOLVED, Our AMA-MSS support distribution of emergency funding to healthcare institutions 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

RECOMMENDATION B:

The second Recommendation in CEQM COLA Report A be amended by addition:

RESOLVED, Our AMA-MSS 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.

RECOMMENDATION C:

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

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.

VRC testimony on CEQM COLA Report A was limited. Your Reference Committee proffers amendments here from the authors and the MSS Section Delegates. We note that many of these asks were covered in a recent CSAPH Report. We believe these amendments address the concerns of overlap with this report. We recommend the recommendations in CEQM COLA Report A be adopted as amended and the remainder of the report be filed.

(33) CSI REPORT A – AMEND H-150.927 AND H-150.933, TO INCLUDE FOOD PRODUCTS WITH ADDED SUGAR

RECOMMENDATION A:

Recommendations in CSI Report A be amended by addition:

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
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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; and (5) recognizes that excise taxes on food products with added sugars may burden families with limited access to food alternatives and if implemented the funds should be directed towards community health programs. (5) and supports that any excise taxes are reinvested in community programs promoting health.

RECOMMENDATION B:

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

RECOMMENDATION C:

The title of CSI Report A be changed to “Amend H-150.927 to Include Food Products with Added Sugar.”

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:

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.

VRC testimony was limited on CSI Report A. Your Reference Committee proffers an amendment to include a clause on excise taxes, as we believe the evidence presented in the report supports this ask. We also believe that adding this clause will make the policy more impactful. While there were concerns raised about an excise tax on sugary foods disproportionately impacting those with lower SES, the evidence presented in the report actually supports the opposite. We also recommend the title of this report be changed to reflect the policies that it ultimately suggests amending. The recommendations in this report will help move AMA advocacy forward on this issue and we recommend the recommendations in CSI Report A be adopted as amended and the remainder of the report be filed.
RESOLVED, That our AMA work with appropriate stakeholders to encourage residency programs to annually publish and share with FREIDA and other appropriate stakeholders, (a) demographic data, including but not limited to the composition of their program over the last 5 years by age, gender identity, URM status, and LGBTQIA+ status of their programs from over the last 5 years; (b) parental and family leave policies; and (c) the number and/or proportion of residents who have utilized parental or family leave in the past 5 years and be it further

RECOMMENDATION B:

The second Recommendation in WIM CHIT Report A be amended by addition and deletion:

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 and publish this data with disaggregation by gender identity and specialty, in their current and all future resident cohorts; and be it further

RECOMMENDATION C:

The third Recommendation in WIM CHIT Report A be deleted:

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.

RECOMMENDATION D:

The Recommendations in WIM CHIT Report A be adopted as amended and the remainder of the report be filed.
RECOMMENDATION E:

The title of WIM CHIT Report A be changed to “Reporting of Residency Demographic Data.”

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.

There was limited VRC testimony on WIM CHIT Report A. The MSS Councilor on the AMA Council on Medical Education recommended some clarifying amendments to make this more feasible and recommended a title change. We found these amendments compelling and proffer those here. Your Reference Committee recommends the recommendations in WIM CHIT Report A be adopted as amended and the remainder of the report be filed.
RECOMMENDED FOR ADOPTION IN LIEU OF

(35) RESOLUTION 01 – AMENDING AMA BYLAW 2.12.2, SPECIAL MEETINGS OF THE HOD

RECOMMENDATION:

Substitute Resolution 01 be adopted in lieu of Resolution 01.

RESOLVED, Our AMA amend its bylaws to incorporate changes to the relevant bylaws regarding Special Meetings, including but not limited to 2.12.2 Special Meetings of the House of Delegates. to allow for:

a. 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.

b. 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.

c. 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.

d. 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.
e. 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.

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

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.

2.12.2.2 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.

VRC testimony was generally supportive of Resolution 01, although there were concerns on the prescriptive nature of the language. Your Reference Committee found this compelling and proffer this substitute resolution which captures the nature of the original resolution, but leaves the language more general. This will allow the AMA Council on Constitution and Bylaws to craft the most appropriate language and take all potential scenarios into account, not just AMA Special Meetings related to the COVID-19 pandemic.

We also note that several other AMA Sections were consulted on both this resolution and the accompanying letter that was already sent to the AMA Board of Trustees. Many of those Sections supported and co-signed the letter, but were not supportive of this prescriptive language. We believe our amendments to make the language broad will help garner support from other members of the AMA House of Delegates. Your Reference Committee recommends that Substitute Resolution 01 be adopted in lieu of Resolution 01.

(36) RESOLUTION 10 – CULTURAL LEAVE FOR AMERICAN INDIAN TRAINEES

RECOMMENDATION:

Substitute Resolution 10 be adopted in lieu of Resolution 10.

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

Eliminating Religious and Cultural Discrimination from Residency and Fellowship Programs and Medical Schools, H-310.923
Our AMA encourages residency programs, fellowship programs, and medical schools to:

(1) make an effort to accommodate residents trainees to take leave and attend religious and cultural holidays and observances, including those practiced by American Indians and Alaskan Natives, provided that patient care and the rights of other residents trainees 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.

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 schedule accommodations are allowed; and (f) leave policy for adoption.

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

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

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

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

7. Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.

8. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians,
medical students, and physicians in practice regardless of gender or gender identity.

9. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.

10. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, cultural 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. In support of and in compliance with the American Indian Religious Freedom Act of 1978, our AMA encourages all medical schools, residency programs, specialty 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.

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.

There was overwhelming support for the spirit of this resolution on the VRC. There were concerns raised about citing a specific law as well as asking individuals to provide proof to justify their leave. We also believe this resolution fits better into H-310.923. We provide clarifying amendments to address these concerns and recommend Substitute Resolution 10 be adopted in lieu of Resolution 10.

(37) RESOLUTION 13 – PROVIDING REDUCED OR WAIVED PARKING FEES FOR MEDICAL STUDENTS

RECOMMENDATION:

Substitute Resolution 13 be adopted in lieu of Resolution 13.

RESOLVED, That our AMA-MSS amend 155.008MSS by addition and deletion as follows:

155.008MSS – PROVIDING REDUCED PARKING FEES FOR PATIENTS AND TRAINEES

Our AMA-MSS will ask the AMA to work with relevant stakeholders to recognize parking fees as a burden of barrier to patient care for patients and encourage mechanisms for reducing parking costs for patients and trainees.

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.

VRC testimony was mixed on Resolution 13. Region 1 and Region 4 supported the resolution as written, the Massachusetts delegation supported making this internal, and the MSS Councilor to the AMA Council on Medical Education supported not adopting this resolution. Your Reference Committee does not see the benefit of bringing forward two separate resolutions on parking (see pending transmittal titled “Providing Reduced Parking for Patients”) and recommend these amendments to combine Resolution 13 with the pending transmittal. We note that this transmittal has already been submitted to the HOD, and if it is accepted for business at the N-21 meeting, we would suggest offering these amendments during HOD Reference Committee sessions. If the aforementioned pending transmittal is not accepted for business, we would suggest incorporating these amendments prior to re-submitting at a future meeting. Your
Reference Committee recommends Substitute Resolution 13 be adopted in lieu of
Resolution 13.

(38) RESOLUTION 22 – SUPPORTING MINIMUM CONTENT
STANDARDS OF LGBTQ+ HEALTH CURRICULUM IN
UNDERGRADUATE MEDICAL EDUCATION

RECOMMENDATION:

Substitute Resolution 22 be adopted in lieu of
Resolution 22.

RESOLVED, That our AMA-MSS supports that LCME-
and COCA- accredited institutions 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.

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
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.

VRC testimony was supportive of Resolution 22. The MSS Councilor on the AMA Council on Medical Education proposed amendments to the resolution. The Section Delegates recommended reaffirmation of H-295.878 in lieu of Resolution 22, but your Reference Committee respectfully disagrees. Our interpretation of H-295.878 is that it relates to student support groups on campuses, and Resolution 22 is novel because it specifically relates to minimum requirements for curriculum. Although we find the resolution novel, we also believe it would be better brought forward by GLMA. Ultimately, we recommend Resolution 22 be amended to be an internal resolution. We also propose an amendment to include recommendations from the Commission on Osteopathic College Accreditation (COCA) and recommend Substitute Resolution 22 be adopted in lieu of Resolution 22.

RESOLUTION 26 – OPPOSITION TO DEBT LITIGATION AGAINST PATIENTS

RECOMMENDATION:

Substitute Resolution 26 be adopted in lieu of Resolution 26.

RESOLVED, That our AMA encourage health care organizations to:
1) Manage medical debt with patients directly and consider several options, including assistance applying for coverage, discounts, payment plans with flexibility and extensions as needed, or forgiveness of debt altogether, before using third-party debt collectors, while avoiding those that harass debtors;
2) Consider the relative financial benefit of collecting medical debt to their revenue, against the detrimental cost to patient’s well-being; and
3) Make multiple attempts to reach and negotiate with patients before proceeding with litigation against patients or any other punitive actions and reserve litigation for patients who are able but unwilling to pay.

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.

VRC testimony was mixed, but generally supportive of Resolution 26. Region 3 and
Region 4 supported as written. The Massachusetts delegation and the Committee on
Economics and Quality in Medicine (CEQM) supported with amendments to strike the first
and third resolve clauses as the first clause was too specific and the third clause cited
another organization’s guidelines, though they were supportive of the general spirit of the
resolution. The MSS Councilor on the AMA Council on Medical Services recommended
striking the first and third resolve clauses. Region 1 opposed the resolution as written and
Region 2 did not believe there was enough evidence presented in the Whereas clauses
to justify the asks.

