AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 021
(A-22)

Introduced by: Mississippi

Subject: National Cancer Research Patient Identifier

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, In the United States, too often critical information needed by medical researchers to improve the safety and effectiveness of medical treatment is distributed in fragments across large databases. To protect patient privacy, these data elements reside in databases stripped of patient identifying information (PII) making it extremely difficult to consistently reassemble the fragments back into a complete picture for research; and

Whereas, At the time patients present for care, identifying information (e.g. name, date of birth, social security number if available, etc.) could be transformed into a privacy ensuring National Cancer Registry Identifier (NCRI) using novel cryptographic solution (patent pending) that includes a combination of established techniques (hash functions, blinding functions, single use transactional tokens); and

Whereas, Creating a privacy-ensuring, unique cancer research identifier could travel with the anonymous fragments of medical information currently collected by large databases, and therefore allow the fragments to be reunited into a complete, yet anonymous cancer journey that researchers can study to improve care; and

Whereas, The proposed initiative would build on existing data-transfer relationships between health care facilities and quality improvement databases. For example, as medical facilities submit information to various databases (e.g. Medicare, National Cancer Database, Society of Thoracic Surgeons Database, etc.) as part of current workflow, the NCRI would remain associated with the transferred medical information (but PII would not leave the health care entity); and

Whereas, Requests for data could be handled by a separate entity serving as the honest broker that would curate, link, and distribute the data in compliance with state and federal data use agreements; and

Whereas, Nearly half of the 1.8 million cancer patients diagnosed each year in the U.S. will have their lives shortened by cancer, highlighting the ongoing urgent need for cancer research which is felt by the public, the medical community, and policymakers; and

Whereas, Prospective clinical trials are considered the gold-standard for cancer research, and advances from trials have transformed cancer care. However, clinical trials typically require more than 5 years and several million dollars to conduct; and

Whereas, There is simply not enough time or money to test all of the important aspects of cancer care. The NCRI will dramatically increase the speed and power of real-world research; and

Whereas, a nonprofit entity could be established to oversee the NCRI process including managing grant funding, subcontracting to private entities to oversee specific functions (e.g. the identifier workflow, and data curation and research distribution), privacy assurance, security, and compliance. The nonprofit entity would engage federal policy makers, cancer organizations, patient advocacy groups and the data science community for support, access and authorization to move forward; therefore be it

RESOLVED, That in order to increase the power of medical research, our American Medical Association propose a novel approach to linking medical information while still maintaining patient confidentiality through the creation of a National Cancer Research Identifier (NCRI) (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage the formation of an organization or organizations to oversee the NCRI process, specific functions, and engagement of interested parties to improve care for patients with cancer. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 05/06/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 112
(A-22)

Introduced by: Maryland

Subject: Support for Easy Enrollment Federal Legislation

Referred to: Reference Committee A

Whereas, In 2019, the Maryland General Assembly passed legislation to establish the Maryland Easy Enrollment Health Insurance Program with strong support from MedChi, The Maryland State Medical Society; and

Whereas, The easy enrollment legislation established a statewide mechanism for uninsured people filing Maryland income tax returns to begin the process of enrolling into health coverage by consenting, on their tax return, to have relevant information shared with the health insurance exchange serving state residents; and

Whereas, A federalized version of the Maryland legislation, entitled the Easy Enrollment in Health Care Act, has been introduced by Senator Chris Van Hollen (D-Maryland) and Congressman Ami Bera, MD (D-California); and

Whereas, The Easy Enrollment in Health Care Act is supported by the American Academy of Pediatrics, the American Heart Association, and many other stakeholders in health care; and

Whereas, The legislation will "establish a program which allows any taxpayer who is not covered under minimum essential coverage at the time their return of tax for the taxable year is filed, as well as any other household member who is not covered under such coverage, to, in conjunction with the filing of their return of tax for any taxable year which begins after December 31, 2022, elect to—

> (1) have a determination made as to whether the household member who is not covered under such coverage is eligible for an insurance affordability program; and (2) have such household member enrolled into minimum essential coverage;" and

Whereas, The legislation establishes appropriate limitations, including a prohibition on the collection of information relating to citizenship, immigration status, and health status of any household member; and

Whereas, The legislation will establish a process for the easy enrollment information to be immediately transferred to relevant health insurance exchange and insurance affordability programs "in order to increase the potential for immediate determinations of eligibility for and enrollment in insurance affordability programs and minimum essential coverage;" and

Whereas, The legislation aligns with our AMA's mission to strive for the betterment of public health; therefore be it

RESOLVED, That our American Medical Association advocate for the federal legislation known as the Easy Enrollment in Health Care Act to allow Americans to receive health care information and enroll in healthcare coverage through their federal tax returns. (Directive to Take Action)

References:

https://www.vanhollen.senate.gov/imo/media/doc/Easy%20Enrollment%20in%20Health%20Care%20Act%20[Final%20Bill%20Text].pdf

https://www.vanhollen.senate.gov/news/press-releases/van-hollen-bera-introduce-new-bicameral-bill-to-make-it-easier-for-americans-to-sign-up-for-health-care-close-massive-enrollment-gap

Fiscal Note: Not yet determined

Received: 04/05/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 222
(A-22)

Introduced by: Mississippi, Florida, Arizona, Texas, New Jersey, California

Subject: To Study the Economic Impact of Mid-Level Provider Employment in the United States of America

Referred to: Reference Committee B

Whereas, 24 out of 50 states have granted full practice rights for registered nurse practitioners (https://www.aanp.org/advocacy/state/state-practice-environment); and

Whereas, In a CDC funded study performed in 2016, it was discovered that patients were more frequently prescribed antibiotics if evaluated and treated by a NP or PA vs a physician only. The frequency of antibiotic prescriptions was 17% to 12% for overall visits and 61% to 54% for acute respiratory infection visits, respectively (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5047413/); and

Whereas, A study published in 2013 determined that the quality of referrals to an academic medical center was higher for physicians than that of NPs and PAs regarding the clarity of the referral question, understanding of pathophysiology, and adequate pre-referral evaluation and documentation (https://www.mayoclinicproceedings.org/article/S0025-6196(13)00732-5/fulltext); and

Whereas, A study published in *JAMA* in 2015 concluded that mid-level providers ordered more imaging studies during clinic visits (https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1939374); and

Whereas, A study published in *JAMA Dermatology* in 2015 determined that the number needed to biopsy (NNB) for NP's/PA's was significantly higher compared to physicians. 2.9 v 5.9 respectively (https://jamanetwork.com/journals/jamadermatology/fullarticle/2203840); and

Whereas, A recent study published in the *Journal of the Mississippi State Medical Association* found that the care for over 33,000 Medicare patients provided by nonphysician providers was $43 higher per patient per month than the care provided by physicians. This difference was estimated to add $10.3 million annually to the cost of providing care to these patients if all of the care was provided by nonphysician providers. When adjusted for risk due to patient complexity, the cost increased to $119 per patient per month or $28.5 million annually (https://www.ama-assn.org/print/pdf/node/82301); therefore be it

RESOLVED, That our American Medical Association encourage and support studies sponsored by relevant state and federal agencies to determine the economic impact of mid-level unsupervised practice on American consumers (Directive to Take Action); and further be it

RESOLVED, That our AMA develop model state legislation that opposes enactment of legislation and reversal of such legislation, if present, that would authorize the independent practice of medicine by any individual who is not a physician. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 05/06/22

