DATE: September 11, 2020

MEMO TO: Members of the MSMS House of Delegates

FROM: Theodore B. Jones, MD, Speaker
Phillip G. Wise, MD, Vice Speaker

RE: House of Delegates Reference Committee Testimony and Next Steps

As communicated earlier this summer, the House of Delegates survey achieved consensus on how to proceed with the 2020 meeting. MSMS will hold a virtual meeting to consider a subset of resolutions determined by a Resolution Review Committee. Reference Committee testimony will be submitted online, Reference Committees will deliberate via video, and a vote on the final report/consent calendar will be completed online. Any extractions will be tabled until 2021.

Resolution Review Committee
The Resolution Review Committee (RRC) was selected by the Speaker and Vice Speaker to identify resolutions that are time sensitive and must be acted on yet this year, and those that can be postponed until 2021. Members of the Committee included: Theodore B. Jones, Speaker of the House, Wayne; Phillip G. Wise, Vice Speaker of the House, Kent; Pino D. Colone, MD, President-elect, Past Speaker of the House and AMA Delegate, Genesee; James C. Mitchiner, MD, MPH, former Board member, Washtenaw; Rose M. Ramirez, MD, former Speaker of the House and AMA Delegate, Kent; Caroline G. M. Scott, MD, former Chair of Rules and Order, Saginaw; David T. Walsworth, MD, AMA Delegate, Ingham; Sanjay Das, AMA Delegate, Central Michigan University.

The Resolution Review Committee met last week and utilized the following criteria to review 13 resolutions that had been submitted by the authors for evaluation:

- Is the resolution time sensitive? Will this policy or ask be needed before April 2021?
- Is there existing policy that already covers all or some of the same intent?
- Is the resolution already being addressed by MSMS or regular staff work?
- Can the resolution be addressed within MSMS in another venue like an MSMS Committee or regular staff work?

The RRC determined nine of the resolutions met the criteria to be considered at the 2020 House of Delegates. The House of Delegates handbook may be found in the pages following this memo and online at www.msms.org/hod.
Written Online Reference Committee Testimony

Reference Committee testimony for the nine resolutions will be submitted online until September 20, 2020. Delegates may access the online resolution forum at:
https://msms2020resolutions.freeforums.net/board/1/general-discussion

To submit testimony, click on the resolution desired.

Comment in the box at the end of the resolution titled “Quick Reply.” Click “Post Quick Reply” to post your comment. You will be asked to submit your name in order to post. Please include your first and last name.

To return to the list of nine resolutions, either click your back arrows or click on the “General Discussion” tab in the header.
The online forum most closely resembles in person testimony where delegates are able to hear (or read in this case) their colleagues’ comments. If you would prefer to send your testimony directly to staff, you may email rblake@msms.org. Both types of submissions will be shared with the Reference Committee prior to their deliberations.

Next Steps
MSMS developed a tentative timeline to complete the House process by the end of October. The Speakers intend to remain flexible should the status of the state change between now and then.

- Online testimony: September 14 - 20, 2020
- Reference Committee Meeting: Week of September 28, 2020
- Online voting: October 12 - 18, 2020
- Post final report: October 26, 2020

Treasurer’s Report
The Treasurer’s Report may be found on the website at www.msms.org/hod. The report is password protected. The password is: msms2020tr

Thank you for your patience as we work through a new process for us all. We look forward to hosting a meaningful and productive House of Delegates. Please feel free to contact Rebecca Blake at rblake@msms.org or (517) 336-5729 with any questions. Thank you again.
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Title: Curb Human Trafficking

Introduced by: Joseph M. Beals, MD and Alireza Meysami, MD, for the Wayne County Delegation

Original Author: Joseph M. Beals, MD

Referred To: Reference Committee B

House Action:

Whereas, more than 20 million persons worldwide are victims of forced labor and sexual exploitation, and

Whereas, human trafficking generates more than $150 billion in annual profits, and

Whereas, while educating the public and young people is extremely important, the problem will not go away through education alone because the profits are so great, and

Whereas, a trafficker can make thousands of dollars each year—this is our modern-day slavery, and

Whereas, human traffickers prey on vulnerable groups such as adolescents and young adults with a history of child abuse, as well as the lesbian, gay, bisexual, transgender, and queer communities, and

Whereas, 55 percent of the victims are women and girls, and

Whereas, human trafficking is the third highest crime activity in the state of Michigan and Michigan is ranked second in the country in human trafficking, and

Whereas, over the past two years, the Wayne County Medical Society of Southeast Michigan (WCMS) Foundation has circulated in schools and health organizations its video, "Stuck in Traffic," which is addressed to high school and college students about the danger signals of human trafficking, and

Whereas, human trafficking is identified as a major public health problem in an October 2016 Annals of Internal Medicine article addressing human trafficking, and

Whereas, the Michigan Human Trafficking Commission has worked with the Michigan Attorney General's office and WCMS, and has created a video on human trafficking which is part of the state licensing process, "Human Trafficking: Making the Invisible Visible," and

Whereas, states like Connecticut have passed human trafficking laws that define new penalties for "buyers of sex," and

Whereas, other countries including Sweden, Norway, Iceland, Northern Ireland, Canada, France, Ireland, and Israel have adopted the "Nordic Model" as "the best way to decrease demand," and

Whereas, the "Nordic Model" approaches "human trafficking as a gender inequality and human rights issue" and "focuses on criminalizing the act of buying sex, and at the same time decriminalizing the selling of sex. In other words, the focus is on punishing the customer that buys access to other people’s bodies while keeping the people that are being sold safe and immune from prosecution," and
Whereas, while educating the public on the evils of human trafficking is vital, as well as education of young people about the signs of human trafficking, the problem will not be improved to any extent unless the buyers of sex are discouraged from this activity; therefore be it RESOLVED: That MSMS advocate for the passage of human trafficking legislation which toughens criminal and financial penalties for persons soliciting sex; and be it further RESOLVED: That MSMS advocate for the implementation of the “Nordic Model” approach in Michigan to combat human trafficking by maximizing criminal penalties for the buying of sex rather than the selling of sex.

