

Reference Committee D

BOT Report(s)

- 11 Policy and Economic Support for Early Child Care
- 16 Developing Sustainable Solutions to Discharge of Chronically-Homeless Patients
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- 422 Promoting Nutrition Education Among Healthcare Providers
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- 425# Distracted Driver Education and Advocacy
- 426# Health Care Accreditation of Correctional, Detention and Juvenile Facilities
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Reference Committee D

Resolution(s)

- 430# Compassionate Release for Incarcerated Patients
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REPORT OF THE BOARD OF TRUSTEES

B of T Report 11-A-19

Subject: Policy and Economic Support for Early Child Care
(Resolution 416-A-17)

Presented by: Jack Resneck, Jr., MD, Chair

Referred to: Reference Committee D
(Diana Ramos, MD, MPH, Chair)

1 INTRODUCTION

2 At the 2017 Annual Meeting of the House of Delegates (HOD), Resolution 416-A-17 was referred.
3 Introduced by the New England Delegation and the Minority Affairs Section, Resolution 416-A-17
4 asked that our American Medical Association (AMA) advocate for: (1) improved social and
5 economic support for paid family leave to care for newborns, infants and young children; and
6 (2) federal tax incentives to support early child care and unpaid child care by extended family
7 members. Board of Trustees Report 27 was submitted to the HOD at the 2018 Annual Meeting.
8

9 Reference Committee D received testimony that supported the general policy intent of the original
10 resolution and also the recommendations in BOT Report 27-A-18. Testimony was also received
11 pointing out that that smaller employers (including small practices) could face potential challenges
12 in running their businesses if they were required to comply with new time off policies that may be
13 more appropriate for larger employers as was pointed out in the original Board Report. There was
14 further testimony and suggestions that the House go back to the original language in Resolution
15 416-A-17. The HOD referred BOT 27-A-18 back to the Board for additional study.
16

17 This report addresses the recommendations of Reference Committee D, and discusses the language
18 in the original resolution, and any new developments in additional research. It also adopts by
19 reference the analysis and recommendations of the original BOT Report 27-A-18 and provides
20 additional recommendations.
21

22 The Background, policy discussion, research and legislative activities noted below are from the
23 original BOT Report 27-A-18 and are considered still relevant to the issue today. New information
24 in response to the testimony and referral from Reference Committee D is in italics in the discussion
25 and recommendation portion of this Board Report.
26

27 BACKGROUND (From: BOT Report 27-A-18)

28 Increases in paid parental leave were associated with decreases in perinatal, neonatal, post-
29 neonatal, infant, and child mortality in a sample of 18 Organization for Economic Co-operation and
30 Development countries.¹
31 Unpaid maternal leave provided through the Family and Medical Leave Act of 1993 (FMLA) in the
32 US was associated with decreases in neonatal, post-neonatal, and infant mortality, but only among
33

1 women who were married and had graduated from college, suggesting that women of lower
2 socioeconomic position were unable to benefit from unpaid leave.
3

4 Although the FMLA requires larger employers to provide unpaid job-protected time off, there is no
5 current federal law that requires employers to provide paid time off for the birth or care of children.
6 About 38 percent of employers offer paid parental leave for employees who are new parents.² Paid
7 parental leave is distinct from other paid-leave programs such as short-term disability, sick days,
8 and government-funded disability or insurance payments.³ Smaller employers in particular are less
9 likely to provide meaningful paid time off beyond generic vacation or sick time. Further, much of
10 the time off that is provided as it relates to children is oriented toward the period surrounding the
11 birth of a child and typically does not extend to infants and young children as contemplated by
12 Resolution 416-A-17. What success there has been in providing paid parental leave has been
13 primarily at the state and local level and with a small number of high profile employers. For
14 example, IBM offers 20 weeks of paid maternity leave to both salaried and hourly workers who are
15 birth mothers and offers 12 weeks of paid paternity leave for all other parents.⁴ A few states have
16 enacted paid medical and family leave laws – California, New Jersey, New York and Rhode Island.
17 Additionally, a number of cities have enacted paid leave policies but most are oriented toward paid
18 sick leave. While upwards of 20 other states have proposed their own paid leave laws, none have
19 yet enacted a law. Regarding tax incentives to support early child care, tax law changes for 2018
20 raised child care tax credits up to a maximum of \$2000 per child. The amount of the credit is
21 indexed by income level. The credits do not differentiate between medically-related child care and
22 general day care. This provision of the tax code already allows amounts paid to certain extended
23 family members to be considered in the tax credit calculation under certain circumstances. For
24 instance, if a child was sick at home and both parents had to work, a grandmother could provide
25 care and if paid, the expense could be considered in the credit calculation, but the expenses are still
26 subject to the maximums.
27

28 AMA POLICY 29

30 AMA policy supports voluntary employer policies that provide employees with reasonable job
31 security and continued availability of health plan benefits in the event leave becomes necessary due
32 to documented medical conditions (Policy H-420.979). The AMA recognizes the public health
33 benefits of paid sick leave and other paid time off, although mandatory paid sick leave is not
34 specifically endorsed by the AMA. Council on Medical Service (CMS) Report 3-A-16 provided a
35 comprehensive review of sick leave and paid leave policies. The HOD adopted the
36 recommendations in the report, which established policy supporting employer policies that provide
37 employees with unpaid sick days to care for themselves or a family member (Policy H-440.823).
38

39 As it relates specifically to physician practices, AMA Policies for Parental, Family and Medical
40 Necessity Leave (Policy H-405.960) established guidelines that encourage medical group practices
41 to incorporate and/or encourage development of leave policies, including parental, family, and
42 medical leave policies, as part of the physician's standard benefit agreement.
43

44 Existing AMA policy also includes Policy H-405.954, "Parental Leave." BOT Report 9-I-17 was
45 written and filed as an informational report, primarily to address possible expansion of the FMLA,
46 but also made reference to paid parental leave. Policy H-405.954 states that the AMA will: "(1)
47 encourage the study of the health implications among patients if the United States were to modify
48 one or more of the following aspects of the Family and Medical Leave Act (FMLA) (a) a reduction
49 in the number of employees from 50 employees; (b) an increase in the number of covered weeks
50 from 12 weeks; (c) creating a new benefit of paid parental leave; and (2) study the effects of FMLA
51 expansion on physicians in varied practice environments."

1 RESEARCH AND LEGISLATIVE ACTIVITIES
2

3 Currently, federal law does not require employers to provide paid family or parental leave. The
4 FMLA requires employers of a certain size to provide medically-related unpaid time off.
5

6 The most recent effort at the federal level to provide a broad paid parental leave approach is
7 currently stalled. The Family and Medical Insurance Leave Act (“FAMILY Act,” H.R. 947/S. 337)
8 was introduced in Congress in 2017. The bill would, among other things, provide paid family and
9 medical leave to individuals who meet certain criteria. It would be financed through a tax on every
10 individual and employer, and all self-employment income. Thus far, the bill has been supported by
11 Democratic members of Congress and has seen little action since introduction. The bill as
12 originally drafted would:
13

- 14 • Create a national program to provide all workers, regardless of company size, with up to 12
15 weeks of partially paid leave; and
- 16 • Enable workers to receive up to 66 percent of their monthly wages, up to a capped amount,
17 during their time of leave.

18 The AMA has not taken a position on this bill. In 2016 the Society for Human Resources
19 Management (SHRM) partnered with the Families and Work Institute to conduct a National Study
20 of Employers (NSE) practices on workplace benefits, and paid parental leave was part of that
21 study.⁵ The study seems to be the most recent and relevant broad-based employer analysis of what
22 policies are in place today for parental leave as well as trends for the future.
23

24 The NSE’s surveys have been conducted five times since 2005, providing both snapshots in time
25 and current trends in employer practices and attitudes. The 2016 study samples 920 employers with
26 more than 50 employees, with a blend of for-profit and non-profit as well as single and multi-cite
27 locations. Note that the findings cited below all relate to employers with more than 50 employees.
28

29 The NSE noted that despite announcements of expanded parental leave benefits from Netflix,
30 Amazon, Microsoft, Johnson & Johnson, Ernst & Young and a few others, “The media blitz over
31 the past few years regarding paid parental leave was not representative of the majority of U.S.
32 employers with 50 or more employees in 2016.”⁵ It also noted that the average maximum number
33 of weeks of parental and caregiving leaves did not change significantly between 2012 and 2016,
34 and in fact the average number of weeks provided had slightly declined when looking back to pre-
35 recession 2005. 2016 data showed that employers seemed to be more supportive of easing the
36 transition of a parent back into the workforce upon the birth of child (81% of employers), and more
37 supportive of work from home options (40 percent of employers), but the percentage of employers
38 allowing at least some employees to take time off during the workday for family or personal needs
39 without loss of pay had declined from 87 percent to 81 percent.
40

41 Another finding demonstrated that employer support for flexible work arrangements had dropped
42 dramatically from 31 percent in 2005 to 14 percent in 2016. While definitive research was not
43 available to explain this change, it may be that many employers had narrowed benefit offerings
44 during the prolonged period of economic difficulty that began in 2008. While the study tended to
45 focus more on whether employers provided time off, it did note that of those employers providing
46 at least some pay to women during maternity leave, most (78 percent) did so by providing some
47 type of short term disability pay. The survey also indicated that for those employers that do offer
48 pay, 6 percent of employers offered full pay, 39 percent offered partial pay, and 11 percent said it
49 depends on the situation. Forty-two percent of the employers responding offered no pay at all.
50 However, in contrast to those findings, the same report indicated that 39 percent of employers

1 allowed employees to take time off (at least 5 days) to care for *mildly ill* children without having to
2 use vacation days or losing pay. The implication of this particular data is that employer policies on
3 paid time off lack consistency.

4

5 As articulated in Board of Trustees Report 9-I-17, there is an abundance of literature about the
6 benefits of employee access to medical leave provided under existing law, much of which was
7 summarized in CMS Report 3-A-16.⁶ Paid sick leave has been increasing throughout the United
8 States whether by state or local law mandates or decisions by employers. However, paid leave to
9 care for others outside of paid vacation, PTO (generic paid time off), or paid sick leave is still not
10 prevalent in the US.

11

12 Given that only a handful of states have enacted paid parental leave programs, research on their
13 effectiveness is limited. However, what little research there is has demonstrated generally neutral to
14 positive feedback from employers. In particular, BOT Report 9-I-17 noted California's experience:

15

16 In California, for example, the Paid Family Leave program provides employees with up
17 to six weeks of paid leave to care for a new child or ill family member. The program is
18 funded by employee payroll contributions, so while employers do not face financial
19 burden as a result of the law, they are faced with ensuring the employees' workload is
20 covered and that gaps in staffing are filled. The program in California, however, does not
21 assure job protection during leave, provides wage replacement at only 55 percent, and
22 does not cover care for grandparents, grandchildren, parents-in-law, or siblings. A 10-
23 year review of California's expansion demonstrated that the Paid Family Leave benefit
24 promoted family well-being, improved family economic security, equalized access to
25 leave across occupations and income levels, and bolstered businesses by reducing
26 workforce turnover. It was also noted that overall awareness of the program among those
27 most likely to utilize it was low, implying that utilization rates could be higher if
28 education and outreach were improved upon. Similar outcomes have been reported for
29 other cities and states.⁷⁻⁹

30

31 An analysis published by IMPAQ International, Inc. and the Institute for Women's Policy Research
32 summarizes a simulation of five paid family and medical leave model programs based on working
33 programs in three states and a federal proposal, all applied to the national workforce. The findings
34 suggest that expansion of FMLA laws, through covering more eligible workers, replacing a larger
35 percentage of usual earnings, and offering more weeks of paid leave would increase costs. If based
36 on any of the five models in the simulation, the cost for benefits would range from \$31 billion to
37 \$43 billion. This report also projects that a national paid family and medical leave policy,
38 depending on the type of expansion, would increase the amount of leave taken by 6 to 11 percent
39 annually.¹⁰

40

41 Some employer groups claim paid leave policies or policies that provide coverage for more
42 employees may burden and negatively impact employer operations.

43

44 When predicting employer reactions to programs, policies and benefits related to caregiving leaves
45 and child and elder care, the NSE research articulated four primary factors: (1) the demographics of
46 their workplace; (2) the demographics of the workforce; (3) financial health of the employer; and
47 (4) human resources issues such as the difficulty or ease of attracting and retaining employees as
48 well as the costs of employee benefits.

49

50 The attitude and approach of employers is fundamental to progress on a broad national approach to
51 paid parental leave. It is not atypical for employers to consider all four of these factors when

1 considering what benefits to offer their employees. As it relates to paid time off, some employers
2 are specific about how that time can be used (vacation, sick time). Other employers are more
3 flexible (“paid time off”), wherein the employer provides a bank of paid time off that employees
4 can use for any purpose. Employers typically review benefits offerings every year, with time off
5 being only one of a myriad of benefits being evaluated.

6
7 As noted above, recent changes in the federal tax code increased the child care tax credit up to
8 \$2000 per child. While it may be debatable whether the increase goes far enough, it is a positive
9 step forward toward the intent of Resolution 416 and supporting the child care efforts of people
10 with lower economic status.

11
12 While there has been recent publicity about proposals to have some type of child care financial
13 assistance by allowing people to draw down future Social Security benefits, it does not seem at
14 present that such proposals will receive meaningful consideration in Congress.

15
16 **DISCUSSION**
17

18 The Board’s review of existing research has demonstrated that despite positive health outcomes for
19 children being cared for by their parents, meaningful progress on national policy mandating paid
20 parental leave is unlikely in the near term. The necessary broad-based support of employers to
21 support such policy is simply not present at this point in time. Additionally, the anti-regulatory
22 views of the current Administration and political climate in Washington DC may not be ripe for
23 federal policy or action on paid family leave.

24
25 The first resolve of Resolution 416-A-17 asked the AMA to advocate for improved social and
26 economic support for paid family leave to care for newborns, infants and young children. The
27 Board of Trustees believes that there would be considerable challenges to pursuing a public policy
28 that would require employers to provide paid parental leave. Nevertheless, the Board believes that
29 HOD policy supporting paid parental leave for the care of children is good public policy. Policy H-
30 440.823 does support employer policies that allow employees to accrue paid time off and to use
31 such time to care for themselves or a family member. As noted earlier in this report, approximately
32 38 percent of employers currently offer paid parental leave for employees who are new parents.
33 Accordingly, the Board of Trustees also supports encouraging employers to offer and/or to expand
34 these types of policies. The Board believes that state medical associations should also be
35 encouraged to work with their state legislatures to establish and promote parental leave policies.

36
37 The second resolve of Resolution 416-A-17 asked the AMA to advocate for federal tax incentives
38 to support early child care and unpaid child care by extended family members. As previously noted
39 in this report, recent changes to Federal tax law have raised child care tax credits to a maximum of
40 \$2000 per child, beginning in 2018. The expense of paying extended family members to perform
41 child care can be considered in the calculation of this credit under certain circumstances.

42
43 *As noted in prior Board reports on paid parental leave proposals, there are several primary
44 sources that influence progress. The first is the general proposition that such policies are, in and of
45 themselves, the right thing to do for the betterment of public health as noted in the original
46 Resolution 416-A-17. The second and third would be governmental action at the state or federal
47 level either requiring or encouraging via incentives compliance with potentially new law or
48 regulations. The fourth is action by employers in making decisions on benefit offerings to their
49 employees.*

1 *It should be noted that there is little new additional research available to inform these issues*
2 *beyond that articulated in Board Report 27-A-18. However, at the federal level several new bills*
3 *have been introduced new Congress. The FAMILY Act, originally introduced in both the House*
4 *and Senate in 2017 has been reintroduced, but as of yet has support only from Democrats. HR*
5 *1185 has been introduced in the House with 178 Democratic co-sponsors. S 463 has been*
6 *introduced in the Senate with 34 Democratic cosponsors. No hearings have yet been scheduled on*
7 *any of the bills and none of them yet seem to have traction with Republicans.*

8
9 *Given that testimony at Reference Committee D suggested the possibility of going back to the*
10 *original language of Resolution 416 A-17, and the fact that there are competing proposals in*
11 *Congress the Board believes it prudent to support the original resolutions but also restate portions*
12 *of the Board's recommendations from BOT Report 27-A-18 and continue to study and monitor*
13 *developments as more specifics be available.*

14
15 RECOMMENDATIONS
16

17 Therefore, the Board of Trustees recommends that the following be adopted in lieu of Resolution
18 416-A-17 and the remainder of this report be filed.

