MICHIGAN STATE MEDICAL SOCIETY
2021 HOUSE OF DELEGATES
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RESOLUTION 09-20

Title: Medication-Assisted Treatment in Physician Health Programs

Introduced by: Clara Hwang, MD, for the Wayne County Delegation

Original Author: Clara Hwang, MD

Referred To:

House Action:

Whereas, Physician Health Programs (PHPs) are designed to allow physicians with potentially impairing conditions who either come forward or are referred to be given the opportunity for evaluation, rehabilitation, treatment, and monitoring without disciplinary action in an anonymous, confidential, and respectful manner, and

Whereas, the PHP model is intended to ensure participants receive effective clinical care for mental, physical, and substance abuse disorders and access to a variety of clinical interventions and support, and

Whereas, currently, almost all of the physicians referred to PHPs who are diagnosed with substance use disorder (SUD) involving monitoring or sanctions are also subjected to punitive action by their respective licensing boards, and

Whereas, the majority of state PHP treatment programs adhere to abstinence only policies even as it relates to the use of medication-assisted treatment (MAT) for physicians diagnosed with substance use disorder (SUD) and will not refer physicians to addiction programs that include MAT as part of their program, and

Whereas, other treatment modalities used for SUDs include neuro-psychiatric testing and behavioral counseling, and

Whereas, FDA-approved MAT for SUD includes the opioid agonists buprenorphine, buprenorphine-naloxone combination products, and methadone, and the opioid antagonist naltrexone, and

Whereas, MAT has been proven to help maintain recovery and prevent death in patients with opioid use disorder (OUD), being referred to as the "gold standard" of treatment for OUD in the U.S. Surgeon General's "Spotlight on Opioids" report, and

Whereas, it is reported that patients who use MAT to treat their OUD remain in therapy longer than people who do not, and are less likely to use illicit opioids, and

Whereas, patients with OUD who receive the gold-standard MAT have significantly lower rates of relapse than those who do not have access to these treatments, and

Whereas, for physicians with OUD who are denied MAT, relapses and recurrences are common, and

Whereas, a 2019 report from the *National Academies of Sciences, Engineering, and Medicine* stated that "there is no scientific evidence that justifies withholding medications from OUD patients in any setting" and that such practices amount to "denying appropriate medical treatment," and

Whereas, physicians with OUD should have access to all the same evidenced-based treatment provided to patients which includes the use of counseling and MAT when medically indicated, and

Whereas, these outcomes are critical to ensuring a pathway to recovery and continuation of clinical practice in a safe and ethical manner with patient protection at the forefront, and

Whereas, there is no evidence to suggest that physicians maintained on therapeutic doses of MAT pose an increased risk to patient safety, and

Whereas, on August 29, 2019, the *New England Journal of Medicine* printed a perspective titled, "Practicing What We Preach- Ending Physician Health Program Bans on OPIOID-Agonist Therapy," by Leo Beletsky,JD; Sarah Wakeman, MD; and Kevin Fiscella, MD, MPH; therefore be it

RESOLVED: That MSMS work with the Michigan Legislature, the Michigan Department of Licensing and Regulatory Affairs, and the Michigan Boards of Medicine and Osteopathic Medicine and Surgery to direct Michigan's Health Professional Recovery Programs to adopt policy that permits physicians diagnosed with substance use disorder to receive counseling and medication assisted treatment as a means to ensure they receive effective clinical care to aid in their recovery and safe and ethical return to clinical practice; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) encourage our AMA to work with stakeholders including the Federation of State Medical Boards and the Federation of State Physician Health Programs to develop guidelines supporting the adoption of policies by state-based Physician Health Programs to permit physicians diagnosed with substance use disorder to receive counseling and medication assisted treatment to ensure physicians receive effective clinical care to aid in their recovery and safe and ethical return to clinical practice; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to work with stakeholders including the Federation of State Medical Boards and the Federation of State Physician Health Programs to develop model legislation permitting state Boards of Medicine and Osteopathic Medicine to waive punitive sanctions for physicians who voluntarily self-report their physical, mental, and substance use disorders by engaging with a Physician Health Program and who successfully complete the terms of participation.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions requesting governmental advocacy - $25,000+

Relevant MSMS Policy:

Physician Health Program
Programs for physicians whose capacity to function professionally has been impaired by addictive, psychiatric, medical, behavioral or other potentially impairing conditions should be motivated by humanitarian concerns for the public and the impaired physician.

All actions with regard to physician health programs should be intended to be in the best interest of the physician and the public. They should not be designed to be punitive in nature since the best current evidence indicates none of these conditions are voluntarily acquired or "self-inflicted." Physician health programs should enable effective clinical care for mental, physical and substance use disorders, including easy access to a variety of clinical interventions and treatment programs.

Relevant AMA Policy:

Support the Elimination of Barriers to Medication-Assisted Treatment for Substance Use Disorder D-95.968
1. Our AMA will: (a) advocate for legislation that eliminates barriers to, increases funding for, and requires access to all appropriate FDA-approved medications or therapies used by licensed drug treatment clinics or facilities; and (b) develop a public awareness campaign to increase awareness that medical treatment of substance use disorder with medication-assisted treatment is a first-line treatment for this chronic medical disease.
2. Our AMA supports further research into how primary care practices can implement medication-assisted treatment (MAT) into their practices and disseminate such research in coordination with primary care specialties.
3. The AMA Opioid Task Force will increase its evidence-based educational resources focused on methadone maintenance therapy (MMT) and publicize those resources to the Federation.

Educating Physicians About Physician Health Programs and Advocating for Standards D-405.990
Our AMA will:
(1) work closely with the Federation of State Physician Health Programs (FSPHP) to educate our members as to the availability and services of state physician health programs to continue to create opportunities to help ensure physicians and medical students are fully knowledgeable about the purpose of physician health programs and the relationship that exists between the physician health program and the licensing authority in their state or territory;
(2) continue to collaborate with relevant organizations on activities that address physician health and wellness;
(3) in conjunction with the FSPHP, develop state legislative guidelines addressing the design and implementation of physician health programs;
(4) work with FSPHP to develop messaging for all Federation members to consider regarding elimination of stigmatization of mental illness and illness in general in physicians and physicians in training;
(5) continue to work with and support FSPHP efforts already underway to design and implement the physician health program review process, Performance Enhancement and Effectiveness Review (PEER™), to improve accountability, consistency and excellence among its state member PHPs. The AMA will partner with the FSPHP to help advocate for additional national sponsors for this project; and
(6) continue to work with the FSPHP and other appropriate stakeholders on issues of affordability, cost effectiveness, and diversity of treatment options.

RESOLUTION 11-20

Title: Fentanyl Patch for Patch Exchange Program

Introduced by: David Whalen, MD, for the Kent County Delegation

Original Authors: Sandy Dettmann, MD, and Gerald Lee, MD

Referred To:

House Action:

Whereas, fentanyl is a powerful synthetic opioid analgesic and 50-100 times more potent than morphine, and

Whereas, fentanyl is a Schedule II prescription drug, and it is typically used to treat patients with severe pain or to manage pain after surgery, and

Whereas, roughly 28,400 people died from overdose of synthetic opiates, other than methadone, in 2017 alone, and

Whereas, Michigan's overdose rate of 21.2 per 100,000 is above the national average of 14.6 per 100,000, and

Whereas, synthetic opioids, mainly fentanyl, overdose deaths have increased in Michigan from 72 in 2012 to 1,368 in 2017, and

Whereas, Ontario, Canada, has instituted a successful patch for patch (P4P) exchange program, and

Whereas, a key component of the Ontario P4P program includes the labeling of a new fentanyl prescription as a first prescription, and

Whereas, this action will result in a onetime return of 9 out of 10 patches, and

Whereas, the returned patches should be stuck to a sheet of paper and turned into the pharmacist when getting a new prescription, and

Whereas, if a pharmacy receives a prescription for fentanyl patches but does not collect all used patches or collects fewer than the quantity to be dispensed, the pharmacy must contact the prescriber, and

Whereas, this enables the pharmacist, together with the prescriber, to make an assessment, consider the circumstances, and determine the best course of action and the quantity to be dispensed, and

Whereas, it is the responsibility of the pharmacist to properly store and dispose of used patches, as well as contacting appropriate law enforcement if there is suspected counterfeiting, misuse, and/or tampering; therefore be it

RESOLVED: That MSMS supports and shall propose a fentanyl "patch for patch" (P4P) exchange program in the state of Michigan modeled after the successful P4P program implemented in Ontario, Canada; and be it further

RESOLVED: That MSMS advocate the Michigan Legislature adopt a fentanyl "patch for patch" exchange program in Michigan modeled after the successful P4P program implemented in Ontario, Canada.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions requesting governmental advocacy - $25,000+

Relevant MSMS Policy:

Prescription Drug Abuse
MSMS supports the following AMA position on "Curtailing Prescription Drug Abuse While Preserving Therapeutic Use – Recommendations for Drug Control Policy:"

"Our AMA (1) opposes expansion of multiple-copy prescription programs to additional states or classes of drugs because of their documented ineffectiveness in reducing prescription drug abuse, and their adverse effect on the availability of prescription medications for therapeutic use; (2) supports continued efforts to address the problems of prescription drug diversion and abuse through physician education, research activities, and efforts to assist state medical societies in developing proactive programs; and (3) encourages further research into development of reliable outcome indicators for assessing the effectiveness of measures proposed to reduce prescription drug abuse.