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

Relevant MSMS Policy:

The Recognition and Protection of Human Trafficking Victims
MSMS supports training medical students, residents, and physicians to understand their role in treating patients who are victims of human trafficking.

Human Trafficking Education and Awareness
MSMS encourages the State Board of Education, Michigan secondary schools and colleges, as well as other influential organizations to increase awareness of human trafficking and increase awareness of signs of human trafficking.

Relevant AMA Policy:

Commercial Exploitation and Human Trafficking of Minors H-60.912
Our AMA supports the development of laws and policies that utilize a public health framework to address the commercial sexual exploitation and sex trafficking of minors by promoting care and services for victims instead of arrest and prosecution.

Physicians Response to Victims of Human Trafficking H-65.966
1. Our AMA encourages its Member Groups and Sections, as well as the Federation of Medicine, to raise awareness about human trafficking and inform physicians about the resources available to aid them in identifying and serving victims of human trafficking.

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

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

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

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

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

Source:
2. Annals of Internal Medicine, Vol. 165, No. 8 – 18, October 2016
Title: Safe Disposal of Controlled Substances Prescribed for Home Hospice Patients

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

Original Author: Jayne E. Courts, MD, FACP

Referred To: Reference Committee B

House Action:

Whereas, patients who have a terminal illness often elect to receive hospice care, and

Whereas, many hospice patients choose to receive hospice care in their private residence/home
due to the often-cited preference to die at home, and

Whereas, patients in hospice care often receive controlled substances, including but not limited
to opioid-containing medications or benzodiazepines, to ease pain and discomfort, and/or agitation
during the dying process, and

Whereas, the controlled substances may be accessible to family members, people who live in the
home, and visitors to a patient’s home during the dying process and shortly after the patient’s death, and

Whereas, safe disposal of these controlled substances may be performed by the hospice nurse,
family members, or people who live in the home with proper instruction, and

Whereas, this potential access to controlled substances may lead to other people misusing the
controlled substances, potentially fostering or supporting the development of substance use disorder;
therefore be it

RESOLVED: That MSMS collaborate with the Michigan Home Care and Hospice Association to
determine safe disposal guidelines for controlled substances that have been dispensed for hospice
patients in the home-based setting that are no longer needed after the patient has died; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our
AMA to collaborate with the National Hospice and Palliative Care Organization and other stakeholders to
determine safe disposal guidelines for controlled substances that have been dispensed for hospice
patients in the home-based setting that are no longer needed after the patient has died.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $2,000-$4,000 to engage in collaborative outreach
activities.

Relevant MSMS Policy:

None

Relevant AMA Policy:

Proper Disposal of Unused Prescription and Over-the-Counter (OTC) Drugs H-135.936
1. Our AMA supports initiatives designed to promote and facilitate the safe and appropriate disposal of unused
medications.
2. Our AMA will work with other national organizations and associations to inform, encourage, support and guide hospitals, clinics, retail pharmacies, and narcotic treatment programs in modifying their US Drug Enforcement Administration registrations to become authorized medication collectors and operate collection receptacles at their registered locations.

3. Our AMA will work with other appropriate organizations to develop a voluntary mechanism to accept non-controlled medication for appropriate disposal or recycling.

**Safe Use, Storage and Disposal of Leftover Opioids and Other Controlled Substances D-95.971**

Our AMA and its Opioid Task Force: (1) will continue to adapt current educational materials to distribute to prescribers and patients, emphasizing the importance of safe storage and disposal of opioids, and encouraging prescribers and patients to investigate and advocate for more local drug take back programs; (2) encourages all prescribers to work with local organizations and pharmacists to develop and disseminate the most up-to-date information on local Take Back resources; and (3) will continue to educate all prescribers on the importance of optimal use of opioids, including appropriately limiting the quantities of opioid prescriptions and advocating for e-prescription capabilities for controlled substances.
Title: Preserve and Increase Graduate Medical Education Funding

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

Original Author: Jayne E. Courts, MD, FACP

Referred To: Reference Committee D

House Action:

Whereas, the U.S. General Accountability Office (GAO) recently announced their fiscal year budget, and

Whereas, their announcement included information about potential changes in graduate medical education (GME) funding, and

Whereas, the GAO released a report in December 2019, entitled, "Views on Expanding Medicare Graduate Medical Education Funding to Nurse Practitioners and Physician Assistants," and

Whereas, this report contains potential errors that may adversely influence legislative decisions, and

Whereas, GME funding, direct and indirect funding, has been earmarked for resident physicians to support their education and training in teaching hospitals, and

Whereas, advanced practice professionals, such as nurse practitioners or physician assistants, have a shorter training period with an associated lower overall cost for the trainee and no requirement for a residency, and

Whereas, the number of residency slots has not been increased for most residency programs since 1997 due to the restrictions imposed by the Balanced Budget Act, and

Whereas, teaching hospitals rely on GME funding to offset the increased cost of providing care that may occur in a teaching hospital setting due to the presence of additional health care personnel who are trainees, and

Whereas, an increase in GME funding has been an ongoing request to our legislators for the past few years due to concerns about the rising expenses of providing education coupled with the stagnation of GME funding, and

Whereas, the United States is facing a significant and severe physician shortage based on current predictors and estimates, and

Whereas, the diversion of GME funding to non-physicians will only make this situation worse with potential serious consequences for the health of our nation due to lack of physician access; therefore be it

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to work with the Liaison Committee on Medical Education, the Accreditation Council for Graduate Medical Education, and other interested stakeholders to encourage the U.S. Government Accountability Office to oppose and refrain from further consideration of the diversion of direct and indirect graduate medical education funding to non-physicians.
WAYS AND MEANS COMMITTEE FISCAL NOTE: $12,000-$24,000 for regulatory advocacy.

Relevant MSMS Policy:

Adopting Alternative Sources of Graduate Medical Education Funding
MSMS supports the principle or concept of an all-payer fund that would distribute the cost of training physicians across Medicare, Medicaid, and private health insurance plans.

Increasing Post-Graduate Medical Education Slots in the State of Michigan
MSMS supports increased funding from private and federal sources for post-graduate residency training in the state of Michigan.