RELEVANT AMA POLICY

Independent Practice of Medicine by Advanced Practice Registered Nurses H-35.988
Our AMA, in the public interest, opposes enactment of legislation to authorize the independent practice of medicine by any individual who has not completed the states requirements for licensure to engage in the practice of medicine and surgery in all of its branches. Our AMA opposes enactment of the Advanced Practice Registered Nurse (APRN) Multistate Compact, due to the potential of the APRN Compact to supersede state laws that require APRNs to practice under physician supervision, collaboration or oversight.
Citation: Sub. Res. 53, I-82; Reaffirmed: A-84; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 9, I-11; Modified: Res. 214, I-17; Modified: BOT Rep. 15, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 223
(A-22)

Introduced by: American Academy of Dermatology, American Society for Dermatologic Surgery Association, American Society of Dermatopathology, American College of Mohs Surgery, Society for Investigative Dermatology, American Society of Ophthalmic Plastic and Reconstructive Surgery, Louisiana, South Carolina, Missouri, Arizona, International Society of Hair Restoration Surgery, Iowa, Texas, Florida, Mississippi, Kansas, American Academy of Otolaryngology- Head and Neck Surgery, American Association of Neurological Surgeons, Congress of Neurological Surgeons, American College of Rheumatology

Subject: National Drug Shortages of Lidocaine and Saline Preparations

Referred to: Reference Committee B

Whereas, Despite repeated legislative attempts to alleviate national drug shortages, critical drug shortages for many medications, including lidocaine, lidocaine with epinephrine, and saline preparations remain; and

Whereas, There is need for greater transparency regarding what actions the Food and Drug Administration (FDA) has taken or plans to take to help alleviate current drug shortages; and

Whereas, Small and independent physician practices have minimal if any bargaining power with drug distributors and wholesalers, and thus are often disproportionately affected by drug shortages. Additionally, products in short supply are frequently allocated based on previous order history, which unfairly discriminates against new or growing medical practices; and

Whereas, National drug shortages negatively impact patients with the potential for delays in care and patient harm; therefore be it

RESOLVED, That our American Medical Association work with national specialty societies and other relevant stakeholders to draft a letter to the FDA calling for direct and prompt actions to alleviate current national shortages of lidocaine and normal saline preparations (Directive to Take Action); and be it further

RESOLVED, That our AMA amend existing HOD policy H-100.956 on National Drug Shortages by addition and deletion to read as follows:

> "8. Our AMA supports the view that wholesalers should routinely institute a transparent allocation-based system for distribution of drugs in short supply that does not discriminate against small, independent or new medical practices or those with less purchasing power ~~that attempts to fairly distribute drugs in short supply based on remaining inventory and considering the customer's purchase history~~." (Modify Current HOD Policy)

Fiscal Note: Not yet determined
Received: 05/11/22

Reference:
US FDA: Current and Resolved Drug Shortages and Discontinuations Reported to the FDA, https://www.accessdata.fda.gov/scripts/drugshortages/
Institute for Safe Medication Practices: Management of Drug Shortages with 0.9% Sodium Chloride, Sterile Water for Injection, and EPINEPHrine, https://www.ismp.org/resources/management-drug-shortages-09-sodium-chloride-sterile-water-injection-and-epinephrine

RELEVANT AMA POLICY

National Drug Shortages H-100.956

1. Our AMA considers drug shortages to be an urgent public health crisis, and recent shortages have had a dramatic and negative impact on the delivery and safety of appropriate health care to patients.
2. Our AMA supports recommendations that have been developed by multiple stakeholders to improve manufacturing quality systems, identify efficiencies in regulatory review that can mitigate drug shortages, and explore measures designed to drive greater investment in production capacity for products that are in short supply, and will work in a collaborative fashion with these and other stakeholders to implement these recommendations in an urgent fashion.
3. Our AMA supports authorizing the Secretary of the U.S. Department of Health and Human Services (DHHS) to expedite facility inspections and the review of manufacturing changes, drug applications and supplements that would help mitigate or prevent a drug shortage.
4. Our AMA will advocate that the US Food and Drug Administration (FDA) and/or Congress require drug manufacturers to establish a plan for continuity of supply of vital and life-sustaining medications and vaccines to avoid production shortages whenever possible. This plan should include establishing the necessary resiliency and redundancy in manufacturing capability to minimize disruptions of supplies in foreseeable circumstances including the possibility of a disaster affecting a plant.
5. The Council on Science and Public Health shall continue to evaluate the drug shortage issue, including the impact of group purchasing organizations on drug shortages, and report back at least annually to the House of Delegates on progress made in addressing drug shortages.
6. Our AMA urges continued analysis of the root causes of drug shortages that includes consideration of federal actions, evaluation of manufacturer, Group Purchasing Organization (GPO), and distributor practices, contracting practices by market participants on competition, access to drugs, pricing, and analysis of economic drivers.
7. Our AMA urges regulatory relief designed to improve the availability of prescription drugs by ensuring that such products are not removed from the market due to compliance issues unless such removal is clearly required for significant and obvious safety reasons.
8. Our AMA supports the view that wholesalers should routinely institute an allocation system that attempts to fairly distribute drugs in short supply based on remaining inventory and considering the customer's purchase history.
9. Our AMA will collaborate with medical specialty society partners and other stakeholders in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs.
10. Our AMA urges that during the evaluation of potential mergers and acquisitions involving pharmaceutical manufacturers, the Federal Trade Commission consult with the FDA to determine whether such an activity has the potential to worsen drug shortages.
11. Our AMA urges the FDA to require manufacturers to provide greater transparency regarding the pharmaceutical product supply chain, including production locations of drugs, and provide more detailed information regarding the causes and anticipated duration of drug shortages.
12. Our AMA supports the collection and standardization of pharmaceutical supply chain data in order to determine the data indicators to identify potential supply chain issues, such as drug shortages.
13. Our AMA encourages global implementation of guidelines related to pharmaceutical product supply chains, quality systems, and management of product lifecycles, as well as expansion of

global reporting requirements for indicators of drug shortages.
14. Our AMA urges drug manufacturers to accelerate the adoption of advanced manufacturing technologies such as continuous pharmaceutical manufacturing.
15. Our AMA supports the concept of creating a rating system to provide information about the quality management maturity, resiliency and redundancy, and shortage mitigation plans, of pharmaceutical manufacturing facilities to increase visibility and transparency and provide incentive to manufacturers. Additionally, our AMA encourages GPOs and purchasers to contractually require manufacturers to disclose their quality rating, when available, on product labeling.
16. Our AMA encourages electronic health records (EHR) vendors to make changes to their systems to ease the burden of making drug product changes.
17. Our AMA urges the FDA to evaluate and provide current information regarding the quality of outsourcer compounding facilities.
18. Our AMA urges DHHS and the U.S. Department of Homeland Security (DHS) to examine and consider drug shortages as a national security initiative and include vital drug production sites in the critical infrastructure plan.
Citation: CSAPH Rep. 2, I-11; Modified: CSAPH Rep. 7, A-12; Modified: CSAPH Rep. 2, I-12; Modified: CSAPH Rep. 8, A-13; Modified in lieu of Res. 912, I-13; Modified: CSAPH Rep. 3, A-14; Modified: CSAPH Rep. 2, I-15; Appended: CSAPH Rep. 04, I-17; Modified: CSAPH Rep. 02, A-18; Reaffirmed: CMS Rep. 08, A-19; Reaffirmed: Res. 105, A-19; Modified: CSAPH Rep. 1, I-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 227
(A-22)