Relevant AMA Policy:

Curtailing Prescription Drug Abuse While Preserving Therapeutic Use - Recommendations for Drug Control Policy H-95.979 (see language above)

RESOLUTION 12-20

Title: Non-Stigmatizing Verbiage

Introduced by: David Whalen, MD, for the Kent County Delegation

Original Author: Sandy Dettmann, MD, DABAM, FASAM

Referred To:

House Action:

Whereas, we are in the midst of the largest manmade epidemic in the history of the United States, and

Whereas, drug overdose is the most common cause of death in Americans under the age of 50, and

Whereas, addiction is a medical disease with effective, evidence-based medical treatment available, and

Whereas, persons who suffer from the disease of addiction are frequently referred to as "drug addicts," and

Whereas, the verbiage "drug addict" conjures up a somewhat negative image in the minds of most people, and

Whereas, in reality, addiction is an "equal opportunity destroyer;" therefore be it

RESOLVED: That MSMS encourages the use of clinically accurate, non-stigmatizing, person first terminology when referring to persons with the disease of addition and shall incorporate such terminology in future communications and publications, as well as update existing policies during the normal process of updating the MSMS Policy Manual; and be it further

RESOLVED: That MSMS believes an individual with the disease of addiction should be accurately referred to as a "person with the disease of addiction" instead of "drug addict" or other stigmatizing verbiage.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions only requesting new or revised MSMS or AMA policy - $500

Relevant MSMS Policy:

Communication, Documentation, and Professionalism
MSMS endeavors to educate physicians and other health care providers about the importance of careful and accurate verbal discussions and written documentation of care provided.

MSMS encourages physicians to demonstrate and maintain high ethical standards to avoid inadvertently discrediting other physicians or other health care providers; thereby, leading by example so that resident physicians and medical students can learn in a supportive environment while providing excellent care for our mutual patients.

Relevant AMA Policy:

Destigmatizing the Language of Addiction H-95.917
Our AMA will use clinically accurate, non-stigmatizing terminology (substance use disorder, substance misuse, recovery, negative/positive urine screen) in all future resolutions, reports, and educational materials regarding substance use and addiction and discourage the use of stigmatizing terms including substance abuse, alcoholism, clean and dirty.

Destigmatizing the Language of Addiction D-95.966
Our AMA and relevant stakeholders will create educational materials on the importance of appropriate use of clinically accurate, non-stigmatizing terminology and encourage use among all physicians and U.S. healthcare facilities.

RESOLUTION 19-20

Title: Medicare-For-All

Introduced by: James Mitchiner, MD, MPH, for the Washtenaw County Delegation

Original Author: James Mitchiner, MD, MPH

Referred To:

House Action:

Whereas, approximately 29 million people remain uninsured despite the Affordable Care Act, with an additional 44 million under-insured, and

Whereas, lack of health insurance causes citizens to forego care, to receive care in expensive and inappropriate settings, or to receive care only at an advanced stage of disease, and

Whereas, Medicare-for-All is an alternative financing mechanism for national health insurance that does not supplant the private practice of medicine, and preserves existing doctor-patient relationships, and

Whereas, Medicare-for-All is subject to myths and misconceptions, including the false belief that Medicare-for-All is “socialized medicine” and that physicians will be paid at the current Medicare fee schedule rate, and

Whereas, Medicare is a single-payer model that receives high patient satisfaction ratings, yet has much lower administrative costs, and

Whereas, Medicare-for-All has advantages to medical practices including simplicity in billing and administration, and

Whereas, Medicare-for-All can make American businesses more competitive by eliminating corporate responsibility for financing employee health care, and

Whereas, Medicare-for-All provides the opportunity to improve medical care according to themes of the 2006 MSMS Future of Medicine report, including "Universal Coverage," "Prevention and Wellness," and "Partnering with Patients;" therefore be it

RESOLVED: That MSMS create a Health Care Reform Task Force charged with thoughtful and evidence-based deliberations on Medicare-for-All, with at least four periodic meetings throughout the year, leading to recommendations on MSMS taking a definitive “pro or con” position on Medicare-for-All. The Task Force shall report its recommendations to the 2022 MSMS House of Delegates.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions to form or join task forces (internal or external) - $5,000+

Relevant MSMS Policy:

National Health Care
MSMS supports voluntary, free-choice methods of medical and health care rather than a system dominated and controlled by the federal government.

Physician Input for National Health Care Programs
MSMS supports physician input at all levels in the development of any national health care programs.

Universal Coverage
MSMS supports comprehensive health system reform described in the MSMS Future of Medicine Report. *(See Addendum P "Guiding Principles for the Future of Medicine and Health Care" in website version)*

Relevant AMA Policy:

Educating the American People About Health System Reform H-165.844
Our AMA reaffirms support of pluralism, freedom of enterprise and strong opposition to a single payer system.

Health System Reform Legislation H-165.838
1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy:
a. Health insurance coverage for all Americans
b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps
c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials
d. Investments and incentives for quality improvement and prevention and wellness initiatives
e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care
f. Implementation of medical liability reforms to reduce the cost of defensive medicine
g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens

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

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

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

5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.

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

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

8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation:
a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services
b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system
c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted
d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate
e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another
f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest

9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA's position based on AMA policy.

10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.

11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal.

12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.

13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform.

Evaluating Health System Reform Proposals H-165.888
1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles:
A. Physicians maintain primary ethical responsibility to advocate for their patients' interests and needs.
B. Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed.
C. All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be.

D. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan.
E. Any national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care.
F. Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce an adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system.
G. All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President.
H. True health reform is impossible without true tort reform.

2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be specifically included in national health care reform legislation.

3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use / addiction disorders and will advocate for the inclusion of full parity for the treatment of mental illness and substance use / addiction disorders in all national health care reform legislation.

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

Sources:

1. Tolbert J, Orgera K. Key facts about the uninsured population. Kaiser Family Foundation, Nov. 6, 2020. https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/
2. Collins SR, Bhupal HK, Doty MM. Health insurance coverage eight years after the ACA: fewer uninsured Americans and shorter coverage gaps, but more underinsured (Commonwealth Fund, Feb. 2019), at: https://www.commonwealthfund.org/publications/issue-briefs/2019/feb/health-insurance-coverage-eight-years-after-aca
3. eHealth Insurance. Medicare Consumer Survey, February 2019. https://news.ehealthinsurance.com/_ir/68/20191/eHealth%20Medicare%20Consumer%20Survey%20February%202019.pdf

RESOLUTION 20-20

Title: Michigan State Medical Society Judicial Commission

Introduced by: David Whalen, MD, for the Kent County Delegation

Original Author: Jayne E. Courts, MD, FACP

Referred To:

House Action:

Whereas, the Judicial Commission serves to review any concern about the conduct of a physician member that is potentially in violation of the American Medical Association (AMA) Code of Ethics, and

Whereas, concerns may originate from patients or other people and may include, but are not limited to, inappropriate behavior, sexual harassment, or issues of gender identity, and

Whereas, the MSMS Judicial Commission serves as the disciplinary body within MSMS, and

Whereas, the Judicial Commission works through the component county medical societies, often in a slow and potentially inequitable process, and

Whereas, the Official Procedures of the Judicial Commission allow determination of appropriate disciplinary action of a physician member, including possible censure, suspension, or expulsion from MSMS membership, and

Whereas, clear and concise approaches to the judicial and disciplinary process would improve timeliness, consistency, equity, and protection due to standardized processes and expedited decisions; therefore be it

RESOLVED: That the MSMS Board of Directors consider making the Judicial Commission a Committee of the Board so the Committee may perform its function in a more efficient and equitable manner; and be it further

RESOLVED: That the MSMS Board of Directors study the structure and function of the Judicial Commission and recommend Constitution and Bylaws changes that will be brought to the 2022 MSMS House of Delegates for first reading.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions to form or join task forces (internal or external) - $5,000+

Relevant MSMS Policy:

Judicial Commission Complaint Process

1. MSMS staff receive inquires from patients or physicians about filing a complaint for a physician, nurse, hospital, or any other healthcare facility.
2. If the complaint is about a physician, the staff member verifies that the physician is a MSMS member. If the physician is a member, the staff member explains that the Judicial Commission process is a peer review process which starts with the county society peer review committee. We encourage the complainant to personally discuss the issue with the physician. Finally, the staff member explains that the MSMS Judicial Commission does not have jurisdiction to award money damages, revoke, restrict or limit a physician's license.
3. Many times, when the complainant realizes it is a peer review process only, they decide not to proceed. If they decide to proceed, the staff member sends a complaint form to gather further information. The complainant has 30 days to submit the form with the detailed information.
4. Once the form is received by MSMS, the MSMS staff member determines the appropriate county medical society (CMS) who should review the complaint and forwards the information to that CMS. If there is not an active county medical society, the MSMS Judicial Commission reviews the complaint.
5. Each CMS has their own process for reviewing a complaint. The MSMS staff member stays in touch with the CMS staff member asking for updates.
6. Once the CMS peer review process makes their determination, they send information about the final decision to the MSMS staff member.
7. The MSMS staff member notifies the Judicial Commission chair about the decision. The Chair decides how the full Commission will be notified of the complaint.

Statistics on Complaints

Year	Forms Mailed	Forms Received	Full Complaint Process
2016	2	0	0
2017	1	1	1
2018	3	0	0
2019	1	0	0
2020	3	2	2

Relevant AMA Policy:

Conflicts of Interest H-140.967
Our AMA calls on state and county medical societies to seek out and to respond to complaints of significant violations of the Council on Ethical and Judicial Affairs' guidelines, and it reminds those societies of the AMA's pledge to stand behind and to provide financial support for any society enforcing in good faith and under approved disciplinary procedures AMA's code of ethics.

Source:
1. Michigan State Medical Society. Constitution and Bylaws, Supplement: Official Procedures for the MSMS Judicial Commission, 2015 edition.