After reviewing the amendments proposed, we believe Resolution 26 is strengthened by
more streamlined language and specific asks. We believe that this will push advocacy
forward on this issue to decrease the impact of medical debt on patients and improve
conditions within our health system for patients. Your Reference Committee was hesitant
to include language that includes blanket opposition to debt litigation, as we did not find
enough support present in the resolution for this ask. We also removed the reference to
the American Hospital Association guidelines and instead opted to specifically cite parts
of those guidelines in the language presented here. This codifies the MSS’ specific stance
should the guidelines change. We recommend that Substitute Resolution 26 be adopted
in lieu of Resolution 26.

(40) COLA REPORT A – SUPPORT FOR EVIDENCE-BASED
POLICY

RECOMMENDATION:

The following Substitute Recommendation be adopted
in lieu of the recommendations in COLA Report A and
the remainder of the report be filed:

Your Committee on Legislation and Advocacy
recommends that MSS Resolution 074 (N-20) not be
adopted and the remainder of the report be filed.

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

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 cannot await further study.

VRC testimony generally opposed COLA Report A. The Committee on Legislation and Advocacy (COLA), the MSS Section Delegates, and the Committee on Scientific Issues (CSI) recommended the new third resolve clause be deleted. The MSS Councilor on the AMA Council of Medical Service noted that the MSS Caucus is not bound to vote or take positions on any issues that aren’t currently covered by existing MSS policy. This is intentional because it allows the delegates the flexibility to make their own decisions on all issues and does not tie their hands. The second resolve clause could be interpreted as a binding requirement that would force MSS delegates to vote in favor of something solely because it is evidence-based. We agree with VRC testimony that this is problematic. If we strike the second and third resolve clauses, we are left with the first resolve clause which does not add to our policy compendium on its own.

Your Reference Committee appreciates COLA’s time in working on this report. At this time we do not believe there are merits in moving forward with this report, or the original resolution from the November 2020 MSS Assembly meeting. We recommend the Substitute Recommendation be adopted in lieu of the Recommendations in COLA Report A and the remainder of the report be filed.
**RECOMMENDED FOR REFERRAL**

(41) RESOLUTION 03 – ELIMINATION OF SOBRIETY REQUIREMENTS IN EVALUATION FOR LIVER TRANSPLANT FOR ALCOHOL-ASSOCIATED LIVER DYSFUNCTION

RECOMMENDATION:

Resolution 03 be referred.

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

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.

VRC testimony was mixed on Resolution 03. Most testimony was supportive, although there was concern raised about references being out of date, specifically one study from 2006. The Massachusetts delegation was opposed to Resolution 03 as written. There were several comments on the limited feasibility of this resolution, given that it is an internal MSS resolution. Your Reference Committee believes this is a complicated and nuanced idea and shares concerns that the argument for these asks hinges on one outdated review study. We believe that the source itself does not draw appropriate conclusions and is instead based on assumptions. Your Reference Committee supports
the spirit of Resolution 03, but believe there is much better evidence out there to support these recommendations.

We recognize that the authorship team has connected with the American Society of Transplant Surgeons (ASTS) and commend them for this initiative. If ASTS were to bring forward a similar resolution to a future meeting, having internal MSS policy would allow our caucus to support this potential resolution in lieu of submitting our own. However, as it is currently written your Reference Committee recommends that Resolution 03 be referred for further study and refinement.

We share the potential strategy of working with ASTS for the Standing Committee(s) assigned this resolution to consider when writing this report. However, as currently written there are several concerns with Resolution 03: 1) as an internal resolution, there is concern about feasibility; 2) the references cited are outdated and were not conducted as primary research, but instead as review studies; and 3) the language presented in the second resolve could be potentially interpreted as patients being able to show up intoxicated on the day of surgery, which we do not believe to be the intent of that ask. For these reasons, we think that Resolution 03 would benefit from further work by our MSS Standing Committees.

The Reference Committee thinks this is an important but potentially controversial topic that needs to be fully refined before being adopted by the MSS, or before being presented before the AMA House of Delegates. For these reasons, we recommend Resolution 03 be referred.

(42) RESOLUTION 21 – ADDRESSING HEALTH INSURANCE COVERAGE DISPARITY AMONG LATINX CHILDREN

RECOMMENDATION A:


RECOMMENDATION B:

The fourth Resolve clause of Resolution 21 be referred.

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

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

VRC testimony on Resolution 21 was mixed. Region 2 and the Committee on Economics and Quality in Medicine (CEQM) opposed the resolution as written. The MSS Councilor to the AMA Council on Medical Service, the Minority Issues Committee (MIC) and the MSS Section Delegates supported reaffirmation of existing policy in lieu of this resolution.

Your Reference Committee found the recommendation for reaffirmation compelling for the first, second and third resolve clauses. However, we believe there are novel aspects to the fourth resolve clause, but it could benefit from further refinement from the appropriate MSS Standing Committee(s). We note that some of the references cited were mismatched in the citations and would ask the assigned Standing Committee(s) to address this. Most importantly, however, we feel the question that still needs to be answered is how the DACA program relates to other public programs. We believe that one of the clauses included in DACA legislation stipulates that if an individual is a DACA recipient they cannot be on any other welfare programs – so, if an individual qualifies for and enrolls in the Children’s Health Insurance Program (CHIP) does that impact their eligibility for DACA, or vice versa?

Your Reference Committee believes this is a very important distinction that needs to be studied thoroughly before being adopted by our MSS. We recommend that Policies H-350.975, D-440.927, H-290.982, and 350.023MSS be reaffirmed in lieu of the first three resolve clauses of Resolution 21 and the fourth resolve clause be referred for study.
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H-350.975 – IMPROVING HEALTHCARE OF HISPANIC POPULATIONS IN THE UNITED STATES

It is the policy of our AMA to: (1) Encourage health promotion and disease prevention through educational efforts and health publications specifically tailored to the Hispanic community.
(2) Promote the development of substance abuse treatment centers and HIV/AIDS education and prevention programs that reach out to the Hispanic community.
(3) Encourage the standardized collection of consistent vital statistics on Hispanics by appropriate state and federal agencies.
(4) Urge federal and local governments, as well as private institutions, to consider including Hispanic representation on their health policy development organization.
(5) Support organizations concerned with Hispanic health through research and public acknowledgment of the importance of national efforts to decrease the disproportionately high rates of mortality and morbidity among Hispanics.
(6) Promote research into effectiveness of Hispanic health education methods.
(7) Continue to study the health issues unique to Hispanics, including the health problems associated with the United States/Mexican border.

D-440.927 – OPPOSITION TO REGULATIONS THAT PENALIZE IMMIGRANTS FOR ACCESSING HEALTH CARE SERVICES

Our AMA will, upon the release of a proposed rule, regulations, or policy that would deter immigrants and/or their dependents from utilizing non-cash public benefits including but not limited to Medicaid, CHIP, WIC, and SNAP, issue a formal comment expressing its opposition.

H-290.982 – TRANSFORMING MEDICAID AND LONG-TERM CARE AND IMPROVING ACCESS TO CARE FOR THE UNINSURED

AMA policy is that our AMA: (1) urges that Medicaid reform not be undertaken in isolation, but rather in conjunction with broader health insurance reform, in order to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients;
(2) encourages physicians to participate in efforts to enroll children in adequately funded Medicaid and State Children's Health Insurance Programs using the mechanism of "presumptive eligibility," whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be, in fact, eligible;
(3) encourages states to ensure that within their Medicaid programs there is a pluralistic approach to health care financing delivery including a choice of primary care case management, partial capitation models, fee-for-service, medical savings accounts, benefit payment schedules and other approaches;

(4) calls for states to create mechanisms for traditional Medicaid providers to continue to participate in Medicaid managed care and in State Children's Health Insurance Programs;

(5) calls for states to streamline the enrollment process within their Medicaid programs and State Children's Health Insurance Programs by, for example, allowing mail-in applications, developing shorter application forms, coordinating their Medicaid and welfare (TANF) application processes, and placing eligibility workers in locations where potential beneficiaries work, go to school, attend day care, play, pray, and receive medical care;

(6) urges states to administer their Medicaid and SCHIP programs through a single state agency;

(7) strongly urges states to undertake, and encourages state medical associations, county medical societies, specialty societies, and individual physicians to take part in, educational and outreach activities aimed at Medicaid-eligible and SCHIP-eligible children. Such efforts should be designed to ensure that children do not go without needed and available services for which they are eligible due to administrative barriers or lack of understanding of the programs;

(8) supports requiring states to reinvest savings achieved in Medicaid programs into expanding coverage for uninsured individuals, particularly children. Mechanisms for expanding coverage may include additional funding for the SCHIP earmarked to enroll children to higher percentages of the poverty level; Medicaid expansions; providing premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level; providing some form of refundable, advanceable tax credits inversely related to income; providing vouchers for recipients to use to choose their own health plans; using Medicaid funds to purchase private health insurance coverage; or expansion of Maternal and Child Health Programs. Such expansions must be implemented to coordinate with the Medicaid and SCHIP programs in order to achieve a seamless health care delivery system, and be sufficiently funded to provide incentive for families to obtain adequate insurance coverage for their children;