Increase Funding for Post-Graduate Education
MSMS supports increased federal funding for post graduate medical education, nationwide.

Increasing Residency Slots for Post-Graduate Medical
Education in the State of Michigan MSMS encourages the American Medical Association, American Counsel of Graduate Medical Education (ACGME), federal government, and financially supporting hospital(s) and institution(s) to increase residency positions for qualified American and International medical graduates in the state of Michigan.

Medicaid Funding for Graduate Medical Education
MSMS supports increased funding for graduate medical education by Medicaid.

Reform Michigan Medicaid GME Funding
MSMS supports requiring that all Medicaid Graduate Medical Education (GME) funding to hospitals be earmarked and spent for GME purposes only; that the current GME funding be replaced with a new formula of paying hospitals and institutions for direct medical education expenses (i.e., resident salaries and benefits, faculty salaries, program support staff, and hospital overhead) for additional slots exceeding the Medicare funding cap only; and that GME funding for innovative residency programs to promote access to patient care in urban and rural areas and in specialties with limited patient access be encouraged.

State Medicaid GME Funding for New GME Slots
MSMS supports using current Medicaid GME funding to fund new residency slots in Michigan, and seeking extra GME funding with financial incentives provided through the Michigan Department of Community Health to programs whose graduates choose to stay in Michigan in great proportion.

Relevant AMA Policy:

Funding to Support Training of the Health Care Workforce H-310.916
1. Our American Medical Association will insist that any new GME funding to support graduate medical education positions be available only to Accreditation Council for Graduate Medical Education (ACGME) and/or American Osteopathic Association (AOA) accredited residency programs, and believes that funding made available to support the training of health care providers not be made at the expense of ACGME and/or AOA accredited residency programs.
2. Our AMA strongly advocates that: (A) there be no decreases in the current funding of MD and DO graduate medical education while there is a concurrent increase in funding of graduate medical education (GME) in other professions; and (B) there be at least proportional increases in the current funding of MD and DO graduate medical education similar to increases in funding of GME in other professions.

Securing Funding for Graduate Medical Education H-310.917
Our American Medical Association: (1) continues to be vigilant while monitoring pending legislation that may change the financing of medical services (health system reform) and advocate for expanded and broad-based funding for graduate medical education (from federal, state, and commercial entities); (2) continues to advocate for graduate medical education funding that reflects the physician workforce needs of the nation; (3) encourages all funders of GME to adhere to the Accreditation Council for Graduate Medical Education’s requirements on restrictive covenants and its principles guiding the relationship between GME, industry and other funding sources, as well as the AMA’s Opinion 8.061, and other AMA policy that protects residents and fellows from exploitation, including
physicians training in non-ACGME-accredited programs; and (4) encourages entities planning to expand or start GME programs to develop a clear statement of the benefits of their GME activities to facilitate potential funding from appropriate sources given the goals of their programs.

**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 and ensure 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:
RESOLUTION 34-20

Title: Board Exam Reciprocity for Canadian Physicians in Michigan

Introduced by: Jawad Shah, MD, for the Genesee County Delegation

Original Author: Jawad Shah, MD

Referred To: Reference Committee B

House Action:

Whereas, the United States will see a shortage of up to nearly 122,000 physicians by 2032 as demand for physicians continues to grow faster than supply, and

Whereas, Michigan faces a physician shortage greater than the national average, and

Whereas, in the next 10 years, 45 percent of Michigan’s physicians plan to retire, and

Whereas, the Licentiate of the Medical Council of Canada is the Canadian equivalent of the United States Medical Licensing Examination, and

Whereas, 44 other U.S. state boards endorse the Medical Council of Canada Qualifying Examination Part I and Part II as evidence of passing an acceptable licensing examination; therefore be it

RESOLVED: That MSMS work with the Michigan Legislature to ensure Canadian physicians who have passed the Medical Council of Canada Qualifying Examination Part I and Part II are eligible to be licensed in Michigan without having to take the United States Medical Licensing Examination.

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

Relevant MSMS Policy:

None

Relevant AMA Policy:

Abolish Discrimination in Licensure of IMGs H-255.966

Medical Licensure of International Medical Graduates

1. Our AMA supports the following principles related to medical licensure of international medical graduates (IMGs):

A. State medical boards should ensure uniformity of licensure requirements for IMGs and graduates of U.S. and Canadian medical schools, including eliminating any disparity in the years of graduate medical education (GME) required for licensure and a uniform standard for the allowed number of administrations of licensure examinations.

B. All physicians seeking licensure should be evaluated on the basis of their individual education, training, qualifications, skills, character, ethics, experience and past practice.

C. Discrimination against physicians solely on the basis of national origin and/or the country in which they completed their medical education is inappropriate.

D. U.S. states and territories retain the right and responsibility to determine the qualifications of individuals applying for licensure to practice medicine within their respective jurisdictions.

E. State medical boards should be discouraged from a) using arbitrary and non-criteria-based lists of approved or unapproved foreign medical schools for licensure decisions and b) requiring an interview or oral examination prior to licensure endorsement. More effective methods for evaluating the quality of IMGs' undergraduate medical
education should be pursued with the Federation of State Medical Boards and other relevant organizations. When available, the results should be a part of the determination of eligibility for licensure.

2. Our AMA will continue to work with the Federation of State Medical Boards to encourage parity in licensure requirements for all physicians, whether U.S. medical school graduates or international medical graduates.

3. Our AMA will continue to work with the Educational Commission for Foreign Medical Graduates and other appropriate organizations in developing effective methods to evaluate the clinical skills of IMGs.