RESOLUTION 23-20

Title: Signage Balancing Patient Safety, Quality of Care, and Patient Dignity

Introduced by: David Whalen, MD, for the Kent County Delegation

Original Author: Jayne E. Courts, MD, FACP

Referred To:

House Action:

Whereas, patients who reside in a skilled nursing facility (SNF), either for sub-acute rehabilitation (SAR) or long-term care (LTC), often have safety or care needs that need to be addressed by the health care team at the SNF, and

Whereas, included in these patient care needs are often simple, but important, care plan concerns such as the number needed for assist due to the fall risk, the need to follow a dysphagia diet (with thickened liquids), or the need to follow a fluid restriction, and

Whereas, SNF staff are trained to respond to call lights as quickly as possible, including responding to call lights of any residents who require assistance, even if the patient has not been assigned to that staff member, and

Whereas, a staff member may provide assistance to a patient with whom he/she is not familiar, including lack of familiarity with the care plan, and

Whereas, in the inpatient setting or in the acute rehabilitation setting, patients at risk for falls often wear wristbands clearly indicating this potential risk in an effort to reduce falls and the possible adverse consequences for the patient, and

Whereas, this readily visible reminder is seen as a patient safety and quality of care measure that benefits the patient and helps to reduce the number of fall "never events," and

Whereas, the regulatory environment in the SNF setting is determined by the Centers for Medicare and Medicaid Services (CMS), and

Whereas, CMS's interpretive guidelines require that an environment must be maintained in which there are no signs posted in residents' rooms or in staff work areas able to be seen by other residents and/or visitors that include confidential clinical or personal information (though signage in non-visible, non-readily seen locations such as the inside of a cupboard door in the resident's room is permissible), and

Whereas, any publicly visible identification of residents with a fall risk such as a wristband is deemed to be a violation of patient dignity requirements, rather than as a potential method of ensuring the patient's safety and provision of quality of care, and

Whereas, this requirement to ensure information is not viewable by the public doesn't even allow a colored dot on the room number by the door to alert SNF staff members to patient care needs such as a dysphagia diet, fluid restrictions, or other patient safety and quality concerns, and

Whereas, non-adherence to this regulatory approach, believed to preserve the dignity of the patient, will result in a citation which may include plan of correction requirements, education of the staff, and monetary infractions, including but not limited to denial of payment until the CMS 7 surveyors have resurveyed the SNF and have determined that the regulatory guidelines have been met through the plan of correction, and

Whereas, CMS citations may result in a reduction in the SNF's five-star rating which may affect reimbursement rates and the SNF's reputation and possible referral rates until the five-star rating has improved, and

Whereas, identification of patients at risk for falls in the inpatient setting or the acute rehabilitation setting is not considered to be an infringement on the patient's dignity, but is viewed instead as a safety concern for the protection of the patient; therefore be it

RESOLVED: That MSMS work with appropriate stakeholders to review the rationale for the Centers for Medicare and Medicaid Services' patient dignity regulations applicable to long-term care facilities and determine acceptable indicators or markers with better visibility to indicate patients with an increased fall risk or other health care risk concerns; and be it further

RESOLVED: That MSMS work with the appropriate stakeholders to develop and advocate for recommended changes to the Centers for Medicare and Medicaid Services' patient dignity regulations applicable to long-term care facilities so that discrete, but readily visible, indicators or markers of a patient's health care risk concerns may be used for the benefit and safety of patients without triggering a citation; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to work with the Centers for Medicare and Medicaid Services (CMS) to review the rationale for CMS's patient dignity regulations applicable to long-term care facilities and determine acceptable indicators or markers with better visibility to indicate patients with an increased fall risk or other health care risk concerns; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to work with the Centers for Medicare and Medicaid Services (CMS) to change the patient dignity regulations applicable to long-term care facilities so that discrete, but readily visible, indicators or markers of a patient's health care risk concerns may be used for the benefit and safety of patients without triggering a citation.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions requesting governmental advocacy - $25,000+

Relevant MSMS Policy:
None

Relevant AMA Policy:

Residential Facility Regulations H-280.984
Our AMA advocates for patients in long-term care, group home and other residential settings and will: (1) strive to see that enhanced quality of care results from any new proposed state or federal regulations; (2) attempt to ensure that appropriate and necessary physician involvement be maintained for patients; (3) urge state regulatory bodies and HHS to seek consultation and advice from the AMA and other professional medical societies when developing rules and regulations that affect medical care; (4) support cooperative efforts with appropriate groups for the purpose of developing mutually supported positions regarding medical care regulations; (5) support efforts to monitor federal and state legislation and regulations which affect physicians involved in long-term, group home or other residential setting care, and provide testimony and information about appropriate medical management of patients to regulatory and/or licensing bodies; and (6) support actions to establish better understanding and cooperation among federal and state health agencies as they formulate health and safety standards.

RESOLUTION 24-20

Title: Prescription Medication Pill Size

Introduced by: David Whalen, MD, for the Kent County Delegation

Original Authors: Michelle M. Condon, MD and David Whalen, MD

Referred To:

House Action:

Whereas, dosing of medication frequently requires a patient to cut pills in half to achieve the proper dose recommended by their physician, and

Whereas, these medication types requiring alteration in pill tab size may be to limit the dose of controlled substances which is an advantage to many patients, and

Whereas, these dosage adjustments may be difficult for patients with limited dexterity to cut on their own; therefore be it

RESOLVED: That MSMS ask the Michigan Board of Pharmacy to pursue pill medication size to be no smaller than six mm in diameter or other size found by research to be best suited for pill cutting by elderly or disabled patients; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to request pharmaceutical companies to manufacture pills larger than five mm in diameter for medications most likely to be prescribed to elderly and disabled persons, especially those consisting of controlled substances, to better allow pill cutting to help control dosages, unless research shows this to be unnecessary in this group of patients.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions requesting governmental advocacy - $25,000+

Relevant MSMS Policy:
None

Relevant AMA Policy:
None

RESOLUTION 25-20

Title: Limit Copay on Emergency Department Visits

Introduced by: David Whalen, MD, for the Kent County Delegation

Original Author: Michelle M. Condon, MD, FACP

Referred To:

House Action:

Whereas, some insurance products require a patient to pay an extra or larger co-pay or deductible if an emergency department evaluation does not lead to a hospital admission, and

Whereas, these patients may have waited to confer with their private physician until office hours are open, but are instructed by that physician to go to the emergency department for evaluation; therefore be it

RESOLVED: That MSMS advocate that insurance companies waive the imposition of higher co-pays or deductibles when a patient is directed by their primary care physician to seek treatment for an acute problem in the emergency department, even if the patient is not admitted to the hospital.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions requesting governmental advocacy - $25,000+

Relevant MSMS Policy:
None

Relevant AMA Policy:
None

RESOLUTION 26-20

Title: Joint Task Force to Improve Prior Authorization Processes

Introduced by: Richard Burney, MD, for the Washtenaw County Delegation

Original Author: Richard Burney, MD

Referred To:

House Action:

Whereas, prior authorization of physician orders for selected medications, tests, and procedures has long been a contentious issue associated with feelings of intense frustration by health care providers, and

Whereas, the prior authorization process is perceived by physicians as excessively bureaucratic, inefficient, and counterproductive, and

Whereas, the physicians believe that the majority of prior authorization requests are approved, rendering the process a waste of time and money, and

Whereas, physicians believe patients are suffering from delays due to required authorizations, and

Whereas, as with many policy issues, there is more than one side to this issue, and

Whereas, insurers may have legitimate reasons for instituting prior authorization programs, and

Whereas, physicians acting in good faith on behalf of insurers to carry out prior authorization programs may feel equally frustrated, and

Whereas, impediments in the current system, which is complex and misunderstood, are unlikely to go away, and

Whereas, the American Medical Association has endorsed collaborative efforts to improve the prior authorization process, and

Whereas, regardless of the outcome of any legislation regarding prior authorization, the need will still exist to collaborate with insurers, therefore be it

RESOLVED: That in addition to legislative pursuits, MSMS advocate for a joint task force process facilitated by a neutral, expert party, bringing together health care providers and insurers, to examine ways in which a better mutual understanding of prior authorization processes can be achieved, which can lead to mutually beneficial improvements in prior authorization processes.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions requiring external consultants - $50,000+

Relevant MSMS Policy:

Compensation for Prior Authorization Efforts
MSMS supports working with Michigan insurance companies to study the effectiveness, efficiency, and outcomes of prior authorization processes with the goal of minimizing the burden of prior authorization activities and eliminating non-value added processes including, but not limited to, such issues as value, efficiency, and compensation.

Prior Authorization for Delivery
MSMS opposes the current practice/rule requiring prior authorization for elective delivery of any patient.

Prior Authorization for Surgical Procedures
MSMS supports requiring Michigan health plans to finalize their decisions on "prior authorization" at least one calendar week before the scheduled procedure.

Prior Authorization Reform
MSMS supports the American Medical Association's 21 guiding principles to reform prior authorization requirements and will utilize the principles as a guide for prior authorization reform.

Coverage of Approved Medications
MSMS supports that Medicaid Health Plans in Michigan cover all medications on the Michigan Medicaid's Preferred Drug List, without having to repeat prior authorization or step-therapy that has already been documented on the patient.

Prior Authorization Compensation
MSMS supports appropriate and adequate reimbursement for physicians who are required to spend time and resources defending orders for diagnostic tests due to the utilization of prior authorization policies by third-party payers.

Relevant AMA Policy

Prior Authorization and Utilization Management Reform H-320.939
1. Our AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.
2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.
3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.

Prior Authorization Reform D-320.982
Our AMA will explore emerging technologies to automate the prior authorization process for medical services and evaluate their efficiency and scalability, while advocating for reduction in the overall volume of prior authorization requirements to ensure timely access to medically necessary care for patients and reduce practice administrative burdens.

Remuneration for Physician Services H-385.951

1. Our AMA actively supports payment to physicians by contractors and third party payers for physician time and efforts in providing case management and supervisory services, including but not limited to coordination of care and office staff time spent to comply with third party payer protocols.
2. It is AMA policy that insurers pay physicians fair compensation for work associated with prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements and that compensates physicians fully for the legal risks inherent in such work.
3. Our AMA urges insurers to adhere to the AMA's Health Insurer Code of Conduct Principles including specifically that requirements imposed on physicians to obtain prior authorizations, including pre-certifications and prior notifications, must be minimized and streamlined and health insurers must maintain sufficient staff to respond promptly.

Preauthorization for Payment of Services H-320.961
Our AMA supports legislation and/or regulations that would prevent the retrospective denial of payment for any claim for services for which a physician had previously obtained authorization, unless fraud was committed or incorrect information provided at the time such prior approval was obtained.