19
20 1. That our AMA reaffirm Policy H-440.823, which recognizes the public health benefits of paid
21 sick leave and other discretionary paid time off, and supports employer policies that allow
22 employees to accrue paid time off and to use such time to care for themselves or a family
23 member. (Reaffirm HOD Policy)
24
25 2. That our AMA encourage employers to offer and/or expand paid parental leave policies. (New
26 HOD Policy)
27
28 3. That our AMA encourage state medical associations to work with their state legislatures to
29 establish and promote paid parental leave policies. (New HOD Policy).
30
31 4. *That our AMA advocate for improved social and economic support for paid family leave to*
32 *care for newborns, infants and young children (New HOD Policy).*
33
34 5. *That our AMA advocate for federal tax incentives to support early child care and unpaid child*
35 *care by extended family members (New HOD Policy).*

Fiscal Note: Less than \$500.

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 16-A-19

Subject: Developing Sustainable Solutions to Discharge of Chronically-Homeless Patients
(Resolution 826-I-18)

Presented by: Jack Resneck, Jr., MD, Chair

Referred to: Reference Committee D
(Diana Ramos, MD, MPH, Chair)

1 At the 2018 Interim Meeting, the House of Delegates referred Resolution 826, Developing
2 Sustainable Solutions to Discharge of Chronically-Homeless Patients, which was introduced by the
3 Resident and Fellow Section. Resolution 826 asked that our AMA “work with relevant
4 stakeholders in developing sustainable plans for the appropriate discharge of chronically-homeless
5 patients from hospitals.” The resolution further asked that our AMA reaffirm Policy H-270.962,
6 Unfunded Mandates, and Policy H-130.940, Emergency Department Boarding and Crowding.
7

8 This report (1) explores how homelessness contributes to emergency department (ED) overuse and
9 hospitalization, (2) outlines current regulatory requirements related to homelessness and discharge
10 planning, and (3) describes the need for broader efforts to address the unique healthcare and social
11 needs of homeless patients.

12 BACKGROUND

13

14 Homeless individuals are more likely than the general population to experience behavioral health
15 disorders, acute and chronic conditions, and injuries resulting from assaults and accidents. This
16 increased prevalence, in concert with lack of insurance or access to a usual source of medical care,
17 leads homeless individuals to seek care at EDs at a high rate and increases their rates of
18 hospitalization. Indeed, as many as two-thirds of homeless individuals visit an ED each year, as
19 compared to just one-fifth of the general population, and the hospitalization rate for homeless
20 individuals is as much as four times higher than that for non-homeless individuals.¹⁻⁶
21

22 Not only are homeless patients more likely to visit an ED, but they are also more likely to re-visit
23 an ED. Indeed, an analysis of national ED utilization rates found that homeless patients were more
24 than three times as likely as non-homeless patients to have been evaluated in the same ED within
25 the previous three days, and were more than twice as likely to visit an ED within a week of
26 discharge from the hospital.⁷
27

28 ED utilization is not uniform across the homeless population, with one study representative of the
29 literature on the topic finding that a small proportion of frequent users (7.9%) account for an
30 outsized proportion of total use (54.5%).⁵ Anecdotal accounts, which are not uncommon, cite cases
31 of individual homeless patients with more than 100 ED visits in a year and total costs topping
32 \$1 million.^{8,9}
33

1 DISCUSSION

2

3 *Discharge planning and ED overuse*

4

5 As suggested by Resolution 826-I-18, hospital and ED discharge planning plays a key role in
6 ending the revolving door of ED visits, hospitalizations, and readmissions, especially among
7 homeless frequent users. Specifically, evidence shows that well-coordinated case management (the
8 development and initiation of which is a key outcome of discharge planning) may reduce ED use
9 and costs, and improve both clinical and social outcomes for homeless patients.¹⁰⁻¹² Despite these
10 findings, discharge planning for homeless patients remains rare: one analysis found that 64% of ED
11 visits resulted in homeless patients being discharged back to the street, with only 4% having a
12 discharge plan addressing their housing status.¹³

13

14 Current approaches to discharge planning also overlook important opportunities to improve the
15 health of homeless patients in areas unrelated to their ED visits. For example, given that the CDC
16 Advisory Committee on Immunization Practices now recognizes “homelessness” as an indication
17 for hepatitis A vaccination,¹⁴ patient encounters in the ED present an excellent opportunity to
18 assess immunization status and need for vaccination, and to administer vaccines or refer patients
19 for vaccination.¹⁵ As an added bonus, this holistic approach ensures that homeless patients are
20 immunized, which helps keep them well and out of the ED.

21

22 *Hospital requirements for discharge planning*

23

24 Recognizing the value of discharge planning in preventing hospital readmissions, the Centers for
25 Medicare and Medicaid Services (CMS) Conditions of Participation (CoPs) include comprehensive
26 discharge planning requirements for hospitals participating in the Medicare or Medicaid programs.
27 These requirements include:

28

29 (1) Identifying inpatients for whom discharge planning is necessary;*

30

31 (2) Providing a discharge plan evaluation to each identified patient, which “must include an
32 evaluation of the likelihood of a patient’s capacity for selfcare or of the possibility of the
33 patient being cared for in the environment from which he or she entered the hospital;”

34

35 (3) Developing and “[arranging] for the initial implementation of the patient’s discharge plan;”

36

37 (4) Transferring or referring the patient, “along with necessary medical information, to
38 appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary
39 care;” and

40

41 (5) Reassessing the discharge planning process “on an on-going basis;” which must include “a
42 review of discharge plans to ensure that they are responsive to discharge needs.”¹⁶

43

44 The CoPs do not require discharge planning for ED visits without hospital admission, which are
45 categorized as outpatient visits. However, in recent revisions to its interpretive guidelines for
46 discharge planning, CMS observes that “many of the same concerns for effective posthospital care
47 coordination arise [for outpatients] as for inpatients” and therefore recommends that “hospitals

* Note that “in the absence of a finding by the hospital that a patient needs a discharge plan, the patient’s physician may request a discharge plan...[and] the hospital must develop a discharge plan for the patient.”

1 might consider utilizing, on a voluntary basis, an abbreviated post-hospital planning process for
2 certain categories of outpatients...and for certain categories of emergency department discharges.”¹⁷
3

4 At the state level, in 2018 California adopted regulations requiring more stringent discharge
5 planning requirements and services for homeless patients. Set to take effect July 1, 2019, these new
6 regulations require California hospitals to “include a written homeless patient discharge planning
7 policy and process within the hospital discharge policy.”¹⁸ The law further requires hospitals to
8 perform a variety of specific tasks and in a specific manner, including but not limited to:
9

10 • logging all discharges of homeless patients;
11 • providing a meal, clothing, medication, and transportation upon discharge;
12 • coordinating with social service agencies; and
13 • discharging homeless patients only during the daytime.^{19,20}
14

15 The California law was met with concern by many in the healthcare community, including the
16 California chapter of the American College of Emergency Physicians and the California Hospital
17 Association.^{20,21} While recognizing the importance of and supporting appropriate discharge
18 planning and protocols, critics questioned the feasibility of many aspects of the law—for example,
19 how exactly would a hospital go about maintaining a supply of clothing for homeless patients?
20 They also pointed to severe unintended consequences of the law—for example, that prohibiting
21 overnight discharges would further exacerbate ED overcrowding and constrain hospitals’ capacity
22 to provide timely, lifesaving care to those patients who need it most. And, at the broadest level,
23 they questioned why the societal costs of homelessness should be borne by hospitals, especially
24 safety net hospitals that treat a disproportionately large share of homeless patients and are least able
25 to comply with unfunded mandates.
26

27 *Moving beyond discharge planning*
28

29 Effective ED and hospital discharge planning constitutes just one component of what ought to be a
30 more comprehensive approach to addressing the unique healthcare needs of homeless patients—
31 one which, as stated by CMS in its interpretive guidelines for discharge planning, “moves away
32 from a focus primarily on a patient’s hospital stay to consideration of transitions among the
33 multiple types of patient care settings that may be involved at various points in the treatment of a
34 given patient.”¹⁷
35

36 Central to these more comprehensive efforts is housing security, an area in which, in the absence of
37 comprehensive state and local homelessness strategies, hospitals and health systems have been
38 obligated to take action in recent years. In 2017, for example, the American Hospital Association
39 published a guidebook, *Housing and the Role of Hospitals*, identifying how hospitals can address
40 this particular social determinant of health. This resource outlines strategies and provides case
41 studies on:
42

43 • neighborhood revitalization;
44 • home assessment and repair programs;
45 • medical care for the homeless;
46 • medical respite care; and
47 • transitional or permanent supportive housing.²²
48

49 The last of these strategies has received considerable attention, with hospitals and health systems
50 investing an estimated \$75 to \$100 million in housing for homeless patients.²³ Insurers and local
51 units of government also have contributed to these efforts, typically in partnership with hospitals

1 and health systems.²⁴⁻²⁶ Initial outcomes data on these endeavors suggest that providing housing for
2 homeless patients can decrease ED use and hospitalizations while yielding net savings on
3 combined expenditures for healthcare and social services.²⁷ Despite these outcomes, the long-term
4 desirability and feasibility of this approach is uncertain, as questions of appropriate resource
5 allocation (is there a better way to spend these monies?), cost-sharing (is it appropriate to ask
6 hospitals to cover the cost of social services for homeless patients?), and society's overall approach
7 to eliminating homelessness remain unresolved.

8

9 *AMA policy on discharge planning and care for homeless patients*

10

11 AMA policy recognizes the link between housing security and health outcomes, and supports a
12 coordinated, collaborative approach to care for homeless patients that combines clinical and social
13 services. For example, Policy H-160.903, Eradicating Homelessness, "supports improving the
14 health outcomes and decreasing the health care costs of treating the chronically homeless through
15 clinically proven, high quality, and cost-effective approaches which recognize the positive impact
16 of stable and affordable housing coupled with social services."

17

18 Furthermore, Policy H-160.978, The Mentally Ill Homeless, avers that "public policy initiatives
19 directed to the homeless, including the homeless mentally ill population, should...[promote] care
20 that is sensitive to the overriding needs of this population for food, clothing, and residential
21 facilities."

22

23 Finally, the AMA's comprehensive Evidence-Based Principles of Discharge and Discharge Criteria
24 (Policy H-160.942), while not explicitly addressing homelessness, "calls on physicians, specialty
25 societies, insurers, and other involved parties to join in developing, promoting, and using evidence-
26 based discharge criteria that are sensitive to the physiological, psychological, social, and functional
27 needs of patients."

28

29 CONCLUSION

30

31 Homelessness is an exacerbating factor in ED overuse, excess hospitalization, and preventable
32 readmissions. Hospital discharge planning for homeless patients, with a holistic focus on case
33 management that coordinates clinical and social services, has been shown to alleviate some of these
34 problems. Despite this evidence, focused discharge planning remains rare for homeless ED
35 patients. Our AMA should educate physicians about the importance of discharge planning for
36 homeless patients, and encourage the development of holistic, cost-effective, evidence-based
37 discharge plans for homeless patients who present to the emergency department but are not
38 admitted to the hospital.

39

40 While critical, discharge planning alone will not prevent unnecessary ED visits and hospitalizations
41 for homeless individuals. Instead, a more comprehensive approach to addressing the unique
42 healthcare and social needs of homeless patients is required, with efforts reaching beyond the
43 hospital and into the community. Our AMA should encourage collaborative efforts to address
44 homelessness that do not leave hospitals and physicians alone to bear their costs.

1 RECOMMENDATIONS

2
3 The Board of Trustees recommends that the following be adopted in lieu of Resolution 826-I-18
4 and that the remainder of the report be filed:

5

6 1. That our American Medical Association partner with relevant stakeholders to educate
7 physicians about the unique healthcare and social needs of homeless patients and the
8 importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role
9 therein, in addressing these needs. (Directive to Take Action)

10

11 2. That our AMA encourage the development of holistic, cost-effective, evidence-based discharge
12 plans for homeless patients who present to the emergency department but are not admitted to
13 the hospital. (New HOD Policy)

14

15 3. That our AMA encourage the collaborative efforts of communities, physicians, hospitals,
16 health systems, insurers, social service organizations, government, and other stakeholders to
17 develop comprehensive homelessness policies and plans that address the healthcare and social
18 needs of homeless patients. (New HOD Policy)

19

20 4. That our AMA reaffirm Policy H-160.903, Eradicating Homelessness, which "supports
21 improving the health outcomes and decreasing the health care costs of treating the chronically
22 homeless through clinically proven, high quality, and cost-effective approaches which
23 recognize the positive impact of stable and affordable housing coupled with social services."
24 (Reaffirm HOD Policy)

25

26 5. That our AMA reaffirm Policy H-160.978, The Mentally Ill Homeless, which states that
27 "public policy initiatives directed to the homeless, including the homeless mentally ill
28 population, should...[promote] care that is sensitive to the overriding needs of this population
29 for food, clothing, and residential facilities." (Reaffirm HOD Policy)

30

31 6. That our AMA reaffirm Policy H-160.942, Evidence-Based Principles of Discharge and
32 Discharge Criteria, which "calls on physicians, specialty societies, insurers, and other involved
33 parties to join in developing, promoting, and using evidence-based discharge criteria that are
34 sensitive to the physiological, psychological, social, and functional needs of patients."
35 (Reaffirm HOD Policy)

36

37 7. That our AMA reaffirm Policy H-130.940, Emergency Department Boarding and Crowding,
38 which "supports dissemination of best practices in reducing emergency department boarding
39 and crowding." (Reaffirm HOD Policy)

40

41 8. That our AMA reaffirm Policy H-270.962, Unfunded Mandates, which "vigorously opposes
42 any unfunded mandates on physicians." (Reaffirm HOD Policy)

Fiscal Note: \$5,000

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AMA POLICIES RECOMMENDED FOR REAFFIRMATION

H-160.942 Evidence-Based Principles of Discharge and Discharge Criteria

- (1) The AMA defines discharge criteria as organized, evidence-based guidelines that protect patients' interests in the discharge process by following the principle that the needs of patients must be matched to settings with the ability to meet those needs.
- (2) The AMA calls on physicians, specialty societies, insurers, and other involved parties to join in developing, promoting, and using evidence-based discharge criteria that are sensitive to the physiological, psychological, social, and functional needs of patients and that are flexible to meet advances in medical and surgical therapies and adapt to local and regional variations in health care settings and services.
- (3) The AMA encourages incorporation of discharge criteria into practice parameters, clinical guidelines, and critical pathways that involve hospitalization.
- (4) The AMA promotes the local development, adaption and implementation of discharge criteria.
- (5) The AMA promotes training in the use of discharge criteria to assist in planning for patient care at all levels of medical education. Use of discharge criteria will improve understanding of the pathophysiology of disease processes, the continuum of care and therapeutic interventions, the use of health care resources and alternative sites of care, the importance of patient education, safety, outcomes measurements, and collaboration with allied health professionals.
- (6) The AMA encourages research in the following areas: clinical outcomes after care in different health care settings; the utilization of resources in different care settings; the actual costs of care from onset of illness to recovery; and reliable and valid ways of assessing the discharge needs of patients.
- (7) The AMA endorses the following principles in the development of evidence-based discharge criteria and an organized discharge process:
 - (a) As tools for planning patients' transition from one care setting to another and for determining whether patients are ready for the transition, discharge criteria are intended to match patients' care needs to the setting in which their needs can best be met.
 - (b) Discharge criteria consist of, but are not limited to: (i) Objective and subjective assessments of physiologic and symptomatic stability that are matched to the ability of the discharge setting to monitor and provide care. (ii) The patient's care needs that are matched with the patient's, family's, or caregiving staff's independent understanding, willingness, and demonstrated performance prior to discharge of processes and procedures of self care, patient care, or care of dependents. (iii) The patient's functional status and impairments that are matched with the ability of the care givers and setting to adequately supplement the patients' function. (iv) The needs for medical follow-up that are matched with the likelihood that the patient will participate in the follow-up. Follow-up is time-, setting-, and service-dependent. Special considerations must be taken to ensure follow-up in vulnerable populations whose access to health care is limited.
 - (c) The discharge process includes, but is not limited to: (i) Planning: Planning for transition/discharge must be based on a comprehensive assessment of the patient's physiological, psychological, social, and functional needs. The discharge planning process should begin early in the course of treatment for illness or injury (prehospitalization for elective cases) with involvement of patient, family and physician from the beginning. (ii)

Teamwork: Discharge planning can best be done with a team consisting of the patient, the family, the physician with primary responsibility for continuing care of the patient, and other appropriate health care professionals as needed. (iii) Contingency Plans/Access to Medical Care: Contingency plans for unexpected adverse events must be in place before transition to settings with more limited resources. Patients and caregivers must be aware of signs and symptoms to report and have a clearly defined pathway to get information directly to the physician, and to receive instructions from the physician in a timely fashion. (iv) Responsibility/Accountability: Responsibility/accountability for an appropriate transition from one setting to another rests with the attending physician. If that physician will not be following the patient in the new setting, he or she is responsible for contacting the physician who will be accepting the care of the patient before transfer and ensuring that the new physician is fully informed about the patient's illness, course, prognosis, and needs for continuing care. If there is no physician able and willing to care for the patient in the new setting, the patient should not be discharged. Notwithstanding the attending physician's responsibility for continuity of patient care, the health care setting in which the patient is receiving care is also responsible for evaluating the patient's needs and assuring that those needs can be met in the setting to which the patient is to be transferred. (v) Communication: Transfer of all pertinent information about the patient (such as the history and physical, record of course of treatment in hospital, laboratory tests, medication lists, advanced directives, functional, psychological, social, and other assessments), and the discharge summary should be completed before or at the time of transfer of the patient to another setting. Patients should not be accepted by the new setting without a copy of this patient information and complete instructions for continued care.