Introduced by: Louisiana

Subject: Supporting Improvements to Patient Data Privacy

Referred to: Reference Committee B

Whereas, Patients are increasingly using smartphones, connected consumer devices, and cloud-based applications to monitor vital signs, fitness metrics, and biological cycles, as well as to store and maintain medical information as a personal health record, and

Whereas, Data collected through these tools and stored in personal digital applications is not currently protected under HIPAA because software and technology companies and vendors are not classified as covered entities, and

Whereas, It has been documented that certain health care providers have allowed Google, – which owns large fitness tracker company Fitbit – access to sensitive medical records, including visit location and time data, as part of a corporate partnership, without patient permission or physician notification, and

Whereas, Sen. Bill Cassidy of Louisiana introduced the Stop Marketing and Revealing the Wearables and Trackers Consumer Health Data Act (“Smartwatch Data Act”) – new federal legislation to expand health data protections to include these types of device-collected information; therefore, be it

RESOLVED, That our American Medical Association support legislation to strengthen patient data privacy protections by making health information collected or stored on smartphones and similar consumer devices subject to the same privacy protections as standard medical records. (New HOD Policy)

Fiscal Note: Not yet determined

Received: 05/11/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 318
(A-22)

Introduced by: Oklahoma

Subject: CME for Preceptorship

Referred to: Reference Committee C

Whereas, Continuing Medical Education (CME) credits are vital to all physicians; and

Whereas, Being a “preceptor” for medical students, residents, fellows, and other allied health professional students requires countless hours of preparation; and

Whereas, The American Osteopathic Association (AOA) offers category 1B credit to its members for participation in the AOA Didactic and Preceptor Program; and

Whereas, 60 AOA category 1B credits may be applied to the required 120 hours of CME for AOA physicians; and

Whereas, The American Academy of Family Physicians offers CME credits to its members for teaching of medical students, residents, and other allied health professional students; and

Whereas, The AMA does not recognize the AOA credits awarded for teaching and being a preceptor; and

Whereas, Recognizing such efforts would encourage more physicians to be involved in preceptor programs, which in turn would expose more students to the world of private practice and the practice of medicine in more rural and underserved areas; therefore be it

RESOLVED, That our American Medical Association study formulating a plan, in collaboration with other interested bodies, to award AMA Category 1 credits to physicians who serve as preceptors and teach medical students, residents, fellows, and other allied health professional students training in Liaison Committee on Medical Education/Accreditation Council for Graduate Medical Education accredited institutions (Directive to Take Action); and be it further

RESOLVED, That our AMA devise a method of converting those credits awarded by other organizations into AMA recognized credits for the purpose of CME. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 05/04/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 327
(A-22)

Introduced by: New Jersey

Subject: Leadership Training Must Become an Integral Part of Medical Education

Referred to: Reference Committee C

"No one other than physicians can do what physicians do. They have a unique skill set in healing and "fixing" people. If doctors aren't willing to contribute their professional expertise in these areas, they will essentially leave the health of their profession to those outside of the profession" - General Mark Hertling

Whereas, Physicians play a leading role in the healthcare team and are considered to be ultimately responsible for the overall outcome of patient care (1); and

Whereas, Medical graduates are expected to "provide leadership skills that enhance team functioning, the learning environment, and/or the healthcare delivery system" (1); and

Whereas, A physician's role as a leader of medicine is currently underestimated within the current medical curriculum (6); and

Whereas, Medical students report that they do not feel that they have received an adequate level of leadership training required to be an effective leader (5); and

Whereas, The number of medical programs implementing some form of leadership training into their curriculum is growing, experiences are rare and inconsistent (6); and

Whereas, There is an essential need for a clearly developed and standardized form of training that can be implemented throughout the graduate and postgraduate medical curriculum (4); and

Whereas, Many schools lack formal leadership programs, which may reflect the time constraints of existing curricula, limited resources, beliefs that leadership cannot be taught, lack of consensus on leadership content, and other factors (2); and

Whereas, Students report a lack of support structure for practicing leadership skills, a lack of opportunity to serve in a leadership position, and the number of time-related pressures present for medical students during their training (4); and

Whereas, Addressing leadership training opportunities for physicians has been in the AMA policy radar since at least 2018 per D-295.316, the urgency for implementation of concrete steps cannot be overstated (9); therefore be it

RESOLVED, That our American Medical Association study the extent of the impact of AMA Policy D-295.316, "Management and Leadership for Physicians," on elective curriculum and provide a report at the interim meeting (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for the implementation of concrete steps to incorporate leadership training as an integral part of the core curriculum of medical school education, post-graduate training, and for practicing physicians.

Fiscal Note: Not yet determined

Received: 05/10/22

References:
1. Chen TY. Medical leadership: An important and required competency for medical students. Ci Ji Yi Xue Za Zhi. 2018;30(2):66-70. doi:10.4103/tcmj.tcmj_26_18
2. Clyne B, Rapoza B, George P. Leadership in undergraduate medical education: Training future physician leaders. *R I Med J (2013)* 2015;98:36–40.
3. Suvedi M, Langone L. Leadership Skills Development Program evaluation: 2006–2007. Michigan State University website. Accessed November 1, 2016.
4. Swanwick T, McKimm J. Clinical leadership development requires system-wide interventions, not just courses. Clin Teach 2012;9: 89–93
5. Varkey P, Peloquin J, Reed D, Lindor K, Harris I Med Teach. 2009 Mar; 31(3):244-50.
6. Warren OJ, Carnall RMedical leadership: why it's important, what is required, and how we develop it. *Postgraduate Medical Journal* 2011;87:27-32.
7. Druker PF. What makes an effective executive? Harv Bus Rev. 2004;82(6):58–63 136.
8. Clarke J. In: Patole S, editor. Management and Leadership – A Guide for Clinical Professionals. Switzerland: Springer International Publishing; 2015.
9. Management and Leadership for Physicians D-295.316. AMA Policy Finder. (n.d.). Retrieved February 9, 2022, from https://policysearch.ama-assn.org/policyfinder/detail/Management%20and%20Leadership%20for%20Physicians?uri=%2FAMADoc%2Fdirectives.xml-0-804.xml

RELEVANT AMA POLICY

Management and Leadership for Physicians D-295.316
1. Our AMA will study advantages and disadvantages of various educational options on management and leadership for physicians with a report back to the House of Delegates; and develop an online report and guide aimed at physicians interested in management and leadership that would include the advantages and disadvantages of various educational options.
2. Our AMA will work with key stakeholders to advocate for collaborative programs among medical schools, residency programs, and related schools of business and management to better prepare physicians for administrative, financial and leadership responsibilities in medical management.
3. Our AMA: (a) will advocate for and support the creation of leadership programs and curricula that emphasize experiential and active learning models to include knowledge, skills and management techniques integral to achieving personal and professional financial literacy and leading interprofessional team care, in the spirit of the AMA's Accelerating Change in Medical Education initiative; and (b) will advocate with the Liaison Committee for Medical Education, Association of American Medical Colleges and other governing bodies responsible for the education of future physicians to implement programs early in medical training to promote the development of leadership and personal and professional financial literacy capabilities.
Citation: Sub. Res. 918, I-14; Appended: Res. 306, I-16; Reaffirmed in lieu of: Res. 307, A-17; Modified: Res. 313, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 416
(A-22)

Introduced by: Oklahoma

Subject: School Resource Officer Violence De-Escalation Training and Certification

Referred to: Reference Committee D

Whereas, A school resource officer (SRO), by federal definition, is a career law enforcement officer with sworn authority who is deployed by an employing police department or agency in a community-oriented policing assignment to work in collaboration with one or more schools(1); and