Payer Accountability H-320.982
Our AMA: (1) Urges that state medical associations and national medical specialty societies to utilize the joint Guidelines for Conduct of Prior Authorization Programs and Guidelines for Claims Submission, Review and Appeals Procedures in their discussions with payers at both the national and local levels to resolve physician/payer problems on a voluntary basis.
(2) Reaffirms the following principles for evaluation of preadmission review programs, as adopted by the House of Delegates at the 1986 Annual Meeting: (a) Blanket preadmission review of all or the majority of hospital admissions does not improve the quality of care and should not be mandated by government, other payers, or hospitals. (b) Policies for review should be established by state or local physician review committees, and the actual review should be performed by physicians or under the close supervision of physicians. (c) Adverse decisions concerning hospital admissions should be finalized only by physician reviewers and only after the reviewing physician has discussed the case with the attending physician. (d) All preadmission review programs should provide for immediate hospitalization, without prior authorization, of any patient whose treating physician determines the admission to be of an emergency nature. (e) No preadmission review program should make a payment denial based solely on the failure to obtain preadmission review or solely on the fact that hospitalization occurred in the face of a denial for such admission.
(3) Affirms as policy and advocates to all public and private payers the right of claimants to review by a physician of the same general specialty as the attending physician of any claim or request for prior authorization denied on the basis of medical necessity.

Sources:

1. Rosneck JS. Refocusing Medication Prior Authorization on Its Intended Purpose. JAMA 2020; 323:703-704
2. American Medical Association. Consensus statement on improving the prior authorization process. https//:www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf. Accessed March 5, 2020

RESOLUTION 28-20

Title: ICD-10-CM Code for 'Statin Refusal'

Introduced by: David Whalen, MD, for the Kent County Delegation

Original Author: Rose Ramirez, MD

Referred To:

House Action:

Whereas, we are moving from a fee-for-service payment model to a value-based payment model, and

Whereas, measuring and reporting quality metrics by providers has continued to increase, and

Whereas, the Centers for Medicare and Medicaid Services (CMS) Medicare Stars program requires insurers to also meet and report on quality metrics, and

Whereas, because of HEDIS measures and the CMS Medicare Stars program, there is a very strong push by insurers to get all patients that might benefit from a statin onto one, and even measuring the number of refills per unit of time to show patient compliance, and

Whereas, the number of allowed exclusions to the statin measure in specific have decreased, which can reduce a provider's ability to hit quality targets and impact the providers quality payments, and

Whereas, despite our recommendations and education about the benefits of statins, some patients still refuse to accept a statin, and

Whereas, patient choice in the partnership between physician and patient should be honored whenever possible, and

Whereas, physicians simply cannot force patients to take a medication they do not want to take, and

Whereas, there is an ICD-10-CM code for coumadin refusal and one for medication refusal, but not a code for statin refusal, and

Whereas, a specific code for statin refusal could be useful for those patients who do not have other exclusion criteria for a statin; therefore be it

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA for the creation of a new specific 'statin refusal' code and advocate it be a valid exclusion criterion for patients.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions only requesting new or revised MSMS or AMA policy - $500

Relevant MSMS Policy:
None

Relevant AMA Policy:
None

RESOLUTION 29-20

Title: Enforce AMA Principles on Continuing Board Certification

Introduced by: David Whalen, MD, for the Kent County Delegation

Original Authors: Megan Edison, MD, and David Whalen, MD

Referred To:

House Action:

Whereas, the American Medical Association (AMA) Principles on Continuing Board Certification have been developed through the democratic process of various states' Houses of Delegates and the AMA House of Delegates, reflecting the collective will of state and national medical societies and their physician members, and

Whereas, these longstanding principles clearly demand a continuing board certification process that is low cost, evidence-based, untied to insurance and hospital credentialing, and free of harm to the physician workforce, and

Whereas, the proprietary American Board of Medical Specialties (ABMS) and American Osteopathic Association (AOA) continuing board certification product continues to be high cost, high stress, without evidence over other forms of continuing medical education, required for insurance and hospital credentialing, and harmful to the physician workforce, and

Whereas, ABMS and AOA boards continue to ignore the AMA on nearly every aspect of the AMA policy handbook on continuing board certification, and

Whereas, this failure to protect physicians from recertification harm is having significant effects upon cost of care, physician burnout, and access to qualified physicians, and

Whereas, this failure to advocate successfully for these principles reflects poorly upon the ability of organized medicine to defend physicians and our right to care for patients; therefore be it

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to continue to actively work to enforce current AMA Principles on Continuing Board Certification; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to publicly report their work on enforcing AMA Principles on Continuing Board Certification at the Annual and Interim meetings of the AMA House of Delegates.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions only requesting new or revised MSMS or AMA policy - $500

Relevant MSMS Policy:

Review Board Recertification and Maintenance of Certification Process
MSMS supports Maintenance of Certification (MOC) only under all of the following circumstances:
1. MOC must be voluntary.
2. MOC must not be a condition of licensure, hospital privileges, health plan participation, or any other function unrelated to the specialty board requiring MOC.
3. MOC should not be the monopoly of any single entity. Physicians should be able to access a range of alternatives from different entities.
4. The status of MOC should be revisited by MSMS if it is identified that the continuous review of physician competency is objectively determined to be a benefit for patients. If that benefit is determined to be present by objective data regarding value and efficacy, then MSMS should support the adoption of an evidence based process that serves only to improve patient care.

Relevant AMA Policy:

Continuing Board Certification H-275.924
Continuing Board Certification AMA Principles on Continuing Board Certification
1. Changes in specialty-board certification requirements for CBC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in CBC must be reasonable and take into consideration the time needed to develop the proper CBC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the CBC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for CBC.
4. Any changes in the CBC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. CBC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of CBC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for CBC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of CBC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with CBC participation.
9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for CBC Part II. The content of CME and self-assessment programs receiving credit for CBC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 Credit", American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)."
10. In relation to CBC Part II, our AMA continues to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.
11. CBC is but one component to promote patient safety and quality. Health care is a team effort, and changes to CBC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.

12. CBC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.
13. The CBC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.
14. CBC should be used as a tool for continuous improvement.
15. The CBC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.
16. Actively practicing physicians should be well-represented on specialty boards developing CBC.
17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.
18. CBC activities and measurement should be relevant to clinical practice.
19. The CBC process should be reflective of and consistent with the cost of development and administration of the CBC components, ensure a fair fee structure, and not present a barrier to patient care.
20. Any assessment should be used to guide physicians' self-directed study.
21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.
22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.
23. Physicians with lifetime board certification should not be required to seek recertification.
24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in CBC.
25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.
26. The initial certification status of time-limited diplomates shall be listed and publicly available on all American Board of Medical Specialties (ABMS) and ABMS Member Boards websites and physician certification databases. The names and initial certification status of time-limited diplomates shall not be removed from ABMS and ABMS Member Boards websites or physician certification databases even if the diplomate chooses not to participate in CBC.
27. Our AMA will continue to work with the national medical specialty societies to advocate for the physicians of America to receive value in the services they purchase for Continuing Board Certification from their specialty boards. Value in CBC should include cost effectiveness with full financial transparency, respect for physicians' time and their patient care commitments, alignment of CBC requirements with other regulator and payer requirements, and adherence to an evidence basis for both CBC content and processes.

RESOLUTION 31-20

Title: Bring Insurance Credentialing into Legal Compliance on Maintenance of Certification

Introduced by: David Whalen, MD, for the Kent County Delegation

Original Author: Megan Edison, MD

Referred To:

House Action:

Whereas, Public Act 487 of 2018 became law on December 27, 2018, and

Whereas, this law was a direct result of resolutions adopted by the MSMS House of Delegates to end insurance company mandates to participate in or purchase maintenance of certification products in order to be accepted as an in-network provider eligible to care for patients, and

Whereas, the law states, "an insurer that delivers, issues for delivery, or renews in this state a health insurance policy issued under chapter 34 or a health maintenance organization that issues a health maintenance contract under chapter 35 shall not require as the sole condition precedent to the payment or reimbursement of a claim under the policy or contract that an allopathic or osteopathic physician in the medical specialties of family practice, internal medicine, or pediatrics maintain a national or regional certification not otherwise specifically required for licensure under article of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838," and

Whereas, despite passage of this law over two years ago, there are insurance companies in Michigan ignoring the law by not changing credentialing policy and continuing to reject physicians solely for not maintaining American Board of Medical Specialties or the American Osteopathic Association board certification; therefore be it

RESOLVED: That MSMS work with Michigan health insurance companies to change credentialing requirements to be in compliance with Public Act 487 of 2018, by requiring only initial board certification for the credentialing of in-network physicians specializing in family medicine, internal medicine, and pediatrics; and be it further

RESOLVED: That MSMS pursue legal action against Michigan health insurance companies that refuse to work with MSMS to bring the health insurance company's credentialing requirements into legal compliance with Public Act 487 of 2018 and continue to discriminate against family medicine, internal medicine, and pediatric physicians for not participating in or purchasing a maintenance of certification product.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions calling for legal intervention - $100,000+

Relevant MSMS Policy:

Review Board Recertification and Maintenance of Certification Process
MSMS supports Maintenance of Certification (MOC) only under all of the following circumstances:
1. MOC must be voluntary.
2. MOC must not be a condition of licensure, hospital privileges, health plan participation, or any other function
unrelated to the specialty board requiring MOC.
3. MOC should not be the monopoly of any single entity. Physicians should be able to access a range of alternatives from different entities.
4. The status of MOC should be revisited by MSMS if it is identified that the continuous review of physician competency is objectively determined to be a benefit for patients. If that benefit is determined to be present by objective data regarding value and efficacy, then MSMS should support the adoption of an evidence based process that serves only to improve patient care.