- (8) The AMA supports the position that the care of the patient treated and discharged from a treating facility is done through mutual consent of the patient and the physician; and
- (9) Policy programs by Congress regarding patient discharge timing for specific types of treatment or procedures be discouraged.

H-160.978 The Mentally Ill Homeless

- (1) The AMA believes that public policy initiatives directed to the homeless, including the homeless mentally ill population, should include the following components:
 - (a) access to care (e.g., integrated, comprehensive services that permit flexible, individualized treatment; more humane commitment laws that ensure active inpatient treatment; and revisions in government funding laws to ensure eligibility for homeless persons);
 - (b) clinical concerns (e.g., promoting diagnostic and treatment programs that address common health problems of the homeless population and promoting care that is sensitive to the overriding needs of this population for food, clothing, and residential facilities);
 - (c) program development (e.g., advocating emergency shelters for the homeless; supporting a full range of supervised residential placements; developing specific programs for multiproblem patients, women, children, and adolescents; supporting the development of a clearinghouse; and promoting coalition development);
 - (d) educational needs;
 - (e) housing needs; and
 - (f) research needs.
- (2) The AMA encourages medical schools and residency training programs to develop model curricula and to incorporate in teaching programs content on health problems of the homeless population, including experiential community-based learning experiences.

- (3) The AMA urges specialty societies to design interdisciplinary continuing medical education training programs that include the special treatment needs of the homeless population.

H-160.903 Eradicating Homelessness

Our American Medical Association:

- (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;
- (2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless;
- (3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;
- (4) recognizes the need for an effective, evidence-based national plan to eradicate homelessness; and
- (5) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 28-A-19

Subject: Opposition to Measures that Criminalize Homelessness
(Resolution 410-A-18)

Presented by: Jack Resneck, Jr., MD, Chair

Referred to: Reference Committee D
(Diana Ramos, MD, MPH, Chair)

1 INTRODUCTION

2
3 Resolution 410-A-18, “Opposition to Measures that Criminalize Homelessness,” introduced by the
4 Medical Student Section and referred by the House of Delegates asks that:

5
6 Our American Medical Association oppose measures that criminalize necessary means of
7 living among homeless persons, including but not limited to, sitting or sleeping in public
8 spaces; and advocate for legislation that requires non-discrimination against homeless persons,
9 such as homeless bills of rights.

10 CURRENT AMA POLICY

11
12 Existing AMA policy supports improving health outcomes and decreasing the health care costs of
13 treating people who are chronically homeless through clinically proven, high quality, and cost-
14 effective approaches, which recognize the positive impact of stable and affordable housing coupled
15 with social services. The AMA recognizes that stable, affordable housing as a first priority, without
16 mandated therapy or services compliance, is effective in improving housing stability and quality of
17 life among individuals who are chronically-homeless. Furthermore, the AMA recognizes that lack
18 of identification is a barrier to accessing medical care and fundamental services that support health;
19 and supports policy changes that streamline, simplify, and reduce or eliminate the cost of obtaining
20 identification cards for the homeless population. Current policy does not specifically address
21 criminalizing homelessness.

22 BACKGROUND

23
24 Insufficient income and lack of affordable housing are leading causes of homelessness in the
25 United States. The Great Recession contributed to a shortage of affordable housing. It is estimated
26 that we currently have a shortage of 7.2 million rental homes affordable and available to extremely
27 low-income renters (those whose income is at or below the poverty guideline or 30 percent of their
28 area median income).¹ Extremely low-income households face a shortage of affordable housing in
29 every state and major metropolitan area. In addition to the shortage of affordable housing, in many
30 U.S. cities, there are fewer shelter beds than are needed, leaving people experiencing homelessness
31 with no choice, but to live in public places.²

32
33 In January 2018, almost 553,000 people were homeless on a single night in the United States, with
34 nearly two-thirds found in emergency shelters or transitional housing programs.³ While the number

1 of people experiencing homelessness increased by less than one percent between 2017 and 2018,
2 overall homelessness has declined by more than 84,000 people (13 percent) since 2010.⁴ In the
3 United States, sixty percent of people experiencing homelessness in 2018 were men or boys, and
4 39 percent were women or girls.⁵ Less than one percent were transgender or gender
5 nonconforming.⁶ Nearly half (49 percent) of all people experiencing homelessness self-identified
6 as white and almost 40 percent identified as black or African American.⁷ People identifying as
7 white were underrepresented compared to their share of the U.S. population (72 percent), while
8 African Americans were considerably overrepresented compared to their share of the U.S.
9 population (13 percent).⁸ One in five people experiencing homelessness was Hispanic or Latino (22
10 percent), which is slightly higher than their share of the U.S. population (18 percent).⁹

11
12 Substance use disorders and mental health problems are more prevalent among people who are
13 homeless than in the general population. According to the Office of National Drug Control Policy,
14 approximately 30 percent of people experiencing chronic homelessness have a serious mental
15 illness, and around two-thirds have a primary substance use disorder or other chronic health
16 condition.¹⁰ Lack of stable housing leaves them vulnerable to substance use and/or relapse,
17 exacerbation of mental health problems, and a return to homelessness.¹¹

18
19 *Laws Criminalizing Homelessness*

20
21 Criminalizing homelessness refers to laws enacted by municipalities to prohibit life-sustaining
22 activities such as sitting, sleeping, loitering, panhandling, camping, eating, storing belongings, and
23 urinating in public spaces. Laws criminalizing homelessness trap vulnerable populations in the
24 criminal justice system.¹² The continuous threat of citations and possibility of arrest contributes to a
25 pervasive sense of fear and insecurity among the homeless population. For individuals
26 experiencing homelessness, fines typically cannot be paid, leaving individuals to contest citations
27 in court.¹³ Without a reliable address or transportation, citations can result in not receiving a notice
28 to appear in court or having no way to get there. Failure to appear in court can result in a warrant
29 for arrest.¹⁴ Arrests and criminal records make housing, employment, and social services more
30 difficult to access thereby perpetuating the cycle of homelessness and health inequity.¹⁵

31
32 Laws criminalizing homelessness have increased in cities across the United States over the past 10
33 years.¹⁶ Since 2006, citywide bans on loitering, loafing, and vagrancy increased by 88 percent, bans
34 on camping increased by 69 percent, bans on sitting and lying down in certain public places
35 increased by 52 percent, bans on panhandling grew by 43 percent, and bans on sleeping in public
36 increased by 31 percent.¹⁷ These laws are designed to move visibly homeless people out of
37 commercial and tourist districts and are often justified based on the government's responsibility to
38 maintain orderly, aesthetically pleasing public parks and streets as well as the responsibility to
39 protect public health and safety.

40
41 DISCUSSION

42
43 Laws criminalizing homelessness have been found to violate international and, in some instances,
44 federal law. In 2014, the United Nation's (UN) Committee on the Elimination of Racial
45 Discrimination, called on the United States to abolish laws and policies making homelessness a
46 crime and ensure cooperation among stakeholders to find solutions for people experiencing
47 homelessness in accordance with human rights standards.¹⁸ Furthermore, the UN encouraged the
48 United States to provide incentives to decriminalize homelessness, including financial support to
49 local authorities that implement alternatives to criminalization, and withdrawing funding from local
50 authorities that criminalize homelessness.¹⁹

1 In 2017, the UN Special Rapporteur on extreme poverty and human rights visited the United States
2 to report to the Human Rights Council on the extent to which the government's policies and
3 programs relating to extreme poverty are consistent with its human rights obligations and to offer
4 recommendations to the government and other stakeholders. The report stated that:

5
6 In many cities, homeless persons are effectively criminalized for the situation in which they
7 find themselves. Sleeping rough¹, sitting in public places, panhandling, public urination and
8 myriad other offences have been devised to attack the 'blight' of homelessness... Ever more
9 demanding and intrusive regulations lead¹ to infraction notices for the homeless, which rapidly
10 turn into misdemeanours, leading to warrants, incarceration, unpayable fines and the stigma of
11 a criminal conviction that in turn virtually prevents subsequent employment and access to most
12 housing.²⁰

13
14 Courts in the United States have come to differing conclusions on laws criminalizing
15 homelessness, particularly anti-camping ordinances, due to differing interpretations of whether the
16 Eighth Amendment's protection against cruel and unusual punishment prohibits only
17 criminalization of status or also the criminalization of involuntary conduct.²¹ In 2015, the United
18 States government issued a statement indicating its position on the issue in the case of *Bell et al v.*
19 *City of Boise*:

20
21 If the Court finds that it is impossible for homeless individuals to secure shelter space on some
22 nights because no beds are available, no shelter meets their disability needs, or they have
23 exceeded the maximum stay limitations, then the Court should also find that enforcement of
24 the ordinances under those circumstances criminalizes the status of being homeless and
25 violates the Eighth Amendment to the Constitution.²²

26
27 In the case in question, the 9th Circuit Court of Appeals held that the Cruel and Unusual
28 Punishments Clause of the Eighth Amendment precluded enforcement of a statute prohibiting
29 sleeping outside against homeless individuals with no access to alternative shelter. The court held
30 that as long as there is no option of sleeping indoors, the government cannot criminalize indigent,
31 homeless people for sleeping outdoors, on public property, on the false premise that they had no
32 choice in the matter.²³ The court further explained that "[e]ven where shelter is unavailable, an
33 ordinance prohibiting sitting, lying, or sleeping outside at particular times or in particular locations
34 might well be constitutionally permissible. So, too, might an ordinance barring the obstruction of
35 public rights of way or the erection of certain structures."²⁴

36
37 *Homeless Bill of Rights*

38
39 Rhode Island, Illinois, and Connecticut, and Puerto Rico have enacted laws that protect the civil
40 rights of people experiencing homelessness, these laws are referred to as a Homeless Bill of Rights.
41 While the laws vary by jurisdiction, they specify that a person who is homeless has the same rights
42 and privileges as any other state resident. The laws each outline the rights of persons experiencing
43 homelessness (i.e. move freely in public spaces, receive equal treatment by state and municipal
44 authorities, not face discrimination while seeking or maintaining employment, access to emergency
45 medical services, etc.).²⁵ The impact these laws have had is unclear.

¹ "Sleeping rough" – refers to sleeping outside without shelter

1 *Public Health Nuisance Laws*

2
3 Actions by government officials aimed at individuals experiencing homelessness are often justified
4 based on public health and safety concerns. While laws criminalizing homelessness are of concern,
5 it should be clear that there are legitimate instances in addressing homeless populations where the
6 government needs to act to protect the health of the public. For example, the environmental
7 conditions associated with homelessness, which can include overcrowding in encampments and
8 shelters, exposure to the elements, and poor hygiene, facilitate the transmission of infectious
9 diseases.

10
11 The United States is currently experiencing the worst multi-state outbreak of hepatitis A virus
12 (HAV) in over 20 years, due in part to the lack of access to proper sanitation and hygiene among
13 persons experiencing homelessness.²⁶ In response to this multi-state HAV outbreak, the CDC's
14 Advisory Committee on Immunization Practices, voted in 2018 to add a new policy recommending
15 that everyone ages 1 and older who is experiencing homelessness routinely be immunized against
16 hepatitis.²⁷ In some jurisdictions, there have been campaigns to vaccinate and educate people at
17 risk and to provide portable hygiene facilities in areas where people who are homeless congregate.
18 To address public health risks, some jurisdictions have created sanctioned tent encampments where
19 they provide essential public services to help ensure that residents are in a safe environment. It has
20 been cautioned that while these measures may prevent immediate harm, they are not long-term
21 solutions to the problem of homelessness in the United States.²⁸

22
23 CONCLUSION

24
25 Insufficient income and lack of affordable housing are leading causes of homelessness in the
26 United States. Laws criminalizing homelessness, or laws prohibiting life-sustaining activities in
27 public spaces when there are no sheltered alternatives, have increased in U.S. cities over the past 10
28 years. These laws trap vulnerable populations in the criminal justice system and raise both human
29 rights and constitutional concerns. Actions by government officials aimed at individuals
30 experiencing homelessness are often justified based on public health and safety concerns. While
31 there are instances where the government needs to act to protect public health and safety, such as
32 during an infectious disease outbreak, governments should work to mitigate hazards and direct
33 individuals to resources and services outside of the criminal justice system. Criminal sanctions
34 should be a last resort.

35
36 Current AMA policy recognizes that stable, affordable housing as a first priority, without mandated
37 therapy or services compliance, is effective in improving housing stability and quality of life
38 among individuals who are chronically-homeless. In addition, to reaffirming this policy, the AMA
39 should recognize the lack of affordable housing as a leading cause of homelessness and support
40 measures to address this problem through policies that preserve and expand affordable housing
41 across all neighborhoods.

42
43 RECOMMENDATIONS

44
45 The Board of Trustees recommends that the following statements be adopted in lieu of Resolution
46 410-A-18 and the remainder of the report be filed.

47
48 1. That our American Medical Association: (1) supports laws protecting the civil and human
49 rights of individuals experiencing homelessness and (2) opposes laws and policies that
50 criminalize individuals experiencing homelessness for carrying out life-sustaining activities
51 conducted in public spaces that would otherwise be considered non-criminal activity (i.e.,

1 eating, sitting, or sleeping) when there is no alternative private space available. (New HOD
2 Policy)
3
4 2. That our AMA recognizes that stable, affordable housing is essential to the health of
5 individuals, families, and communities, and supports policies that preserve and expand
6 affordable housing across all neighborhoods. (New HOD Policy)
7
8 3. That our AMA reaffirm Policy H-160.903, "Eradicating Homelessness"
9 Our American Medical Association: (1) supports improving the health outcomes and
10 decreasing the health care costs of treating the chronically homeless through clinically proven,
11 high quality, and cost effective approaches which recognize the positive impact of stable and
12 affordable housing coupled with social services; (2) recognizes that stable, affordable housing
13 as a first priority, without mandated therapy or services compliance, is effective in improving
14 housing stability and quality of life among individuals who are chronically-homeless;
15 (3) recognizes adaptive strategies based on regional variations, community characteristics and
16 state and local resources are necessary to address this societal problem on a long-term basis;
17 (4) recognizes the need for an effective, evidence-based national plan to eradicate
18 homelessness; and (5) encourages the National Health Care for the Homeless Council to study
19 the funding, implementation, and standardized evaluation of Medical Respite Care for
20 homeless persons. (Reaffirm Current HOD Policy)

Fiscal Note: less than \$500

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 29-A-19

Subject: Improving Safety and Health Code Compliance in School Facilities
(Resolution 413-A-18)

Presented by: Jack Resneck, Jr., MD, Chair

Referred to: Reference Committee D
(Diana Ramos, MD, MPH, Chair)

1 INTRODUCTION

2 Resolution 423-A-18, “Improving Safety and Health Code Compliance in School Facilities,” which
3 was introduced by the Medical Student Section, and was referred by the House of Delegates, asked:

4 That our American Medical Association (1) support the development and implementation of
5 standardized, comprehensive guidelines for school safety and health code compliance
6 inspections; and (2) That our AMA support policies aiding schools in meeting said guidelines,
7 including support for financial and personnel-based aid for schools based in vulnerable
8 neighborhoods; and (3) That our AMA support creation of a streamlined reporting system for
9 school facility health data potentially through application of current health infrastructure.

10 Testimony during reference committee noted that there are already extensive guidelines
11 provided for schools by the Centers for Disease Control and Prevention, Environmental
12 Protection Agency, and state departments of health, and that our American Medical
13 Association should review guidelines from these sources. It was further noted that there is
14 no governing body that enforces the compliance of safety standards in schools. This
15 report addresses school environmental health and safety.

16 C CURRENT AMA POLICY

17 Existing American Medical Association (AMA) policy addresses environmental health and safety,
18 including drinking water and indoor air quality (see Appendix for full text). Relevant to this report
19 is AMA Policy H-135.928, “Safe Drinking Water,” that supports creating and implementing
20 standardized protocols and regulations pertaining to water quality testing, and reporting and
21 remediation to ensure the safety of water in schools. AMA Policy H-135.998, “AMA Position on
22 Air Pollution,” also supports maximum feasible reduction of all forms of air pollution, including
23 biologically and chemically active pollutants, by all responsible parties, as governmental control
24 programs are implemented primarily by local, regional, or state jurisdictions which possess the
25 resources to bring about equitable and effective control.