(9) advocates consideration of various funding options for expanding coverage including, but not limited to: increases
in sales tax on tobacco products; funds made available
through for-profit conversions of health plans and/or
facilities; and the application of prospective payment or
other cost or utilization management techniques to hospital
outpatient services, nursing home services, and home
health care services;
(10) supports modest co-pays or income-adjusted premium
shares for non-emergent, non-preventive services as a
means of expanding access to coverage for currently
uninsured individuals;
(11) calls for CMS to develop better measurement,
monitoring, and accountability systems and indices within
the Medicaid program in order to assess the effectiveness
of the program, particularly under managed care, in meeting
the needs of patients. Such standards and measures should
be linked to health outcomes and access to care;
(12) supports innovative methods of increasing physician
participation in the Medicaid program and thereby
increasing access, such as plans of deferred compensation
for Medicaid providers. Such plans allow individual
physicians (with an individual Medicaid number) to tax defer
a specified percentage of their Medicaid income;
(13) supports increasing public and private investments in
home and community-based care, such as adult day care,
assisted living facilities, congregate living facilities, social
health maintenance organizations, and respite care;
(14) supports allowing states to use long-term care eligibility
criteria which distinguish between persons who can be
served in a home or community-based setting and those
who can only be served safely and cost-effectively in a
nursing facility. Such criteria should include measures of
functional impairment which take into account impairments
caused by cognitive and mental disorders and measures of
medically related long-term care needs;
(15) supports buy-ins for home and community-based care
for persons with incomes and assets above Medicaid
eligibility limits; and providing grants to states to develop
new long-term care infrastructures and to encourage
expansion of long-term care financing to middle-income
families who need assistance;
(16) supports efforts to assess the needs of individuals with
intellectual disabilities and, as appropriate, shift them from
institutional care in the direction of community living;
(17) supports case management and disease management
approaches to the coordination of care, in the managed care
and the fee-for-service environments;
(18) urges CMS to require states to use its simplified four-
page combination Medicaid / Children's Health Insurance
Program (CHIP) application form for enrollment in these
programs, unless states can indicate they have a comparable or simpler form; and

(19) urges CMS to ensure that Medicaid and CHIP outreach efforts are appropriately sensitive to cultural and language diversities in state or localities with large uninsured ethnic populations.

350.023MSS – AMENDING H-350.957, ADDRESSING IMMIGRANT HEALTH DISPARITIES TO INCLUDE OPPOSITION TO LEGISLATION THAT FORCES DECISIONS BETWEEN HEALTH CARE AND LAWFUL RESIDENCY STATUS

Our AMA-MSS will ask the AMA to amend H-350.957, Addressing Immigrant Health Disparities by addition as follows:

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.

4. Our AMA opposes any rule, regulation, or policy that would worsen health disparities among refugee or immigrant populations by forcing them to choose between health care or future lawful residency status.

RESOLUTION 23 – SINGLE LICENSING EXAM SERIES FOR OSTEOPATHIC AND ALLOPATHIC MEDICAL STUDENTS

RECOMMENDATION:

Resolution 23 be referred.

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.

VRC testimony was supportive of Resolution 23, and had explicit support from the MSS Councilor for the Council on Medical Education. Your Reference Committee supports the spirit and intent of this resolution, but believe it could benefit from further refinement by our MSS Standing Committees. Recently, the Student Osteopathic Medical Association (SOMA) debated a similar resolution and a lot of issues were raised. Particularly, that while the basic science covered on both COMLEX and USMLE is the same, DO students also learn by “four tenants of osteopathic principles” that are incorporated into all aspects of the COMLEX exam. The ethics portion of the exam is also tested differently because the “four tenants” are present there as well. It’s been acknowledged that the Osteopathic Manipulative Medicine (OMM) portion of the exam could be separated out, but the challenge lies in the incorporation of the “four tenants.” We question whether this would require an entire overhaul of DO curriculum and if the Commission on Osteopathic College Accreditation (COCA) would be open to making this change.

Because of the nuances presented, we believe this resolution would benefit from further study, and therefore recommend Resolution 23 be referred.

(44) RESOLUTION 34 – SUPPORTING THE FURTHER STUDY OF KRATOM

RECOMMENDATION:

Resolution 34 be referred.

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.

VRC testimony on Resolution 34 was mixed. Region 3, the Committee on Legislation and Advocacy (COLA), and the Committee on Scientific Issues (CSI) supported the resolution as written. The Massachusetts delegation opposed the resolution. The Section Delegates also opposed the resolution as written because re-scheduling Kratom into Schedule 1 would inhibit proper scientific research and the asks of this resolution are already covered by H-95.934.
Your Reference Committee appreciates the spirit of this resolution, but do have several concerns with passing this resolution as currently written. We do not believe we can ask to study the harms associated with a drug’s use and simultaneously oppose it being added to the Schedule 1 list. Additionally, existing policy already supports research on Kratom. We also note that the FDA effort to place Kratom on the Schedule 1 drug list failed.

We do not believe there was enough evidence presented to recommend adoption of Resolution 34 as currently written. We believe this resolution would benefit from further study and refinement from our MSS Standing Committees. Specifically we would ask the assigned Standing Committee(s) to study the impacts of drug scheduling itself. Your Reference Committee recommends Resolution 34 be referred.

(45) RESOLUTION 35 – AMENDMENT TO POLICY H-405.960: POLICIES FOR PARENTAL, FAMILY, AND MEDICAL NECESSITY LEAVE

RECOMMENDATION:

Resolution 35 be referred.

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 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,
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 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.

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.

VRC testimony on Resolution 35 was mixed. Region 4 supported the resolution as written and the Massachusetts delegation supported the resolution with amendments. Region 2 opposed the resolution, stating that existing policy is sufficient. The MSS Councilor on the AMA Council of Medical Education expressed concern for the legal requirements that would be placed on medical schools, the blanket requirement for every school, and the inability to enforce certain parts of this resolution.
We found the testimony from the CME Councilor compelling, specifically the point made
about the legal requirements surrounding six weeks of leave without prolonging
graduation. We also note that there are important legal distinctions between residents
(who are employees) and medical students (who are student trainees) and this needs to
be considered when enacting these amendments to existing policy. Much of medical
school is stepwise and repeating one class can set students back a full year. We believe
this resolution would benefit from further study and additional support for the arguments
presented. Your Reference Committee recommends Resolution 35 be referred.

(46) RESOLUTION 54 – EXPANSION OF MEDICAID
COVERAGE OF HPV SCREENING

RECOMMENDATION:

Resolution 54 be referred.

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.

VRC testimony on Resolution 54 was mixed. The Committee on Economics and Quality
in Medicine (CEQM) supported with amendments. The Massachusetts delegation and the
MSS Section Delegates did not support CEQM’s amendments and offered additional
amendments. Region 2 generally supported the spirit of the resolution, but thought it would
be best if this were submitted to the HOD from the American College of Obstetricians and
Gynecologists (ACOG). Your Reference Committee had extensive discussion on this
resolution and ultimately believes that Resolution 54 could benefit from further refinement,
specifically the USPSTF guidelines on cervical cancer and HPV screening. We did not
find this information clearly in the resolution and are not sure how this impacts the asks of
Resolution 54. We recommend Resolution 54 be referred.

(47) RESOLUTION 57 – ENSURING COMPETITIVE PRICING
OF PHARMACEUTICAL DRUGS

RECOMMENDATION:

Resolution 57 be referred.

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.

VRC testimony on Resolution 57 was mixed. Region 3, Region 4, Region 5, and Region 7 supported the resolution as written. The Committee on Economics and Quality in Medicine (CEQM) and the Massachusetts delegation support the resolution with amendments. Region 6 and the MSS Councilor on the Council on Medical Service recommended adopting the first resolve clause and striking the second resolve clause. The Committee on Legislation and Advocacy opposed the resolution. Your Reference Committee had extensive discussion on this item. We believe this is novel and innovative, but could benefit from further study. There were concerns raised during deliberations about potential problems around de-linkage and inequities in pharmaceutical access, especially for individuals coming from private plans (or even Medicaid without limited formularies). We agreed that while too many drugs are approved by the FDA without proper clinical comparisons to existing regimens and similar non-proprietary compounds, we are not convinced that de-linking Medicare coverage from FDA-approved drugs is the correct solution. This system would not clearly identify which drugs approved by the FDA are clinically less valuable. There was extensive conversation and debate on these issues within Reference Committee deliberations. We found that our conversation led to more questions instead of answers, and think the best way forward is for this resolution to be studied by our MSS Standing Committees.

Specifically, we would ask the assigned Standing Committee(s) to differentiate between Medicaid and Medicare more clearly and establish how these different programs are involved in the pricing of pharmaceutical drugs. Additionally, we did not feel as if Quality Adjusted Life Years (QALYs) were adequately defined. We would ask for more research on QALYs themselves and how they can specifically be interpreted here. Your Reference Committee recommends Resolution 57 be referred.

(48) RESOLUTION 60 – NATIONAL FERTILITY PRESERVATION COVERAGE MANDATE

RECOMMENDATION A:

The first Resolve clause of Resolution 60 be deleted:

RESOLVED, That our AMA support congressional bill S.1461- Access to Infertility Treatment and Care Act; and be it further

RECOMMENDATION B:

The remainder of Resolution 60 be referred.

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 infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician.

