

DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its June 2021 Special Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (J21 Special Meeting)

Report of Reference Committee E

Shane Hopkins, MD, Chair

1 Your Reference Committee recommends the following consent calendar for acceptance:

2
3 **RECOMMENDED FOR ADOPTION AS AMENDED**

- 4
5 1. Council on Science and Public Health Report 2 – Use of Drugs to Chemically
6 Restrain Agitated Individuals Outside of Hospital Settings
7
8 2. Resolution 503 – Access to Evidence-Based Addiction Treatment in Correctional
9 Facilities*

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11 *For Resolution 503, the double underline and double strikethrough that are
12 traditional format for indicating amendments from the Reference Committee are
13 difficult to discern. Therefore, the Reference Committee has also highlighted these
14 additions in yellow.

Amendments

If you wish to propose an amendment to an item of business, click here: [Submit New Amendment](#)

RECOMMENDED FOR ADOPTION AS AMENDED

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4 (1) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT
5 2 – USE OF DRUGS TO CHEMICALLY RESTRAIN
6 AGITATED INDIVIDUALS OUTSIDE OF HOSPITAL
7 SETTINGS
8

9 **RECOMMENDATION A:**

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11 **Recommendation 1 in Council on Science and Public**
12 **Health Report 2 be amended by addition and deletion to**
13 **read as follows:**
14

15 **1. That the following new AMA policy be adopted:**

16 ~~Use of Drugs to Chemically Restrain Agitated~~
17 ~~Individuals Outside of Hospital Settings~~
18 **Pharmacological Intervention for Agitated Individuals**
19 **in the Out-of-Hospital Setting**

20 **Our American Medical Association:**

- 21 1. Believes that current evidence does not support
22 “excited delirium” or “excited delirium
23 syndrome” as a medical diagnosis and opposes
24 the use of the terms until a clear set of diagnostic
25 criteria are validated;
26 2. **Recognizes that the treatment of medical**
27 **emergency conditions outside of a hospital is**
28 **usually done by a subset of healthcare**
29 **practitioners who are trained and have expertise**
30 **as emergency medical service (EMS)**
31 **practitioners. It is vital that EMS practitioners**
32 **and systems are overseen by physicians who**
33 **have specific experience and expertise in**
34 **providing EMS medical direction.**
35 3. Is concerned about law enforcement officer use
36 of force accompanying “excited delirium” that
37 leads to disproportionately high mortality
38 among communities of color, particularly among
39 Black men, and denounces “excited delirium”
40 solely as a justification for the use of force by
41 law enforcement officers.
42 4. **Opposes the use of sedative/hypnotic and**
43 **dissociative agents, including ketamine, as a**
44 **pharmacological intervention for agitated**
45 **individuals in the out-of-hospital setting, when**
46 **done to chemically restrain an individual solely**
47 **for a law enforcement purpose and not for a**
48 **legitimate medical reason;**

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5. Recognizes that sedative/hypnotic and dissociative pharmacological interventions for agitated individuals ~~drugs for chemical restraint~~ used outside of a hospital setting by non-physicians have significant risks intrinsically, in the context of age, underlying medical conditions, and also related to potential drug-drug interactions with agents the individual may have taken;
 6. Calls for comprehensive reviews, performed by independent investigators including appropriate medical and behavioral health professionals, of law enforcement agencies and emergency medical service agencies to:
 - a. Investigate any cases labeled as “excited delirium” for disproportionate application of the term, including prevalence of its use by race, ethnicity, gender, age, and other demographic factors;
 - b. Evaluate the prevalence of ketamine use in the field in unmonitored individuals;
 - c. Assess that comprehensive training and guidelines, including continuous quality improvement processes, have been properly established by supervising EMS medical directors and behavioral health specialists, to:
 - i. Require appropriate monitoring of any patient who receives sedative/hypnotic and dissociative pharmacological interventions for treatment in the out-of-hospital setting;
 - ii. Ensure proper use of ketamine and other sedative/hypnotic and dissociative pharmacological interventions under defined protocols/guidelines after appropriate education on indications, usage and complications;
 - iii. Include an appropriate stepwise approach to the treatment of patients in the out-of-hospital setting, including de-escalation training, that provides safety to the patient and providers;
 - d. Ensure that appropriate financial support by local and/or state agencies for training and reporting is available; and