1 **BACKGROUND**

2

3 *School Environmental Health and Safety*

4

5 Children are a vulnerable population with smaller body size and higher metabolism, which may
6 increase susceptibility to environmental contaminants.¹ Children may also be more likely to
7 encounter contaminants, due to proximity to the ground, where they may ingest substances such as
8 toxic dust by placing objects in their mouths, and where levels of airborne pollutants may also be
9 higher. Regardless of route of administration, encounters with toxins such as heavy metals can lead
10 to lifelong negative health and behavioral impacts,² including via altered brain development.³

11

12 Safety implies prevention of unintentional injuries, a leading cause of death and disability among
13 children. Unsafe environments can lead to chronic health conditions, including asthma and
14 allergies. As many as 25 percent of school-age children in the United States have a chronic health
15 condition. Children spend large amounts of time in schools, where better management of their
16 chronic health conditions may be associated with improved academic achievement.⁴

17

18 Budget shortfalls for school infrastructure impact school operating resources, negatively affecting
19 routine and preventative maintenance, particularly in lower-income districts. Lack of well-
20 maintained school environments can pose obstacles to student learning and well-being, negatively
21 affect surrounding communities, and contribute to health inequities.⁵

22

23 Environmental health and safety laws and guidelines have been designed to protect private and
24 public employees, students, the public, and the environment.⁶ A complex jurisdictional
25 arrangement throughout federal, state, county, and municipal levels may create confusion for
26 schools about which regulations apply. The following provides a broad overview of various
27 agencies and entities with interests in school environmental health and safety.

28

29 **FEDERAL AGENCIES**

30

31 The federal government's role in education has traditionally been limited, due to the Tenth
32 Amendment of the U.S. Constitution, which reserves powers not assigned to the federal
33 government for the states of the people. Rather than mandating direct federal oversight of schools,
34 state and local districts have generally retained school regulatory authorities under existing law.

35

36 *U.S. Environmental Protection Agency (EPA)*

37

38 The EPA is responsible for protecting the environment and public through legislative mandates.
39 These laws include air pollution, drinking water, pesticides, hazardous waste, and asbestos, among
40 other topics. The Energy Independence and Security Act of 2007 added a requirement for the EPA
41 to develop voluntary guidelines (together with other relevant federal agencies) for K-12 schools,
42 and then assist states in establishing and implementing environmental health programs.⁷

43

44 Other recent EPA mandates address drinking water and aging infrastructure, including: the
45 Drinking Water State Revolving Fund of 2013 that provides loans that support lead pipe
46 replacement projects across the United States; the Water Infrastructure Improvements for the
47 Nation Act of 2016 that supports grant programs⁸ (e.g., the State Lead Testing in School and Child
48 Care Program Drinking Water Grant⁹); the Water Infrastructure Finance and Innovation Act of
49 2018 that leverages funding for water infrastructure projects to reduce exposure to lead and other
50 contaminants; and the America's Water Infrastructure Act of 2018 that offers programs and
51 resources to help reduce lead in drinking water.

1 The EPA assists states and local school districts by providing grant support¹⁰ and capacity building,
2 developing policy and data tools,¹¹ and offering guidance on compliance and monitoring. The
3 EPA's voluntary guidelines provide examples of best practices from existing state environmental
4 health programs for schools, recommend a six-step plan states can use to build or enhance a
5 sustainable school environmental health program, and provide extensive resources for states to
6 promote healthy learning environments for children and school staff.

7
8 In addition to the voluntary guidelines, in 2018 the EPA announced the Tools for Schools program
9 to support schools in ensuring clean, healthy, and environmentally conscious school communities.
10 The Tools for Schools approach provides strategies and a robust suite of tools to help schools
11 identify, correct, and prevent a wide range of environmental health and safety risks, and to put in
12 place a sustainable system to institutionalize a successful program at the school or school district
13 level.¹³ The EPA also offers comprehensive Healthy Schools, Healthy Kids educational resources
14 and tools to help maintain and enhance environmental health programs.¹² These resources include
15 educating students and school staff about prevention and management, as well as hands-on
16 resources such as inspection manuals for staff and pest management professionals.¹⁴

17
18 *Centers for Disease Control and Prevention (CDC)*
19

20 The CDC conducts critical science and provides health information that protects our nation against
21 dangerous health threats, and responds when these arise. The CDC serves a key role in
22 environmental health, as well as health promotion and education activities designed to improve
23 health.

24
25 Various CDC centers and agencies address environmental health and safety, including the
26 Agency for Toxic Substances and Disease Registry, which works towards minimizing risks
27 associated with exposure to hazardous substances, and maintains toxicological profiles for
28 substances; the Division of Adolescent and School Health, which collects data to monitor healthy
29 and safe school environments such as School Health Policies and Practices Study¹⁵ and conducts
30 surveys of schools including School Health Profiles¹⁶ covering asthma and other chronic
31 conditions; and the National Center for Environmental Health which conducts research including
32 the Environmental Public Health Tracking Program¹⁷ and collects state surveillance data¹⁸ on
33 children affected by lead.

34
35 The National Institute for Occupational Safety and Health (NIOSH) has a Safety Checklist for
36 Schools¹⁹ to help K-12 schools with health compliance, including with EPA regulations and
37 Occupational Safety and Health Administration (OSHA) standards. NIOSH also responds to
38 requests to investigate health and safety problems in the workplace, via the Division of
39 Surveillance, Hazard Evaluations, and Field Studies, including in public schools²⁰. It also provides
40 training in occupational safety and health, conducts occupational disease and injury research, and
41 recommends standards to OSHA.

42
43 The School Health Index²¹ was developed by the CDC as a confidential online self-assessment and
44 planning tool that schools can use to help improve health and safety policies and programs. The
45 CDC also has additional resources for drinking water access²² through Healthy Schools,²³ which
46 offers the Whole School, Whole Community, Whole Child (WSCC) model as a framework for
47 addressing health in schools.²⁴ According to the WSCC model:

48
49 The physical school environment encompasses the school building and its contents, the land on
50 which the school is located, and the area surrounding it. A healthy school environment will
51 address a school's physical condition during normal operation as well as during renovation

1 (e.g., ventilation, moisture, temperature, noise, and natural and artificial lighting), and protect
2 occupants from physical threats (e.g., crime, violence, traffic, and injuries) and biological and
3 chemical agents in the air, water, or soil as well as those purposefully brought into the school
4 (e.g., pollution, mold, hazardous materials, pesticides, and cleaning agents).

5
6 A recent report²⁵ provided a comprehensive analysis of state policies for alignment with the CDC's
7 WSCC model, and these findings are available by state and category,²⁶ including physical
8 environment.

9
10 STATE AGENCIES
11

12 State agencies also play a role in school environmental health and safety, and these vary by
13 jurisdiction. Those that may be relevant include the state departments of education, labor,
14 environmental protection, community affairs, and health.¹⁹

15
16 *Departments of Education*

17
18 State departments of education issue regulations that deal with private and public schools, as well
19 as regulations related to school construction. Besides regulations for environmental safety and
20 health regulations, a state department of education or school district may also provide policies
21 and/or guidelines related to environmental safety and health programs.

22
23 *Departments of Labor*

24
25 Although students are not generally covered by federal OSHA, state legislative mandates may
26 "adopt by reference" the OSHA standards. "Adoption by reference" requires compliance in the
27 state with federal OSHA requirements. State OSHA programs then assume responsibility for
28 enforcing regulations through the state department of labor, including health and safety.

29
30 *Departments of Environmental Protection*

31
32 In most states, the state EPA covers the same areas addressed by federal EPA, such as air pollution,
33 drinking water, hazardous waste, pesticides, and noise pollution. When incorporated into state
34 regulations, state EPAs are authorized by the U.S. EPA to enforce almost all EPA regulations.
35 States have typically assumed responsibility for enforcement of EPA mandates, following adoption
36 of their own state regulations, including inspections and enforcing EPA regulations in schools. The
37 U.S. EPA provides voluntary guidelines for states to follow, and encourages a leadership role from
38 state agencies, such as more comprehensive strategies, including by using available resources such
39 as model programs for indoor air quality.²⁷

40
41 *Departments of Community Affairs*

42
43 Agencies such as the Department of Community Affairs may enforce state fire safety and building
44 regulations. In many states, cities and counties are free to adopt their own codes, in the absence of
45 state codes.

46
47 *Departments of Health*

48
49 State departments of health enforce health regulations directed by legislative mandate. Health
50 departments may also work with schools and local health departments to provide technical
51 assistance on school environmental health and safety issues and promote best practices.

1 LOCAL GOVERNMENTS
2

3 Various codes and standards have been adopted by states, counties, cities/towns and districts to
4 help ensure school safety. One example includes building codes, which may also
5 regulate children's play spaces and equipment. Another example is fire protection codes that
6 address topics such as means of egress from buildings. Many safety codes apply to public schools
7 via entities such as the local building or fire department,²⁸ and some cover environmental health
8 areas such as radon testing and elimination. At state or city levels, additional public safety statutes
9 may apply.²⁹

10 11 KEY AREAS OF SCHOOL ENVIRONMENTAL HEALTH AND SAFETY
12

13 *Air Quality*

14 15 Airborne contaminants including mold³⁰ and chemicals such as cleaning products and pesticides,
16 can trigger a variety of health issues, including allergies and asthma. Various state indoor air
17 quality statutes cover topics such as HVAC system inspection and inadequate ventilation, while
18 others focus primarily on green cleaning. Nearly every state has a statute that heavily regulates
19 smoking in schools and most prohibit smoking in schools completely. There is no state statute that
20 encompasses all facets of indoor air quality safety in schools.

21 22 *Chemical Hazards*
23

24 Asbestos. Asbestos minerals are a group of silicate compounds that cause chronic lung disease and
25 have been classified as a known human carcinogen.³¹ Asbestos statutes generally pertain to any
26 public building and not just schools, and require certification and licensure before any contracting
27 can occur for an asbestos abatement program, and substantial monitoring before and during any
28 programs. Most state statutes provide for state or federal money for abatement programs in public
29 buildings, including schools.

30 31 Radon. Radon is a colorless, odorless radioactive gas that seeps into buildings from surroundings,
32 and can become trapped inside. Some states have radon statutes that provide that schools must be
33 checked for radon, but most states delegate authority to various departments in the state.

34 35 Lead. Lead is a neurotoxin for which young children are particularly susceptible. Lead exposure is
36 linked to impaired brain and nervous system development during childhood and associated with
37 adverse effects including behavioral problems and additional health conditions later in life. Nearly
38 every state has a statute that mitigates lead risks, though most are focused on reducing the risks of
39 lead-based paint. Of the states that specifically address children, many only address children up to
40 age six. The EPA offers voluntary guidance¹³ for preventing and mitigating some lead hazards in
41 schools, including drinking water.³²

42 43 *Water Quality*
44

45 Currently, no federal law requires testing for lead in school drinking water. Although public water
46 systems are regulated by the EPA, this regulation does not apply to downstream users such as
47 schools. To date, federal agencies including the EPA, Department of Education and CDC have had
48 a limited role in monitoring school drinking water. Improved federal guidance has been called for
49 by the Government Accountability Office.³³

1 In 2017, 41 percent of school districts nationwide had not tested their water for lead, and additional
2 16 percent reported that they did not know whether the water had been tested.³³ In 2016, New York
3 became the first state to require lead testing in school drinking water and by 2018, 15 states had
4 requirements for lead testing in school drinking water³⁴ but many jurisdictions do not have
5 programs to test for lead in drinking water.

6
7 Recent findings have highlighted challenges due a lack of standardized practices in data collection,
8 reporting, and decision making. When testing has been performed, elevated levels of lead have
9 often been found, and many schools must decide the levels that trigger retesting, prevent continued
10 use of the source, and eventually spur remediation efforts.

11
12 CONCLUSION
13

14 Children are a vulnerable population and are susceptible to environmental contaminants. Given the
15 amount of time children spend in schools, promoting healthy school environments is of importance.
16 Existing guidelines recommend steps towards sustainable school environmental health programs,
17 and additional tools are available to help schools implement guidelines to promote children's
18 health. While some state and local governments have adopted these guidelines into law, overall
19 adoption and enforcement of such guidelines remains voluntary. Budgets and school operating
20 expenses directly impact school building infrastructure and maintenance. Schools in lower-income
21 districts may be particularly vulnerable to environmental health hazards, which can pose obstacles
22 to student learning and well-being, and contribute to health inequities.

23
24 RECOMMENDATIONS
25

26 The Board of Trustees recommends that the following recommendations be adopted in lieu of
27 Resolution 413-A-18 and that the remainder of this report be filed.

28 1. That our AMA adopt the following new policy:

29
30 “Environmental Health and Safety in Schools”
31 Our AMA supports the adoption of standards in schools that limit harmful substances from
32 school facility environments, ensure safe drinking water, and indoor air quality, and promote
33 childhood environmental health and safety in an equitable manner. (New HOD Policy)

34
35 2. That the following policies be reaffirmed: H-135.928, “Safe Drinking Water,” and H-135.998,
36 “AMA Position on Air Pollution.” (Reaffirm HOD Policy)

37
Fiscal Note: Less than \$500.

APPENDIX – Current AMA Policy

H-135.928, “Safe Drinking Water”

Our AMA supports updates to the U.S. Environmental Protection Agency’s Lead and Copper Rule as well as other state and federal laws to eliminate exposure to lead through drinking water by: (1) Removing, in a timely manner, lead service lines and other leaded plumbing materials that come into contact with drinking water; (2) Requiring public water systems to establish a mechanism for consumers to access information on lead service line locations; (3) Informing consumers about the health-risks of partial lead service line replacement; (4) Requiring the inclusion of schools, licensed daycare, and health care settings among the sites routinely tested by municipal water quality assurance systems; (5) Creating and implementing standardized protocols and regulations pertaining to water quality testing, reporting and remediation to ensure the safety of water in schools and child care centers; (6) Improving public access to testing data on water lead levels by requiring testing results from public water systems to be posted on a publicly available website in a reasonable timeframe thereby allowing consumers to take precautions to protect their health; (7) Establishing more robust and frequent public education efforts and outreach to consumers that have lead service lines, including vulnerable populations; (8) Requiring public water systems to notify public health agencies and health care providers when local water samples test above the action level for lead; (9) Seeking to shorten and streamline the compliance deadline requirements in the Safe Drinking Water Act; and (10) Actively pursuing changes to the federal lead and copper rules consistent with this policy.

H-135.998, “AMA Position on Air Pollution”

Our AMA urges that: (1) Maximum feasible reduction of all forms of air pollution, including particulates, gases, toxicants, irritants, smog formers, and other biologically and chemically active pollutants, should be sought by all responsible parties. (2) Community control programs should be implemented wherever air pollution produces widespread environmental effects or physiological responses, particularly if these are accompanied by a significant incidence of chronic respiratory diseases in the affected community. (3) Prevention programs should be implemented in areas where the above conditions can be predicted from population and industrial trends. (4) Governmental control programs should be implemented primarily at those local, regional, or state levels which have jurisdiction over the respective sources of air pollution and the population and areas immediately affected, and which possess the resources to bring about equitable and effective control.

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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 3-A-19

Subject: Low Nicotine Product Standard
(Resolution 431-A-18)

Presented by: Robyn F. Chatman, MD, MPH, Chair

Referred to: Reference Committee D
(Diana Ramos, MD, MPH, Chair)

1 Resolution 431-A-18, introduced by the American Thoracic Society and referred by the House of
2 Delegates asks:

3
4 That our American Medical Association (AMA) direct the Council on Science and Public
5 Health to develop a report on the individual health and public health implications of a low
6 nicotine standard for cigarettes. Such a report should consider and make recommendations on
7 scientific criteria for selection of a nicotine standard that is non-addictive, regulatory strategies
8 to ensure compliance with an established standard, how a low nicotine standard should work
9 with other nicotine products in a well-regulated nicotine market.

10
11 **METHODS**
12

13 English language reports were selected from searches of the PubMed, Google Scholar, and
14 Cochrane Library databases from January 2018 to January 2019 using the search terms “nicotine
15 standard,” “nicotine content,” and “very low nicotine content cigarette.”

16
17 **BACKGROUND**
18

19 At the 2018 Annual Meeting of the House of Delegates, the Council on Science and Public Health
20 (CSAPH) presented a report on “Tobacco Harm Reduction: A Comprehensive Nicotine Policy to
21 Reduce Death and Disease Caused by Smoking.” That report outlined the Food and Drug
22 Administration’s (FDA) plan to reduce the devastating toll of tobacco use and noted that the plan
23 involves two primary parts: (1) reducing the addictiveness of combustible cigarettes and (2)
24 recognizing and clarifying the role that potentially less harmful tobacco products could play in
25 improving public health. The FDA also has acknowledged the need for medicinal nicotine and
26 other therapeutic products to play a greater role in helping smokers to quit and remain nonsmokers.