Relevant AMA Policy:

Continuing Board Certification D-275.954
Our AMA will:
1. Continue to monitor the evolution of Continuing Board Certification (CBC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for CBC, and prepare a yearly report to the House of Delegates regarding the CBC process.
2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review CBC issues.
3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of CBC, and encourage the ABMS to report its research findings on the issues surrounding certification and CBC on a periodic basis.
4. Encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and CBC.
5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of CBC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.
6. Work with interested parties to ensure that CBC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that CBC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.
7. Recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.
8. Work with the ABMS to eliminate practice performance assessment modules, as currently written, from CBC requirements.
9. Encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting CBC and certifying examinations.
10. Encourage the ABMS to ensure that CBC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle.
11. Work with the ABMS to lessen the burden of CBC on physicians with multiple board certifications, particularly to ensure that CBC is specifically relevant to the physician's current practice.
12. Work with key stakeholders to (a) support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for CBC; (b) support ABMS member board activities in facilitating the use of CBC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement; (c) encourage ABMS member boards to enhance the consistency of quality improvement programs across all

boards; and (d) work with specialty societies and ABMS member boards to develop tools and services that help physicians meet CBC requirements.
13. Work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.
14. Work with the ABMS to study whether CBC is an important factor in a physician's decision to retire and to determine its impact on the US physician workforce.
15. Encourage the ABMS to use data from CBC to track whether physicians are maintaining certification and share this data with the AMA.
16. Encourage AMA members to be proactive in shaping CBC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and CBC Committees.
17. Continue to monitor the actions of professional societies regarding recommendations for modification of CBC.
18. Encourage medical specialty societies' leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant CBC process for its members.
19. Continue to work with the ABMS to ensure that physicians are clearly informed of the CBC requirements for their specific board and the timelines for accomplishing those requirements.
20. Encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.
21. Recommend to the ABMS that all physician members of those boards governing the CBC process be required to participate in CBC.
22. Continue to participate in the National Alliance for Physician Competence forums.
23. Encourage the PCPI Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of CBC.
24. Continue to assist physicians in practice performance improvement.
25. Encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty board's CBC and associated processes.
26. Support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the CBC program.
27. Oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Continuing Board Certification.
28. Ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on continuing board certification activities relevant to their practice.
29. Call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.
30. Support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician's practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.
31. Continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam.
32. Continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.
33. Through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Continuing Board Certification not be a requirement for: (a) medical staff membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure.
34. Increase its efforts to work with the insurance industry to ensure that continuing board certification does not become a requirement for insurance panel participation.

35. Advocate that physicians who participate in programs related to quality improvement and/or patient safety receive credit for CBC Part IV.
36. Continue to work with the medical societies and the American Board of Medical Specialties (ABMS) member boards that have not yet moved to a process to improve the Part III secure, high-stakes examination to encourage them to do so.
37. Our AMA will, through its Council on Medical Education, continue to work with the American Board of Medical Specialties (ABMS), ABMS Committee on Continuing Certification (3C), and ABMS Stakeholder Council to pursue opportunities to implement the recommendations of the Continuing Board Certification: Vision for the Future Commission and AMA policies related to continuing board certification.

RESOLUTION 33-20

Title: Access to Direct Primary Care Physicians

Introduced by: David Whalen, MD, for the Barry County Delegation

Original Author: Belen Amat, MD

Referred To:

House Action:

Whereas, Michigan Compiled Law 500.129 recognizes direct primary care (DPC) and requires DPC practices to charge a periodic fee, avoid billing third-party payers on a fee-for-service basis, and limit any per visit charge to less than the monthly equivalent of the periodic fee, and

Whereas, DPC practices do not participate with, or bill any insurance companies, allowing DPC practices to provide high quality individualized care at affordable rates for patients, and

Whereas, the DPC options offers a plan that provides individuals and families with unlimited access to their personal physician for a flat, monthly fee, and

Whereas, patients choose DPC practices for longer office visits with their physician, increased access via phone calls, text messages, and video chat, all while being cost conscious, and

Whereas, DPC plans are not health insurance, and DPC patients often carry high deductible insurance plans and are responsible for most of the cost of outpatient testing, medications, and consults, and

Whereas, DPC physicians are very skilled at finding and negotiating low cost medication, referrals, and studies for their patients, and

Whereas, some insurance companies consider DPC physicians "out of network," and will not allow them to order medications, tests, or referrals on patients who have health insurance, even when the medical treatment is being paid 100 percent by the patient due to high deductibles, and

Whereas, insurance companies will require a patient to visit an insurance-based doctor solely to make the referral, thereby increasing healthcare costs and delaying care, and

Whereas, unlike traditional insurance-based physicians who may be out of network with particular insurance companies, DPC physicians are, by definition and legal distinction, a unique class of physicians, and out-of-network with all insurances, and

Whereas, the state of Maine recognized this distinction, and passed legislation prohibiting denial of referrals by DPC physicians; therefore be it

RESOLVED: That MSMS educate health insurers on the role of direct primary care physicians in promoting high quality care while decreasing health care costs for patients with health insurance; and be it further

RESOLVED: That MSMS work with health insurers to allow direct primary care physicians to prescribe medications, order tests, and make referrals for patients with health insurance.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions requesting governmental advocacy - $25,000+

Relevant MSMS Policy:

Resolution 23-15
Resolved: That MSMS study and educate it members regarding alternative payment models for primary care including direct primary care contracts and "concierge" medicine using methods such as email, website, and webinar programs.

Relevant AMA Policy:

Direct Primary Care H-385.912
1. Our AMA supports: (a) inclusion of Direct Primary Care as a qualified medical expense by the Internal Revenue Service; and (b) efforts to ensure that patients in Direct Primary Care practices have access to specialty care, including efforts to oppose payer policies that prevent referrals to in-network specialists.
2. AMA policy is that the use of a health savings account (HSA) to access direct primary care providers and/or to receive care from a direct primary care medical home constitutes a bona fide medical expense, and that particular sections of the IRS code related to qualified medical expenses should be amended to recognize the use of HSA funds for direct primary care and direct primary care medical home models as a qualified medical expense.
3. Our AMA will seek federal legislation or regulation, as necessary, to amend appropriate sections of the IRS code to specify that direct primary care access or direct primary care medical homes are not health "plans" and that the use of HSA funds to pay for direct primary care provider services in such settings constitutes a qualified medical expense, enabling patients to use HSAs to help pay for Direct Primary Care and to enter DPC periodic-fee agreements without IRS interference or penalty.

RESOLUTION 39-20

Title: End Time Limited Board Certification

Introduced by: David Whalen, MD, for the Kent County Delegation

Original Authors: Megan Edison, MD, and David Whalen, MD

Referred To:

House Action:

Whereas, achievement of initial board certification status after residency or fellowship is widely regarded as a marker of academic competency in a medical or surgical specialty, and

Whereas, initial board certification is all that is required of time-unlimited, or "grandfathered," physicians to be board-certified without any concerns about their competence or professionalism, and

Whereas, time-unlimited physicians have the option to participate and purchase the maintenance of certification (MOC) educational product, but they do not lose initial board certification if they choose not to participate, and

Whereas, time-limited physicians must continually participate and purchase MOC, or they will lose initial board certification and be erased from publicly available certification websites if they do not comply with the MOC process, and

Whereas, continuing medical education (CME) from a robust competitive CME marketplace is widely regarded as the physician pathway to staying current and up to date in a specialty and is therefore required by most states for medical licensure and renewal, and

Whereas, the proprietary MOC educational products from the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA) have no proven academic benefit over other forms of CME to improve quality of care and patient outcomes, and

Whereas, robust local accountability systems throughout our profession (including direct observation through our work together as fellow colleagues, employer peer review, hospital peer review, and review by state Boards of Medicine) exist and assure professionalism, discipline, and self-regulation of our profession locally, and

Whereas, private medical specialty boards (e.g., ABMS, AOA) have little to no jurisdiction to ensure discipline, accountability, and professionalism of physicians, and

Whereas, the MOC product is not academically superior to other forms of CME in terms of patient outcomes and is jurisdictionally inferior to local forms of professional accountability and discipline, rendering it a duplicative burden upon younger physicians, at best, and

Whereas, loss of initial board certification status for not participating and purchasing the MOC product results in significant financial and professional harm to time-limited physicians as they are removed from insurance panels and hospitals; thereby, forcing many physicians to comply with MOC, and

Whereas, all good faith efforts by organized medicine asking ABMS and AOA to limit the cost, burden, and stress of forced MOC have been ignored, resulting in ongoing harm to physicians, and

Whereas, all good faith efforts by organized medicine asking that MOC not be tied to insurance reimbursement and hospital privileges have been ignored, and

Whereas, it is time to stop this nonsense and the harm forced MOC is causing physicians; therefore be it

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to call for an end to time-limited American Board of Medical Specialties and American Osteopathic Association board certification; thereby, ending discrimination against time-limited board-certified physicians, and

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to allow the purchase and participation of any proprietary continuing board certification or maintenance of certification or osteopathic continuous certification product to be a voluntary process for all board-certified physicians; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to call on the American Board of Medical Specialties and the American Osteopathic Association to make continuing board certification or maintenance of certification or osteopathic continuous certification a voluntary process separate from initial certification; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) work with the American Board of Medical Specialties and the American Osteopathic Association to ensure that initial board certification remain as a time-unlimited, earned marker of academic competency, and should not be nullified for not participating in or purchasing the maintenance of certification product.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions only requesting new or revised MSMS or AMA policy - $500

Relevant MSMS Policy:

Review Board Recertification and Maintenance of Certification Process

MSMS supports Maintenance of Certification (MOC) only under all of the following circumstances:

1. MOC must be voluntary.
2. MOC must not be a condition of licensure, hospital privileges, health plan participation, or any other function unrelated to the specialty board requiring MOC.
3. MOC should not be the monopoly of any single entity. Physicians should be able to access a range of alternatives from different entities.
4. The status of MOC should be revisited by MSMS if it is identified that the continuous review of physician

competency is objectively determined to be a benefit for patients. If that benefit is determined to be present by objective data regarding value and efficacy, then MSMS should support the adoption of an evidence based process that serves only to improve patient care.

Relevant AMA Policy:

Continuing Board Certification H-275.924
Continuing Board Certification AMA Principles on Continuing Board Certification
1. Changes in specialty-board certification requirements for CBC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in CBC must be reasonable and take into consideration the time needed to develop the proper CBC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the CBC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for CBC.
4. Any changes in the CBC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. CBC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of CBC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for CBC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of CBC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with CBC participation.
9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for CBC Part II. The content of CME and self-assessment programs receiving credit for CBC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 Credit", American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)."
10. In relation to CBC Part II, our AMA continues to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.
11. CBC is but one component to promote patient safety and quality. Health care is a team effort, and changes to CBC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.
12. CBC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.
13. The CBC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.
14. CBC should be used as a tool for continuous improvement.
15. The CBC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.
16. Actively practicing physicians should be well-represented on specialty boards developing CBC.