Whereas, National Association of School Resource Officers recommends that agencies select officers carefully for SRO assignments and that officers receive at least 40 hours of specialized training in school policing before being assigned(1); and

Whereas, The Oklahoma Association of School Resource Officers report most but not all SRO in schools throughout Oklahoma receive this nationally-recognized, basic and advanced SRO training(2); and

Whereas, Widespread protests against police brutality and racial injustice over several years have spurred districts across the nation to debate whether to keep police officers in schools(3); therefore be it

RESOLVED, That our American Medical Association highly recommend mandatory conflict de-escalation training for all school resource officers (New HOD Policy); and be it further

RESOLVED, That our AMA actively advocate to the National Association of School Resource Officers to develop a program for certification of School Resource Officers including but not limited to violence de-escalation training requirements, expiration date, renewal continuing education requirements and a revocation procedure in the rare event of misconduct. (Directive to Take Action)

REFERENCES
1. https://www.nasro.org/faq/
2. https://m.facebook.com/OklahomaAssociationOfSchoolResourceOfficers/
3. https://www.google.com/amp/s/oklahoman.com/article/5666711/okc-board-approves-2-million-contract-for-school-resource-officers/amp

Fiscal Note: Not yet determined

Received: 04/26/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution:417
(A-22)

Introduced by: Oklahoma

Subject: Tobacco Control

Referred to: Reference Committee D

Whereas, Tobacco remains the leading cause of preventable disease in America, killing more than 480,000 Americans each year; and

Whereas, 16 million Americans are living with a tobacco-related disease; and

Whereas, The tobacco companies have conducted an organized conspiracy to commit fraud in violation of the federal Racketeer Influenced and Corrupt Organization (RICO) Act; and

Whereas, 2020 should be the year that health of our citizens is prioritized over the tobacco industry; and

Whereas, A smoke-free work environment should be afforded to all U.S. citizens; and

Whereas, Secondhand smoke is a serious health hazard causing, or making worse, many diseases and conditions, including lung cancer, heart disease, stroke, and asthma; and

Whereas, The U.S. Surgeon General has concluded there is no safe level of exposure to secondhand smoke; and

Whereas, Oklahoma is one of 22 states that has failed to pass comprehensive smoke-free laws; and

Whereas, Many workplaces like the hospitality industry (i.e., restaurants, bars, and gaming establishments) in Oklahoma are often exposed to secondhand smoke daily; and

Whereas, By making white-collar workplaces smoke free while allowing blue-collar workplaces to continue to expose people to hazardous air, our current policies are widening inequalities in health; and

Whereas, If 100% of workplaces were covered by smoke free policies, health disparities would be significantly reduced; therefore be it

RESOLVED, That American Medical Association policy H-490.913, “Smoke-Free and Vape-Free Environments and Workplaces,” be amended by addition and deletion to read as follows:

On the issue of the health effects of environmental tobacco smoke (ETS), passive smoke, and vape aerosol exposure in the workplace and other public facilities, our AMA: (1)(a) supports classification of ETS as a known human carcinogen, and (b) concludes that passive smoke exposure is associated with increased risk of sudden infant death syndrome and of cardiovascular disease, and (c) encourages physicians and medical

societies to take a leadership role in defending the health of the public from ETS risks and from political assaults by the tobacco industry, and and (d) encourages the concept of establishing smoke-free and vape-free campuses for business, labor, education, and government, and (2) (a) honors companies and governmental workplaces that go smoke-free and vape-free, and (b) will petition the Occupational Safety and Health Administration (OSHA) to adopt regulations prohibiting smoking and vaping in the workplace, and will use active political means to encourage the Secretary of Labor to swiftly promulgate an OSHA standard to protect American workers from the toxic effects of ETS in the workplace, preferably by banning smoking and vaping in the workplace, and (c) encourages state medical societies (in collaboration with other anti-tobacco organizations) to support the introduction of local and state legislation that prohibits smoking and vaping around the public entrances to buildings and in all indoor public places, restaurants, bars, and workplaces, and and (d) will update draft model state legislation to prohibit smoking and vaping in public places and businesses, which would include language that would prohibit preemption of stronger local laws. (3) (a) encourages state medical societies to: (i) support legislation for states and counties mandating smoke-free and vape-free schools and eliminating smoking and vaping in public places and businesses and on any public transportation, and (ii) enlist the aid of county medical societies in local anti-smoking and anti-vaping campaigns, and and (iii) through an advisory to state, county, and local medical societies, urge county medical societies to join or to increase their commitment to local and state anti-smoking and anti-vaping coalitions and to reach out to local chapters of national voluntary health agencies to participate in the promotion of anti-smoking and anti-vaping control measures, and (b) urges all restaurants, particularly fast food restaurants, and convenience stores to immediately create a smoke-free and vape-free environment, and (c) strongly encourages the owners of family-oriented theme parks to make their parks smoke-free and vape-free for the greater enjoyment of all guests and to further promote their commitment to a happy, healthy life style for children, and (d) encourages state or local legislation or regulations that prohibit smoking and vaping in stadia and encourages other ball clubs to follow the example of banning smoking in the interest of the health and comfort of baseball fans as implemented by the owner and management of the Oakland Athletics and others, and (e) urges eliminating cigarette, pipe and cigar smoking and vaping in any indoor area where children live or play, or where another person's health could be adversely affected through passive smoking inhalation, and (f) urges state and county medical societies and local health professionals to be especially prepared to alert communities to the possible role of the tobacco industry whenever a petition to suspend a nonsmoking or non-vaping ordinance is introduced and to become directly involved in community tobacco control activities, and and (g) will report annually to its membership about significant anti-smoking and anti-vaping efforts in the prohibition of smoking and vaping in open and closed stadia, and (4) calls on corporate headquarters of fast-food franchisers to require that one of the standards of operation of such franchises be a no smoking and no vaping policy for such restaurants, and endorses the passage of laws, ordinances and regulations that prohibit smoking and vaping in fast-food restaurants and other entertainment and food outlets that target children in their marketing efforts, and (5) advocates that all American hospitals ban tobacco and supports working toward legislation and policies to promote a ban on smoking, vaping, and use of tobacco products in, or on the campuses of, hospitals, health care institutions, retail health clinics, and educational institutions, including medical schools, and (6) will work with the Department of Defense to explore ways to encourage a smoke-free and vape-free environment in the military through the use of mechanisms such as health education, smoking and vaping cessation programs, and the elimination of discounted prices for tobacco products in military resale facilities, and

(7) ~~encourages and supports~~ collaborates with local and state medical societies and tobacco control coalitions to work with (a) Native American casino and tribal leadership to voluntarily prohibit smoking and vaping in their casinos, and (b) legislators and the gaming industry to support the prohibition of smoking and vaping in all casinos and gaming venues. (Modify Current HOD Policy)

REFERENCES
https://www.lung.org/our-initiatives/tobacco/reports-resources/sotc/
https://no-smoke.org/wp-content/uploads/pdf/BridgingtheGap-ExecutiveSummary.pdf