27
28 On July 16, 2018, the AMA along with 39 other medical and public health organizations submitted
29 comments to the Food and Drug Administration (FDA) on Docket No. FDA-2017-N-6189,
30 Tobacco Product Standard for Nicotine Level of Combusted Cigarettes (See Appendix).¹ These
31 comprehensive comments on the FDA’s Advance Notice of Proposed Rule Making (ANPRM)
32 addressed the following issues:

- 1 I. Public Health Impact of Reducing Nicotine in Combustible Tobacco Products
- 2 A. Reducing the Nicotine Content of Cigarettes Will Help Smokers Quit
- 3 B. Reducing the Nicotine Content of Combustibles Will Prevent Kids from Becoming
- 4 Addicted Smokers
- 5 C. Vulnerable Populations Will Benefit from a Nicotine Reduction Policy
- 6
- 7 II. A Nicotine Content Standard Should Apply to Other Combustible Tobacco Products
- 8 A. The Tobacco Industry Manipulates Loopholes in Product Regulation
- 9 B. Cigars Are a Harmful and Addictive Substitute for Cigarettes
- 10 C. Hookah (Waterpipe) Tobacco is Harmful and Addictive
- 11 D. The rule should prohibit other changes in cigarettes that might counteract the effect of the
- 12 reduction in nicotine.
- 13
- 14 III. Implementation Considerations
- 15 A. Maximum Nicotine Level
- 16 B. An Immediate Nicotine Content Reduction Will Have a Larger Public Health Impact than a
- 17 Gradual Reduction
- 18 C. Reducing the Nicotine Content of Combustibles Will Not Lead to Compensation
- 19 D. FDA Must Counter Misperceptions about the Harms of Reduced Nicotine Products
- 20
- 21 IV. Technical Achievability
- 22 A. Reducing Nicotine in Cigarettes is Technologically Feasible
- 23 B. FDA Should Make the Effective Date of the Rule as Early as Possible.
- 24 C. Manufacturers, Distributors, and Retailers Should Not Be Allowed to Sell Off Existing
- 25 Nonconforming Inventories.
- 26 D. FDA Should Require a Standard Method of Product Testing to Analyze Nicotine Levels.
- 27
- 28 V. Possible Countervailing Effects
- 29 A. The Product Standard Should Prohibit the Sale or Distribution of Liquid Nicotine or Any
- 30 Other Tobacco Product Designed to Supplement the Nicotine Content of Combusted
- 31 Tobacco Products.
- 32 B. Illicit Trade
- 33
- 34 VI. Other Considerations
- 35 A. The Potential Consumer Surplus or Utility Loss from the Removal of Nicotine from
- 36 Combusted Tobacco Products is Minimal in Light of the Availability of Other Sources of
- 37 Nicotine and the Continued Availability of Tobacco Products.
- 38 B. FDA Should Consider Externalities, Such as the Reduction in Secondhand Smoke, in
- 39 Evaluating the Consequences of the Rule
- 40 C. Post-market Surveillance is Critical
- 41
- 42 The AMA also submitted individual comments (see Appendix) calling on the FDA to:
- 43
- 44 create a non-addictive nicotine level standard for all tobacco products, not just cigarettes. This
- 45 includes smokeless tobacco, electronic nicotine delivery systems (ENDS), 'heat not burn'
- 46 products,' and any other tobacco products containing nicotine for recreational use. If FDA
- 47 reduces nicotine content in combustible tobacco products without already having a regulatory
- 48 strategy in place that appropriately addresses ENDS, it will miss a critical opportunity to
- 49 reduce overall nicotine addiction and use of tobacco products. Comprehensive and specific
- 50 regulations are necessary to prevent new products that may circumvent the nicotine level
- 51 requirement.

1 DISCUSSION

2

3 Several studies have been released on the issue of low nicotine cigarette product standards since the
4 AMA submitted comments to the FDA regarding a tobacco product standard for nicotine. These
5 studies have largely been consistent with the AMA's comments or have addressed gaps where
6 information was not previously available. One study found that when nondaily smokers switch to
7 very low nicotine content cigarettes, they reduced their cigarette consumption by 51 percent,
8 though they did not necessarily stop smoking.² A study looking at whether smoking intensity
9 increased when intermittent smokers switched to very low nicotine content cigarettes found that
10 smoking intensity decreased.³ Another study examined the effects of immediate vs. gradual
11 reduction in nicotine content to very low levels and as compared with usual nicotine level
12 cigarettes on biomarkers of toxicant exposure. Among smokers, immediate reduction of nicotine in
13 cigarettes (to 0.4 mg of nicotine per gram of tobacco) led to significantly greater decreases in
14 biomarkers of smoke exposure across time compared with gradual reduction (from 15.5 mg to 0.4
15 mg of nicotine per gram of tobacco cigarettes with 5 monthly dose changes) or a control group
16 (maintenance on 15.5 mg of nicotine per gram of tobacco cigarettes), with no significant
17 differences between gradual reduction and control.⁴

18

19 A search on clinicaltrials.gov indicates that there are a number of clinical trials underway that will
20 provide additional information on very low nicotine content cigarettes and nicotine product
21 standards.

22

23 CURRENT AMA POLICY

24

25 Existing AMA policy acknowledges that all tobacco products are harmful to health, and that there
26 is no such thing as a safe cigarette. Policy also recognizes that complete cessation of the use of
27 tobacco and nicotine-related products is the goal and supports the use of FDA-approved tools for
28 smoking cessation. The AMA supports the FDA's regulatory authority over tobacco products and
29 encourages the FDA and other appropriate agencies to conduct or fund research on how tobacco
30 products might be modified to facilitate cessation of use, including elimination of nicotine and
31 elimination of additives (e.g., ammonia) that enhance addictiveness.

32

33 RECOMMENDATION

34

35 The Council on Science and Public Health recommends that the following be adopted in lieu of
36 Resolution 431-A-18 and the remainder of the report be filed:

37

38 1. That AMA Policy H-495.988, "FDA Regulation of Tobacco Products" be amended by addition
39 to read as follows:

40

41 1. Our AMA: (A) acknowledges that all tobacco products (including but not limited to,
42 cigarettes, smokeless tobacco, chewing tobacco, and hookah/water pipe tobacco) are harmful to
43 health, and that there is no such thing as a safe cigarette; (B) recognizes that currently available
44 evidence from short-term studies points to electronic cigarettes as containing fewer toxicants
45 than combustible cigarettes, but the use of electronic cigarettes is not harmless and increases
46 youth risk of using combustible tobacco cigarettes; (C) encourages long-term studies of vaping
47 (the use of electronic nicotine delivery systems) and recognizes that complete cessation of the
48 use of tobacco and nicotine-related products is the goal; (D) asserts that tobacco is a raw form
49 of the drug nicotine and that tobacco products are delivery devices for an addictive substance;
50 (E) reaffirms its position that the Food and Drug Administration (FDA) does, and should
51 continue to have, authority to regulate tobacco products, including their manufacture, sale,

1 distribution, and marketing; (F) strongly supports the substance of the August 1996 FDA
2 regulations intended to reduce use of tobacco by children and adolescents as sound public
3 health policy and opposes any federal legislative proposal that would weaken the proposed
4 FDA regulations; (G) urges Congress to pass legislation to phase in the production of less
5 hazardous and less toxic tobacco, and to authorize the FDA have broad-based powers to
6 regulate tobacco products; (H) encourages the FDA and other appropriate agencies to conduct
7 or fund research on how tobacco products might be modified to facilitate cessation of use,
8 including elimination of nicotine and elimination of additives (e.g., ammonia) that enhance
9 addictiveness; and (I) strongly opposes legislation which would undermine the FDA's authority
10 to regulate tobacco products and encourages state medical associations to contact their state
11 delegations to oppose legislation which would undermine the FDA's authority to regulate
12 tobacco products.
13

14 2. Our AMA: (A) supports the US Food and Drug Administration (FDA) as it takes an
15 important first step in establishing basic regulations of all tobacco products; (B) strongly
16 opposes any FDA rule that exempts any tobacco or nicotine-containing product, including all
17 cigars, from FDA regulation; and (C) will join with physician and public health organizations
18 in submitting comments on FDA proposed rule to regulate all tobacco products.
19

20 3. Our AMA: (A) will continue to monitor the FDA's progress towards establishing a low
21 nicotine product standard for tobacco products and will submit comments on the proposed rule
22 that are in line with the current scientific evidence and (B) recognizes that rigorous and
23 comprehensive post-market surveillance and product testing to monitor for unintended tobacco
24 use patterns will be critical to the success of a nicotine reduction policy. (Modify Current HOD
25 Policy)
26

27 2. That American Medical Association Policy H-495.972, "Electronic Cigarettes, Vaping, and
28 Health" be reaffirmed. (Reaffirm HOD Policy)

Fiscal Note: Less than \$500.

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3. Shiffman S, Mao JM, Kurland BF, Scholl SM. Do non-daily smokers compensate for reduced cigarette consumption when smoking very-low-nicotine-content cigarettes? *Psychopharmacology (Berl)*. 2018; 235(12):3435-3441.
4. Hatsukami, D. K., Luo, X., Jensen, J. A., Al'Absi, M., Allen, S. S., Carmella, S. G., Donny, E. C. Effect of immediate vs gradual reduction in nicotine content of cigarettes on biomarkers of smoke exposure a randomized clinical trial. *JAMA - Journal of the American Medical Association*. 2018; 320(9): 880-891.



July 16, 2018

Dockets Management Staff [HFA-305]
 Food and Drug Administration
 5630 Fishers Lane, Room 1061
 Rockville, MD 20852

Re: Docket No. FDA-2017-N-6189, Tobacco Product Standard for Nicotine Level of Combusted Cigarettes

The undersigned organizations submit these comments in the above-designated docket regarding the FDA's Advance Notice of Proposed Rulemaking on a Tobacco Product Standard for Nicotine Level of Combusted Cigarettes.

Introduction

For decades, researchers have agreed that nicotine is the fundamental addictive agent in tobacco, leading the U.S. Surgeon General to affirmatively conclude in the 1988 report, *The Health Consequences of Smoking: Nicotine Addiction*, that, “nicotine is the drug in tobacco that causes addiction.”¹ Now, strong scientific evidence also demonstrates that reducing the nicotine

¹ U.S. Department of Health and Human Services (HHS). *The Health Consequences of Smoking: Nicotine Addiction. A Report of the Surgeon General*. 1988.

content to a very low level can reduce smoking and nicotine addiction.² Reducing nicotine levels in combustible tobacco products provides enormous potential to accelerate progress in preventing and reducing smoking and the death and disease it causes. We urge you to move forward with this proposal as quickly as possible.

As FDA noted in the Advance Notice of Proposed Rulemaking (ANPRM at 11822), reducing the nicotine content of cigarettes will: “(1) Give addicted users of cigarettes the choice and ability to quit more easily by reducing the nicotine to a minimally addictive or nonaddictive level and (2) reduce the risk of progression to regular use and nicotine dependence for persons who experiment with the tobacco products covered by the standard.” Making cigarettes minimally or non-addictive will prevent most kids from ever becoming regular smokers and will increase the number of smokers who make a quit attempt and successfully quit. The FDA estimates that this proposal would prevent more than 33 million youth and young adults from becoming regular smokers this century, prompt 5 million smokers to quit within one year (rising to 13 million in five years) and save more than 8 million lives by the end of the century.³ The impact of this policy would be historic. There are few actions FDA could take that would prevent as many young people from smoking and save as many lives.

It is important, however, that FDA consider a nicotine product standard as part of a comprehensive set of regulatory policies to curb the use of combustible tobacco products. Thus, moving toward adoption of such a standard would not obviate the need to implement, as soon as possible, proposals that include prohibiting menthol in cigarettes and characterizing flavors in all tobacco products, as well as graphic health warnings for cigarettes. Moreover, there is, and will continue to be, a need for FDA to exercise its full authority to reduce the use of and pursue public education campaigns directed at informing the public of the health risks of all tobacco products, including those subject to the nicotine reduction proposal. Reducing nicotine in combustible products to minimally or non-addictive levels will not make those products “safe,” and the public, particularly young people, need to understand that any use of these products will continue to carry substantial health risks.

I. Public Health Impact of Reducing Nicotine in Combustible Tobacco Products

Despite great progress in curbing smoking prevalence in recent years, tobacco use – primarily smoking – remains the leading cause of preventable death and disease in the United States, killing more than 480,000 Americans every year.⁴ Nearly 38 million Americans currently

² World Health Organization (WHO) Study Group on Tobacco Product Regulation, *Global Nicotine Reduction Strategy*, 2015, http://apps.who.int/iris/bitstream/10665/189651/1/9789241509329_eng.pdf?ua=1.

³ Apelberg, BJ, et al., “Potential Public Health Effects of Reducing Nicotine Levels in Cigarettes in the United States,” *New England Journal of Medicine*, published online March 15, 2018. See also Tobacco Product Standard for Nicotine Level of Combusted Cigarettes; Advanced Notice of Proposed Rulemaking, 83 Fed. Reg. at 11818 (March 16, 2018).

⁴ HHS, *The Health Consequences of Smoking – 50 Years of Progress: A Report of the Surgeon General*, 2014.

smoke and every day about 2,300 kids try their first cigarette and another 350 additional kids become regular smokers.⁵ Approximately half of continuing smokers will die prematurely as a result of their addiction, losing at least a decade of life on average compared to nonsmokers.⁶

Reducing the nicotine content in cigarettes to minimally or non-addictive levels will prevent young people who experiment from becoming addicted and save them from a lifetime of addiction, tobacco-caused disease, and premature death. It also will reduce the level of nicotine dependence in adult smokers, making it easier for them to quit. Ultimately, this will dramatically reduce the number of adult smokers. The FDA estimates that reducing nicotine levels in combusted tobacco products would prevent more than 33 million youth and young adults from initiating regular smoking by 2100. In addition, within five years, the FDA estimates it would cause 13 million smokers to quit, including five million within just the first year of implementation. Ultimately, more than 8 million lives would be saved by the end of the century.⁷

A. Reducing the Nicotine Content of Cigarettes will Help Smokers Quit

As stated by a Philip Morris researcher in 1972, “*No one has ever become a cigarette smoker by smoking cigarettes without nicotine.*”⁸ Nicotine is the primary addictive agent in cigarettes.⁹ According to the U.S. Surgeon General, “the addiction caused by the nicotine in tobacco smoke is critical in the transition of smokers from experimentation to sustained smoking and, subsequently, in the maintenance of smoking for the majority of smokers who want to quit.”¹⁰ Most adult smokers want to quit (nearly 70 percent) and wish they had never started (about 90 percent), but overcoming an addiction to nicotine is difficult and smokers often need to make multiple quit attempts before succeeding.¹¹

⁵ CDC, “Current Cigarette Smoking Among Adults – United States, 2016,” *Morbidity and Mortality Weekly Report (MMWR)* 67(2):53-59, January 19, 2018. <https://www.cdc.gov/mmwr/volumes/67/wr/pdfs/mm6702a1-H.pdf>; Substance Abuse and Mental Health Services Administration (SAMHSA), HHS, *Results from the 2016 National Survey on Drug Use and Health, NSDUH: Detailed Tables*, 2017. <https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2016/NSDUH-DetTabs-2016.pdf>.

⁶ HHS, *The Health Consequences of Smoking – 50 Years of Progress: A Report of the Surgeon General*, 2014.

⁷ Apelberg, BJ, et al., “Potential Public Health Effects of Reducing Nicotine Levels in Cigarettes in the United States,” *New England Journal of Medicine*, published online March 15, 2018. See also Tobacco Product Standard for Nicotine Level of Combusted Cigarettes; Advanced Notice of Proposed Rulemaking, 83 Fed. Reg. at 11818 (March 16, 2018).

⁸ Philip Morris, Dunn,W Jr., “Motives And Incentives In Cigarette Smoking”; R107. 1972. <https://www.industrydocumentslibrary.ucsf.edu/tobacco/docs/jspf0085>. For additional industry quotes on nicotine, see Campaign for Tobacco-Free Kids fact sheet, “Tobacco Company Quotes: Nicotine as a Drug,” <https://www.tobaccofreekids.org/research/factsheets/pdf/0009.pdf>.

⁹ HHS, *How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Disease: A Report of the Surgeon General*, 2010.

¹⁰ HHS, *The Health Consequences of Smoking—50 Years of Progress, A Report of the Surgeon General*, 2014. See also, HHS, *How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Disease: A Report of the Surgeon General*, 2010, <http://www.ncbi.nlm.nih.gov/books/NBK53017/>.