17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.
18. CBC activities and measurement should be relevant to clinical practice.
19. The CBC process should be reflective of and consistent with the cost of development and administration of the CBC components, ensure a fair fee structure, and not present a barrier to patient care.
20. Any assessment should be used to guide physicians' self-directed study.
21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.
22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.
23. Physicians with lifetime board certification should not be required to seek recertification.
24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in CBC.
25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.
26. The initial certification status of time-limited diplomates shall be listed and publicly available on all American Board of Medical Specialties (ABMS) and ABMS Member Boards websites and physician certification databases. The names and initial certification status of time-limited diplomates shall not be removed from ABMS and ABMS Member Boards websites or physician certification databases even if the diplomate chooses not to participate in CBC.
27. Our AMA will continue to work with the national medical specialty societies to advocate for the physicians of America to receive value in the services they purchase for Continuing Board Certification from their specialty boards. Value in CBC should include cost effectiveness with full financial transparency, respect for physicians' time and their patient care commitments, alignment of CBC requirements with other regulator and payer requirements, and adherence to an evidence basis for both CBC content and processes.

RESOLUTION 40-20

Title: Tuition Cost Transparency

Introduced by: Eric James, for the Medical Student Section

Original Authors: Awais Ahmed, Kaylie Bullock, Amy Cox, Kelly Fahey, Eric James, Benjamin Malamet, Ramiz Memon, Grace Peterson, and Stephanie Wong

Referred To:

House Action:

Whereas, in 2018, the Association of American Medical Colleges (AAMC) reported that 76 percent of medical students graduated with a median loan debt of $200,000. Compared to the median medical student debt of $50,000 in 1992, there is an approximate 220 percent increase in medical school debt, even after accounting for the rate of inflation, and

Whereas, the capitalizing interest rates of Stafford Subsidized loans increased from 1.87 percent prior to 2006, to a current fixed rate of 6.87 percent, thereby exacerbating the rising debt of medical students, and

Whereas, MSMS policy advocates for a variety of means in order to decrease medical student debt in the short-term and long-term, and

Whereas, higher levels of medical school debt are associated with worse academic outcomes in undergraduate medical education, negative effects on mental well-being, and higher levels of stress, and

Whereas, higher medical school debt influences the way medical students approach major life choices; students with higher aggregate amounts of debt were more likely to delay marriage or having children and disagree that they would choose to become a physician, again, and

Whereas, medical students with higher debt compared to their peers were more likely to choose a specialty with a higher annual income, were less likely to choose primary care, and less likely to plan to practice in underserved locations, and

Whereas, the number of graduate medical students exceeds the number of available post graduate year positions. The increasing number of students not matching, and the increase in medical student debt can make medical school seem more of a financial risk, and

Whereas, the American Medical Association (AMA) supports continued assessment of the value of graduate medical education (GME) and transparency of federal funding, which is received by GME institutions, and

Whereas, undergraduate medical students are not provided specific breakdowns of tuition costs or reasons for tuition increases, and

Whereas, the AMA supports improving the systematic reporting of undergraduate medical student expenditures to determine which items are included and the ranges of costs; therefore be it

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to collaborate with organizations such as the Association of American Medical Colleges in creating transparency in tuition costs of undergraduate medical education institutions; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to collaborate with the Association of American Medical Colleges in systematic reporting of itemized tuition cost of undergraduate medical education annually thereby releasing an annual public report; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to work with other national organizations to support the responsible use of tuition funds by undergraduate medical institutions to improve the affordability of medical education.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions only requesting new or revised MSMS or AMA policy - $500

Relevant MSMS Policy:

Medical School Debt Forgiveness
MSMS supports the principle of debt forgiveness for students of Michigan medical schools in return for service in primary care in the state of Michigan.

Resolution 17-12A
RESOLVED: That MSMS encourage legislation that would address the burden of medical school debt of future physicians through city, county, or regional purchase of tuition costs of medical students in return for service in these communities upon completion of training; and be it further

RESOLVED: That MSMS seek employment opportunities for medical students with area health systems and/or hospitals affiliated with medical schools to work during breaks, with wages that may be used to significantly reduce the debt burden of medical students.

Resolution 46-08A
RESOLVED: That MSMS pursue immediate debt relief for medical students at the statewide level by advocating for tuition freezes upon matriculation at state medical schools, pursuing scholarship and loan repayment options for students who stay to train and practice in the state, and continue to advocate at the state and national level for medical student debt relief; and be it further

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to pursue long-term solutions to the student debt crisis by hiring an economic consulting firm to analyze the feasibility of novel solutions1 including; 1) competency-based curriculums that shorten the length of undergraduate education and medical school, 2) work-study opportunities, 3) paid rotating internships for fourth-year students who have passed initial licensing exams and have the training equivalents of mid-level providers, 4) financial investment funds that match parental savings, 5) relief for dual degrees not covered by the National Institute of Health, 6) pursuit of government Medicare funding for undergraduate medical education funding, and 7) implementing international medical student tuition models, among other viable options.

Relevant AMA Policy:

Cost and Financing of Medical Education and Availability of First-Year Residency Positions H-305.988
Our AMA:
1. believes that medical schools should further develop an information system based on common definitions to display the costs associated with undergraduate medical education;
2. in studying the financing of medical schools, supports identification of those elements that have implications for the supply of physicians in the future;
3. believes that the primary goal of medical school is to educate students to become physicians and that despite the economies necessary to survive in an era of decreased funding, teaching functions must be maintained even if other commitments need to be reduced;
4. believes that a decrease in student enrollment in medical schools may not result in proportionate reduction of expenditures by the school if quality of education is to be maintained;
5. supports continued improvement of the AMA information system on expenditures of medical students to determine which items are included, and what the ranges of costs are;
6. supports continued study of the relationship between medical student indebtedness and career choice;
7. believes medical schools should avoid counterbalancing reductions in revenues from other sources through tuition and student fee increases that compromise their ability to attract students from diverse backgrounds;
8. supports expansion of the number of affiliations with appropriate hospitals by institutions with accredited residency programs;
9. encourages for profit-hospitals to participate in medical education and training;
10. supports AMA monitoring of trends that may lead to a reduction in compensation and benefits provided to resident physicians;
11. encourages all sponsoring institutions to make financial information available to help residents manage their educational indebtedness; and
12. will advocate that resident and fellow trainees should not be financially responsible for their training.

The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967
1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.

10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.
20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.
21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.
22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.
23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.

24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.
25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.
26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.
27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.
28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.
29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.
30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.
31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of "Cap-Flexibility" and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.
32. Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates' rates of placement into GME as well as GME completion.
33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation's health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.

Sources:

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2. Pisaniello MS, Asahina AT, Bacchi S, et al. Effect of medical student debt on mental health, academic performance and specialty choice: A systematic review. BMJ Open. 2019;9(7). doi:10.1136/bmjopen-2019-029980
3. Craft III J, Craft T. Rising Medical Education Debt a Mounting Concern. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6179784/pdf/ms109_p0266.pdf. Accessed January 13, 2020.
4. Hill MR, Goicochea S, Merlo LJ. In their own words: stressors facing medical students in the millennial generation. Med Educ Online. 2018;23(1). doi:10.1080/10872981.2018.1530558

5. Rohlfing J, Navarro R, Maniya OZ, Hughes BD, Rogalsky DK. Medical student debt and major life choices other than specialty. Med Educ Online. 2014;19(1). doi:10.3402/meo.v19.25603
6. Grayson MS, Newton DA, Thompson LF. Payback time: the associations of debt and income with medical student career choice. Med Educ. 2012;46(10):983-991. doi:10.1111/j.1365-2923.2012.04340.x

RESOLUTION 44-20

Title: Uniform Standards for Brain Death Determination

Introduced by: Mara Darian, for the Medical Student Section

Original Authors: Bhavna Guduguntla, Ahmad Hider, and Jiwon Park

Referred To:

House Action:

Whereas, the American Academy of Neurology (AAN) has called for uniform brain death laws, policies, and practices, and

Whereas, a specific, uniform standard for declaring brain death is critical for high quality patient-centered neurologic and end-of-life care, as well as for patient and public trust, and

Whereas, the American Neurological Association and the Child Neurology Society have declared their support for this AAN statement position, and

Whereas, brain death is defined as the death of the individual due to irreversible loss of function of the entire brain and is the equivalent of circulatory death, which is due to irreversible loss of function of the circulatory system, which includes the heart, and

Whereas, the 1981 Uniform Determination of Death Act (UDDA) deferred to the medical profession to identify the "accepted medical standards" regarding death determination, the lack of specificity in most states' laws and inconsistency among institutional brain death protocols has led to differing interpretations by courts, and

Whereas, brain death policies vary considerably between institutions, states, and other governing bodies, and

Whereas, AAN has published evidence-based guideline recommendations to assist clinicians in determining brain death, and

Whereas, the AAN is unaware of a single case where these guidelines failed to accurately declare brain death, and

Whereas, these guidelines function to clarify ambiguity in the UDDA while presenting a uniform evidence-based protocol to declare brain death, and

Whereas, establishing such a uniform protocol will decrease the burden and reliance on individual clinician judgement in determining brain death and will create consistency in practice; therefore be it

RESOLVED: That MSMS support the American Academy of Neurology in their efforts to establish universal brain death protocols; and be it further

RESOLVED: That MSMS support legislation that defers to current adult and pediatric brain death guidelines and any future updates in the declaration of brain death; and be it further

RESOLVED: That MSMS support the adoption of uniform policies in medical facilities that ensure compliance with uniform evidence-based guidelines for declaring brain death; and be it further

RESOLVED: That MSMS support the development of programs that train physicians to declare death by neurologic criteria and provide public and medical education regarding brain death and its determination.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions requesting governmental advocacy - $25,000+

Relevant MSMS Policy:

Declaring a Patient Dead/End-of-Life Care Training
MSMS supports implementation of curricula in end-of-life care, hospice, and declaration of patient death in residency training programs where appropriate and the development of continuing medical education programs in end-of-life care and sensitivity/communication training for physicians. (Res34-13)

Relevant AMA Policy:
None

Sources:

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3. Wijdicks, E. F. M., Varelas, P. N., Gronseth, G. S., & Greer, D. M. (2010). Evidence-based guideline update: Determining brain death in adults: Report of the Quality Standards Subcommittee of the American Academy of Neurology. Neurology, 74(23), 1911-1918. doi: 10.1212/wnl.0b013e3181e242a8
4. Bartscher , J. F., & Varelas, P. N. (2010). Determining Brain Death: No Room for Error. AMA Journal of Ethics, 12(11), 879-884. doi: 10.1001/virtualmentor.2010.12.11.pfor1-1011

RESOLUTION 46-20

Title: Depression Screening in Adolescents after Sport-Related Concussion

Introduced by: Mara Darian, for the Medical Student Section

Original Author: Grace Peterson

Referred To:

House Action:

Whereas, the estimated lifetime prevalence of concussion in middle school and high school students is 20 percent, and

Whereas, the most common psychological sequelae diagnosed after concussion are depression and anxiety, and

Whereas, the lifetime prevalence of depression in adolescents is estimated to be 11 percent, and

Whereas, multiple studies have demonstrated that approximately 40 percent of children and adolescents with depressive disorders do not receive treatment, and

Whereas, the sequelae of depression during childhood and adolescence include academic difficulties and school avoidance, social withdrawal, and dysfunction in interpersonal relationships, and

Whereas, athletes who have had previous concussions are shown to have higher levels of depression than athletes who have not been concussed, and

Whereas, there is evidence that former athletes have higher rates of depression and cognitive deficits when they have had multiple prior concussions, or with younger age of first participation in organized sports, and

Whereas, the Michigan High School Athletic Association protocol for return to activity after concussion states that students may not return to activity the same day as the injury and must be examined and cleared by a physician, physician assistant, or nurse practitioner before they can return to activity, and

Whereas, while individual schools, districts, and leagues may have more stringent inactivity and screening requirements before a student athlete can return to activity after a concussion, there are no reported recommendations for depression screening in athletes following concussion, and

Whereas, the Patient Health Questionnaire Modified for Teens (PHQ-9) is a rating scale used for depression screening in adolescents age 12-18 and its use is supported by the American Academy of Child and Adolescent Psychiatry; therefore be it

RESOLVED: That MSMS supports the screening of student athletes participating in Michigan High School Athletic Association sports for depression after concussion by physicians, physician assistants, or nurse practitioners using a screening tool such as the Patient Health Questionnaire Modified for Teens; and be it further

RESOLVED: That MSMS encourage the Michigan High School Athletic Association to include depression screening after concussion in the return to activity protocol.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions only requesting new or revised MSMS or AMA policy - $500

Relevant MSMS Policy:
None

Relevant AMA Policy:

Reduction of Sports-Related Injury and Concussion H-470.954
1. Our AMA will: (a) work with appropriate agencies and organizations to promote awareness of programs to reduce concussion and other sports-related injuries across the lifespan; and (b) promote awareness that even mild cases of traumatic brain injury may have serious and prolonged consequences.
2. Our AMA supports the adoption of evidence-based, age-specific guidelines on the evaluation and management of concussion in all athletes for use by physicians, other health professionals, and athletic organizations.
3. Our AMA will work with appropriate state and specialty medical societies to enhance opportunities for continuing education regarding professional guidelines and other clinical resources to enhance the ability of physicians to prevent, diagnose, and manage concussions and other sports-related injuries.
4. Our AMA urges appropriate agencies and organizations to support research to: (a) assess the short- and long-term cognitive, emotional, behavioral, neurobiological, and neuropathological consequences of concussions and repetitive head impacts over the life span; (b) identify determinants of concussion and other sports-related injuries in pediatric and adult athletes, including how injury thresholds are modified by the number of and time interval between head impacts and concussions; (c) develop and evaluate effective risk reduction measures to prevent or reduce sports-related injuries and concussions and their sequelae across the lifespan; and (d) develop objective biomarkers to improve the identification, management, and prognosis of athletes suffering from concussion to reduce the dependence on self-reporting and inform evidence-based, age-specific guidelines for these patients.
5. Our AMA supports research into the detection, causes, and prevention of injuries along the continuum from subconcussive head impacts to conditions such as chronic traumatic encephalopathy (CTE).

Reducing the Risk of Concussion and Other Injuries in Youth Sports H-470.959
1. Our American Medical Association promotes the adoption of requirements that athletes participating in school or other organized youth sports and who are suspected by a coach, trainer, administrator, or other individual responsible for the health and well-being of athletes of having sustained a concussion be removed immediately from the activity in which they are engaged and not return to competitive play, practice, or other sports-related activity without the written approval of a physician (MD or DO) or a designated member of the physician-led care team who has been properly trained in the evaluation and management of concussion. When evaluating individuals for return-to-play, physicians (MD or DO) or the designated member of the physician-led care team should be mindful of the potential for other occult injuries.
2. Our AMA encourages physicians to: (a) assess the developmental readiness and medical suitability of children and adolescents to participate in organized sports and assist in matching a child's physical, social, and cognitive maturity with appropriate sports activities; (b) counsel young patients and their parents or caregivers about the risks and potential consequences of sports-related injuries, including concussion and

recurrent concussions; (c) assist in state and local efforts to evaluate, implement, and promote measures to prevent or reduce the consequences of concussions, repetitive head impacts, and other injuries in youth sports; and (d) support preseason testing to collect baseline data for each individual.
3. Our AMA will work with interested agencies and organizations to: (a) identify harmful practices in the sports training of children and adolescents; (b) support the establishment of appropriate health standards for sports training of children and adolescents; (c) promote evidenced-based educational efforts to improve knowledge and understanding of concussion and other sport injuries among youth athletes, their parents, coaches, sports officials, school personnel, health professionals, and athletic trainers; and (d) encourage further research to determine the most effective educational tools for the prevention and management of pediatric/adolescent concussions.
4. Our AMA supports (a) requiring states to develop and revise as necessary, evidenced-based concussion information sheets that include the following information: (1) current best practices in the prevention of concussions, (2) the signs and symptoms of concussions, (3) the short-and long-term impact of mild, moderate, and severe head injuries, and (4) the procedures for allowing a student athlete to return to athletic activity; and (b) requiring parents/guardians and students to sign concussion information sheets on an annual basis as a condition of their participation in sports.

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RESOLUTION 54-20

Title: Resentencing for Individuals Convicted of Marijuana-Based Offenses

Introduced by: Mara Darian, for the Medical Student Section

Original Authors: Mara Darian, Vikas Kanneganti, Tabitha Moses, Jaya Parulekar, Siri Sarvepalli, Aaron Sherwood, and Brianna Sohl

Referred To:

House Action:

Whereas, from 2016 to 2017, more than 20,000 arrests involving marijuana charges were made in Michigan, which accounted for about eight percent of all arrests in the state and about 10 percent of all drug-related arrests; of these marijuana-related arrests, 87 percent were for possession and 13 percent were for sales/distribution with 90 percent of possession arrests accounting for one ounce or less of cannabis, and

Whereas, the Michigan Department of Corrections spent approximately $214,900,160 in 2017 to jail individuals for marijuana-related offenses; however, a 2014 report by the National Research Council found that mandatory minimum sentences for drug offenders "have few, if any, deterrent effects," and

Whereas, incarceration is a key issue under the domain of Social and Community Context in the Social Determinants of Health topic area of Healthy People 2020 due to numerous disparities in inmate mental and physical health compared to the population, as well as the increased rate of mental health disorders in the children of incarcerated parents, and

Whereas, there is a clear link between incarceration and health, with incarcerated individuals showing higher risk of chronic conditions such as cardiovascular disease, hypertension, and cancer compared to the general population; a study in March 2013 found that each additional year an individual spends in prison corresponds with a decline in life expectancy by two years, and

Whereas, incarcerated populations are particularly vulnerable to the coronavirus disease 2019 (COVID-19) given the demographics of those experiencing incarceration in addition to the inability to properly "social distance", high population turnover, unsanitary living conditions, poor ventilation systems, inability or inadequacy to properly test and track COVID-19 cases and exposure which have led to an estimated 113,664 COVID-19 cases and 887 related deaths among incarcerated people as of August 2020, and

Whereas, arrests for cannabis possession, regardless of whether the person was later convicted on these charges, have been shown to negatively impact opportunities such as finding employment, housing, and obtaining student loans, which can lead to widespread and multifactorial individual health consequences; furthermore, criminalization of drug use is associated with increased stigma and discrimination of drug users and that stigma and discrimination is also a causal factor for decreased mental and physical health, and

Whereas, nationally, African Americans are three times more likely to be arrested for marijuana possession than Whites, a difference mirrored in Michigan where African Americans are 2.6 times more likely to be arrested, a finding that cannot be explained by differences in use, and

Whereas, fifteen states have legalized the use of recreational and medicinal cannabis, and in the past four years, 23 states have passed laws addressing expungement of certain cannabis convictions, pairing these laws with other policies to its decriminalization or legalization, and

Whereas, in 2018, California became the first state to enact legislation ordering its Department of Justice to conduct a review of criminal records and identify past convictions eligible for sentence dismissal or re-designation in accordance with the Adult Use of Marijuana Act; the outcomes of this legislation showed that reductions in criminal penalties for drug possession reduce racial and ethnic disparities in the criminal justice system, allowing for improvements in health inequalities linked to social determinants of health, and

Whereas, Illinois passed a bill in May 2019, to expunge convictions for non-violent crimes of possession, manufacturing, and distribution of up to 30 grams and possession up to 500 grams, and Colorado and Massachusetts have approved legislation allowing individuals convicted for possession to petition to seal criminal records of misdemeanor offenses that are no longer considered crimes, and

Whereas, a recent study examining the impact of this type of expungement found that those who do obtain expungement have extremely low subsequent crime rates and experience a significant increase in their wage and employment trajectories and an overall positive impact on the lives of those affected; however, of those legally eligible for expungement, only 6.5 percent obtain it within five years of eligibility, findings that support the development of "automatic" expungement procedures, and