VRC testimony was mixed on Resolution 60. Region 2 and Region 5 supported the resolution. Region 1, Region 6, GLMA, the Women in Medicine Committee (WIM), the Committee on Economics and Quality in Medicine (CEQM), and the MSS Councilor on the AMA Council of Medical Service supported with amendments. The MSS Section Delegates recommended existing policy be reaffirmed in lieu of Resolution 60. Your Reference Committee found the recommendation to strike the first resolve compelling. There were several amendments proposed to the second resolve clause and we think these questions would be best addressed by the appropriate MSS Standing Committee(s). We recommend the first resolve of Resolution 60 be deleted and the remainder of the resolution be referred.

(49) **CEQM MIC REPORT A – LAYING THE FIRST STEPS TOWARDS A TRANSITION TO A FINANCIAL AND CITIZENSHIP NEED-BLIND MODEL FOR ORGAN PROCUREMENT AND TRANSPLANTATION**

**RECOMMENDATION:**

Recommendations in CEQM MIC Report A be referred.

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 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 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

There was no VRC testimony on CEQM MIC Report A. During Reference Committee deliberations there were several questions raised: 1) Is there a standardized definition of what it means to “live” in the United States? 2) What are the UNOS guidelines with respect to consideration of the “ability to receive follow-up treatment” and is that affected by citizenship status? What is the previous AMA policy mentioned in the report that supports equal access in receiving transplants regardless of citizenship status?

Your Reference Committee believes these questions are crucial and need to be addressed before the recommendations in this report can be accepted. We recommend the recommendations in CEQM MIC Report A be referred.

(50) WIM CEQM REPORT A – AMENDING H-420.978, ACCESS TO PRENATAL CARE, TO SUPPORT THE PRACTICE OF AN APPROPRIATE REIMBURSEMENT FOR GROUP PRENATAL CARE

RECOMMENDATION:

Recommendations in WIM CEQM Report A be referred.

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.

VRC testimony on WIM CEQM Report A was limited. Your MSS Section Delegates noted concerns that the asks contradict one another. We agree. Your Reference Committee had extensive debate on which resolve to strike and which to keep in order to rectify this issue. Ultimately we feel that more research is warranted to strengthen the recommendations of WIM CEQM Report A. We ask the Standing Committees to consider if they are trying to argue that group prenatal care is superior or equal to one-on-one prenatal care. There were concerns raised during Reference Committee conversations that there is bias to overstate the effectiveness of group prenatal care since it is more cost-effective. Is there evidence showing this may be the case? Is group prenatal care more frequently used by low-income individuals? If it is and if it is not equal to one-on-one prenatal care, are there equity considerations we need to take into account? We appreciate the work done thus far, but believe more evidence is needed to answer these critical questions. Your Reference Committee recommends the recommendations in WIM CEQM Report A be referred.

(51) GC REPORT A – POLICY SUNSET REPORT FOR AMA-MSS POLICIES

RECOMMENDATION A:

GC Report A be amended by addition of a new Recommendation:

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.
3. That our AMA-MSS study our MSS’ sunset mechanism and gather feedback from MSS members, including our MSS Caucus, Standing Committees, and Regions, in order to devise and optimize a consistent protocol to be used when deciding to retain, amend, consolidate, or rescind MSS policies scheduled to be sunset.
RECOMMENDATION B:

GC Report A be referred.

Your AMA-MSS Governing Council recommends that the following be adopted and the remainder of the report be 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.

Your Reference Committee appreciates the time spent by the MSS Governing Council and Standing Committees reviewing the policies included in the Sunset report. We note however, there are several inconsistencies with how these were reviewed and call on the Governing Council to establish a more formal set of guidelines to help Standing Committees review and assess the policies in not only this Sunset Report but all future Sunset Reports. We also ask for the Governing Council to consider a way to amend language from “Our AMA-MSS will ask our AMA to…” to another phrase that would be more streamlined.

We believe that each policy reviewed in the Sunset Report should be assessed by the same criteria so all MSS policies are treated equally. We note specifically that some policies in this Sunset Report were sunset when they were accomplished by the AMA, while others were retained even after they were completed, just in case AMA policy were to change.

We believe establishing these guidelines, as called for in the new Recommendation proposed here, will help strengthen and streamline the MSS policy compendium. We ask that the MSS Governing Council establish these guidelines, distribute amongst the Standing Committees, and re-evaluate the policies included in this Sunset Report in a new report at the 2022 Annual meeting. We recommend that a new Recommendation calling for these guidelines be added and GC Report A be referred.
RECOMMENDED FOR NOT ADOPTION

(52) RESOLUTION 09 – MICROPLASTICS

RECOMMENDATION:

Resolution 09 not be adopted.

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.

VRC testimony on Resolution 09 was mixed. There were concerns raised regarding the lack of support presented in the Whereas clauses. The Massachusetts delegation and the MSS Section Delegates suggested that the third resolve clause was the only one that has appropriate justification based on the sources cited, and your Reference Committee agrees. The Massachusetts delegation also questioned the optics of the AMA advocating for plastic removal when the medical field relies so heavily on plastics.

As the authors themselves pointed out during testimony, there have not been direct studies on the cytotoxic effects of microplastics on humans, and looking through the references cited in the resolution your Reference Committee is not convinced there is enough evidence to justify the asks of Resolution 09. Additionally, we believe the AMA has an abundance of policy that links pollution and negative public health outcomes. We did not find the evidence presented in Resolution 09 made the connection strongly enough to add to or improve existing AMA policy. Specifically we would like to mention D-135.997, as we believe this broadly covers the asks of this resolution. Your Reference Committee recommends Resolution 09 not be adopted.

(53) RESOLUTION 25 – SUPPORTING SENSITIVE LANGUAGE AROUND SUICIDE

RECOMMENDATION:

Resolution 25 not be adopted.

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/unsuccesful” or “failed” suicide/attempts.
VRC testimony was supportive of the spirit of Resolution 25, however, there were concerns raised about the Whereas clauses. Region 2, the Committee on Bioethics and Humanities (CBH), the Massachusetts delegation, and PsychSIGN supported the resolution as written. Your Reference Committee questions the lack of evidence presented that proves this change in language would actually change outcomes. While we recognize this may be true in other circumstances, we do not believe the argument was made specifically in the case of suicide by the Whereas clauses presented in this resolution.

We also note potential overlap with H-345.981 and H-60.937. Furthermore, the AMA typically does not include specific stakeholder names in policy. We do recognize the importance of the American Psychiatric Association (APA) on this topic specifically and would encourage the authors to collaborate with APA and potentially re-submit a new resolution at a future meeting.

Additionally, in our review, your Reference Committee found that many of the references do not match the in-text citations, and there are inconsistencies with the references throughout the resolutions (i.e. years, titles, content of the references don’t match). Given all of these concerns – potential reaffirmation, inconsistent references, citing specific stakeholders – your Reference Committee recommends Resolution 25 not be adopted.

RESOLUTION 32 – AMENDING H-160.903, ERADICATING HOMELESSNESS, TO INCLUDE SUPPORT FOR STREET MEDICINE PROGRAMS

RECOMMENDATION:

Resolution 32 not be adopted.

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;
(45) recognizes the need for an effective, evidence-based national plan to eradicate homelessness;
(56) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;
(67) 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;
(78) 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;
(89) 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;
(910) (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
(1011) 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.

VRC testimony on Resolution 32 was mixed. Region 1, Region 3, Region 4, the Committee on Global and Public Health (CGPH), the Minority Issues Committee (MIC), and PsychSIGN supported the resolution as written. Region 6 recommended an amendment to eliminate the phrase “student-led.” The Massachusetts delegation suggested that policy H-160.903 be reaffirmed in lieu of this resolution. We found the concern with the phrase “student-led” most compelling.

Overall, Resolution 32 was well-written but lacking in research. Most of the evidence presented comes from the recently formed Street Medicine Coalition and we were
concerned about the potential bias from those sources. Your Reference Committee considered making this an internal policy, but ultimately determined that this would not have enough impact. We then considered reaffirmation, but we found the point made regarding funding and reimbursement to be novel. However, there was no non-biased data to support this point.

Finally, we addressed the concern around the phrase “student-led.” We believe that this raises ethical concerns regarding treatment of an already underserved population by non-physicians. We agree with Region 6 testimony that this would be problematic. Given this, we recommend that Resolution 32 not be adopted.

(55) RESOLUTION 39 – REDESIGNING THE U.S. IMMIGRATION SYSTEM

RECOMMENDATION:

Resolution 39 not be adopted.

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.

Resolution 39 was widely opposed on the VRC. Many of the resolve clauses were unrelated and not well-supported. Region 3, the Committee on Legislation and Advocacy (COLA), the Minority Issues Committee (MIC), and the Massachusetts delegation all opposed Resolution 39 as written. Your Reference Committee agrees with the testimony presented on the VRC. This resolution is unrelated to health, lacks evidentiary support, and ultimately is completely out of scope. We recommend Resolution 39 not be adopted.
RESOLUTION 41 – SUPPORT THE WORLD HEALTH ORGANIZATION’S MORATORIUM ON COVID-19 BOOSTER SHOTS

RECOMMENDATION A:

Policy D-440.917 be reaffirmed in lieu of the first and third Resolve clauses Resolution 41.

RECOMMENDATION B:

The remainder of Resolution 41 not be adopted.

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.