4. Our AMA will work with state medical societies in states with discriminatory licensure requirements between IMGs and graduates of U.S. and Canadian medical schools to advocate for parity in licensure requirements, using the AMA International Medical Graduate Section licensure parity model resolution as a resource.
Title: Involuntary Hospitalizations of Patients with Serious Mental Health Illness

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

Original Authors: James Mitchiner, MD, MPH, and Robert Sain, MD

Referred To: Reference Committee D

House Action:

Whereas, patients with acute mental health crises are often sent to the hospital emergency department, and

Whereas, patients with serious mental health issues, such as psychosis, suicidal or homicidal ideation, should undergo involuntary hospitalization in dedicated inpatient behavioral health facilities, and

Whereas, there is a state and nation-wide shortage of available psychiatric beds, and

Whereas, an easily-accessible method for patients or physicians to identify available psychiatric beds and treatment facilities does not exist, and

Whereas, many patients seeking care are uninsured or covered by county-specific Medicaid health plans, and

Whereas, county-designated community mental health (CMH) agencies are tasked with evaluating these patients to determine the appropriateness of inpatient care, and specifically whether CMH should reimburse the hospital for such care, and

Whereas, CMH evaluators are not physicians, and decisions on involuntary commitment can only be made by physicians and psychologists under current law, and

Whereas, decisions on involuntary hospitalizations at the hospital of origin are inherently medical decisions, not financial decisions; therefore be it

RESOLVED: That MSMS work with appropriate stakeholder groups, including the Michigan Department of Health and Human Services, to better understand the external, non-medical motivations for facility transfers of patients with serious mental health issues; and be it further

RESOLVED: That MSMS work with community mental health agencies to emphasize that involuntary hospitalization is based on medical rather than financial criteria; and be it further

RESOLVED: That MSMS continue to advocate that community mental health agencies and hospital administrators should, at all times, respect the Emergency Medical Treatment and Labor Act regarding inter-facility transfers of patients with serious mental health issues; and be it further

RESOLVED: That MSMS supports appropriate modification of the Michigan Mental Health Code in order to make involuntary hospitalization more rapidly accessible for mentally ill persons requiring such intervention for the benefit of their safety and the safety of others.
WAYS AND MEANS COMMITTEE FISCAL NOTE: $12,000-$32,000 for legislative and regulatory/industry advocacy.

**Relevant MSMS Policy:**

**Increasing Funding for Mental Health Hospitals**
MSMS supports restoration of budget cuts and increased expenditures in the public mental health hospital system so that quality care again may be provided by upgrading staff levels to recommended requirements.

MSMS supports increased state funding for psychiatric research so as to develop more efficacious treatment for the mentally ill.

MSMS supports efforts to assure adequate treatment in Michigan Department of Community Health mental health facilities as required by state law.

**Involuntary Hospitalization**
MSMS supports appropriate modification of the Michigan Mental Health Code in order to make involuntary hospitalization more rapidly accessible for mentally ill persons requiring such intervention for the benefit of their safety and the safety of others.

**Support for Mental Health Reform in Michigan**
MSMS supports efforts to improve mental health services in Michigan, including those that address mental health disparities, promote interdepartmental coordination and shared accountability, and provide greater access to timely outpatient treatment, crisis intervention, specialty behavioral health services, inpatient psychiatric hospitalizations and other medically necessary related therapies.

**Relevant AMA Policy:**

**Statement of Principles on Mental Health H-345.999**
1. Tremendous strides have already been made in improving the care and treatment of patients with psychiatric illness, but much remains to be done. The mental health field is vast and includes a network of factors involving the life of the individual, the community and the nation. Any program designed to combat psychiatric illness and promote mental health must, by the nature of the problems to be solved, be both ambitious and comprehensive.
2. The AMA recognizes the important stake every physician, regardless of type of practice, has in improving our mental health knowledge and resources. The physician participates in the mental health field on two levels, as an individual of science and as a citizen. The physician has much to gain from a knowledge of modern psychiatric principles and techniques, and much to contribute to the prevention, handling and management of emotional disturbances. Furthermore, as a natural community leader, the physician is in an excellent position to work for and guide effective mental health programs.
3. The AMA will be more active in encouraging physicians to become leaders in community planning for mental health.
4. The AMA has a deep interest in fostering a general attitude within the profession and among the lay public more conducive to solving the many problems existing in the mental health field.

**Access to Psychiatric Beds and Impact on Emergency Medicine H-345.978**
Our AMA supports efforts to facilitate access to both inpatient and outpatient psychiatric services and the continuum of care for mental illness and substance use disorders, ameliorate the psychiatric workforce shortage, and provide adequate reimbursement for the care of patients with mental illness.
Title: Oppose Criminalization of Physicians and Patients for Evidence Based Standard of Medical Care

Introduced by: Nabiha Hashmi for the Medical Student Section

Original Authors: Anjali Alangaden, May Chammaa, Jody Chou, Mara Darian, Tabitha Moses, Siri Sarvepalli, and Brianna Sohl

Referred To: Reference Committee B

Whereas, there has been an increase in the last few years in the number of legislative bills which interfere with a physician’s ability to make medical decisions and provide evidence-based care to their patients, and

Whereas, there are bills under review in multiple states including Texas, Georgia, Kentucky, South Dakota, South Carolina, Oklahoma, Missouri, and Colorado that seek to ban physicians from providing gender affirming care to transgender youth, in some cases designating such medical procedures a felony, and

Whereas, a bill introduced in the Ohio legislature received national attention for its efforts to dictate medical practice contradictory to science by pushing for re-implantation of ectopic pregnancy under criminal punishment for physicians who do not abide by this, and

Whereas, House Bill 1890 in the Pennsylvania legislature places additional restrictions on providers of pregnancy termination, such as an indirect requirement to file death certificates to the state for pregnancy terminations, miscarriages, and unsuccessful embryos used for IVF; furthermore, failure to do so will result in a fine or prison sentence even though it is not always possible for a medical professional to distinguish between a spontaneous and induced loss of pregnancy, and

Whereas, a campaign led by Connecticut breast cancer patient Nancy Cappello successfully lobbied for the passage of dense breast tissue legislation in 35 states, mandating that patients be notified of their dense breast tissue, as well as suggesting that they may benefit from supplemental screening; however, ACOG guidelines do not recommend alternative or adjunctive testing in women with dense breasts who are asymptomatic and have no additional risk, and