Fiscal Note: Not yet determined

Received: 04/26/22

RELEVANT AMA POLICY

Smoke-Free and Vape-Free Environments and Workplaces H-490.913
On the issue of the health effects of environmental tobacco smoke (ETS), passive smoke, and vape aerosol exposure in the workplace and other public facilities, our AMA: (1)(a) supports classification of ETS as a known human carcinogen; (b) concludes that passive smoke exposure is associated with increased risk of sudden infant death syndrome and of cardiovascular disease; (c) encourages physicians and medical societies to take a leadership role in defending the health of the public from ETS risks and from political assaults by the tobacco industry; and (d) encourages the concept of establishing smoke-free and vape-free campuses for business, labor, education, and government; (2) (a) honors companies and governmental workplaces that go smoke-free and vape-free; (b) will petition the Occupational Safety and Health Administration (OSHA) to adopt regulations prohibiting smoking and vaping in the workplace, and will use active political means to encourage the Secretary of Labor to swiftly promulgate an OSHA standard to protect American workers from the toxic effects of ETS in the workplace, preferably by banning smoking and vaping in the workplace; (c) encourages state medical societies (in collaboration with other anti-tobacco organizations) to support the introduction of local and state legislation that prohibits smoking and vaping around the public entrances to buildings and in all indoor public places, restaurants, bars, and workplaces; and (d) will update draft model state legislation to prohibit smoking and vaping in public places and businesses, which would include language that would prohibit preemption of stronger local laws. (3) (a) encourages state medical societies to: (i) support legislation for states and counties mandating smoke-free and vape-free schools and eliminating smoking and vaping in public places and businesses and on any public transportation; (ii) enlist the aid of county medical societies in local anti-smoking and anti-vaping campaigns; and (iii) through an advisory to state, county, and local medical societies, urge county medical societies to join or to increase their commitment to local and state anti-smoking and anti-vaping coalitions and to reach out to local chapters of national voluntary health agencies to participate in the promotion of anti-smoking and anti-vaping control measures; (b) urges all restaurants, particularly fast food restaurants, and convenience stores to immediately create a smoke-free and vape-free environment; (c) strongly encourages the owners of family-oriented theme parks to make their parks smoke-free and vape-free for the greater enjoyment of all guests and to further promote their commitment to a happy, healthy life style for children; (d) encourages state or local legislation or regulations that prohibit smoking and vaping in stadia and encourages other ball clubs to follow the example of banning smoking in the interest of the health and comfort of baseball fans as implemented by the owner and management of the Oakland Athletics and others; (e) urges eliminating cigarette, pipe and cigar smoking and vaping in any indoor area where children live or play, or where another person's health could be adversely affected through passive smoking inhalation; (f) urges state and county medical societies and local health professionals to be especially

prepared to alert communities to the possible role of the tobacco industry whenever a petition to suspend a nonsmoking or non-vaping ordinance is introduced and to become directly involved in community tobacco control activities; and (g) will report annually to its membership about significant anti-smoking and anti-vaping efforts in the prohibition of smoking and vaping in open and closed stadia; (4) calls on corporate headquarters of fast-food franchisers to require that one of the standards of operation of such franchises be a no smoking and no vaping policy for such restaurants, and endorses the passage of laws, ordinances and regulations that prohibit smoking and vaping in fast-food restaurants and other entertainment and food outlets that target children in their marketing efforts; (5) advocates that all American hospitals ban tobacco and supports working toward legislation and policies to promote a ban on smoking, vaping, and use of tobacco products in, or on the campuses of, hospitals, health care institutions, retail health clinics, and educational institutions, including medical schools; (6) will work with the Department of Defense to explore ways to encourage a smoke-free and vape-free environment in the military through the use of mechanisms such as health education, smoking and vaping cessation programs, and the elimination of discounted prices for tobacco products in military resale facilities; and (7) encourages and supports local and state medical societies and tobacco control coalitions to work with (a) Native American casino and tribal leadership to voluntarily prohibit smoking and vaping in their casinos; and (b) legislators and the gaming industry to support the prohibition of smoking and vaping in all casinos and gaming venues.
CSA Rep. 3, A-04; Appended: Sub. Res. 426, A-04; Modified: CSAPH Rep. 1, I-07; Reaffirmation I-14; Reaffirmation I-15; Modified: Res. 902, I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 418
(A-22)

Introduced by: Oklahoma

Subject: Lung Cancer Screening Awareness

Referred to: Reference Committee D

Whereas, Oklahoma health outcomes are poor and rank low on a yearly basis; and

Whereas, Lung cancer is the number one cause of cancer-related death in Oklahoma, U.S., and the world, and is more deadly than the next major causes combined: Breast, prostate, colon(1), and

Whereas, According to the American Lung Association State of Lung Cancer Report, most lung cancer cases are diagnosed at later stages when the cancer has spread to other organs, treatment options are less likely to be curative, and survival is lower(2); and

Whereas, The rationale for lung cancer screening is that it is prevalent, detectable, non-invasive at an early stage, outcome depends on stage, and stage is a function of time(3); and

Whereas, Lung cancer screening with low-dose CT scans has been recommended for those at high risk since 2013 but only 4.2 percent of those eligible were screened in 2018(2); and

Whereas, Lung cancer screening with low-dose CT scans has been shown to decrease mortality by 20%(4); and

Whereas, 12.7% adults aged 55–80 years met the United States Preventive Services Task Force (USPSTF) criteria for lung cancer screening. Among those meeting these criteria, only 12.5% reported they had received a CT scan to screen for lung cancer in the last 12 months(1); and

Whereas, Oklahoma was one of 31 states that has improved access to screening by covering it through its fee-for-service Medicaid program as of January 2019. The program used recommended guidelines for determining eligibility but it requires prior authorization(2); therefore be it

RESOLVED, That our American Medical Association empower the American public with knowledge through an education campaign to raise awareness of lung cancer screening with low-dose CT scans in high-risk patients to improve screening rates and decrease the leading cause of cancer death in the United States. (Directive to Take Action)

REFERENCES:
(1) https://www.cdc.gov/mmwr/volumes/69/wr/mm6908a1.htm?s_cid=mm6908a1_w
(2) https://www.lung.org/assets/documents/research/ALA-SOLC-2019-Key-Findings.pdf
(3) https://www.ncbi.nlm.nih.gov/m/pubmed/22031728/
(4) https://www.nejm.org/doi/full/10.1056/NEJMoa1911793

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 04/26/22

Evidence-based review:

https://www.nejm.org/doi/full/10.1056/NEJMoa1102873

8/4/2011, NEJM
Screening with the use of low-dose CT reduces mortality from lung cancer. (Funded by the National Cancer Institute; National Lung Screening Trial ClinicalTrials.gov number, **NCT00047385.**

https://www.nejm.org/doi/full/10.1056/NEJMoa1911793

2/06/2020 NEJM
In this trial involving high-risk persons, lung-cancer mortality was significantly lower among those who underwent volume CT screening than among those who underwent no screening. There were low rates of follow-up procedures for results suggestive of lung cancer.

https://www.cdc.gov/mmwr/volumes/69/wr/mm6908a1.htm?s_cid=mm6908a1_w
2.28/2020 MMWR

What is already known about this topic?
The U.S. Preventive Services Task Force (USPSTF) recommends annual lung cancer screening for adults aged 55–80 years who have a ≥30 pack-year cigarette smoking history and currently smoke or have quit <15 years ago.

What is added by this report?
In 10 states, one in eight persons aged 55–80 years met USPSTF criteria, and, among those meeting USPSTF criteria, only one in eight reported a lung cancer screening exam in the last 12 months.