¹¹ Babb, S, et al., “Quitting Smoking Among Adults—United States, 2000—2015,” *MMWR* 65:1457–1464, 2017. Fong, G., et al., “The Near-Universal Experience of Regret Among Smokers in Four Countries: Findings from

Research demonstrates that significantly reducing nicotine levels holds great promise for accelerating progress in reducing smoking. Scientific evidence establishes that it is possible to lower nicotine levels in ways that dramatically reduce dependence. Based on a comprehensive review of the evidence, the World Health Organization Study Group on Tobacco Product Regulation concluded that reducing nicotine content in cigarettes could:¹²

- Reduce smoking acquisition and progression to addiction;
- Increase cessation and reduce relapse; and, ultimately,
- Reduce smoking prevalence.

The first large scale clinical trial of very low nicotine content (VLNC) cigarettes in the US, conducted in 2013-2014, randomly assigned over 800 smokers to use their usual brand of cigarettes or cigarettes with varying levels of nicotine for six weeks. Smokers assigned to smoke cigarettes with lower nicotine content smoked fewer cigarettes, reduced their exposure and dependence to nicotine, and reduced cravings, compared to the control group. The same study also found that those smoking cigarettes with the lowest nicotine content (0.4 mg/g) were twice as likely to report trying to quit in the 30 days after the study ended compared to those smoking cigarettes with 15.8 mg/g (34% vs. 17%). Smokers assigned to smoke cigarettes with 2.4 mg/g nicotine or less smoked between 23 and 30 percent fewer cigarettes per day at six-week follow-up compared to smokers assigned to smoke cigarettes with 15.8 mg/g nicotine.¹³

Other smaller studies have shown that use of reduced nicotine cigarettes leads to reductions in smoking, nicotine dependence, and biomarkers of exposure to nicotine and other toxins.¹⁴ Research also shows that reduced nicotine cigarettes increase abstinence among smokers trying to quit.¹⁵ For example, a 2009-2010 randomized controlled trial in New Zealand assigned over 1400 smokers seeking treatment from the Quitline to receive VLNC cigarettes with standard Quitline care (nicotine replacement therapy and behavioral counseling) for six

the International Tobacco Control Policy Evaluation Survey,” *Nicotine & Tobacco Research*, Vol. 6, Supplement 3, December 2004.

¹² WHO, *Global Nicotine Reduction Strategy*, 2015.

¹³ Donny, EC, et al., “Randomized trial of reduced-nicotine standards for cigarettes,” *New England Journal of Medicine*, 373: 1340-1349, 2015.

¹⁴ See e.g., Donny EC, et al. Smoking in the absence of nicotine: behavioral, subjective and physiological effects over 11 days. *Addiction* 2007; 102: 324-34. Benowitz NL, et al., Nicotine and carcinogen exposure with smoking of progressively reduced nicotine content cigarette. *Cancer Epidemiol Biomarkers Prev* 2007; 16: 2479-85. Benowitz NL, et al., Urine nicotine metabolite concentrations in relation to plasma cotinine during low-level nicotine exposure. *Nicotine & Tobacco Research* 2009; 11: 954-60. Benowitz NL, et al. Smoking behavior and exposure to tobacco toxicants during 6 months of smoking progressively reduced nicotine content cigarettes. *Cancer Epidemiol Biomarkers Prev* 2012; 21: 761-9. Hatsukami DK, et al. Reduced nicotine content cigarettes: effects on toxicant exposure, dependence and cessation. *Addiction* 2010; 105: 343-55.

¹⁵ See e.g., Walker, N, et al., “The combined effect of very low nicotine content cigarettes, used as an adjunct to usual Quitline care (nicotine replacement therapy and behavioural support), on smoking cessation: a randomized controlled trial,” *Addiction*, 107(10): 1857-1867, 2012. McRobbie, H, et al., “Complementing the standard multicomponent treatment for smokers with denicotinized cigarettes: a randomized controlled trial,” *Nicotine & Tobacco Research*, 18(5): 1134-1141, 2016.

weeks, or Quitline care alone. At 6-month follow-up, smokers who had received VLNC cigarettes were more likely to have quit smoking (33% vs. 28% seven-day point prevalence abstinence; 23% vs. 15% continuous abstinence).¹⁶ This evidence suggests that VLNC cigarettes can help smokers who are making a quit attempt.

B. Reducing the Nicotine Content of Combustibles Will Prevent Kids from Becoming Addicted Smokers

The FDA noted in the ANPRM (at 11821, 11823-11824) the powerful addictiveness of nicotine, particularly on the adolescent brain. Tobacco use almost always begins during adolescence and adolescents are particularly vulnerable to the addictive effects of nicotine because the brain continues to develop until about age 25. Because adolescence and young adulthood are critical periods of growth and development, exposure to nicotine may have lasting, adverse consequences on brain development.¹⁷ The parts of the brain most responsible for decision making, impulse control, sensation seeking, and susceptibility to peer pressure continue to develop and change through young adulthood.¹⁸ As a result, nicotine exposure during adolescence may result in impaired attention and memory, problems with learning, reduced self-control and anxiety.¹⁹ Nicotine not only harms the adolescent brain, but is critical to the progression to regular smoking behavior, reinforcing a behavior that exposes smokers to the harmful chemicals responsible for tobacco-related death and disease. While ethical considerations limit the possibilities for research of VLNC on adolescents, a secondary analysis of data from the randomized controlled trial described earlier (Donny et al., 2015), found that young adults smoked fewer VLNC cigarettes per day than older adults after two weeks in the trial, suggesting that younger populations may be more sensitive and responsive to a nicotine reduction policy.²⁰

C. Vulnerable Populations Will Benefit from a Nicotine Reduction Policy

As smoking rates have declined nationally, smoking has become increasingly concentrated among certain vulnerable populations. According to data from the 2012-2014

¹⁶ Walker, N, et al., “The combined effect of very low nicotine content cigarettes, used as an adjunct to usual Quitline care (nicotine replacement therapy and behavioural support), on smoking cessation: a randomized controlled trial,” *Addiction*, 107(10): 1857-1867, 2012.

¹⁷ HHS. *The Health Consequences of Smoking: 50 Years of Progress. A Report of the Surgeon General*, 2014; Institute of Medicine, *Public Health Implications of Raising the Minimum Age of Legal Access to Tobacco Products*, Washington, DC: The National Academies Press, 2015.

¹⁸ Institute of Medicine, *Public Health Implications of Raising the Minimum Age of Legal Access to Tobacco Products*, Washington, DC: The National Academies Press, 2015.

¹⁹ England, LJ, et al., “Nicotine and the Developing Human: A Neglected Element in the Electronic Cigarette Debate.” *American Journal of Preventive Medicine*, 2015; Goriounova NA, Mansvelder HD, “Short-and Long-Term Consequences of Nicotine Exposure During Adolescence for Prefrontal Cortex Neuronal Network Function,” *Cold Spring Harbor Perspectives in Medicine*, 2012; Steinberg, Laurence, “Should the Science of Adolescent Brain Development Inform Public Policy?,” *Issues in Science and Technology*, Volume XXVIII, Issue 3, Spring 2012.

²⁰ Cassidy, RN, et al., “Age moderates smokers’ subjective response to very low nicotine content cigarettes: evidence from a randomized controlled trial,” *Nicotine & Tobacco Research*, published online April 28, 2018.

National Survey on Drug Use and Health (NSDUH), 33.3% of adults with any mental illness were current (past month) smokers, compared to 20.7% of adults without any mental illness.²¹ Further, about three out of ten smokers (29.5%) have a mental illness.²² Additional national data from the National Health Information Survey (NHIS) of adults ages 18 and over find that 35.8 percent of adults with serious psychological distress are current smokers, compared to 14.7 percent of adults without serious psychological distress.²³

It is important to ensure that a nicotine reduction policy would not exacerbate existing disparities by causing negative side effects for those with affective disorders. Fortunately, the evidence to date indicates that these populations do in fact benefit from VLNC cigarettes. A secondary analysis of data from the randomized controlled trial described earlier (Donny et al., 2015) found that smokers with elevated depressive symptoms at baseline who were assigned to smoke VLNC cigarettes did in fact show lower smoking rates and nicotine dependence, without worsening depressive symptoms.²⁴ Preliminary *ad libitum* smoking session studies have also found that VLNC cigarettes do not affect psychiatric symptoms in schizophrenic patients and result in a reduction in cigarette craving, total puff volume, and nicotine withdrawal symptoms.²⁵ VLNC cigarettes also have reduced addiction potential in other vulnerable populations, including smokers with opioid dependence and socioeconomically disadvantaged women, without substantial impact on withdrawal, craving, or compensatory smoking.²⁶

II. A Nicotine Content Standard Should Apply to Other Combustible Tobacco Products (ANPRM Section A, Scope, Question 1)

To realize the potential public health benefits of a nicotine product standard, FDA must extend that standard beyond cigarettes, to other combustible tobacco products, particularly those that serve as or might serve as substitutes for cigarettes, such as roll-your-own tobacco (RYO)

²¹ Lipari, R.N. and Van Horn, S.L. “Smoking and mental illness among adults in the United States.” *The CBHSQ Report*: March 30, 2017. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Rockville, MD,

https://www.samhsa.gov/data/sites/default/files/report_2738/ShortReport-2738.html.

²² CDC, “Vital Signs: Current Cigarette Smoking Among Adults Aged ≥18 Years with Mental Illness—United States, 2009-2011,” *MMWR*, 62(5): 81-87, 2013. NSDUH defines any mental illness as “having a mental, behavioral, or emotional disorder, excluding developmental and substance use disorders, in the past 12 months” and defines current smoking as “smoking all or part of a cigarette within the 30 days preceding the interview.”

²³ CDC, “Current Cigarette Smoking Among Adults – United States, 2016,” *MMWR* 67(2):53-59, January 19, 2018. Serious psychological distress defined by the Kessler psychological distress scale. Across all age groups, current cigarette smoking increased significantly for each of the four categories of psychological distress (no, low, moderate, high).

²⁴ Tidey, JW, et al., “Effects of 6-week use of reduced-nicotine content cigarettes in smokers with and without elevated depressive symptoms,” *Nicotine & Tobacco Research*, 19(1): 59-67, 2017.

²⁵ Tidey, JW, et al., “Smoking topography characteristics of very low nicotine content cigarettes, with and without nicotine replacement, in smokers with schizophrenia and controls,” *Nicotine & Tobacco Research*, 18(9): 1807-1812, 2016. Tidey, JW, et al., “Separate and combined effects of very low nicotine cigarettes and nicotine replacement in smokers with schizophrenia and controls,” *Nicotine & Tobacco Research*, 15(1): 121-129, 2013.

²⁶ Higgins, ST, et al., “Addiction potential of cigarettes with reduced nicotine in populations with psychiatric disorders and other vulnerabilities to tobacco addiction,” *JAMA Psychiatry*, 74(1): 1056-1064, 2017

and smaller cigars. As FDA noted in the ANPRM (at 11825), other combusted tobacco products have similar negative health effects to cigarettes and cigarette smokers may switch to these products if the nicotine reduction standard is only applied to cigarettes. Extending the proposed nicotine reduction policy to other combustible tobacco products will limit the possibility that cigarette smokers will switch to other dangerous combustible products. Furthermore, extending the nicotine standard to these products, which are often flavored and popular among youth, will prevent youth experimenters from becoming addicted to these and other tobacco products. It will also prevent tobacco manufacturers from circumventing a nicotine content standard in cigarettes by marketing and developing non-cigarette substitutes like the small flavored cigars the industry introduced after flavored cigarettes were removed from the market.

A. The Tobacco Industry Manipulates Loopholes in Product Regulation

History shows that the tobacco industry is adept in manipulating loopholes in tobacco control regulations. Tobacco companies have skillfully modified their products to circumvent regulation and minimize the effectiveness of policies designed to reduce tobacco use. For example, in the 1960s and 1970s, “little cigars” that look like cigarettes were developed to avoid the ban on broadcast advertising of cigarettes and higher cigarette taxes.²⁷

More recently, manufacturers have modified their products to be classified as cigars rather than cigarettes to evade the TCA’s prohibition of characterizing flavors in cigarettes²⁸ and the use of misleading cigarette descriptors such as “light” and “low.”²⁹ The 2012 Surgeon General’s report, *Preventing Tobacco Use Among Youth and Young Adults*, noted that flavored cigarettes such as Sweet Dreams re-emerged as Sweet Dreams flavored cigars after the federal restriction on flavored cigarettes went into effect.³⁰ In October 2009, U.S. Representatives Henry Waxman and Bart Stupak sent letters to two flavored cigarette companies, Cheyenne International and Kretek International, that began making little cigars shortly after the federal flavored cigarette ban went into effect.³¹ Rep. Waxman discovered that Kretek International

²⁷ Delnevo, CD & Hrywna, M, “A Whole ‘Nother Smoke’ or a Cigarette in Disguise: How RJ Reynolds Reframed the Image of Little Cigars,” *American Journal of Public Health* 97(8):1368-75, August 2007.

²⁸ Delnevo, CD, et al., “Close, but no cigar: certain cigars are pseudo-cigarettes designed to evade regulation,” *Tobacco Control* 26(3):349-354, May 2017. Delnevo, CD & Hrywna, M, “Clove cigar sales following the US flavoured cigarette ban,” *Tobacco Control* 24(e4):e246-50, December 2015.

²⁹ See generally, Campaign for Tobacco-Free Kids, *Not Your Grandfather’s Cigar: A New Generation of Cheap and Sweet Cigars Threatens a New Generation of Kids*, March 13, 2013, at 14-15 (*Not Your Grandfather’s Cigar*),

http://www.tobaccofreekids.org/content/what_we_do/industry_watch/cigar_report/2013CigarReport_Full.pdf.

³⁰ HHS, *Preventing Tobacco Use Among Youth and Young Adults, A Report of the Surgeon General*, 2012, <http://www.cdc.gov/Features/YouthTobaccoUse/>.

³¹ House Committee on Energy & Commerce, “Energy and Commerce Committee Requests Information on Sales and Marketing of Flavored Tobacco Products,” October 2, 2009, accessed April 18, 2012 at <http://democrats.energycommerce.house.gov/index.php?q=news/energy-and-commerce-committee-requests-information-on-sales-and-marketing-of-flavored-tobacco-p>.

intentionally changed its cigarettes to cigars to exploit a loophole in the TCA.³² In December 2016, the FDA issued warning letters to four tobacco manufacturers – Swisher International, Inc., Cheyenne International LLC, Prime Time International Co. and Southern Cross Tobacco Company Inc. – for marketing and selling fruit-flavored cigarettes labeled as cigars, in violation of the Tobacco Control Act.³³

Tobacco companies have also added weight to filters to allow for reclassification of their cigarettes or “little cigars” as “large cigars” subject to lower federal excise taxes.³⁴ Moreover, tobacco companies intentionally designed and marketed little cigars as similar products to cigarettes to appeal to cigarette smokers.³⁵

FDA recognized reclassification as a potential problem in its Final Regulatory Impact Analysis of the final deeming rule when it stated, “Deeming all tobacco products, except accessories of a newly deemed tobacco product, to be subject to chapter IX of the FD&C Act would be the necessary first step to rectify an institutional failure in which tobacco products that are close substitutes are not regulated by FDA in a like manner. ...Historically, when products have been taxed or regulated differently, substitutions have occurred.”³⁶

There is little doubt that tobacco companies will promote cigars and potentially other combustible tobacco products as alternatives to cigarettes if the nicotine policy does not address other forms of combustible tobacco. Failure to extend the prohibition to other combusted tobacco products would greatly limit the chances for the regulation to accomplish its goal.

³² Representative Henry A. Waxman, “Rep. Waxman Urges FDA to Ban Clove-Flavored Cigars,” Letter to FDA Commissioner Margaret Hamburg, March 28, 2011, accessed April 18, 2012 at <http://democrats.energycommerce.house.gov/index.php?q=news/rep-waxman-urges-fda-to-ban-clove-flavored-cigars>.

³³ FDA, Center for Tobacco Products, “FDA takes action against four tobacco manufacturers for illegal sales of flavored cigarettes labeled as little cigars or cigars,” December 9, 2016, <http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm532563.htm>.

³⁴ Delnevo, CD, et al., “Close, but no cigar: certain cigars are pseudo-cigarettes designed to evade regulation,” *Tobacco Control* 26(3):349-354, May 2017. Campaign for Tobacco-Free Kids, *Not Your Grandfather’s Cigar: A New Generation of Cheap and Sweet Cigars Threatens a New Generation of Kids*, March 13, 2013, at 14-15 (*Not Your Grandfather’s Cigar*), http://www.tobaccofreekids.org/content/what_we_do/industry_watch/cigar_report/2013CigarReport_Full.pdf at 15.

³⁵ Delnevo, CD, et al., “Close, but no cigar: certain cigars are pseudo-cigarettes designed to evade regulation,” *Tobacco Control* 26(3):349-354, May 2017.