Whereas, multiple states, including Michigan, have seen increased efforts to restrict access to reproductive care, including a ban on dilation and evacuation (D&E) procedures with threat of fine and imprisonment, although the American College of Obstetrics and Gynecology (ACOG) states that these procedures result in the fewest complications compared to other methods, and

Whereas, interruption of pregnancy is a safe and legal medical procedure; however, illegal procedures to interrupt a pregnancy were a leading cause of maternal mortality in Pre-Roe America, and remain so today in countries with restrictive reproductive laws, and

Whereas, in the U.S., states with more restrictive reproductive laws have higher rates of maternal and infant mortality, and

Whereas, most recent Centers for Disease Control and Prevention collected data from 2016, illustrated that 26,395 medically induced interruption of pregnancy procedures occurred in Michigan, the
majority (60.8 percent) at eight weeks gestation or earlier, and an estimated four percent were for non-Michigan residents, and

Whereas, the patient-physician relationship is damaged by legislation that forces physicians to provide misleading or incomplete information to patients about their reproductive health options, and

Whereas, increasing the financial and logistical burden of accessing comprehensive reproductive care disproportionately disadvantages low-income individuals and people of color, and

Whereas, ACOG, American Academy of Pediatrics, American Psychiatric Association, American Osteopathic Association, American Academy of Family Physicians, and the American College of Physicians oppose legislative interference which “unnecessarily regulates the evidence-based practice of medicine and, in some cases, even criminalizes physicians who deliver safe, legal, and necessary medical care,” and

Whereas, MSMS policy states, “Patients have the right to be free from coercion in determining when and if they will submit to medical procedures...,” and

Whereas, MSMS issued a letter to the Senate Judiciary Committee in 2019 to voice concerns about Senate Bills 229 and 230 which would ban the D&E procedure due to “potential criminal penalties that could be imposed, and the concerning precedent the legislation sets with respect to interference into the sanctity and confidentiality of the physician-patient relationship,” and

Whereas, MSMS does not have policy to speak on the D&E procedure, nor to the criminalization of physicians and patients for delivering evidence-based standard of medical care; therefore be it

RESOLVED: That MSMS oppose the criminalization of physicians for delivering evidence-based standard of medical care, as well as for refusing to engage in care that is neither safe nor evidence based; and be it further

RESOLVED: That MSMS advocate against legislation that criminalizes physicians and patients for interruption of pregnancy procedures which are consistent with the American College of Obstetricians and Gynecologists clinical guidelines.

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

Relevant MSMS Policy:

Physician’s Rights in Treatment Decisions
Neither physicians, hospitals nor hospital personnel shall be required to perform any act that violates good medical judgment or is contrary to moral principles of the individual. In such circumstances, the physician or other professional may withdraw from the case as long as the withdrawal is consistent with good medical practice.

Determination of Medical Necessity of Medical Case Management
The treating physician shall be the sole determinant of medical case management and medical necessity. MSMS believes that an insurer, a health care corporation or a government agency may not interfere with the patient/physician relationship by determining medical necessity or medical case management without a fair and reasonable appeals process and independent binding arbitration in a timely fashion.

Quality of Patient Care
Medical services to the patient should be allocated based upon the physician’s best medical judgment with regard to the patient’s health and welfare. Financial consideration shall not alter the physician’s best medical judgment and treatment of that patient.
No Constitutional Prohibition
There should be no amendment to the Constitution of the United States that would prohibit abortion.

Anti-abortion Coercion
Patients have the right to be free from coercion in determining when and if they will submit to medical procedures such as sterilization and abortion.

Good Samaritan Protection
MSMS supports legal protection for doctors, nurses, and paramedical personnel who assist travelers experiencing medical problems.

Gender Selection
MSMS opposes prohibiting physicians from performing abortions for women who want to terminate their pregnancy based on the gender of the fetus because MSMS opposes infringement upon the physician/patient relationship.

Relevant AMA Policy:

Government Interference in Patient Counseling H-373.995
1. Our AMA vigorously and actively defends the physician-patient-family relationship and actively opposes state and/or federal efforts to interfere in the content of communication in clinical care delivery between clinicians and patients.
2. Our AMA strongly condemns any interference by government or other third parties that compromise a physician's ability to use his or her medical judgment as to the information or treatment that is in the best interest of their patients.
3. Our AMA supports litigation that may be necessary to block the implementation of newly enacted state and/or federal laws that restrict the privacy of physician-patient-family relationships and/or that violate the First Amendment rights of physicians in their practice of the art and science of medicine.
4. Our AMA opposes any government regulation or legislative action on the content of the individual clinical encounter between a patient and physician without a compelling and evidence-based benefit to the patient, a substantial public health justification, or both.
5. Our AMA will educate lawmakers and industry experts on the following principles endorsed by the American College of Physicians which should be considered when creating new health care policy that may impact the patient-physician relationship or what occurs during the patient-physician encounter: 1. Is the content and information or care consistent with the best available medical evidence on clinical effectiveness and appropriateness and professional standards of care? 2. Is the proposed law or regulation necessary to achieve public health objectives that directly affect the health of the individual patient, as well as population health, as supported by scientific evidence, and if so, are there no other reasonable ways to achieve the same objectives? 3. Could the presumed basis for a governmental role be better addressed through advisory clinical guidelines developed by professional societies? 4. Does the content and information or care allow for flexibility based on individual patient circumstances and on the most appropriate time, setting and means of delivering such information or care? 5. Is the proposed law or regulation required to achieve a public policy goal - such as protecting public health or encouraging access to needed medical care - without preventing physicians from addressing the healthcare needs of individual patients during specific clinical encounters based on the patient’s own circumstances, and with minimal interference to patient-physician relationships? 6. Does the content and information to be provided facilitate shared decision-making between patients and their physicians, based on the best medical evidence, the physician’s knowledge and clinical judgment, and patient values (beliefs and preferences), or would it undermine shared decision-making by specifying content that is forced upon patients and physicians without regard to the best medical evidence, the physician’s clinical judgment and the patient's wishes? 7. Is there a process for appeal to accommodate individual patients’ circumstances?
6. Our AMA strongly opposes any attempt by local, state, or federal government to interfere with a physician’s right to free speech as a means to improve the health and wellness of patients across the United States.