VRC testimony was mixed on Resolution 41. The Committee on Global and Public Health (CGPH) and the Committee on Scientific Issues (CSI) supported the resolution. Region 1, Region 2, the Massachusetts delegation, and the Committee on Legislation and Advocacy (COLA) opposed the resolution. The MSS House Coordination Committee (HCC) placed the first and third resolve clauses on the reaffirmation calendar. The MSS Section Delegates also recommended reaffirmation. We concur with reaffirmation for the first and third resolve clauses. We believe that the ideas presented in the second resolve clause are novel, however, we share the concerns raised on the VRC regarding these asks. Your Reference Committee recommends that policy D-440.917 be reaffirmed in lieu the first and third resolve clauses and the remainder of Resolution 41 not be adopted.

D-440.917 – PROMOTING EQUITABLE RESOURCE DISTRIBUTION GLOBALLY IN RESPONSE TO THE COVID-19 PANDEMIC
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.

(57) RESOLUTION 43 – SUPPORT OF INCREASED FORMAL TRAINING OF CORRECTIONAL MEDICINE PHYSICIANS

RECOMMENDATION:

Resolution 43 not be adopted.

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

RESOLVED, That our AMA-MSS supports enforcing patient care standards in training programs that are affiliated with correctional facilities.

VRC testimony was mixed on Resolution 43. Region 3, Region 4, Region 7, and the Committee on Global and Public Health (CGPH) supported the resolution as written. The Massachusetts delegation supported the resolution with amendments. The MSS Councilor on the AMA Council of Medical Education recommended referral or not adoption. This opinion was shared by the MSS Section Delegates.

Your Reference Committee believes that the authors lay out the problem well, but do not adequately lay out evidence to substantiate the proposed solution. We would encourage the authors to provide move evidence to support their resolve clauses and potentially re-submit this resolution at a future meeting. Additionally we note that the resolve clauses are not actionable as an internal MSS resolution. At this time we recommend Resolution 43 not be adopted.
RESOLUTION 47 – OVERCOMING MEDICAL MISINFORMATION THROUGH UTILIZING BOTS TO PROVIDE ACCURATE MEDICAL INFORMATION

RECOMMENDATION A:

Policy D-440.915 be reaffirmed in lieu of the first Resolve clause of Resolution 47.

RECOMMENDATION B:

The remainder of Resolution 47 not be adopted.

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;

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.

VRC testimony on Resolution 47 was limited and mixed. The Committee on Health Information and Technology (CHIT) supported with amendments, Region 1 opposed the resolution as written, and the Massachusetts delegation and the MSS Section Delegates recommended this be added to the reaffirmation calendar.

We found the testimony for both reaffirmation and non-adoption compelling. The ask of the first resolve clause is sufficiently covered under D-440.915. We found the second resolve to be novel, as we do not believe the current policy includes the use of bots to provide this information, however, we are concerned that there is not enough evidence presented to support the ask and that as written the language will not be actionable. We agree with the point raised by CHIT that the example of the World Health Organization (WHO) chatbot is inaccurate. For these reasons, we recommend policy D-440.915 be reaffirmed in lieu of the first resolve clause and the remainder of Resolution 47 not be adopted.

D-440.915 – MEDICAL AND PUBLIC HEALTH MISINFORMATION IN THE AGE OF SOCIAL MEDIA

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.

(59) RESOLUTION 49 – 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

RECOMMENDATION:

Resolution 49 not be adopted.

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 whose education meets International Confederation of Midwives’ Global Standards for Midwifery Education; (2) support state legislation regarding appropriate physician and regulatory oversight of midwifery practice, under the jurisdiction of state nursing and/or medical boards; (3) continue to monitor state legislative activities regarding the licensure and scope of practice of midwives; and (4) work with state medical societies and interested specialty societies to advocate in the interest of safeguarding maternal and neonatal health regarding the licensure and the scope of practice of midwives.

VRC testimony generally supported the spirit of Resolution 49. Region 3, Region 4, the Committee on Legislation and Advocacy (COLA), the Women in Medicine Committee (WIM), and the Massachusetts delegation supported the resolution. The MSS Councilor on the AMA Council on Legislation opposed the resolution. The American College of Obstetricians and Gynecologists (ACOG) provided feedback stating: “This resolution is consistent with ACOG policy. However, we do caution that this resolution may not be received well by others in the HOD and we fear may lead to an unfortunate scope battle in a very public setting.”
Your Reference Committee found ACOG’s testimony compelling. We also question the feasibility of a resolution on this topic being brought to the HOD without explicit support from ACOG and the optics around this being introduced by the Medical Student Section. We would advise the authors to reconsider their ask and perhaps reach out to the ACOG delegation for feedback and/or future collaboration. We recommend Resolution 49 not be adopted.

(60) RESOLUTION 51 – AMENDING POLICY H-50.973, TO SUPPORT THE IMPLEMENTATION OF HEALTH CARE REFERRALS IN BLOOD DONATION CENTERS FOR DONORS AT RISK FOR HIV

RECOMMENDATION:

Resolution 51 not be adopted.

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.

VRC testimony was mixed on Resolution 51. Region 1, Region 4, and the Standing Committee on LGBTQ+ Affairs supported the resolution as written. The MSS Section Delegates recommended not adoption for this resolution. Your Reference Committee notes that this topic has been raised several times in the past few years – with mixed results. Some resolutions have been deemed to be reaffirmation, while others were not adopted. We do find the asks of Resolution 51 novel. However, we also find the asks problematic. We believe that as written the result of this would lead to perpetuating stereotypes. How are high-risk individuals supposed to be flagged when they are donating blood? We don’t believe that blood donation centers are equipped to make these referrals without a full-time physician present and adding a full-time physician to the staff of a blood donation center would not be feasible. We recommend Resolution 51 not be adopted.
(61) RESOLUTION 52 – EARLY INTERVENTION AND TREATMENT PROGRAMS FOR ADOLESCENTS WITH SUBSTANCE USE DISORDERS

RECOMMENDATION:

Resolution 52 not be adopted.

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.

VRC testimony was mixed on Resolution 52. The MSS House Coordination Committee (HCC) did not place the second resolve on the reaffirmation calendar, but noted some overlap between this resolution and existing policy. PsychSIGN and the Massachusetts delegation supported the resolution. The MSS Section Delegates recommended reaffirmation of the entire item.

Your Reference Committee examined existing policy, specifically H-95.973 cited on the VRC, and while there are some similarities, we do not feel Resolution 52 can be considered a reaffirmation of this policy. However, we also note that as written this resolution is not well-supported and the asks are a bit misguided. Asking for funding for this particular group is distinct, but we are not convinced there was sufficient evidence presented to support these asks. Ultimately, your Reference Committee does not find this resolution to be actionable and recommend Resolution 52 not be adopted.

(62) RESOLUTION 62 – EXPANDING ACCESS TO BEHAVIORAL THERAPY IN ATTENTION-DEFICIT HYPERACTIVITY DISORDER

RECOMMENDATION A:

Policy H-60.950 and H-90.968 be reaffirmed in lieu of the second and fourth Resolve clauses Resolution 62.

RECOMMENDATION B:

The remainder of Resolution 62 not be adopted.

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.

VRC testimony on this resolution was mixed. There were several amendments proposed. Your House Coordination Committee (HCC) recommended H-60.950 and H-90.968 be reaffirmed in lieu of the second and fourth resolve clauses of Resolution 62.

We concur. When looking at the first and third resolve clauses, we determined the third resolve clause is redundant with the first resolve clause, and the first resolve clause needs more research and elaboration on the impact of Medicaid (or public/private) reimbursement changes. We believe the Whereas clauses need to be developed further to support the resolve clauses. Your Reference Committee also notes that this resolution may be more well-received if introduced by the American Psychiatric Association (APA). We recommend the authors reach out with APA to collaborate if they choose to resubmit this resolution at a future meeting. We recommend policies H-60.950 and H-90.968 be reaffirmed in lieu of the second and fourth resolve clauses and the remainder of Resolution 62 not be adopted.

H-60.950 – DIAGNOSIS AND TREATMENT OF ATTENTION DEFICIT/HYPERACTIVITY DISORDER IN SCHOOL-AGE CHILDREN
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.

H-90.968 – MEDICAL CARE OF PERSONS WITH DEVELOPMENTAL DISABILITIES
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 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.
RESOLUTION 65 – PROVIDING PAIN MANAGEMENT
STANDARDS AND PROTOCOLS FOR OUTPATIENT
GYNECOLOGIC PROCEDURES

RECOMMENDATION A:

Policy H-185.931 be reaffirmed in lieu of the first and third Resolve clauses of Resolution 65.

RECOMMENDATION B:

The remainder of Resolution 65 not be adopted.

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

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.

VRC testimony on this resolution was mixed. There were concerns about the novelty and priority of Resolution 65. Your House Coordination Committee (HCC) placed the third resolve clause on the reaffirmation calendar. We agree with this decision and also believe the first resolve clause is covered by existing policy H-185.931.

Looking then at the second and fourth resolve clauses we believe they are novel, as the Center for Medicare and Medicaid Services (CMS) does not currently recognize gynecologic pain as a treatable diagnostic procedure. However, we do not believe the Whereas clauses sufficiently support the asks of the second and fourth resolve clauses. There are conflicting asks of supporting research on guidelines, disseminating information, categorizing via diagnostic code, and looking into the use of opioid analgesics. We would recommend the authorship team streamline their asks, provide more support for their asks, and potentially re-submit this resolution at a future meeting. We would also encourage the authors to reach out to the American College of Obstetricians and Gynecologists (ACOG) for feedback. Your Reference Committee recommends H-185.931 be reaffirmed in lieu of the first and third resolve clauses and the remainder of Resolution 65 not be adopted.
H-185.931 – WORKFORCE AND COVERAGE FOR PAIN MANAGEMENT

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.