³⁶ FDA, *Deeming Tobacco Products to be Subject to the Food, Drug, and Cosmetic Act, as Amended by the Family Smoking Prevention and Tobacco Control Act; Regulations Restricting the Sale and Distribution of Tobacco Products and Required Warning Statements for Tobacco Product Packages and Advertisements, Final Regulatory Impact Analysis; Final Regulatory Flexibility Analysis; Unfunded Mandates Reform Act Analysis*, May 2016, at 60-61, <https://www.fda.gov/downloads/AboutFDA/ReportsManualsForms/Reports/EconomicAnalyses/UCM500254.pdf>.

B. Cigars Are a Harmful and Addictive Substitute for Cigarettes

There is no rational basis for reducing nicotine levels in cigarettes, while leaving cigars highly addictive. Cigars pose an increased risk of disease and addiction. Cigar smoke contains many of the same harmful constituents as cigarette smoke and may have higher levels of several harmful compounds. Cigar smoking causes cancer of the oral cavity, larynx, esophagus and lung and some cigar smokers are at increased risk for heart disease, chronic obstructive pulmonary disease (COPD) and an aortic aneurysm.³⁷

Furthermore, cigars contain nicotine and can deliver nicotine at levels high enough to produce dependence among cigar smokers.³⁸ Nicotine content is not always associated with the size of the cigar. A study found that some cigarillos had higher levels of free nicotine per mass compared to large cigars, leading the authors to state, “consumers smoking the same brand of cigar may unintentionally be exposed to varying doses of nicotine and potentially other smoke constituents.”³⁹

Nicotine levels in cigars vary by product and the type of tobacco used. One full-size cigar may contain as much tobacco as a whole pack of cigarettes and thus contains much more nicotine than one cigarette. Cigarettes contain an average of about 10-15 mg of nicotine;⁴⁰ many popular brands of larger cigars contain between 100 and 200 mg.⁴¹

The amount of nicotine delivered to the cigar smoker depends on various factors, such as how the cigar is smoked, the number of puffs taken, and the degree of inhalation.⁴² The high pH of cigar smoke means that the nicotine is in its free, unprotonated form, making it easily

³⁷ National Cancer Institute (NCI), *Cigars: Health Effects and Trends. Smoking and Tobacco Control Monograph No. 9*, 1998, http://cancercontrol.cancer.gov/Brp/tcrb/monographs/9/m9_complete.pdf.

³⁸ Henningfield, JE, et al., “Nicotine concentration, smoke pH and whole tobacco aqueous pH of some cigar brands and types popular in the United States,” *Nicotine & Tobacco Research* 1(2):163-168, 1999, at 166. NCI Monograph 9, at 186, 191. Baker, F, et al., “Health Risks Associated With Cigar Smoking,” *Journal of the American Medical Association* 284(6):735-740, 2000, at 737. Fabian, LA, et al., “*Ad lib* Smoking of Black & Mild Cigarillos and Cigarettes,” *Nicotine & Tobacco Research* 14(3):368-371, March 2012, at 370. Goel, R, et al., “A Survey of Nicotine Yields in Small Cigar Smoke: Influence of Cigar Design and Smoking Regimens,” *Nicotine & Tobacco Research*, published online September 15, 2017. Pickworth, WB, et al., “Dual Use of Cigarettes, Little Cigars, Cigarillos, and Large Cigars: Smoking Topography and Toxicant Exposure,” *Tobacco Regulatory Science* 3(Suppl 1):S72-S83, April 2017, at S79. Claus, ED, “Use Behaviors, Dependence, and Nicotine Exposure Associated with Ad Libitum Cigar Smoking,” *Tobacco Regulatory Science* 4(1):548-561, 2018, at 558.

³⁹ Koszowski, B, et al., “Nicotine Content and Physical Properties of Large Cigars and Cigarillos in the United States,” *Nicotine & Tobacco Research* 20(3):393-398, 2018, at 395, 397.

³⁹ American Cancer Society, “Is Any Type of Smoking Safe?” March 6, 2018, <https://www.cancer.org/cancer/cancer-causes/tobacco-and-cancer/is-any-type-of-smoking-safe.html>.

⁴⁰ Benowitz, N and Henningfield, J., “Reducing the nicotine content to make cigarettes less addictive,” *Tobacco Control*, 22:i14-i17, 2013.

⁴¹ American Cancer Society, “Is Any Type of Smoking Safe?” March 6, 2018, <https://www.cancer.org/cancer/cancer-causes/tobacco-and-cancer/is-any-type-of-smoking-safe.html>.

⁴² Henningfield, JE, et al., “Nicotine concentration, smoke pH and whole tobacco aqueous pH of some cigar brands and types popular in the United States,” *Nicotine & Tobacco Research* 1(2):163-168, 1999, at 165. NCI Monograph 9, at 186.

absorbed through the oral mucosa, even if the users do not fully inhale the smoke.⁴³ A leading review of the science of cigar smoking concluded that, “[c]igars are capable of providing high levels of nicotine at a sufficiently rapid rate to produce clear physiological and psychological effects that lead to dependence, even if the smoke is not inhaled.”⁴⁴

Authors of a recent study looking at a variety of cigar products noted, “it is clear that all cigar products delivered significant and addictive quantities of nicotine and CO – findings that support the rationale for their regulation.”⁴⁵

Exempting cigars from a reduced nicotine standard is likely to lead current cigarette smokers to switch to cigars or use both cigarettes and cigars to satisfy their need for nicotine. It is not uncommon for cigarette smokers to replace cigarettes with cigars.⁴⁶ According to 2013-2014 data from the Population Assessment of Tobacco and Health (PATH) study, nearly 30 percent of premium cigars smokers were former cigarette smokers, as were 10 to 15 percent of non-premium cigar users (non-premium large cigars, cigarillos, filtered cigars).⁴⁷ The 2012-2013 National Adult Tobacco Survey (NATS) found similar results - 23 percent of premium cigar smokers, 15.3 percent of cigarillo/mass market cigar smokers, and 12.3 percent of little filtered cigar smokers were former cigarette smokers.⁴⁸

Secondary cigar smokers, those who smoked cigarettes before smoking cigars, often inhale and smoke more than cigar smokers who have never used cigarettes (primary cigar smokers).⁴⁹ Because of their tendency to inhale the smoke, secondary cigar smokers can take in

⁴³ NCI Monograph 9, at ii, 4, 11, 97, 183, 191.

⁴⁴ Baker, F., et al., “Health Risks Associated With Cigar Smoking,” *Journal of the American Medical Association*, 284(6): 735-740, 2000, at 737.

⁴⁵ Pickworth, WB, et al., “Dual Use of Cigarettes, Little Cigars, Cigarillos, and Large Cigars: Smoking Topography and Toxicant Exposure,” *Tobacco Regulatory Science* 3(Suppl 1):S72-S83, April 2017, at S79.

⁴⁶ Corey, CG, et al., “U.S. adult cigar smoking patterns, purchasing behaviors, and reasons for use according to cigar type: Findings from the Population Assessment of Tobacco and Health (PATH) Study, 2013-14,” *Nicotine & Tobacco Research*, published online September 15, 2017. Cohn, A, et al., “The Other Combustible Products: Prevalence and Correlates of Little Cigar/Cigarillo Use Among Cigarette Smokers,” *Nicotine & Tobacco Research* 17(12):1473-1481, 2015.

⁴⁷ Corey, CG, et al., “U.S. adult cigar smoking patterns, purchasing behaviors, and reasons for use according to cigar type: Findings from the Population Assessment of Tobacco and Health (PATH) Study, 2013-14,” *Nicotine & Tobacco Research*, published online September 15, 2017.

⁴⁸ Corey, CG, et al., “Little Filtered Cigar, Cigarillo, and Premium Cigar Smoking Among Adults — United States, 2012-2013,” *MMWR* 63(30):650-654, August 1, 2014, at 652, 653. The study authors defined premium cigar smokers as “those reporting their usual cigar did not have a filter or tip and the name of their usual brand was a brand name of a hand-rolled cigar or a cigar described by the manufacturer or merchant as containing high-grade tobaccos in the filler, binder, or wrapper.”

⁴⁹ Claus, ED, “Use Behaviors, Dependence, and Nicotine Exposure Associated with Ad Libitum Cigar Smoking,” *Tobacco Regulatory Science* 4(1):548-561, 2018. Rosenberry, ZR, Pickworth, WB, & Koszowski, B, “Large Cigars: Smoking Topography and Toxicant Exposure,” *Nicotine & Tobacco Research* 20(2):183-191, 2018, at 189.

more nicotine compared to primary cigar smokers.⁵⁰ They also show higher scores of nicotine dependence than primary cigar smokers.⁵¹

PATH data from 2013-2014 show that a fair number of cigar smokers also smoke cigarettes (dual use): nearly 30 percent (29.9%) of premium cigar users and more than half of users of other cigar products (non-premium large cigars, cigarillos, filtered cigars) were also current cigarette smokers.⁵² The 2012-2013 NATS reported similar results, with 35.1 percent of premium cigar smokers, 58.3 percent of cigarillo/mass market cigar smokers, and 75.2 percent of little filtered cigar smokers dual using with cigarettes.⁵³ Cigarette use in the past 30 days can predict current cigar use.⁵⁴

Like secondary cigar smokers, dual users tend to inhale cigar smoke, compared to cigar smokers who never smoked cigarettes.⁵⁵ Dual users smoke cigars in such a way as to obtain a satisfactory level of nicotine,⁵⁶ but they also show greater levels of dependence than exclusive cigar users.⁵⁷ Adolescents who ever used cigars products (cigars, cigarillos, or little cigars) or used them in the past 30 days reported more frequent cigarette smoking in the past month, more daily smoking in the past month, and, notably, higher levels of nicotine dependence compared to adolescents who did not use cigar products.⁵⁸

⁵⁰ NCI Monograph 9, at 94.

⁵¹ Claus, ED, “Use Behaviors, Dependence, and Nicotine Exposure Associated with Ad Libitum Cigar Smoking,” *Tobacco Regulatory Science* 4(1):548-561, 2018.

⁵² Corey, CG, et al., “U.S. adult cigar smoking patterns, purchasing behaviors, and reasons for use according to cigar type: Findings from the Population Assessment of Tobacco and Health (PATH) Study, 2013-14,” *Nicotine & Tobacco Research*, published online September 15, 2017.

⁵³ Corey, CG, et al., “Little Filtered Cigar, Cigarillo, and Premium Cigar Smoking Among Adults — United States, 2012-2013,” *MMWR* 63(30):650-654, August 1, 2014, at 652, 653. The study authors defined premium cigar smokers as “those reporting their usual cigar did not have a filter or tip and the name of their usual brand was a brand name of a hand-rolled cigar or a cigar described by the manufacturer or merchant as containing high-grade tobaccos in the filler, binder, or wrapper.”

⁵⁴ Cullen, J, et al., “Seven-Year Patterns in US Cigar Use Epidemiology Among Young Adults Aged 18–25 Years: A Focus on Race/Ethnicity and Brand,” *American Journal of Public Health* 101(10):1955-62, October 2011, at 1958-1959.

⁵⁵ Baker, F, et al., “Health Risks Associated With Cigar Smoking,” *Journal of the American Medical Association* 284(6):735-740, 2000, at 737. NCI Monograph 9, at 185.

⁵⁶ Pickworth, WB, et al., “Dual Use of Cigarettes, Little Cigars, Cigarillos, and Large Cigars: Smoking Topography and Toxicant Exposure,” *Tobacco Regulatory Science* 3(Suppl 1):S72-S83, April 2017, at 7. Rosenberry, ZR, Pickworth, WB, & Koszowski, B, “Large Cigars: Smoking Topography and Toxicant Exposure,” *Nicotine & Tobacco Research* 20(2):183-191, 2018, at 189.

⁵⁷ Rostron, BL, Schroeder, MJ, & Ambrose, BK, “Dependence symptoms and cessation intentions among US adult daily cigarette, cigar, and e-cigarette users, 2012-2013,” *BMC Public Health* 16:814, 2016.

⁵⁸ Schuster, RM, Hertel, AW, & Mermelstein, R, “Cigar, Cigarillo, and Little Cigar Use Among Current Cigarette-Smoking Adolescents,” *Nicotine & Tobacco Research* 15(5):925-931, May 2013, at 927-928.

C. Hookah (Waterpipe) Tobacco is Harmful and Addictive (*ANPRM Section A, Question 4*)

In a typical waterpipe session, smokers are subjected to up to more than twice the nicotine exposure as the smoker of a single cigarette.⁵⁹ Research shows that waterpipe tobacco use is associated with nicotine dependence, including experiences of withdrawal and difficulty quitting, at least among some users.⁶⁰ Given its addiction potential, waterpipe tobacco should not be excluded from a nicotine product standard.

Studies have shown that hookah smoke contains many of the toxins and carcinogens found in cigarettes.⁶¹ Some of these harmful components are in gaseous form and others are particulates. At least 82 toxicants and carcinogens have been identified in waterpipe tobacco smoke, including tobacco-specific nitrosamines (TSNAs), polycyclic aromatic hydrocarbons (PAHs), and heavy metals.⁶² In addition, the aerosol contains the toxins and carcinogens from the burning of the charcoal, including carbon monoxide. A recently published meta-analysis that analyzed 17 studies of waterpipe tobacco smoking found that a single waterpipe tobacco smoking session was associated with carbon monoxide exposure equivalent to more than half a pack of cigarettes and exposure to tar equivalent to more than two full packs of cigarettes.⁶³ None of these harmful components are eliminated by the passage of the smoke through the water and many of these harmful substances are delivered to the user's lungs.

According to the CDC, using a waterpipe to smoke tobacco poses serious health risks to smokers and others exposed to the smoke from the waterpipe tobacco.⁶⁴ Waterpipe tobacco use is linked to many of the same adverse health effects as cigarette smoking, such as lung, bladder and oral cancers and heart disease.⁶⁵ Other documented long-term effects include impaired

⁵⁹ Primack B, et al. 2016. HHS, *Prevention Tobacco Use Among Youth and Young Adults, A Report of the Surgeon General*, 2012. Eissenberg, T and Shihadeh, A., 2009. Maziak, W, et al., "CO exposure, puff topography, and subjective effects in waterpipe tobacco smokers," *Nicotine & Tobacco Research*, 11(7): 806-811, 2006.

⁶⁰ Aboaziza, E and Eissenberg, T., "Waterpipe tobacco smoking: what is the evidence that it supports nicotine/tobacco dependence?" *Tobacco Control*, published online December 9, 2014.

⁶¹ HHS, *Prevention Tobacco Use Among Youth and Young Adults, A Report of the Surgeon General*, 2012.

⁶² Ward, KD, et al., "The waterpipe: an emerging epidemic in need of action," *Tobacco Control*, 24(S1): i1-i2, 2015. Sepetdjian, E, et al., "Measurement of 16 Polycyclic Aromatic Hydrocarbons in Narghile Waterpipe Tobacco Smoke," *Food and Chemical Toxicology*, 46: 1582-1590, 2008. Schubert, J., et al., "Mainstream Smoke of the Waterpipe: Does this Environmental Matrix Reveal as Significant Source of Toxic Compounds?" *Toxicology Letters*, 205(3): 279-284, 2011. Jacob, P., et al. "Nicotine, Carbon Monoxide and Carcinogen Exposure After a Single Use of a Water Pipe," *Cancer Epidemiology, Biomarkers, & Prevention*, 20: 2345-2353, 2011.

⁶³ Primack B, et al. Systematic review and meta-analysis of inhaled toxicants from waterpipe and cigarette smoking. *Public Health Reports* Jan. 2016. See also, HHS, *Prevention Tobacco Use Among Youth and Young Adults, A Report of the Surgeon General*, 2012. Eissenberg, T and Shihadeh, A. "Waterpipe tobacco and cigarette smoking: direct comparison of toxicant exposure," *American Journal of Preventive Medicine*, 37(6): 518-523, 2009. Maziak, W, et al., "CO exposure, puff topography, and subjective effects in waterpipe tobacco smokers," *Nicotine & Tobacco Research*, 11(7): 806-811.

⁶⁴ Centers for Disease Control and Prevention. "Hookahs." Available at http://www.cdc.gov/tobacco/data_statistics/fact_sheets/tobacco_industry/hookahs/. Accessed March 4, 2016.

⁶⁵ HHS, *Prevention Tobacco Use Among Youth and Young Adults, A Report of the Surgeon General*, 2012. Knishkowy B, Amitai, Y. "Waterpipe (narghile) smoking: an emerging health risk behavior," *Pediatrics* 2005.

pulmonary function, chronic obstructive pulmonary disease, esophageal cancer and gastric cancer.⁶⁶ As a result of exposure to the dangerous chemicals in waterpipe tobacco smoke, research shows that even short-term waterpipe tobacco use is associated with acute health effects, including increased heart rate, blood pressure, reduced pulmonary function and carbon monoxide intoxication.⁶⁷ In a 2015 report, the World Health Organization Study group on tobacco product regulation surveyed the research to date and corroborated these findings.⁶⁸

D. The rule should prohibit other changes in cigarettes that might counteract the effect of the reduction in nicotine. (ANPRM Section B, Question 3)

FDA notes that in addition to nicotine, other substances contained in cigarettes might also have the potential to produce dependence and be addictive and asks whether a proposed rule should establish maximum levels for such substances. It is important for FDA to establish a rule that prohibits any change in products subject to the rule that has the effect of diluting or offsetting the effect produced by the reduction in nicotine. Section 910 of the Tobacco Control Act prohibits tobacco product manufacturers from modifying tobacco products in the absence of a marketing order from FDA. Any product standard establishing a maximum level of nicotine in tobacco products should explicitly prohibit manufacturers from making other changes in a tobacco product with the effect of diluting or offsetting the reduction in dependence produced by reducing the nicotine content of such product.