What are the implications for public health practice?
Public health initiatives to prevent cigarette smoking, increase smoking cessation, and increase recommended lung cancer screening could help reduce lung cancer mortality.

https://pubmed.ncbi.nlm.nih.gov/32001154/
Clinical Lung Cancer, 5/2020
Lung cancer screening remains heavily underutilized despite guideline recommendation since 2013, insurance coverage, and its potential to prevent thousands of lung cancer deaths annually.

file:///C:/Users/wjenkins/Downloads/ritzwoller_2021_oi_210815_1633035210.98986.pdf

JAMA Network Open, 10/12/2021
This cohort study suggests that, in diverse health care systems, adopting the 2021 USPSTF recommendations will increase the number of women, racial and ethnic minority groups, and individuals with lower SES who are eligible for lung cancer screening, thus helping to minimize the barriers to screening access for individuals with high risk for lung cancer.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 512
(A-22)

Introduced by: Mississippi

Subject: Scheduling and Banning the Sale of Tianeptine in the United States

Referred to: Reference Committee E

Whereas, While Tianeptine is approved in some countries to treat depression and anxiety, it is an unapproved drug in the United States due to safety concerns; and

Whereas, Tianeptine is legally sold over the counter in the United States commonly in gas stations and convenience stores; and

Whereas, The U.S. Food and Drug Administration (FDA) is warning consumers they may inadvertently find themselves addicted to tianeptine and should avoid all products containing it, especially those that claim to treat opioid use disorder since reliance on these products may delay appropriate treatment and put consumers at greater risk of overdose and death; and

Whereas, The FDA is aware of several serious adverse event reports including agitation, drowsiness, confusion, sweating, rapid heartbeat, high blood pressure, confusion, nausea, vomiting, slowed or stopped breathing, coma, and death associated with tianeptine and these reports are increasing with poison control centers cases nationwide from 11 cases between 2000 and 2013 to 151 in 2020 alone; and

Whereas, Tianeptine is not approved in the United States for any medical use; and

Whereas, Tianeptine is currently widely available for sale to the public, presenting safety risks and risk of abuse; and

Whereas, Tianeptine is not currently controlled under the Controlled Substances Act, but is being scheduled on a state-by-state basis as a Schedule II controlled substance, as recently passed in Alabama and Michigan. Schedule II drugs by definition mean that a substance may lead to severe psychological or physical dependence and joins other substances such as morphine, methamphetamine, cocaine, methadone, hydrocodone, fentanyl, and phencyclidine (PCP) in that class; therefore be it

RESOLVED, That our American Medical Association advocate to schedule Tianeptine as Schedule II whilst supporting research into the safety and efficacy of the substance (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate to ban the sale of Tianeptine directly to the public. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 04/07/22

https://www.fda.gov/consumers/consumer-updates/tianeptine-products-linked-serious-harm-overdoses-death
https://en.wikipedia.org/wiki/Tianeptine

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 513
(A-22)

Introduced by: Oklahoma

Subject: Education for Patients on Opiate Replacement Therapy

Referred to: Reference Committee E

Whereas, We are in a time of potentially increased respiratory illness, given the threat of COVID-19 and flu season in the United States; and

Whereas, We are simultaneously in a time of increased use of opiate replacement therapy for the treatment of opiate use disorder and chronic pain; and

Whereas, Anecdotally, a death scenario occurs when patients in their 60s and 70s who are on relatively high dose maintenance opioid replacement therapy, take their usual dose after onset of a respiratory illness, and

Whereas, AMA Policy D-95.987, "Prevention of Opioid Overdose," is to educate physicians and at-risk patients, but it fails to specifically address the needs of older patients who are at risk of death from opiate maintenance therapy when the onset of respiratory illness occurs; therefore be it

RESOLVED, That our American Medical Association amend Policy D-95.987, "Prevention of Opioid Overdose," by addition to read as follows:

1. Our AMA: (a) recognizes the great burden that substance use disorders (SUDs) and drug-related overdoses and death places on patients and society alike and reaffirms its support for the compassionate treatment of patients with a SUD and people who use drugs; (b) urges that community-based programs offering naloxone and other opioid overdose and drug safety and prevention services continue to be implemented in order to further develop best practices in this area; (c) encourages the education of health care workers and people who use drugs about the use of naloxone and other harm reduction measures in preventing opioid and other drug-related overdose fatalities; and (d) will continue to monitor the progress of such initiatives and respond as appropriate.
2. Our AMA will: (a) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of a drug-related overdose; and (b) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose.
3. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures.
4. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the use of "drug paraphernalia" designed for harm reduction from drug use, including but not limited to drug contamination testing and injection drug preparation, use, and disposal supplies.

5. Our AMA implement an education program for patients on opiate replacement therapy and their family/caregivers to increase understanding of their increased risk of death with concurrent opiate maintenance therapy and the onset of a serious respiratory illness such as SARS-CoV-2. (Modify Current HOD Policy)

References:
https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2020.20030348

Fiscal Note: Not yet determined

Received: 04/26/22

RELEVANT AMA POLICY

Prevention of Drug-Related Overdose D-95.987
1. Our AMA: (a) recognizes the great burden that substance use disorders (SUDs) and drug-related overdoses and death places on patients and society alike and reaffirms its support for the compassionate treatment of patients with a SUD and people who use drugs; (b) urges that community-based programs offering naloxone and other opioid overdose and drug safety and prevention services continue to be implemented in order to further develop best practices in this area; (c) encourages the education of health care workers and people who use drugs about the use of naloxone and other harm reduction measures in preventing opioid and other drug-related overdose fatalities; and (d) will continue to monitor the progress of such initiatives and respond as appropriate.
2.Our AMA will: (a) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of a drug-related overdose; and (b) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose.
3. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures.
4. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the use of “drug paraphernalia” designed for harm reduction from drug use, including but not limited to drug contamination testing and injection drug preparation, use, and disposal supplies.
Citation: Res. 526, A-06; Modified in lieu of Res. 503, A-12; Appended: Res. 909, I-12; Reaffirmed: BOT Rep. 22, A-16; Modified: Res. 511, A-18; Reaffirmed: Res. 235, I-18; Modified: Res. 506, I-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 514
(A-22)

Introduced by: Oklahoma

Subject: Oppose Petition to the DEA and FDA on Gabapentin

Referred to: Reference Committee E

Whereas, The mission of the American Medical Association is to promote the art and science of medicine and the betterment of public health; and

Whereas, Gabapentin is approved by the U.S. Food and Drug Administration (FDA) to treat specific forms of epilepsy and neuropathic pain;(1),(2) and Gabapentin enacarbil, which is approved by the FDA for treatment of primary restless legs syndrome and postherpetic neuralgia, is a prodrug of gabapentin, and, accordingly, its therapeutic effects are attributable to gabapentin(3); and

Whereas, From 2011 to 2017, total prescriptions for gabapentin doubled to 64.8 million prescriptions per year(4); and

Whereas, A watchdog nonprofit group Public Citizen has filed a petition on 2/08/2022 with the FDA and the U.S. Drug Enforcement Administration (DEA), arguing that gabapentin's risks warrant additional safeguards by requesting regulators to make the drug a controlled substance(5); and

Whereas, Public Citizen noted as of November 2020, seven states--Alabama, Kentucky, Michigan, North Dakota, Tennessee, Virginia, and West Virginia--had classified gabapentin as a schedule V drug, while another 12 states required prescription monitoring of the drug(5); and

Whereas, Public Citizen requested that gabapentin come under the DEA's Schedule V category, which already includes the similar drug, pregabalin (Lyrica); and

Whereas, Schedule V is the lowest rung on the DEA's drug schedule, meaning it has lower potential for abuse than Schedule I through IV drugs; and

Whereas, Patients with pain should receive treatment that provides the greatest benefit and opioids are not the first-line therapy for chronic pain outside of active cancer treatment, palliative care, and end-of-life care(6); and

Whereas, Evidence suggests that nonopioid treatments, including nonopioid medications and nonpharmacological therapies can provide relief to those suffering from chronic pain, and are safer(6); and