- 1 e. ~~are appropriate, and include de-~~
2 ~~escalation training; and~~
3 f. Assess, on an ongoing basis, that
4 personnel are conducting themselves
5 according to guidelines and training to
6 ensure patient safety;
- 7 7. Urges law enforcement and frontline emergency
8 medical service personnel, who are a part of the
9 “dual response” in emergency situations, to
10 participate in appropriate training that, overseen
11 by EMS medical directors. The training should
12 minimally includes de-escalation techniques
13 and the appropriate use of pharmacological
14 intervention for agitated individuals in the out-
15 of-hospital setting ~~drugs used to restrain~~
16 ~~individuals; and~~
- 17 8. Urges medical and behavioral health specialists,
18 not law enforcement, to serve as first
19 responders and decision makers in medical and
20 mental health emergencies in local communities
21 and that administration of any pharmacological
22 treatments in the out-of- a non-hospital setting
23 be done equitably, in an evidence-based, anti-
24 racist, and stigma-free way. (New HOD Policy)

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26 **RECOMMENDATION B:**

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

30
31 **HOD ACTION:**

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33 **Recommendation 1, subsection 6 referred for**
34 **decision.**

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

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

- 42 1. That the following new AMA policy be adopted:
43 Use of Drugs to Chemically Restrain Agitated Individuals Outside of Hospital
44 Settings
45 Our American Medical Association:
46 1. Believes that current evidence does not support “excited delirium” or “excited
47 delirium syndrome” as a medical diagnosis and opposes the use of the terms
48 until a clear set of diagnostic criteria are validated;
49 2. Is concerned about law enforcement officer use of force accompanying
50 “excited delirium” that leads to disproportionately high mortality among
51 communities of color, particularly among Black men, and denounces “excited

- 1 delirium” solely as a justification for the use of force by law enforcement
2 officers.
- 3 3. Opposes the use of sedative/hypnotic agents, including ketamine, to
4 chemically restrain an individual solely for a law enforcement purpose;
- 5 4. Recognizes that drugs for chemical restraint used outside of a hospital setting
6 by non-physicians have significant risks intrinsically, in the context of
7 underlying medical conditions, and also related to potential drug-drug
8 interactions with agents the individual may have taken;
- 9 5. Calls for comprehensive reviews, performed by independent investigators
10 including appropriate medical and behavioral health professionals, of law
11 enforcement agencies and emergency medical service agencies to:
 - 12 a. Investigate any cases labeled as “excited delirium” for disproportionate
13 application of the term, including prevalence of its use by race, ethnicity,
14 gender, age, and other demographic factors;
 - 15 b. Evaluate the prevalence of ketamine use in the field in unmonitored
16 individuals;
 - 17 c. Assess that training and guidelines have been properly established by
18 supervising medical and behavioral health specialists, are appropriate,
19 and include de-escalation training; and
 - 20 d. Assess, on an ongoing basis, that personnel are conducting
21 themselves according to guidelines and training to ensure patient
22 safety; and
- 23 6. Urges law enforcement and emergency medical service personnel to
24 participate in appropriate training that minimally includes de-escalation
25 techniques and the appropriate use of drugs used to restrain individuals; and
- 26 7. Urges medical and behavioral health specialists, not law enforcement, to serve
27 as first responders and decision makers in medical and mental health
28 emergencies in local communities and that administration of any
29 pharmacological treatments in a non-hospital setting be done equitably, in an
30 evidence-based, anti-racist, and stigma-free way. (New HOD Policy)
- 31
- 32 2. That Policy H-65.954, “Policing Reform,” which recognizes police brutality as a
33 manifestation of structural racism which disproportionately impacts Black,
34 Indigenous, and other people of color, notes AMA’s willingness to work with
35 interested national, state, and local medical societies in a public health effort to
36 support the elimination of excessive use of force by law enforcement officers,
37 states that AMA will advocate against the utilization of racial and discriminatory
38 profiling by law enforcement through appropriate anti-bias training, individual
39 monitoring, and other measures, and will advocate for legislation and regulations
40 which promote trauma-informed, community-based safety practices, be
41 reaffirmed. (Reaffirm Current AMA Policy)
- 42
- 43 3. That Policy H-345.972, “Mental Health Crisis Interventions,” which supports jail
44 diversion and community based treatment options for mental illness,
45 implementation of law enforcement-based crisis intervention training programs for
46 assisting those individuals with a mental illness, such as the Crisis Intervention
47 Team model programs, federal funding to encourage increased community and
48 law enforcement participation in crisis intervention training programs, and
49 legislation and federal funding for evidence-based training programs by qualified
50 mental health professionals aimed at educating corrections officers in effectively