(64) RESOLUTION 67 – ADDITIONAL SAFEGUARDS FOR CHILDREN ENROLLED IN CLINICAL STUDIES

RECOMMENDATION:

Resolution 67 not be adopted.

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
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.

VRC testimony on this resolution was mixed. The Massachusetts delegation and the
American Academy of Pediatrics (AAP) liaison supported the resolution as written and
Region 1 and the Committee on Scientific Issues (CSI) supported the resolution with
amendments. The resolution was opposed by the Committee on Bioethics and Humanities
(CBH) and the MSS Section Delegates who suggested that this would be better coming
from the American Academy of Pediatrics (AAP) or the American Academy of Family
Physicians (AAFP).

Your Reference Committee notes that the Department of Health and Human Services
already has guidelines on research involving children. The Whereas clauses presented in
Resolution 67 failed to prove these guidelines are insufficient. In fact, we believed they
actually justified the existence of the current guidelines. Regarding the second resolve
clause, your Reference Committee does not believe that we need explicit policy for the
AMA to support research that is following the law. If there is reason to believe that current
research is not in compliance with federal guidelines, it was not presented here. We
recommend Resolution 67 not be adopted.
RECOMMENDED FOR REAFFIRMATION IN LIEU OF

(65) RESOLUTION 02 – A RESPONSE TO HUMAN
TRAFFICKING AMID A PUBLIC HEALTH EMERGENCY

RECOMMENDATION:

Policies H-65.966 and H-60.912 be reaffirmed in lieu of
Resolution 02.

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.

VRC testimony was generally supportive of the spirit of Resolution 02. Region 3 and
PsychSIGN supported the resolution as written and Region 7 supported the resolution
with amendments. The MSS Section Delegates testified that there were numerous polices
that adequately address the asks for Resolution 02, specifically H-65.966. The resolve
clauses of Resolution 02 would not substantially add to the AMA policy compendium, nor
would they change existing AMA advocacy on this topic. Your Reference Committee found
this compelling and also add that as written this resolution only supports increasing
funding during times of crises, and we believe that funding to stop human trafficking needs
to be increased at all times. Therefore, your Reference Committee recommends policies
H-65.966 and H-60.912 be reaffirmed in lieu of Resolution 02.

H-65.966 – PHYSICIANS RESPONSE TO VICTIMS OF
HUMAN TRAFFICKING
1. Our AMA encourages its Member Groups and
Sections, as well as the Federation of Medicine, to raise
awareness about human trafficking and inform physicians
about the resources available to aid them in identifying
and serving victims of human trafficking.

Physicians should be aware of the definition of human
trafficking and of resources available to help them identify
and address the needs of victims.

The US Department of State defines human trafficking as
an activity in which someone obtains or holds a person in
compelled service. The term covers forced labor and
forced child labor, sex trafficking, including child sex
trafficking, debt bondage, and child soldiers, among other
forms of enslavement. Although it’s difficult to know just
how extensive the problem of human trafficking is, it’s
estimated that hundreds of thousands of individuals may be trafficked every year worldwide, the majority of whom are women and/or children.

The Polaris Project -

In addition to offering services directly to victims of trafficking through offices in Washington, DC and New Jersey and advocating for state and federal policy, the Polaris Project:
- Operates a 24-hour National Human Trafficking Hotline
- Maintains the National Human Trafficking Resource Center, which provides
  a. An assessment tool for health care professionals
  b. Online training in recognizing and responding to human trafficking in a health care context
  c. Speakers and materials for in-person training
  d. Links to local resources across the country

The Rescue & Restore Campaign –
The Department of Health and Human Services is designated under the Trafficking Victims Protection Act to assist victims of trafficking. Administered through the Office of Refugee Settlement, the Department's Rescue & Restore campaign provides tools for law enforcement personnel, social service organizations, and health care professionals.

2. Our AMA will help encourage the education of physicians about human trafficking and how to report cases of suspected human trafficking to appropriate authorities to provide a conduit to resources to address the victim's medical, legal, and social needs.

H-60.912 – COMMERCIAL EXPLOITATION AND HUMAN TRAFFICKING OF MINORS
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.
RESOLUTION 11 – SUPPORTING RESEARCH AND DEVELOPMENT OF VACCINES AGAINST NEGLECTED TROPICAL DISEASES

RECOMMENDATION:

Policy H-440.820 be **reaffirmed in lieu of Resolution 11**.

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.

VRC testimony on Resolution 11 was mixed. Region 1 and Region 3 supported the resolution as written, the Committee on Scientific Issues (CSI) supported referral, and the MSS Section Delegates supported the resolution with amendments. Your Reference Committee recognizes that these tropical diseases are neglected as the authors argue, however, we ultimately believe this can be covered by existing policy D-440.820, which states: “Our AMA supports and will advocate for...research to develop new vaccines, diagnostics, and treatments for existing and emerging vector-borne diseases.” For this reason, your Reference Committee recommends policy H-440.820 be reaffirmed in lieu of Resolution 11.

H-440.820 – VECTOR-BORNE DISEASES

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.
(67) RESOLUTION 14 – ENSURING QUALITY OF MEDICAL INTERPRETATION FOR PATIENTS WITH LIMITED ENGLISH PROFICIENCY

RECOMMENDATION:

164.024MSS be reaffirmed in lieu of Resolution 14.

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.

VRC testimony on Resolution 14 was mixed. Region 4, PsychSIGN, and the MSS Councilor to the AMA Council on Medical Service supported this resolution as written. The Committee on Economics and Quality in Medicine (CEQM) supported this resolution with amendments. The Minority Issues Committee (MIC) supported referral for study. The Massachusetts delegation and the MSS Section Delegates supported reaffirmation.

Your Reference Committee appreciated the amendments from CEQM, but ultimately found this ask to be covered by existing policy. There are several AMA policies that address the financial burden of medical interpreters and advocating for solutions that do not hurt the physician or the patient (i.e. H-385.929, D-385.957, H-385.917, D-160.992, and D-385.978). As currently written the second and third resolve clauses would not change current AMA efforts on the issue of medical interpreters. The first resolve should be struck, as asking the AMA to support third-party certification organizations could make this resolution obsolete as legal and regulatory language changes.

Most relevant to this resolution’s ask and our recommendation is the MSS pending transmittal titled “Support for Standardized Interpreter Training” which is also codified as 160.024MSS. Resolution 14 is broadly covered by this MSS policy; therefore, your Reference Committee recommends 160.024MSS be reaffirmed in lieu of Resolution 14.

160.024MSS – SUPPORT FOR STANDARDIZED INTERPRETER TRAINING

Our AMA-MSS will ask the AMA to: (1) 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; (2) encourage physicians and physicians in training to improve interpreter-use skills and increase education through publicly available resources, such as the AAMC “Guidelines for Use of Medical Interpreter Services”;
and (3) 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.

(68) RESOLUTION 27 – LONGITUDINAL CAPACITY-BUILDING TO ADDRESS CLIMATE ACTION AND JUSTICE

RECOMMENDATION:

135.021MSS and 530.027MSS be reaffirmed in lieu of Resolution 27.

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 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.

VRC testimony was supportive of the spirit of Resolution 27. The MSS Section Delegates recommended reaffirmation of existing policy in lieu of Resolution 27 and your Reference Committee agrees. There are already several groups within the AMA advocating on these issues – both internally and externally. We specifically note the overlap with 135.021MSS and 530.027MSS which have been combined and are currently in the queue to be transmitted to the AMA House of Delegates. We do not believe this resolution would strengthen or change existing efforts on this topic and therefore recommend 135.021MSS and 530.027MSS be reaffirmed in lieu of Resolution 27.

135.021MSS – ENVIRONMENTAL CONTRIBUTORS TO DISEASE AND ADVOCATING FOR ENVIRONMENTAL JUSTICE

AMA-MSS will ask the AMA to amend Policy D-135.997, Research into the Environmental Contributors to Disease, by addition and deletion to read as follows: Research into the Environmental Contributors to Disease and Advocating for Environmental Justice

Our AMA will (1) advocate for the greater public and private funding for research into the environmental causes of disease, and urge the National Academy of Sciences to
undertake an authoritative analysis of environmental causes of disease; (2) ask the steering committee of the Medicine and Public Health Initiative Coalition to consider environmental contributors to disease and environmental racism as a priority public health issues; (3) encourage federal, state, and local agencies to address a remediate environmental injustice, environmental racism, and all other environmental conditions that are adversely impacting health, especially in marginalized communities; and (4) lobby Congress to support ongoing initiatives that include reproductive health outcomes and development particularly in minority populations in Environmental Protection Agency Environmental Justice policies.

530.027MSS – ENVIRONMENTAL SUSTAINABILITY OF AMA NATIONAL MEETINGS
Our AMA-MSS will ask the AMA to: (1) 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 profess towards implementation; (2) 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; (3) 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 (4) 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.

(69) RESOLUTION 33 – INCREASE FEDERAL FUNDING TOWARDS NUTRITION RESEARCH

RECOMMENDATION:
Policies H-150.953 and D-440.978 be reaffirmed in lieu of Resolution 33.

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.