Whereas, Gabapentin has been a lower risk alternative for pain management than opioids in the fight against opioid overdose(6); and

Whereas, In 2019 the FDA issued a warning about serious breathing difficulties associated with gabapentin and pregabalin in patients with respiratory risk factors(7); and

Whereas, A systematic review on PubMed/Scopus that included 106 studies, did not find convincing evidence of a vigorous addictive power of gabapentinoids which is primarily suggested from their limited rewarding properties, marginal notes on relapses, and the very few cases with gabapentinoid-related behavioral dependence symptoms (ICD-10) in patients without a prior abuse history(8); and

Whereas, There was no publication about people who sought treatment for the use of gabapentinoids(8); and

Whereas, Pure overdoses of gabapentinoids appeared to be relatively safe but can become lethal (pregabalin > gabapentin) in mixture with other psychoactive drugs, especially opioids again and sedatives(8); and

Whereas, Making gabapentinoids, medications with little addictive or habit-forming potential, schedule V will make it more complicated for patients to receive treatment and causes an unnecessary barrier for care; therefore be it

RESOLVED, That our American Medical Association actively oppose the placement of (a) gabapentin (2-[1-(aminomethyl) cyclohexyl] acetic acid), including its salts, and all products containing gabapentin (including the brand name products Gralise and Neurontin) and (b) gabapentin enacarbil (1-{[({(1RS)-1-[(2- methylpropanoyl)oxy]ethoxy} carbonyl)amino]methyl} cyclohexyl) acetic acid), including its salts, (including the brand name product Horizant) into schedule V of the Controlled Substances Act (Directive to Take Action); and be it further

RESOLVED, That our AMA submit a timely letter to the Commissioner of the U.S. Food and Drug Administration for the proceedings assigned docket number FDA-2022-P-0149 in opposition to placement of gabapentin and gabapentin enacarbil into the schedule V of the Controlled Substance Act. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 04/26/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 609
(A-22)

Introduced by: Georgia

Subject: Surveillance Management System for Organized Medicine Policies and Reports

Referred to: Reference Committee F

Whereas, An essential function of organized medicine is to represent the voice of their members and patients; and

Whereas, Significant resources are spent in terms of time and money across the local, state and national levels of organized medicine in the formulation of a wide scope of policy resolutions; and

Whereas, These resolutions undergo extensive debate with resulting dismissal, passage or referral at the respective state and/or national levels; and

Whereas, Approved resolutions and reports fall across different areas of priority and action; and

Whereas, Given the volume of resolutions and reports, the vast majority of policy statements and/or recommendations fail to be effectively disseminated back to the local or state membership, in addition to our patients; and

Whereas, Given the volume of resolutions and reports there currently is no system in place to provide surveillance management of the eventual outcome for the respective resolution and/or report; and

Whereas, The lack of timely, transparent and effective communication of the work performed by organized medicine, including at state and national House of Delegates, likely contributes to the apathy, disengagement and/or lack of membership (including renewal) by physicians at the local and state levels; and

Whereas, The practice of medicine is subject to performance metrics, including process and outcome in addition to surveys of satisfaction and service; therefore be it

RESOLVED, That our American Medical Association develop a prioritization matrix across both global and reference committee specific areas of interest (Directive to Take Action); and be it further

RESOLVED, That our AMA develop a web-based surveillance management system, with pre-defined primary and/or secondary metrics, for resolutions and reports passed by their respective governance body (Directive to Take Action); and be it further

RESOLVED, That our AMA share previously approved metrics and results from the surveillance management system at intervals deemed most appropriate to the state and local membership of organized medicine, including where and when appropriate to their patients. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 04/14/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 618
(A-22)

Introduced by: Oklahoma

Subject: Extending the Delegate Apportionment Freeze During COVID-19 Pandemic

Referred to: Reference Committee F

Whereas, The COVID-19 pandemic has been difficult for physicians and the practice of medicine; many physicians have elected not to renew their memberships in organized medicine due to numerous reasons; and

Whereas, 40% of the Oklahoma State Medical Association active dues paying members in 2021 and 36% in 2022 took a self-determined 50% dues reduction for the COVID-19 hardship; and

Whereas, Because of the COVID-19 pandemic, many state and specialty associations have not been able to meet in person to utilize their usual platforms to promote the importance of organized medicine; and

Whereas, At the November 2020 Special Meeting, the House of Delegates asked that our AMA extend the current grace period from one year to two years for losing a delegate from a state medical or national medical specialty society until the end of 2022; and

Whereas, The "freeze" adopted at November 2020 meeting proved to benefit 22 states, Alabama, Arkansas, California, Colorado, District of Columbia, Florida, Hawaii, Illinois, Kansas, Massachusetts, Michigan, Minnesota, Missouri, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, South Dakota, Virginia, and Washington(1); and

Whereas, The current freeze has left the overall size of the House of Delegates unchanged and will seat 693 delegates during 2022(2); and

Whereas, Many states and specialty societies have continued to have decreased AMA membership; therefore be it

RESOLVED, That our American Medical Association extend the current delegate apportionment freeze for losing a delegate from a state medical or specialty society until the end of 2023. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 05/11/22

References
1. https://www.mag.org/wp-content/uploads/2021/05/2021-Delegate-Apportionment-States.pdf
2. https://www.ama-assn.org/system/files/2022-delegate-apportionment-memos.pdf

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 619
(A-22)

Introduced by: Texas, South Carolina, Florida, Mississippi, New Jersey, Pennsylvania

Subject: Focus and Priority for the AMA House of Delegates

Referred to: Reference Committee F

Whereas, The speakers of the American Medical Association House of Delegates established a Resolutions Committee for the 2021 Special Meeting; and

Whereas, The Resolutions Committee will streamline and increase the efficiency of the business of the house; and

Whereas, Resolution 605, Nov. 21, was referred to the Board of Trustees for study with a verbal request for a report back at the 2022 Annual Meeting, and no report has been issued; and

Whereas, The number of resolutions submitted to our AMA continues to remain very high; and

Whereas, Our AMA needs to prioritize and focus to develop policy and act on the issues that are pertinent and important to practicing physicians; that require urgent attention; on which our AMA is the appropriate organization to lead; on which an AMA stance would have a positive impact; that have not been considered previously and voted down; or about which good AMA policy does not already exist; therefore be it

RESOLVED, That the Resolutions Committee be formed as a standing committee of the house, the purpose of which is to review and prioritize all submitted resolutions to be acted upon at the annual and interim meetings of the AMA House of Delegates (Directive to Take Action); and be it further

RESOLVED, That the membership of the Resolutions Committee be composed of one Medical Student Section (MSS) member, one Resident and Fellow Section (RFS) member, and one Young Physicians Section (YPS) member, all appointed by the speakers through nominations of the MSS, RFS, and YPS respectively; six regional members appointed by the speakers through nominations from the regional caucuses; six specialty members appointed by the speakers through nominations from the specialty caucuses; three section members appointed by the speakers through nominations from sections other than the MSS, RFS, and YPS; and one past president appointed by the speakers (Directive to Take Action); and be it further

RESOLVED, That the members of the Resolutions Committee serve staggered two-year terms except for the past president and the MSS and RFS members, who shall serve a one-year term (Directive to Take Action); and be it further

RESOLVED, That members of the Resolutions Committee cannot serve more than four years consecutively (Directive to Take Action); and be it further

RESOLVED, That if a Resolutions Committee member is unable or unwilling to complete his or her term, the speakers will replace that member with someone from a similar member group in consultation with that group the next year, and the new member will complete the unfulfilled term (Directive to Take Action); and be it further