Whereas, those who have received resentencing for past offenses, including decriminalized cannabis-based charges, have experienced an increase of 22 percent in wages on average within one year of resentencing as well as lower subsequent crime rates that compare favorably to the general population, and

Whereas, our American Medical Association supports public health-based strategies, rather than incarceration, in the handling of individuals possessing cannabis for personal use; encourages research on the impact of legalization and decriminalization of cannabis in an effort to promote public health and public safety (H-95.924), and

Whereas, during the 2018 elections, Michigan voters passed Proposal 1 to legalize the recreational use and possession of marijuana for individuals 21 years of age or older, since then Macomb and Oakland County Prosecutors have already begun dismissing low-level cannabis criminal charges, the city of Detroit has hired attorneys to help individuals with expungement cases, and a bill was introduced by state Representative Sheldon Neeley of Flint to require judges to review requests of people convicted of low-level cannabis crimes, and

Whereas, efforts to set up expungement laws for cannabis-based offenses have come through House Bills 4980-4985 and 5120, which were signed into law as Public Acts 187-193 of 2020, and

Whereas, at the federal level, the Marijuana Opportunity Reinvestment and Expungement (MORE) Act asks that cannabis be removed from the Controlled Substances Act and create an opportunity for individuals with cannabis law convictions to petition for expungement and resentencing; this act was brought forth in the House (H.R. 3884) and was approved by the House Judiciary Committee in November 2019, and is also under consideration by the Senate (S. 2227); therefore be it

RESOLVED: That MSMS support legislative initiatives that support the creation of an automatic process, at no cost to the individual, for the expungement, destruction, or sealing of criminal records for cannabis offenses that would now be considered legal under Michigan's adult-use cannabis law; and be it further

RESOLVED: That MSMS support legislative initiatives that support the elimination of violations or other penalties for persons under parole, probation, pre-trial, or criminal supervision for cannabis offenses that would now be considered legal under Michigan's adult-use cannabis law; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to work with states that have legalized cannabis to develop model legislation to create an automatic process, at no cost to the individual, for the expungement, destruction, or sealing of criminal records for cannabis offenses that would now be considered legal; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to work with states that have legalized cannabis to develop model legislation to eliminate violations or other penalties for persons under parole, probation, pre-trial, or other State or local criminal supervision for a cannabis offense that would now be considered legal.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $16,000-$32,000 for legislative advocacy.

Relevant MSMS Policy:

43-19 - Resentencing for People Convicted of Marijuana-Based Offenses - DISAPPROVE
Rationale: The Committee agreed with the underlying intent to decriminalize low-level offenses associated with marijuana possession; however, Committee members determined that the resolution entails a complex legal matter and not within the purview of MSMS.

Relevant AMA Policy:

Cannabis Legalization for Adult Use (commonly referred to as recreational use) H-95.924
Our AMA: (1) believes that cannabis is a dangerous drug and as such is a serious public health concern; (2) believes that the sale of cannabis for adult use should not be legalized (with adult defined for these purposes as age 21 and older); (3) discourages cannabis use, especially by persons vulnerable to the drug's effects and in high-risk populations such as youth, pregnant women, and women who are breastfeeding; (4) believes states that have already legalized cannabis (for medical or adult use or both) should be required to take steps to regulate the product effectively in order to protect public health and safety including but not limited to: regulating retail sales, marketing, and promotion intended to encourage use; limiting the potency of cannabis extracts and concentrates; requiring packaging to convey meaningful and easily understood units of consumption, and requiring that for commercially available edibles, packaging must be child-resistant and come with messaging about the hazards about unintentional ingestion in children and youth; (5) laws and regulations related to legalized cannabis use should consistently be evaluated to determine their

effectiveness; (6) encourages local, state, and federal public health agencies to improve surveillance efforts to ensure data is available on the short- and long-term health effects of cannabis, especially emergency department visits and hospitalizations, impaired driving, workplace impairment and worker-related injury and safety, and prevalence of psychiatric and addictive disorders, including cannabis use disorder; (7) supports public health based strategies, rather than incarceration, in the handling of individuals possessing cannabis for personal use; (8) encourages research on the impact of legalization and decriminalization of cannabis in an effort to promote public health and public safety; (9) encourages dissemination of information on the public health impact of legalization and decriminalization of cannabis; (10) will advocate for stronger public health messaging on the health effects of cannabis and cannabinoid inhalation and ingestion, with an emphasis on reducing initiation and frequency of cannabis use among adolescents, especially high potency products; use among women who are pregnant or contemplating pregnancy; and avoiding cannabis-impaired driving; (11) supports social equity programs to address the impacts of cannabis prohibition and enforcement policies that have disproportionately impacted marginalized and minoritized communities; and (12) will coordinate with other health organizations to develop resources on the impact of cannabis on human health and on methods for counseling and educating patients on the use cannabis and cannabinoids.

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RESOLUTION 58-20

Title: Use Term "Intellectual Disability" in Lieu of "Mental Retardation" in Academic Texts, Published Literature, and Medical Education

Introduced by: Mara Darian, for the Medical Student Section

Original Author: Samantha Rea

Referred To:

House Action:

Whereas, intellectual disability is defined as "a group of developmental conditions characterized by significant impairment of cognitive functions, which are associated with limitations of learning, adaptive behavior and skills," and

Whereas, people with disabilities have experienced disproportionate burdens during the COVID-19 pandemic and will continue to face disparities moving forward unless equitable solutions are created, including consistent use of terminology that is nondiscriminatory, and

Whereas, the term "mental retardation" is pejorative and stigmatizing, leading to poor treatment of people with intellectual disabilities, less health care access, and poorer health, employment, and quality of life outcomes, and

Whereas, physicians are more likely to use the term "mental retardation" than occupational therapists, physiotherapists, nurses, and social workers, and

Whereas, the Department of Education implemented Rosa's Law to use the term "intellectual disability" in federal legislation, and

Whereas, the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) replaced the diagnosis of "mental retardation" with "intellectual disability" for childhood-onset neurodevelopmental disorders, and

Whereas, the American Medical Association (AMA) already supports using the term "intellectual disability" to replace "mental retardation" in clinical settings (H-70.912), and

Whereas, the AMA Code of Style and American Psychological Association recommends person-first language in scholarly writing and speaking, and

Whereas, textbooks, course notes, and published literature in medical education should reflect the same recommendations to encourage appropriate terminology at the earliest stages of physician education as well as continuing medical education for practicing physicians; therefore be it

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to amend AMA policy H-70.912 by addition to read as follows:

Our AMA recommends that physicians adopt the term "intellectual disability" instead of "mental retardation" in clinical settings**, academic texts, published literature, and medical education**.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions only requesting new or revised MSMS or AMA policy - $500

Relevant MSMS Policy:
None

Relevant AMA Policy:

Eliminating Use of the Term "Mental Retardation" by Physicians in Clinical Settings H-70.912
Our AMA recommends that physicians adopt the term "intellectual disability" instead of "mental retardation" in clinical settings.

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RESOLUTION 61-20

Title: 9-1-1 Dispatcher Telephone CPR Training

Introduced by: Mara Darian, for the Medical Student Section

Original Author: Erin Lee Currey

Referred To:

House Action:

Whereas, five-year survival is higher in patients who received bystander cardiopulmonary resuscitation (CPR) during an out-of-hospital cardiac arrest (14.3 percent versus 8.7 percent, $p<0.001$), and

Whereas, increased survival from receiving bystander CPR translates to an average increase of quality-adjusted life-years, and

Whereas, the American Heart Association has determined that the standard of care for out-of-hospital cardiac arrest is 9-1-1 dispatchers delivering telephone CPR (T-CPR), and

Whereas, Module II of the 9-1-1 dispatcher training currently consists of 40 total hours of training, including eight hours of study on domestic violence, suicide intervention, 9-1-1 liability, stress management, and homeland security elective, and

Whereas, rapid recognition of out-of-hospital cardiac arrest and delivery of T-CPR is not currently listed as one of the essential job tasks of 9-1-1 dispatchers in the state of Michigan in the Dispatcher Training Manual, and

Whereas, T-CPR is a set of skills that can be taught in three to four hours of additional training, and

Whereas, Louisiana, Kentucky, Wisconsin, Indiana, West Virginia, and Maryland already mandate T-CPR training for 9-1-1 dispatchers; therefore be it

RESOLVED: That MSMS advocate for mandatory training for 9-1-1 dispatchers to provide telephone cardiopulmonary resuscitation for out-of-hospital cardiac arrests.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions only requesting new or revised MSMS or AMA policy - $500

Relevant MSMS Policy:
None

Relevant AMA Policy:

Cardiopulmonary Resuscitation (CPR) and Defibrillators H-130.938

Our AMA:

(1) supports publicizing the importance of teaching CPR, including the use of automated external defibrillation;

(2) strongly recommends the incorporation of CPR classes as a voluntary part of secondary school programs;

(3) encourages the American public to become trained in CPR and the use of automated external defibrillators;

(4) advocates the widespread placement of automated external defibrillators, including on all grade K-12 school campuses and locations at which school events are held;

(5) encourages all grade K-12 schools to develop an emergency action plan for sudden cardiac events;

(6) supports increasing government and industry funding for the purchase of automated external defibrillator devices;

(7) endorses increased funding for cardiopulmonary resuscitation and defibrillation training of community organization and school personnel;

(8) supports the development and use of universal connectivity for all defibrillators;

(9) supports legislation that would encourage high school students be trained in cardiopulmonary resuscitation and automated external defibrillator use;

(10) will update its policy on cardiopulmonary resuscitation and automated external defibrillators (AEDs) by endorsing efforts to promote the importance of AED use and public awareness of AED locations, by using solutions such as integrating AED sites into widely accessible mobile maps and applications;

(11) urges AED vendors to remove labeling from AED stations that stipulate that only trained medical professionals can use the defibrillators; and

(12) supports consistent and uniform legislation across states for the legal protection of those who use AEDs in the course of attempting to aid a sudden cardiac arrest victim.

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