The Criminalization of Health Care Decision Making H-160.946
The AMA opposes the attempted criminalization of health care decision-making especially as represented by the current trend toward criminalization of malpractice; it interferes with appropriate decision making and is a disservice to the American public; and will develop model state legislation properly defining criminal conduct and prohibiting the criminalization of health care decision-making, including cases involving allegations of medical malpractice, and implement an appropriate action plan for all components of the Federation to educate opinion
leaders, elected officials and the media regarding the detrimental effects on health care resulting from the criminalization of health care decision-making.

**Oppose the Criminalization of Self-Induced Abortion H-5.980**

Our AMA: (1) opposes the criminalization of self-induced abortion as it increases patients' medical risks and deters patients from seeking medically necessary services; and (2) will advocate against any legislative efforts to criminalize self-induced abortion.

**Right to Privacy in Termination of Pregnancy H-5.993**

The AMA reaffirms existing policy that (1) abortion is a medical procedure and should be performed only by a duly licensed physician in conformance with standards of good medical practice and the laws of the state; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment or personally held moral principles. In these circumstances good medical practice requires only that the physician or other professional withdraw from the case so long as the withdrawal is consistent with good medical practice. The AMA further supports the position that the early termination of pregnancy is a medical matter between the patient and the physician, subject to the physician's clinical judgment, the patient's informed consent, and the availability of appropriate facilities.

**4.2.7 Abortion**

The Principles of Medical Ethics of the AMA do not prohibit a physician from performing an abortion in accordance with good medical practice and under circumstances that do not violate the law.

**Sources:**

2. Andrew, Scottie. This year, at least six states are trying to restrict transgender kids from getting gender reassignment treatments. CNN. Jan 22, 2020.
7. Sherman RB. Recent abortion bans will impact poor people and people of color most. VOX. May 18, 2019.

Title: Anonymous Prescribing Option for Expedited Partner Therapy

Introduced by: Nabiha Hashmi for the Medical Student Section

Original Author: Brianna Sohl

Referred To: Reference Committee D

House Action:

Whereas, sexually transmitted infections (STIs) reached an all-time high in the United States in 2018 with more than 580,000 cases of gonorrhea and 1.7 million cases of chlamydia, the highest number of chlamydia cases ever reported to the Centers for Disease Control and Prevention (CDC), and

Whereas, some data suggests that 40 to 70 percent of male partners do not receive STI treatment, and

Whereas, reinfection rates of chlamydia and gonorrhea in women are high, estimated to be 13.9 percent and 11.7 percent, respectively, and

Whereas, untreated STIs can result in adverse health outcomes including pelvic inflammatory disease, infertility, ectopic pregnancy, and increased HIV risk, and

Whereas, Expedited Partner Therapy (EPT) is the clinical practice in which a patient diagnosed with chlamydia or gonorrhea may be given medications for themselves and their sex partners without the health care provider first examining the partner, and

Whereas, evidence indicates that EPT has improved clinical effectiveness in decreasing recurrent infection compared to other methods of partner treatment, and

Whereas, EPT has been found to be cost-saving and cost-effective, improves notification of sexual partners of the STI diagnosis, and safe as severe reactions to treatment are so rare that there are no reported percentages, and

Whereas, physicians have an ethical duty to not only help their patients but also improve public health, which includes the treatment of their patients’ partner(s), and

Whereas, the practice of EPT is supported by the CDC, the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, the American Academy of Pediatrics, and the Society for Adolescent Health and Medicine, and

Whereas, existing AMA policy (D-440.968, H-440.868) supports the practice of EPT and existing policy states it will work with the CDC to develop tools for health departments and health professionals to facilitate the use of EPT, and

Whereas, Michigan has passed legislation making anonymous EPT permissible in which the prescription for the partner(s) is legally allowed to be prescribed to the name “expedited partner therapy,” and
Whereas, the University of Michigan EPT protocol states that the patient may receive
prescriptions for the number of partners the patient self-reports, and each prescription may be given an
Order ID number to be utilized at prescription pick up, maintaining anonymity, and

Whereas, although EPT is well-supported, there is limited discussion surrounding anonymous
prescribing within EPT and current policies do not explicitly address this component of EPT, and

Whereas, most electronic medical record systems do not have the ability to allow a physician to
prescribe medications anonymously; therefore be it

RESOLVED: That MSMS advocate that electronic medical record vendors create an anonymous
prescribing option for the purpose of expedited partner therapy; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our
AMA to work with electronic medical record vendors to create an anonymous prescribing option for the
purpose of expedited partner therapy.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $12,000-$24,000 for regulatory/industry advocacy.

Relevant MSMS Policy:

**Expedited Partner Therapy for Gonorrhea and Chlamydia**
MSMS supports amending the public health code to make expedited partner therapy legal in Michigan and
supports immunity from professional and civil liability if expedited partner therapy is provided according to the
regulations.

MSMS supports immunity from professional and civil liability if expedited partner therapy is provided according to the
regulations.

Relevant AMA Policy:

**Expedited Partner Therapy (Patient-Delivered Partner Therapy) D-440.968**
Our AMA will continue to work with the Centers for Disease Control and Prevention as it implements expedited
partner therapy, such as through the development of tools for local health departments and health care
professionals to facilitate the appropriate use of this therapy.

**Expedited Partner Therapy H-440.868**
Our AMA supports state legislation that permits physicians to provide expedited partner therapy to patients
diagnosed with gonorrhea, chlamydia infection, and other sexually transmitted infections, as supported by scientific
evidence and identified by the CDC.