RESOLVED, That each member of the Resolutions Committee confidentially rank resolutions using a 0-to-5 scale (0 – not a priority to 5 – top priority) based on scope (the number of physicians affected), urgency (the urgency of the resolution and the impact of not acting), appropriateness (whether AMA is the appropriate organization to lead on the issue), efficacy (whether an AMA stance would have a positive impact), history (whether the resolution has been submitted previously and not accepted), and existing policy (whether an AMA policy already effectively covers the issue). Resolutions would not have to meet all of these parameters nor would these parameters have to be considered equally (Directive to Take Action); and be it further

RESOLVED, That the composite (or average) score of all members of the Resolutions Committee be used to numerically rank the proposed resolutions. No resolution with a composite average score of less than 2 would be recommended for consideration. The Resolutions Committee would further determine the cutoff score above which resolutions would be considered by the house based on the available time for reference committee and house discussion, and the list of resolutions ranked available for consideration would be titled "Resolutions Recommended to be Heard by the HOD" (Directive to Take Action); and be it further

RESOLVED, That the Resolutions Committee also make recommendations on all resolutions submitted recommending reaffirmation of established AMA policy and create a list titled "Resolutions Recommended for Reaffirmation," with both lists presented to the house for acceptance (Directive to Take Action); and be it further

RESOLVED, That the membership of the Resolutions Committee be published on the AMA website with a notice that the appointed members should not be contacted, lobbied, or coerced; any such activity must be reported to the AMA Grievance Committee for investigation; and should the alleged violations be valid, disciplinary action of the offending person will follow (Directive to Take Action); and be it further

RESOLVED, That the bylaws be amended to add the Resolution Committee as a standing Committee with the defined charge, composition, and functions as defined above for all AMA HOD meetings effective Interim 2022. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000 assuming the resolution committee would not convene in person.

Received: 05/09/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 703
(A-22)

Introduced by: Maryland

Subject: Mandating Reporting of All Antipsychotic Drug Use in Nursing Home Residents

Referred to: Reference Committee G

Whereas, The federal government does not publicly disclose the use of antipsychotic drugs given to nursing home residents diagnosed with schizophrenia; and

Whereas, Antipsychotic drugs have historically been used as chemical restraints to keep nursing home residents docile, circumventing the costs associated with additional staffing required to manage nursing home residents; and

Whereas, Because the Food and Drug Administration has issued "black box" warnings regarding the risks of antipsychotic use among elderly patients with dementia, high rates of antipsychotic drug use can lower a nursing home's star rating from the federal government, thus damaging the reputation and desirability of the nursing home;[1] and

Whereas, The percentage of nursing home residents diagnosed with schizophrenia has increased in 2021;[2] and

Whereas, Nearly one-third of nursing home residents reported in the Centers for Medicare and Medicaid Services (CMS) Minimum Data Set (MDS) as having schizophrenia did not have any evidence of this diagnosis in their Medicare claims history, meaning they were likely prescribed antipsychotic drugs but were excluded because of their diagnosis;[3] and

Whereas, Current AMA policy "will ask CMS to cease and desist in issuing citations or financial penalties for medically necessary and appropriate use of antipsychotics for the treatment of dementia-related psychosis; and ask CMS to discontinue the use of antipsychotic medication as a factor contributing to the Nursing Home Compare rankings, unless the data utilized is limited to medically inappropriate administration of these medications";[4] therefore be it

RESOLVED, That American Medical Association Policy D-120.951, "Appropriate Use of Antipsychotic Medications in Nursing Home Patients," be amended by addition and deletion to read as follows:

Our AMA will: (1) meet with the Centers for Medicare & Medicaid Services (CMS) for a determination that acknowledges that antipsychotics can be an appropriate treatment for dementia-related psychosis if non-pharmacologic approaches have failed and will ask CMS to cease and desist in issuing citations or financial penalties for medically necessary and appropriate use of antipsychotics for the treatment of dementia-related psychosis; ~~and~~ (2) ask CMS to discontinue the use of antipsychotic medication as a factor contributing to the Nursing Home Compare rankings, unless the data utilized is limited to medically inappropriate administration of these medications; and (3) require the reporting of all antipsychotic drugs used and the diagnoses for which they are prescribed. (Modify Current HOD Policy)

Fiscal Note: Not yet determined

Received: 03/01/22

[1] Five-Star Quality Rating System | CMS https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/FSQRS (accessed 2021 -09 -21).
[2] MDS 3.0 Frequency Report | CMS https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Minimum-Data-Set-3-0-Public-Reports/Minimum-Data-Set-3-0-Frequency-Report (accessed 2021 -09 -21).
[3] CMS Could Improve the Data It Uses to Monitor Antipsychotic Drugs in Nursing Homes, OEI-07-19-00490. 22.
[4] D-120.951 Appropriate Use of Antipsychotic Medications in Nursi | AMA https://policysearch.ama-assn.org/policyfinder/detail/Appropriate%20Use%20of%20Antipsychotic%20Medications%20in%20Nursing%20Home%20Patients%20D-120.951?uri=%2FAMADoc%2Fdirectives.xml-0-77.xml (accessed 2021 -09 -21).

RELEVANT AMA POLICY

Appropriate Use of Antipsychotic Medications in Nursing Home Patients D-120.951
Our AMA will: (1) meet with the Centers for Medicare & Medicaid Services (CMS) for a determination that acknowledges that antipsychotics can be an appropriate treatment for dementia-related psychosis if non-pharmacologic approaches have failed and will ask CMS to cease and desist in issuing citations or financial penalties for medically necessary and appropriate use of antipsychotics for the treatment of dementia-related psychosis; and (2) ask CMS to discontinue the use of antipsychotic medication as a factor contributing to the Nursing Home Compare rankings, unless the data utilized is limited to medically inappropriate administration of these medications.
Res. 523, A-12; Appended: Res. 708, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 722
(A-22)

Introduced by: Oklahoma

Subject: Eliminating Claims Data for Measuring Physician and Hospital Quality

Referred to: Reference Committee G

Whereas, The US Centers for Medicare and Medicaid Services (CMS) has been publishing mortality data of hospitalized patients since 2008; and

Whereas, Public reporting has been expanded to cover multiple quality measures by many entities over the past few years; and

Whereas, The debate rages over whether to focus on outcomes versus care processes when assessing quality; and

Whereas, The validity of outcomes measures is under scrutiny when the data used for reporting purposes is claims data; and

Whereas, Any models that are used for assessing quality should be reliable and valid; and

Whereas, Models using data on severity of illness consistently outperform models using only comorbidity data; and

Whereas, Factors associated with severity of illness are the strongest predictors of quality; and

Whereas, Data from hospital billing systems contain no factors associated with the severity of illness; and

Whereas, Because of the variability of information in the medical record, claims data cannot reliably code comorbid conditions; and

Whereas, It is time to eliminate measures based on claims data from public reporting and other programs designed to hold physicians and hospitals accountable for improving outcomes; therefore be it

RESOLVED, That our American Medical Association collaborate with the Centers for Medicare and Medicaid Services (CMS) and other appropriate stakeholders to ensure physician and hospital quality measures are based on the delivery of care in accordance with established best practices (Directive to Take Action); and be it further

RESOLVED, That our AMA collaborate with CMS and other stakeholders to eliminate the use of claims data for measuring physician and hospital quality. (Directive to Take Action)

Reference: https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2757527?resultClick=1

Fiscal Note: Not yet determined

Received: 04/26/22