1 interacting with people with mental health and other behavioral issues in all
2 detention and correction facilities, be reaffirmed. (Reaffirm Current AMA Policy)
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4 Your Reference Committee heard passionate testimony about CSAPH Report 2. Many who
5 testified applauded the evidence-based review of the controversial topic and are proud that
6 the AMA has taken a stance on this issue which is a representation of systemic racism in
7 medicine. Several commentors noted that delirium is very much an acute psychiatric condition
8 as clearly defined in the DSM-5 and its specifiers do not include “excited;” this unfortunate
9 term has been misapplied to individuals who are agitated in the community for a multitude of
10 reasons. Many commentors agreed that it is concerning that it disproportionately impacts
11 individuals of color, for whom inappropriate and excessive pharmacotherapy continues to be
12 the norm instead of behavioral de-escalation.

13
14 Several commentors were emergency physicians and EMS medical directors and expressed
15 concerns about the report recommendations. Notably that the proposed recommendations did
16 not adequately capture a physician-led approach for emergency response for individuals
17 experiencing delirium. In addition, concerns were raised that physicians and law enforcement
18 were being requested to undergo similar training regimens that may not be appropriate for
19 their roles. In rebuttal, other commentors noted that emergency response typically utilizes a
20 “dual response” method of law enforcement and first responders, indicating that a combined
21 or complimentary training approach may be appropriate. Further concerns were raised about
22 the oversight authority for investigating potential cases in which inappropriate
23 pharmacological intervention was suspected. CSAPH believes that independent investigators
24 were appropriate, whereas members of the emergency medicine community believe that EMS
25 Medical Directors should lead any authority, with a supporting consortium providing guidance.
26 Finally, many emergency medicine practitioners commented that they disagree with their
27 colleagues and believe that “excited delirium” is an appropriate diagnosis and one commentor
28 noted that they worry there could be legal ramifications if the diagnosis is deemed invalid.
29 Your Reference Committee agrees with the majority of testimony that current evidence does
30 not support “excited delirium” as a diagnosis.

31
32 Several amendments to the CSAPH recommendations were offered. CSAPH noted in
33 testimony that they appreciate the input and amendments proffered by our emergency
34 medicine colleagues and concur with many of the amendments, including the title change
35 which aligns with the Joint Commission preferred verbiage, the use of the term
36 pharmacological intervention, the addition of age as a risk factor, and a newly added
37 recommendation which highlights and recognizes the important work of EMS Medical Director
38 physician colleagues and reiterates long standing policy of physician oversight, supervision,
39 and leadership of the health care team, in all forms of settings including the out of the hospital
40 setting. CSAPH, however, prefers the language of their original report recommendations for
41 other items, as they think it hems closer to the findings in the body of the report and maintains
42 its initial focus on the topic that the BOT asked them to review.

43
44 Your Reference Committee agrees with the perspective that independent oversight is
45 important to evaluate this issue, but also understand the need for physician oversight of
46 frontline EMS personnel. Therefore, your Reference Committee recommends that Council on
47 Science and Public Health Report 2 be adopted as amended.