VRC testimony was supportive of Resolution 33. Region 1, Region 3, Region 4, Region 5, the Committee on Legislation and Advocacy (COLA) and the Committee on Scientific Issues (CSI) support this resolution as written. The MSS Section Delegates shared concerns about how this resolution will meaningfully impact the AMA’s advocacy efforts on this topic. While we appreciate the spirit of Resolution 33, your Reference Committee found the Section Delegates’ testimony compelling. We specifically highlight a letter that the AMA sent to Congress which covers the ask of the first resolve clause. Additionally, the first resolve is based on the foundation that there is insufficient federal funding on this issue and that funding has remained flat or declined over the past few decades. However, this is based on a single source that explicitly states that they do not have access to all of the information on federal funding on this issue. Further, we agree with the Section Delegates that the amendments made in the second resolve clause will not significantly change AMA’s current advocacy efforts on this topic. We recommend policies H-150.953 and D-440.978 be reaffirmed in lieu of Resolution 33.

**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.

D-440.978 – CULTURALLY RESPONSIVE DIETARY AND NUTRITIONAL GUIDELINES

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 existing 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.

2. Our AMA will: (a) propose legislation that modifies the National School Lunch Act, 42 U.S.C. § 1758, so as to eliminate requirements that children produce documentation of a disability or a special medical or dietary need in order to receive an alternative to cow's milk; and (b) recommend that the U.S. Department of Agriculture and U.S. Department of Health and Human Services clearly indicate in the Dietary Guidelines for Americans and other federal nutrition guidelines that meat and dairy products are optional, based on an individual's dietary needs.

(70) RESOLUTION 40 – 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

RECOMMENDATION A:

Policy H-65.967 be reaffirmed in lieu of Resolution 40.

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

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.

34. 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.”

45. 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.

Resolution 40 was well-supported on the VRC. Region 1, Region 2, Region 4, the
Committee on Legislation and Advocacy (COLA), the Committee on LGBTQ+ Affairs,
GLMA, and PsychSIGN supported the resolution as written. The Massachusetts
debate supported the resolution with amendments. The MSS Section Delegates
recommended H-65.967 be reaffirmed in lieu of Resolution 40.

While this resolution was well-written and well-researched, we found the testimony from
the Section Delegates compelling. This topic was just discussed at the June 2021 AMA
House of Delegates meeting and the changes made in this resolution do not differ
significantly from the report presented by the AMA Board of Trustees on this issue.
Strategically it does not make sense to re-litigate this topic (which was notably
controversial) for such a minor change to the policy. The ask of this resolution can be
accomplished given existing policy H-65.967 and we recommend that policy be reaffirmed
in lieu of Resolution 40. If the authors would like to see a specific action on this policy, we
recommend they submit a Governing Council Action Item request.

H-65.967 – CONFORMING SEX AND GENDER
DESIGNATION ON GOVERNMENT IDS AND OTHER
DOCUMENTS
1. Our AMA supports every individual’s right to determine
their gender identity and sex designation on government
documents and other forms of government identification.
2. Our AMA supports policies that allow for a sex
designation or change of designation on all government IDs
to reflect an individual’s gender identity, as reported by the
individual and without need for verification by a medical
professional.
3. Our AMA supports policies that include an undesignated
or nonbinary gender option for government records and
forms of government-issued identification, which would be
in addition to “male” and “female.”
4. Our AMA supports efforts to ensure that the sex
designation on an individual’s government-issued
documents and identification does not hinder access to
medically appropriate care or other social services in
accordance with that individual’s needs.
5. Our AMA will advocate for the removal of sex as a legal designation on the public portion of the birth certificate, recognizing that information on an individual's sex designation at birth will still be submitted through the U.S. Standard Certificate of Live Birth for medical, public health, and statistical use only.

(71) RESOLUTION 42 – AMENDING H-345.981, TO ADDRESS INCREASED UTILIZATION OF MOBILE HEALTH TECHNOLOGY FOR THE MANAGEMENT OF MENTAL HEALTH CONDITIONS

RECOMMENDATION:

Policies D-480.972 and H-480.943 be reaffirmed in lieu of Resolution 42.

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;
(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; and
(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.

VRC testimony on Resolution 42 was limited and mixed. Region 5 and PsychSIGN supported the resolution as written, although PsychSIGN noted there may be overlap with D-480.972. The MSS Section Delegates recommended reaffirmation of H-480.943 in lieu of Resolution 42. We agree with the both the Section Delegates and PsychSIGN.
Your Reference Committee believes the asks of this resolution are sufficiently covered by existing policy, specifically clause 1 of H-480.943, which states (emphasis added):

“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:...(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;...(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."

Further, clause 2 of D-480.972 states (emphasis added):

"Our AMA will continue to engage with stakeholders to identify relevant guiding principles to promote a vibrant, useful and trustworthy mHealth market."

And finally, clause 3 of D-480.972 states (emphasis added):

"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."

Given these excerpts, your Reference Committee agrees that this ask is covered by existing policy. We recommend policies H-480.943 and D-480.972 be reaffirmed in lieu of Resolution 42.
is patient-centered, promotes care coordination and facilitates team-based communication; (e) support data portability and interoperability in order to promote care coordination through medical home and accountable care models; (f) abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services facilitated by the app; (g) require that physicians and other health practitioners delivering services through the app be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board; and (h) ensure that the delivery of any services via the app be consistent with state scope of practice laws.

2. Our AMA supports that mHealth apps and associated devices, trackers and sensors must abide by applicable laws addressing the privacy and security of patients' medical information.

3. Our AMA encourages the mobile app industry and other relevant stakeholders to conduct industry-wide outreach and provide necessary educational materials to patients to promote increased awareness of the varying levels of privacy and security of their information and data afforded by mHealth apps, and how their information and data can potentially be collected and used.

4. Our AMA encourages the mHealth app community to work with the AMA, national medical specialty societies, and other interested physician groups to develop app transparency principles, including the provision of a standard privacy notice to patients if apps collect, store and/or transmit protected health information.

5. Our AMA encourages physicians to consult with qualified legal counsel if unsure of whether an mHealth app meets Health Insurance Portability and Accountability Act standards and also inquire about any applicable state privacy and security laws.

6. Our AMA encourages physicians to alert patients to the potential privacy and security risks of any mHealth apps that he or she prescribes or recommends, and document the patient's understanding of such risks.

7. Our AMA supports further development of research and evidence regarding the impact that mHealth apps have on quality, costs, patient safety and patient privacy.

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

D-480.972 – GUIDELINES FOR MOBILE MEDICAL APPLICATIONS AND DEVICES

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.

(72) RESOLUTION 44 – ACCESS TO NALOXONE FOR VULNERABLE AND UNDERSERVED POPULATIONS

RECOMMENDATION:

Policies H-95.932 and D-95.987 be reaffirmed in lieu of Resolution 44.

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. There should be a focus on populations with limited access to naloxone, including but not limited to rural areas and individuals experiencing homelessness.

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.

10. Our AMA supports additional research on the most effective methods of naloxone distribution in emergency departments and solutions to overcome barriers to implementation.

VRC testimony on Resolution 44 was mixed. The Massachusetts delegation and PsychSIGN supported the resolution as written, Region 1 supported the resolution with amendments, and Region 2 opposed the resolution as written. We don’t believe these
resolve clauses fit together particularly well, but we do find that they are both covered by existing policy. The AMA policy, advocacy, and action on naloxone implementation and general response to the opioid crisis is strong. A lot of the implementation of these asks is dependent on individual frontline community-based programs that receive funding. We don’t believe the AMA needs to specify that naloxone should be distributed to underserved populations, as this goes without saying. Amending policy as the authors propose will not fix the flaws that exist in implementation. For these reasons, your Reference Committee recommends policies H-95.932 and D-95.987 be reaffirmed in lieu of Resolution 44.

H-95.932 – INCREASING AVAILABILITY OF NALOXONE
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.

D-95.987 – PREVENTION OF OPIOID OVERDOSE
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.

(73) RESOLUTION 45 – SCREENING FOR SUICIDE RISK IN TRANSGENDER PATIENTS

RECOMMENDATION:

Policies H-60.927, H-60.937, H-345.984, and Opinion 1.1.3 be reaffirmed in lieu of Resolution 45.

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.

VRC testimony on Resolution 45 was mixed. Region 1 supported this resolution with amendments, while the MSS Section Delegates and GLMA supported reaffirmation. The Committee on Scientific Issues (CSI) recommended referral of this item. The MSS House Coordination Committee (HCC) placed the second resolve clause on the reaffirmation consent calendar. Your Reference Committee concurs with the evaluation of HCC and further found the testimony given by GLMA and the Section Delegates compelling; existing policy sufficiently covers the ask of this resolution.
Specifically, while H-60.927 refers to youth, the general spirit of this ask is covered, and there is nothing preventing advocacy efforts for adults. H-60.937 clause 5 states: “…encourages continued research to better understand suicide risk and effective prevention efforts in youth and young adult populations, 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.”

Further, H-345.984 states: “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…(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…”

Finally, we note that Opinion 1.1.3 Patient Rights states that patients should be able to expect their physician to coordinate medically indicated care and that care will not be discontinued while further treatment is needed without sufficient notice and assistance.

Given the numerous existing policies that cover the asks of this resolution, we recommend policies H-60.927, H-60.937, H-345.984, and Opinion 1.1.3 be reaffirmed in lieu of Resolution 45.

H-60.927 – REDUCING SUICIDE RISK AMONG LESBIAN, GAY, BISEXUAL, TRANSGENDER, AND QUESTIONING YOUTH THROUGH COLLABORATION WITH ALLIED ORGANIZATIONS

Our AMA will partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth suicide and improve health among LGBTQ youth.