Sources:
1. New CDC Report: STDs continue to rise in the US. National Center for HIV/AIDS, Viral Hepatitis, STD, and TB
2. Jamison CD, Coleman JS, Mmeje O. Improving women’s health and combatting sexually transmitted
3. Hosenfeld CB, Workowski KA, Berman S, Zaidi A, Dyson J, Mosure D, Bolan G, Bauer HM. Repeat infection with
   chlamydia and gonorrhea among females: a systematic review of the literature. Sexually Transmitted
   Diseases. 2009 August; 36(8): 478-489.
   https://www.cdc.gov/std/ept/default.htm
   Ward H, Low N. Effectiveness and cost-effectiveness of traditional and new partner notification technologies


Title: Access to Opioid Agonist Treatment for Incarcerated Persons

Introduced by: Nabiha Hashmi, for the Medical Student Section

Original Authors: Jennifer Asante, Connor Buechler, May Chammaa, Jody Chou, Emily Currier, Peter Dimitriou, Preetha Ghosh, Aileen Haque, Ashton Lewandowski, Michael Moentmann, Tabitha Moses, Dhruvil Patel, Mauli Patel, Brianna Sohl, Shabber Syed, and Suha Syed

Referred To: Reference Committee B

House Action:

Whereas, an estimated 65 percent of the United States prison population has an active substance use disorder (SUD), and between 24 to 36 percent of persons with opioid use disorder (OUD) pass through U.S. prisons and jails each year; however, only five percent of people with OUD in jail and prison settings receive appropriate medication treatment, and

Whereas, the Centers for Disease Control and Prevention and World Health Organization guidelines recommend any opioid agonist treatment (OAT) during incarceration and upon release from prison; however, only approximately half of all U.S. prisons/jails provide treatment options to incarcerated individuals, and

Whereas, most correctional institutions mandate withdrawal of any OAT upon entry into the criminal justice system, often preventing individuals from engaging in OAT outside of prison in fear of the abrupt cessation of their treatments, and

Whereas, within one year of leaving prison, up to 10 percent of those who were formerly incarcerated die, and 15 percent of deaths of former inmates are due to opioid-related overdoses, and

Whereas, a 2013 study in Washington State determined that overdose was the leading cause of death of persons who were formerly incarcerated, and

Whereas, OAT, which includes the full agonist methadone and the partial agonist buprenorphine, is an evidence-based, effective treatment for OUD that lessens the harmful health and societal effects of such substance use disorders, and

Whereas, OAT has been studied within correctional facilities in numerous settings in the U.S. and worldwide and has been shown to decrease re-incarceration rates by 20 percent and reduce the hazard of death by 75 percent following release, and

Whereas, one study found that those in a prison who started OAT were less likely to report using heroin and sharing syringes during their incarceration than those on the waiting list for OAT, and

Whereas, those who start OAT during incarceration have higher rates of successful re-entry into the community, reduced heroin use, and declining recidivism compared to those who do not, and

Whereas, The American Psychiatric Association (APA) policy states that “Jails and prisons should make available quality treatment for substance use disorders to all inmates who qualify for such treatment” and that whenever possible patients who are treated with medication (buprenorphine or methadone) for their OUD should be continued, and
Whereas, the 2017 Presidential Commission on “Combating Drug Addiction and the Opioid Crisis” recommended increased usage of OAT in corrections settings due to preliminary data suggesting OAT treatment reduces risk of overdose and improves outcomes for those with OUD, and

Whereas, the American Society of Addiction Medicine recommends pharmacotherapy (either methadone or buprenorphine) and psychosocial treatment for those with OUD in the criminal justice system and the initiation of pharmacotherapy a minimum of 30 days before release from prison, and

Whereas, our AMA has endorsed the use of medication for OUD in prisons, encouraged public funding for such programs, and supported the establishment of post-incarceration programs to continue OUD, and

Whereas, the MSMS House of Delegates adopted a resolution in 2007 to advise the Michigan Department of Community Health to “communicate to each county sheriff the standard of care for the management of opioid withdrawal of incarcerated addicts to end forced opioid withdrawal,” and

Whereas, the state of Michigan has begun to provide OAT for prisoners with OUD in three prisons, and there are plans to expand this so that all prisons in the state provide at least one form of medication treatment by 2023; therefore be it

RESOLVED: That MSMS advocate for the availability of all types of opioid agonist treatment for opioid use disorder for incarcerated persons in Michigan; and be it further

RESOLVED: That MSMS encourage correctional facilities to use a validated screening tool to identify withdrawal and determine potential need for treatment for opioid use disorder for all incarcerated persons upon entry; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to amend H-430.987 Opiate Replacement Therapy Programs in Correctional Facilities by addition as follows:

H-430.987 Opiate Replacement Therapy Programs in Correctional Facilities

1. Our AMA endorses: (a) the medical treatment model of employing opiate replacement therapy (ORT) as an effective therapy in treating opiate-addicted persons who are incarcerated; and (b) ORT for opiate-addicted persons who are incarcerated, in collaboration with the National Commission on Correctional Health Care and the American Society of Addiction Medicine.

2. Our AMA advocates for legislation, standards, policies and funding that encourage correctional facilities to increase access to evidence-based treatment of opioid use disorder, including initiation and continuation of opioid replacement therapy in conjunction with counseling, in correctional facilities within the United States and that this apply to all incarcerated individuals including pregnant women.

3. Our AMA supports legislation, standards, policies, and funding that encourage correctional facilities within the United States to work in ongoing collaboration with addiction treatment physician-led teams, case managers, social workers, and pharmacies in the communities where patients, including pregnant women, are released to offer post-incarceration treatment plans for opioid use disorder, including education, medication for addiction treatment and counseling, and medication for preventing overdose deaths and help ensure post-incarceration medical coverage and accessibility to medication assisted therapy.

**4. Our AMA encourages all correctional facilities to use a validated screening tool to identify withdrawal and determine potential need for treatment for opioid use disorder for all incarcerated persons upon entry.**

WAYS AND MEANS COMMITTEE FISCAL NOTE: $12,000-$24,000 for regulatory/industry advocacy.
Relevant MSMS Policy:

Resolution 30-07
RESOLVED: That MSMS advise the Michigan Department of Community Health to communicate to each county sheriff the standard of care for the management of opioid withdrawal of incarcerated addicts to end forced opioid withdrawal; and be it further

RESOLVED: That jail physicians should become qualified in the management of opioid withdrawal.

Relevant AMA Policy:

H-430.987 Opiate Replacement Therapy Programs in Correctional Facilities
See language above.