1 (2) RESOLUTION 503 – ACCESS TO EVIDENCE-BASED
2 ADDICTION TREATMENT IN CORRECTIONAL
3 FACILITIES
4

5 **RECOMMENDATION A:**
6

7 **The first Resolve of Resolution 503 be amended by**
8 **addition and deletion to read as follows:**
9

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

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

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

28 **2. Our AMA advocates for legislation, standards,**
29 **policies and funding that encourage require**
30 **correctional facilities to increase access to evidence-**
31 **based treatment of OUD opiod use disorder, including**
32 **initiation and continuation of opiod replacement**
33 **therapy medications for OUD, in conjunction with**
34 **counseling psychosocial treatment when available and**
35 **desired by the person with OUD, in correctional**
36 **facilities within the United States and that this apply to**
37 **all incarcerated individuals who are incarcerated,**
38 **including pregnant women individuals who are**
39 **pregnant, postpartum, or parenting.**

40 **3. Our AMA supports advocates for legislation,**
41 **standards, policies, and funding that encourage require**
42 **correctional facilities within the United States to work**
43 **in ongoing collaboration with addiction treatment**
44 **physician-led teams, case managers, social workers,**
45 **and pharmacies in the communities where patients,**
46 **including pregnant women individuals who are**
47 **pregnant, postpartum, or parenting, are released to**
48 **offer post-incarceration treatment plans for OUD opiod**
49 **use disorder, including education, medication for**
50 **addiction treatment and counseling, and medication for**
51 **preventing overdose deaths, including naloxone (or**

1 any other medication that is approved by the United
2 States Food and Drug Administration for the treatment
3 of an opioid overdose), and help ensure post-
4 incarceration medical coverage and accessibility to
5 mental health and substance use disorder treatments,
6 that include medication and behavioral health and
7 social supports for addiction treatment—~~including~~
8 ~~medications for addiction treatment—~~medication
9 assisted therapy.

10 4. Our AMA advocates for all correctional facilities to
11 use a validated screening tool to identify opioid
12 withdrawal and take steps to determine potential need
13 for treatment for OUD and opioid withdrawal syndrome
14 for all persons upon entry.

15 (Modify Current HOD Policy)

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17 **RECOMMENDATION B:**

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

21
22 **RESOLVED**, That our AMA amend policy H-430.986,
23 “Health Care While Incarcerated,” by addition and
24 deletion to read as follows:

25 1. Our AMA advocates for adequate payment to health
26 care providers, including primary care and mental
27 health, and addiction treatment professionals, to
28 encourage improved access to comprehensive
29 physical and behavioral health care services to
30 juveniles and adults throughout the incarceration
31 process from intake to re-entry into the community.

32 2. Our AMA ~~supports~~ advocates and requires a smooth
33 transition including partnerships and information
34 sharing between correctional systems, community
35 health systems and state insurance programs to
36 provide access to a continuum of health care services
37 for juveniles and adults in the correctional system.

38 3. Our AMA encourages state Medicaid agencies to
39 accept and process Medicaid applications from
40 juveniles and adults who are incarcerated.

41 4. That our AMA encourage state Medicaid agencies to
42 work with their local departments of corrections,
43 prisons, and jails to assist incarcerated juveniles and
44 adults who may not have been enrolled in Medicaid at
45 the time of their incarceration to apply and receive an
46 eligibility determination for Medicaid.

47 5. Our AMA ~~encourages~~ advocates for states to
48 suspend rather than terminate Medicaid eligibility of
49 juveniles and adults upon intake into the criminal
50 justice legal system and throughout the incarceration

1 process, and to reinstate coverage when the individual
2 transitions back into the community.

3 **6. Our AMA urges advocates for Congress to repeal the**
4 **“inmate exclusion” of the 1965 Social Security Act that**
5 **bars the use of federal Medicaid matching funds from**
6 **covering healthcare services in jails and prisons, the**
7 **Centers for Medicare & Medicaid Services (CMS), and**
8 **state Medicaid agencies to provide Medicaid coverage**
9 **for health care, care coordination activities and**
10 **linkages to care delivered to patients up to 30 days**
11 **before the anticipated release from adult and juvenile**
12 **correctional facilities in order to help establish**
13 **coverage effective upon release, assist with transition**
14 **to care in the community, and help reduce recidivism.**

15 **7. Our AMA advocates for Congress and the Centers for**
16 **Medicare & Medicaid Services (CMS) to revise the**
17 **Medicare statute and rescind related regulations that**
18 **prevent payment for medical care furnished to a**
19 **Medicare beneficiary who is incarcerated or in custody**
20 **at the time the services are delivered.**

21 **8.7. Our AMA advocates for necessary programs and**
22 **staff training to address the distinctive health care**
23 **needs of incarcerated women and adolescent females**
24 **who are incarcerated, including gynecological care and**
25 **obstetrics care for pregnant and postpartum women**
26 **individuals who are pregnant or postpartum.**