H-60.937 – YOUTH AND YOUNG ADULT SUICIDE IN THE UNITED STATES

Our AMA:
(1) Recognizes youth and young adult suicide as a serious health concern in the US;
(2) Encourages the development and dissemination of educational resources and tools for physicians, especially those more likely to encounter youth or young adult patients, addressing effective suicide prevention, including screening tools, methods to identify risk factors and acuity, safety planning, and appropriate follow-up care including treatment and linkages to appropriate counseling resources;
(3) Supports collaboration with federal agencies, relevant state and specialty medical societies, schools, public health agencies, community organizations, and other stakeholders to enhance awareness of the increase in youth and young adult suicide and to promote protective factors, raise
awareness of risk factors, support evidence-based prevention strategies and interventions, encourage awareness of community mental health resources, and improve care for youth and young adults at risk of suicide;
(4) Encourages efforts to provide youth and young adults better and more equitable access to treatment and care for depression, substance use disorder, and other disorders that contribute to suicide risk;
(5) Encourages continued research to better understand suicide risk and effective prevention efforts in youth and young adults, especially in higher risk sub-populations such as Black, LGBTQ+, Hispanic/Latinx, 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.

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.

1.1.3 – PATIENT RIGHTS

The health and well-being of patients depends on a collaborative effort between patient and physician in a mutually respectful alliance. Patients contribute to this alliance when they fulfill responsibilities they have, to seek care and to be candid with their physicians, for example.

Physicians can best contribute to a mutually respectful alliance with patients by serving as their patients’ advocates and by respecting patients’ rights. These include the right:
(a) To courtesy, respect, dignity, and timely, responsive attention to his or her needs.
(b) To receive information from their physicians and to have opportunity to discuss the benefits, risks, and costs of appropriate treatment alternatives, including the risks, benefits, and costs of forgoing treatment. Patients should be able to expect that their physicians will provide guidance about what they consider the optimal course of action for the patient based on the physician’s objective professional judgment.
(c) To ask questions about their health status or recommended treatment when they do not fully understand what has been described and to have their questions answered.
(d) To make decisions about the care the physician recommends and to have those decisions respected. A
patient who has decision-making capacity may accept or refuse any recommended medical intervention.

(e) To have the physician and other staff respect the patient’s privacy and confidentiality.

(f) To obtain copies or summaries of their medical records.

(g) To obtain a second opinion.

(h) To be advised of any conflicts of interest their physician may have in respect to their care.

(i) To continuity of care. Patients should be able to expect that their physician will cooperate in coordinating medically indicated care with other health care professionals, and that the physician will not discontinue treating them when further treatment is medically indicated without giving them sufficient notice and reasonable assistance in making alternative arrangements for care.

(74) RESOLUTION 48 – END FIREARM DEFAULT PROCEED SALES

RECOMMENDATION:

Policy H-145.991 be reaffirmed in lieu of Resolution 48.

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.

VRC testimony on Resolution 48 was mixed. Region 1 and PsychSIGN supported the resolution as written. The Massachusetts delegation and the Committee on Legislation and Advocacy (COLA) proposed amendments. The MSS Section Delegates recommended policies H-145.991 and H-145.992 be reaffirmed in lieu of Resolution 48. We believe there is merit to the amendments proposed by the Massachusetts delegation, but even as amended this ask falls under existing policy H-145.991. We would encourage the authors to specifically bring the language included in the Massachusetts amendment forward as a Governing Council Action Item request. The specificity will provide guidance to the MSS Governing Council to act under what is broadly covered by H-145.991. Your Reference Committee recommends H-145.991 be reaffirmed in lieu of Resolution 48.

H-145.991 – WAITING PERIODS FOR FIREARM PURCHASES

The AMA supports using its influence in matters of health to effect passage of legislation in the Congress of the U.S. mandating a national waiting period that allows for a police background and positive identification check for anyone
who wants to purchase a handgun from a gun dealer anywhere in our country.

(75) RESOLUTION 58 – ADVOCATING FOR BREASTFEEDING PROTECTIONS FOR MEDICAL STUDENTS

RECOMMENDATION:

Policy H-245.982 be reaffirmed in lieu of Resolution 58.

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; (e) (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 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.
VRC testimony on Resolution 58 was limited. The Women in Medicine Committee (WIM) and the Committee on Medical Education (CME) supported this resolution. Your MSS Section Delegates recommended existing policy be reaffirmed in lieu of this resolution. The MSS Councilor on the Council of Medical Education proposed an amendment to this resolution. Your Reference Committee found the proposed amendments benign and do not believe they make this resolution novel. We recommend policy H-245.982 be reaffirmed in lieu of Resolution 58.

H-245.982 – AMA SUPPORT FOR BREASTFEEDING

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 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.

RESOLUTION 59 – SUPPORTING HEALTHCARE WORKER MENTAL HEALTH DURING DISASTERS

RECOMMENDATION:

Policies D-405.978 and 295.022MSS be reaffirmed in lieu of Resolution 59.

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 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:
   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.

VRC testimony was mixed on Resolution 59. Region 2 supported the resolution as written; the Committee on Medical Education (CME) supported the first and fourth resolve clauses, the Committee on Long Range Planning (COLRP) and the MSS Councilor on the AMA Council on Medical Education recommended this be reaffirmed, and the Massachusetts delegation opposed the resolution as written. Your MSS House Coordination Committee (HCC) recommended Resolution 59 be placed on the reaffirmation consent calendar and your Reference Committee agrees. The MSS Councilor on the Council of Medical Education provided several examples of the AMA’s work on this issue: 1) AMA support for the Dr. Lorna Breen Act of 2021; 2) Further amplification and collaboration with the Dr. Lorna Breen Foundation; 3) creating an appendix of mental health resources for patients and providers; and 4) AMA funded research, led by the University of Minnesota medical student on the prevalence of healthcare worker stress and burnout.

We find that existing policy D-405.978 and 295.022MSS, as well as the resources cited above, sufficiently cover the ask of this resolution. Your Reference Committee recommends D-405.978 and 295.022MSS be reaffirmed in lieu of Resolution 59.

D-405.978 – ACCESS TO CONFIDENTIAL HEALTH CARE SERVICES FOR PHYSICIANS AND TRAINEES
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.

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.
RESOLUTION 64 – PROTECTING CLINICAL AI FROM ADVERSARIAL ATTACKS

RECOMMENDATION:

Policy H-480.940 be reaffirmed in lieu of Resolution 64.

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 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. 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.
VRC testimony uniformly recommended that policy H-480.940 be reaffirmed in lieu of this resolution. The proposed amendments do not significantly change the ask of this policy. We agree with VRC testimony and would suggest the authors reach out via a Governing Council Action Item request if they feel more specific action needs to be taken. Your Reference Committee recommends H-480.940 be reaffirmed in lieu of Resolution 64.

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.
(78) RESOLUTION 66 – EARMARKING FOR MORE
RESEARCH TARGETED TOWARDS PREVENTIVE
MEDICINE AND CARDIOLOGY CARE USING
ARTIFICIAL INTELLIGENCE

RECOMMENDATION:

Policies H-480.939, H-480.940, and H-295.857 be
reaffirmed in lieu of Resolution 66.

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
cardio failure in patient populations and machine learning algorithms to create risk models for
heart failure outcomes.

VRC testimony on Resolution 66 was mixed and limited. Region 7 recommended this be
reaffirmed and your MSS Section Delegates proposed amendments. We found Region
7’s testimony compelling. The Whereas clauses offer very minimal support for the resolve
clauses and only one Whereas clauses mentions AI at all. We are not convinced the
authors make a compelling argument for the importance of these asks. It is also not clear
how this would alter existing efforts in this space – there is not enough evidence presented
that the use of AI in preventive medicine and cardiology care is actually underfunded. Your
Reference Committee recommends H-480.939, H-480.940, and H-295.857 be reaffirmed
in lieu of Resolution 66.

H-480.939 – AUGMENTED INTELLIGENCE IN HEALTH
CARE
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:
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.

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.

H-295.857 – AUGMENTED INTELLIGENCE IN MEDICAL EDUCATION

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 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.

(79) RESOLUTION 68 – IMPROVING CARE COORDINATION AMONG PATIENTS, PCPS, AND SPECIALISTS

RECOMMENDATION:

Policy H-160.919 be reaffirmed in lieu of Resolution 68.

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 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.

VRC testimony was limited on Resolution 68. The Massachusetts delegation supported the resolution as written, the Committee on Economics and Quality in Medicine (CEQM) and the MSS Councilor on the Council on Medical Service opposed the resolution, and the Section Delegates supported reaffirmation.

Your Reference Committee notes that the first resolve is not feasible, as the AMA is not a primary research organization. We also note that the resolve clauses are not well-supported by the Whereas clauses and the resolution unnecessarily puts both the blame and solutions onto physicians for this systemic issue. The MSS Councilor on the AMA Council on Medical Service shared concerns that the majority of references cited were not from the last five years and by not including these sources it is likely that significant improvements in the utilization of EHRs has been missed. We also point out that this is a scope of practice issue and the AMA is already active in advocating in this space.

Your Reference Committee agrees with the Section Delegates that H-160.919 captures the spirit of this resolution. We recommend H-160.919 be reaffirmed in lieu of Resolution 68.

H-160.919 – PRINCIPLES OF THE PATIENT-CENTERED MEDICAL HOME

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.

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.

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.