Sources:


Title: Remove Clinic-Specific Caps on Buprenorphine Prescriptions

Introduced by: Nabiha Hashmi for the Medical Student Section

Original Authors: Amer Abu-kwaik, Connor Buechler, May Chammaa, Jody Chou, Peter Dimitrion, Preetha Ghosh, Aileen Haque, Leya Maliekal, Michael Moentmann, Tabitha Moses, Anneliese Petersen, Brianna Sohl, and Lucas Werner

Referred To: Reference Committee B

House Action:

Whereas, in 2017, there were 21.2 opioid overdose deaths per 100,000 persons in Michigan, which is higher than the national rate of 14.6 deaths per 100,000 persons, and

Whereas, nationally, over 2 million people have an opioid use disorder (OUD) but fewer than 10 percent have accessed treatment, and

Whereas, opioid agonist treatment (OAT), such as buprenorphine, is well documented to reduce rates of relapse, decrease self-reported opioid cravings, and increase opioid free urine samples in clinical trials, and is being formulated into extended release and implantable drug eluting systems to improve adherence, and

Whereas, buprenorphine is a long acting partial opioid agonist used in the treatment of OUD and to alleviate the symptoms of opioid withdrawal; it is commonly formulated as suboxone - a sublingual film combined with naloxone, and

Whereas, the Drug Addiction Treatment Act of 2000 (DATA-2000) allows physicians to obtain a waiver from the Narcotic Addict Treatment Act registration requirements to treat OUD with Schedule III, IV, and V drugs or a combination of them (including buprenorphine), and

Whereas, the DATA-2000 law states that physicians are eligible to prescribe buprenorphine-based medications if they pass an eight-hour course through the American Osteopathic Association after obtaining their current state medical license and a valid DEA registration number, then apply for a special waiver, and

Whereas, the DATA-2000 law states that eligible physicians during their first year following certification can treat at one time up to 30 patients, after which physicians may expand their patient cap to 100, and one year thereafter physicians and other qualifying practitioners who meet certain criteria can apply to increase their patient limit to 275, and

Whereas, the SUPPORT act of 2018 expands the ability of certain physicians and other qualified practitioners to treat up to 100 patients in the first year of waiver receipt if they are board-certified in addiction medicine or addiction psychiatry, or if they provide medication treatment in a “qualified practice setting,” and

Whereas, between 2016 and 2018, there was a 175 percent increase in the number of providers with buprenorphine waivers; however, as of 2018 there were still an estimated 47 percent of counties in the United States lacking a physician with a buprenorphine waiver, and
Whereas, physicians in the U.S. cite regulations on buprenorphine prescribing as one of the barriers to their ability and willingness to prescribe the medication, and

Whereas, since 1995, France has allowed all registered medical doctors to prescribe buprenorphine without any waivers, specific training, or licensure, and has since seen an 80 percent reduction in opioid overdoses with no resultant difference in buprenorphine diversion rates compared to the USA, which has much more stringent buprenorphine prescribing policies, and

Whereas, a 2015 survey of 706 opioid users in San Francisco found that less than 1 percent of those prescribed buprenorphine reported using it to get high, serving as evidence of the low misuse potential of buprenorphine in the USA, and

Whereas, one-third of counties within the state of Michigan have no medication treatment programs - including opioid treatment programs, buprenorphine, and naltrexone - for substance use disorder available, and only 18 percent of counties in Michigan have access to OAT programs, and

Whereas, as of September 2019, 2,756 Michigan practitioners - including MDs, DOs, APRNs, NPs, and PAs - have obtained a waiver to prescribe buprenorphine but only 54 percent of counties in Michigan had access to buprenorphine prescribers, and

Whereas, Michigan approved the Bureau of Community and Health System Substance Use Disorder Service Programs Administrative Rules which require any individual or individuals in group practices (excluding pharmacists) who provide buprenorphine or naltrexone treatment to more than 100 individuals at any one time at a specific property to apply for a substance use disorder service program license, and

Whereas, these administrative rules contradict state and federal efforts to expand access to OAT as it severely limits the capabilities of physicians in group practice settings (e.g., family practice offices) to manage patients with OUD with medication treatments; therefore be it

RESOLVED: That MSMS oppose state legislation that attempts to limit the prescription of medication for opioid use disorder beyond those regulations set forth by federal laws; and be it further

RESOLVED: That MSMS advocate the Michigan Bureau of Community and Health System Substance Use Disorder Service Programs Administrative Rules be amended to remove the cap on the number of patients receiving buprenorphine prescriptions from a single site or group practice as a condition of licensure.

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

Relevant MSMS Policy:

**Addiction Treatment, Facilities, and Services**
MSMS supports enhanced availability of and access to addiction treatment, facilities, and services within the State of Michigan.

**Referral to Addiction Medicine Specialists**
MSMS encourages the referral of persons with an opioid use disorder who would benefit from medication-assisted treatment to buprenorphine-waivered physicians when the physician has determined that the patient has an opioid use disorder. Further, MSMS encourages physicians to obtain the DATA 2000 waiver to prescribe opioid replacement for individuals with an opioid use disorder.
Relevant AMA Policy:

**Expanding Access to Buprenorphine for the Treatment of Opioid Use Disorder D-95.972**
1. Our AMA's Opioid Task Force will publicize existing resources that provide advice on overcoming barriers and implementing solutions for prescribing buprenorphine for treatment of Opioid Use Disorder.
2. Our AMA supports eliminating the requirement for obtaining a waiver to prescribe buprenorphine for the treatment of opioid use disorder.

**Third-Party Payer Policies on Opioid Use Disorder Pharmacotherapy H-95.944**
Our AMA opposes federal, state, third-party and other laws, policies, rules and procedures, including those imposed by Pharmacy Benefit Managers working for Medicaid, Medicare, TriCare, and commercial health plans, that would limit a patient's access to medically necessary pharmaceutical therapies for opioid use disorder, whether administered in an office-based opioid treatment setting or in a federal regulated Opioid Treatment Program, by imposing limitations on the duration of treatment, medication dosage or level of care.

**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.

**Sources:**