27 **9.8. Our AMA will collaborate with state medical**
28 **societies, relevant medical specialty societies, and**
29 **federal regulators to emphasize the importance of**
30 **hygiene and health literacy information sessions, as**
31 **well as information sessions on the science of**
32 **addiction, evidence-based addiction treatment**
33 **including medications, and related stigma reduction,**
34 **for both inmates individuals who are incarcerated and**
35 **staff in correctional facilities.**

36 **10.9. Our AMA supports: (a) linkage of those**
37 **incarcerated to community clinics upon release in order**
38 **to accelerate access to comprehensive health care,**
39 **including mental health and substance abuse disorder**
40 **services, and improve health outcomes among this**
41 **vulnerable patient population, as well as adequate**
42 **funding; and (b) the collaboration of correctional health**
43 **workers and community health care providers for those**
44 **transitioning from a correctional institution to the**
45 **community.**

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

1 **12. Our AMA advocates for the prohibition of the use of**
2 **co-payments to access healthcare services in**
3 **correctional facilities (Directive to Take Action).**
4 **(Modify Current HOD Policy)**

5
6 **RECOMMENDATION C:**

7
8 **Resolution 503 be adopted as amended.**

9
10 **HOD ACTION: Resolution 503 adopted as amended.**

11
12 RESOLVED, That our American Medical Association amend policy H-430.987, "Opiate
13 Replacement Therapy Programs in Correctional Facilities," by addition and deletion to read
14 as follows:

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

17 1. Our AMA endorses: (a) the medical treatment model of employing ~~opiate replacement~~
18 ~~therapy (ORT) medications for opioid use disorder (OUD) as an effective therapy in treating~~
19 ~~opiate-addicted the standard of care for persons with OUD~~ who are incarcerated; and (b) ~~ORT~~
20 ~~for opiate-addicted medications for persons with OUD~~ who are incarcerated, an endorsement
21 in collaboration with the National Commission on Correctional Health Care and the American
22 Society of Addiction Medicine.

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

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

41 4. Our AMA advocates for all correctional facilities to use a validated screening tool to identify
42 opioid withdrawal and take steps to determine potential need for treatment for OUD and opioid
43 withdrawal syndrome for all persons upon entry. (Modify Current HOD Policy); and be it further
44

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

47 1. Our AMA advocates for adequate payment to health care providers, including primary care
48 and mental health, and addiction treatment professionals, to encourage improved access to
49 comprehensive physical and behavioral health care services to juveniles and adults
50 throughout the incarceration process from intake to re-entry into the community.

2. Our AMA supports partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. That our AMA encourage state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
5. Our AMA ~~encourages~~ advocates for states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal ~~justice~~ legal system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA ~~urges~~ advocates for Congress to repeal the "inmate exclusion" of the 1965 Social Security Act that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons, ~~the Centers for Medicare & Medicaid Services (CMS), and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from adult and juvenile correctional facilities in order to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism.~~
7. Our AMA advocates for Congress and the Centers for Medicare & Medicaid Services (CMS) to revise the Medicare statute and rescind related regulations that prevent payment for medical care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the services are delivered.
- 8.7. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of incarcerated women and adolescent females who are incarcerated, including gynecological care and obstetrics care for pregnant and postpartum women individuals who are pregnant or postpartum.
- 9.8. Our AMA will collaborate with state medical societies, relevant medical specialty societies, and federal regulators to emphasize the importance of hygiene and health literacy information sessions, as well as information sessions on the science of addiction, evidence-based addiction treatment including medications, and related stigma reduction, for both inmates individuals who are incarcerated and staff in correctional facilities.
- 10.9. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance abuse disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; and (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community. (Modify Current HOD Policy)

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

- 1 Doctor Speaker, this concludes the report of Reference Committee E. I would like to thank,
- 2 Michael A. DellaVecchia, MD, PhD, Farid Ghamsari, William S. Pease, MD, David A. Stumpf,
- 3 MD, Charles W. Van Way, III, MD, Anna Yap, MD, and all those who testified before the
- 4 Committee as well as our AMA staff.

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