III. Implementation Considerations

A. Maximum Nicotine Level (ANPRM Section B, Question 1)

When establishing a nicotine reduction level, FDA should seek a level that reduces the population harm caused by smoking. FDA should seek a level that prevents new users from developing dependence and stops the transition from experimental to regular use. The level should also reduce dependence among current users and make it easier for them to stop smoking. Because of variations in sensitivity to nicotine and the risk of dependence across individuals, to minimize the risk of dependence on a population-wide basis, FDA should set the maximum allowable nicotine at a level that produces the greatest reduction in dependence. To date, the research indicates that a nicotine content of 0.4 mg/g or less reduces dependence, taking into account the potential for individual differences in sensitivity to nicotine, and is technically feasible.⁶⁹ It is critical that there be no compromise in setting the nicotine level because a higher

⁶⁶ El-Zaatari, ZM, et al., “Health effects associated with waterpipe smoking,” *Tobacco Control*, 24(S1): i31-i43, 2015.

⁶⁷ *Id.*

⁶⁸ World Health Organization, Study Group on Tobacco Product Regulation (“TobReg”), 2015.

⁶⁹ Donny, EC, et al., “Randomized trial of reduced-nicotine standards for cigarettes,” *New England Journal of Medicine*, 373: 1340-1349, 2015

nicotine level will not produce the benefits set forth by FDA and is not supported by the scientific evidence that underpins the FDA proposal.

B. An Immediate Nicotine Content Reduction Will Have a Larger Public Health Impact than a Gradual Reduction (ANPRM Section C)

Research shows that an immediate nicotine content reduction will have a greater public health benefit than a gradual reduction in nicotine content. A 20-week randomized controlled trial of 1200 adult smokers assigned smokers to normal nicotine content cigarettes, reduced nicotine content cigarettes (0.4 mg/g), or cigarettes with the nicotine content gradually reduced over the course of the study (from 15.8 mg/g to 0.4 mg/g). The smokers in the immediate nicotine reduction condition showed greater reduction in cigarettes per day, greater decreases in measures of dependence, higher rates and duration of abstinence, and greater reductions in biomarkers of smoke exposure.⁷⁰

As the FDA noted in the ANPRM (at 11829), a stepped-down approach will likely facilitate more compensatory behavior by smokers. While VLNC cigarettes do not contain enough nicotine for compensation to be feasible, smokers may be able to compensate with intermediate-level nicotine cigarettes, smoking these products more intensely and exposing themselves to more toxicants.

Additionally, a stepped-down approach prolongs the implementation process and is more burdensome on farmers and manufacturers who will have to adjust to multiple nicotine content standards. Finally, this prolonged process increases the opportunities for consumers to stockpile cigarettes.

Given the stronger evidence for cessation for an immediate reduction approach and the greater implementation challenges of a stepped-down approach, it is clear that an immediate reduction in nicotine content is preferable.

C. Reducing the Nicotine Content of Combustibles Will Not Lead to Compensation (ANPRM Section F, Question 4)

One potential concern about reducing the nicotine level in cigarettes is that smokers may smoke more cigarettes or inhale smoke more deeply in order to obtain the nicotine fix they are accustomed to (“compensatory smoking”), which would have the unintended consequence of exposing them to even more harmful constituents. However, research to date shows that smokers in fact do not compensate in this manner when nicotine content is reduced to very low levels.⁷¹

⁷⁰ Hatsuhashi, D. *Opening Session: Presidential Symposium Reducing Nicotine Content in Cigarettes: A Discussion of the Evidence and Policy Implications Panel Discussion*. Society for Research on Nicotine and Tobacco Annual Meeting, 2018.

⁷¹ See e.g., Donny, EC, et al., “Randomized trial of reduced-nicotine standards for cigarettes,” *New England Journal of Medicine*, 373: 1340-1349, 2015. Hatsuhashi, DK, et al., “Compensatory smoking from gradual and

One study that examined the number of cigarettes smoked per day (CPD), carbon monoxide exposure and cotinine levels among smokers while they smoked reduced nicotine content cigarettes, found significant decreases in CPD and cotinine levels and a decrease (non-significant) in carbon monoxide exposure compared to when they smoked their usual brand, which suggests minimal, if any, compensatory smoking.⁷² Similarly, a randomized clinical trial that compared outcomes from reduced nicotine cigarettes to standard nicotine cigarettes found that smokers of reduced nicotine cigarettes inhaled less smoke per cigarette, smoked fewer cigarettes and did not have a significant increase in the level of expired carbon monoxide, indicating that smokers did not compensate for the reduction in nicotine by increasing their smoking behavior.⁷³ Substantially reducing nicotine in the tobacco makes it almost impossible for smokers to compensate for the lower nicotine level by smoking more cigarettes, taking more puffs on the cigarette, or inhaling more deeply.

D. FDA Must Counter Misperceptions about the Harms of Reduced Nicotine Products (ANPRM Section, B Question 4)

Reducing the nicotine content of tobacco products will not render them harmless; in fact, products with lower nicotine levels will remain harmful and deadly. While nicotine is the primary addictive agent in cigarettes and is not benign, the overwhelming health consequences of smoking come from the more than 7,000 chemicals and 69 cancer-causing agents produced from combusted cigarettes.⁷⁴

Some studies of adult smokers have shown that they perceive lower nicotine cigarettes to be less harmful than average cigarettes, incorrectly linking nicotine content with risk for smoking-related disease. For example, a 2015-2016 nationally representative survey found that nearly half (47.1%) of smokers thought that smoking VLNC cigarettes would be less likely to cause cancer than smoking regular cigarettes.⁷⁵ 2015 data from the FDA's nationally representative Health Information National Trends Survey (HINTS) found that three-quarters of people either did not know the relationship between nicotine and cancer (24%) or incorrectly believe that nicotine causes cancer (49%). It also found that 30 percent of respondents thought

immediate reduction in cigarette nicotine content," *Cancer Epidemiology, Biomarkers & Prevention*, 24: 472-476, 2015. Benowitz, NL, et al., "Smoking behavior and exposure to tobacco toxicants during 6 months of smoking progressively reduced nicotine content cigarettes," *Cancer Epidemiology, Biomarkers & Prevention*, 21: 761-769, 2012. Hatsukami, DK, et al., "Nicotine reduction revisited: science and future directions," *Tobacco Control*, 19: e1-10, 2010. Hatsukami, DK, et al., "Reduced nicotine content cigarettes: effects on toxicant exposure, dependence and cessation," *Addiction*, 105: 343-355, 2010.

⁷² Hatsukami, DK, et al., "Compensatory smoking from gradual and immediate reduction in cigarette nicotine content," *Cancer Epidemiology, Biomarkers & Prevention*, 24: 472-476, 2015.

⁷³ Donny, EC, et al., "Randomized trial of reduced-nicotine standards for cigarettes," *New England Journal of Medicine*, 373: 1340-1349, 2015.

⁷⁴ HHS, *The Health Consequences of Smoking—50 Years of Progress, A Report of the Surgeon General*, 2014, <http://www.surgeongeneral.gov/library/reports/50-years-of-progress/>.

⁷⁵ Byron, JM, et al., "Public misperception that very low nicotine cigarettes are less carcinogenic," *Tobacco Control*, published online January 23, 2018.

that VLNC were less harmful than regular cigarettes.⁷⁶ In research trials, smokers assigned to use VLNC cigarettes also perceive them to be less harmful.⁷⁷

It is critical for the FDA to carefully regulate the marketing of these products, and precede a nicotine reduction policy with public education campaigns to ensure adequate communication about the health risks of these products so as to not encourage non-smokers to experiment. Smokers should be encouraged to quit completely and be educated about the most effective ways to quit successfully.

While much of the public misunderstanding of the health effects of nicotine is to attribute undue health risk to nicotine, FDA also needs to be careful not to go too far in the other direction. While the most prominent concern about nicotine is its addictive impact, and approved nicotine replacement therapy (NRT) products have demonstrated that at low levels in carefully calibrated doses, nicotine is not the cause of serious disease, nicotine is not benign and the health impact of its long term use at higher levels is not well understood.

IV. Technical Achievability

A. Reducing Nicotine in Cigarettes is Technologically Feasible (ANPRM Section E)

Research demonstrates that reducing nicotine content in cigarettes to minimally or non-addictive levels is technologically feasible. Further, as noted in the ANPRM (at 11830-11832), there is a wide range of techniques available to reduce nicotine content. As FDA notes, more than 96 percent of nicotine can be successfully extracted while achieving a product that was “subjectively rated as average in smoking characteristics.”⁷⁸ Moreover, the FDA’s discussion in the ANPRM identifies several chemical extraction techniques that have been used successfully to reduce the nicotine level in cigarette tobacco (ANPRM, at 11831.)

Tobacco farmers and cigarette manufacturers can reduce the nicotine content of cigarette tobacco by using existing lower-nicotine tobacco plant varieties, creating new plant varieties through genetic manipulation, using tobacco leaves from certain parts of the plant that contain

⁷⁶ O’Brien, EK, et al., “U.S. adults’ addiction and harm beliefs about nicotine and low nicotine cigarettes,” *Preventive Medicine*, 96: 94-100, 2017.

⁷⁷ Denlinger-Apte, RL, et al., “Low nicotine content descriptors reduce perceived health risks and positive cigarette ratings in participants using very low nicotine content cigarettes,” *Nicotine & Tobacco Research*, published online January 18, 2017. Pacek, LR, et al., “Perceived nicotine content of reduced nicotine content cigarettes is a correlate of perceived health risks,” *Tobacco Control*, published online July 22, 2017. 2017.

⁷⁸ 83 Fed. Reg. at 11826, citing Grubbs et al, “Process for Removal of Basic Materials,” Patent No. 5,018,540, May 28, 1991.

lower nicotine content, or using extraction technology to remove nicotine from tobacco during the manufacturing process.⁷⁹

In fact, tobacco companies have already demonstrated their proficiency in reducing the nicotine level of cigarettes.⁸⁰ In the 1980s-1990s, Philip Morris produced three brands of low-nicotine cigarettes: Merit De-Nic, Benson & Hedges De-Nic and Next. Vector Tobacco introduced Quest, a low-nicotine cigarette, in 2003. The tobacco manufacturer, 22nd Century, currently produces Spectrum, a very low nicotine U.S.-grown tobacco cigarette, which is currently used in government-funded clinical research studies. Reducing nicotine content in cigarettes to minimally or non-addictive levels is also consistent with several tobacco companies' purported missions of shifting away from combustible tobacco products by "transforming tobacco" (R.J. Reynolds)⁸¹ and investing in a "smoke-free future" (Philip Morris).⁸²

The tobacco industry's own documents also show that the industry has a long history of manipulating nicotine levels in cigarettes to make them *more* addictive. Internal company documents from as far back as the 1950s expose the tobacco industry's extensive research on the importance of nicotine and how best to deliver nicotine to smokers and optimize its effects.⁸³ The documents demonstrate that they have known for decades that the key to their business is creating and sustaining dependence on nicotine, and they have purposely designed their products to do this effectively and efficiently. As U.S. District Judge Gladys Kessler concluded in her landmark 2006 civil racketeering judgment against the major cigarette manufacturers, *U.S. v. Philip Morris, Inc.*,

"... [C]igarette company defendants researched, developed, and implemented many different methods and processes to control the delivery and absorption of the optimum amount of nicotine which would create and sustain smokers' addiction. These methods and processes included, but were not limited to: altering the physical and chemical make-up of tobacco leaf blends and filler; maintaining or increasing the nicotine to tar ratio by changing filter design, ventilation and air dilution processes, and the porosity and composition of filter paper; altering smoke pH by adding ammonia to speed nicotine absorption by the central nervous system; and using other additives to increase the potency of nicotine."⁸⁴

⁷⁹ Tengs, T.O., et al., "The AMA proposal to mandate nicotine reduction in cigarettes: a simulation of the population health impacts," *Preventive Medicine*, 40: 170-180, 2005.

⁸⁰ Cigarettes with reduced nicotine are often referred to as reduced-nicotine cigarettes, very low nicotine content (VLNC) cigarettes, and de-nicotinized cigarettes.

⁸¹ R.J. Reynolds, "Our vision: We will achieve market leadership by transforming the tobacco industry," accessed August 8, 2017, <http://www.rjrt.com/transforming-tobacco/our-mission-and-vision/>.

⁸² Philip Morris, "Our Manifesto: Designing a Smoke-Free Future," Accessed August 8, 2017, <https://www.pmi.com/who-we-are/designing-a-smoke-free-future>.

⁸³ Wayne, GF & Carpenter, CM, "Tobacco Industry Manipulation of Nicotine Dosing," *Handbook of Experimental Psychology* (192):457-85, 2009.

⁸⁴ U.S. v. Philip Morris, USA, Inc., 449 F. Supp. 2d at 383-84 (D.D.C. 2006).

Finally, producing reduced-nicotine tobacco for other combusted tobacco products should be no more difficult than producing it for cigarettes.

**B. FDA Should Make the Effective Date of the Rule as Early as Possible.
(ANPRM Section E, Question 5)**

The enormous public health benefits that would result from this rule should not be postponed any longer than absolutely necessary. Postponing the effective date of the rule only means that many hundreds of thousands of smokers and prospective smokers will unnecessarily have their lives shortened by an addiction that this rule could have prevented.

As indicated above, tobacco product manufacturers are already capable of extracting nicotine from tobacco and producing VLNC cigarettes. Growing low-nicotine tobacco is only one of several methods of complying with the standard. Thus, a tobacco product standard calling for a nicotine level to be set at non-addictive levels does not necessarily require “substantial changes to the methods of farming domestically grown tobacco;” thus, the statute does not require FDA to postpone the effective date of such a standard until two years after promulgation of the rule. Moreover, industry participants will have been on notice for a significant period of time that such a requirement would be imposed and prudent companies would have been making plans to comply with such a standard. Therefore, in no event should the implementation period be more than the one-year period contemplated for all product standards under Section 907 of the Tobacco Control Act.

Tobacco product manufacturers will no doubt make self-serving claims about how difficult, expensive, and time-consuming it would be to implement such a standard. FDA should view such claims skeptically given the clear economic interest the industry has in resisting or postponing measures designed to shrink the market for a highly profitable product. The public health benefits that will be gained from implementing the rule, however, make it imperative to make the rule effective as soon as possible. These benefits far outweigh the compliance costs the industry will experience.

It is also important for the rule to be applied simultaneously to all manufacturers. The continued availability of combusted products containing conventional levels of nicotine would undermine the effectiveness of the regulatory strategy and would create an opportunity for exempted manufacturers to earn windfall profits by continuing to supply high-nicotine level cigarettes. Manufacturers should not be enabled to undercut the effectiveness of important public health initiatives merely because they are small.

C. Manufacturers, Distributors, and Retailers Should Not Be Allowed to Sell Off Existing Nonconforming Inventories. (ANPRM Section E, Question 6)

Products currently on the market are both deadly and highly addictive. The public health imperatives that provide the foundations for replacing these products with VLNC cigarettes are inconsistent with permitting the continued sale of non-conforming inventories beyond the effective date of the rule. The presence of non-conforming product on the market after the effective date of the rule will only dilute the effectiveness of the rule and provide a wholly unjustified windfall to companies that have stockpiled an inventory in anticipation of its promulgation. Moreover, there is no unfairness to industry participants in prohibiting the sale of such inventories after the effective date of the rule. As noted above, all industry participants will have had a substantial period of prior notice of the promulgation of such a rule and will have had many opportunities to make arrangements to deal with the consequences.

In addition, permitting industry participants to sell off existing non-conforming inventories would create a massive incentive for companies to accumulate large inventories in the anticipation that they would be able to extract windfall profits from the sale of such products after the rule becomes effective.

Moreover, it is unlikely that any industry participants will be left with substantial inventories of nonconforming products. Current smokers are likely to buy up any available inventories of such products prior to the effective date of the rule. Thus, permitting industry participants at any level to sell off existing nonconforming inventories is not only contrary to the policies that underlie adoption of the rule, but is also wholly unnecessary to address any legitimate interest that a seller of tobacco products might have.

D. FDA Should Require a Standard Method of Product Testing to Analyze Nicotine Levels. (ANPRM, Section D, Question 6)

FDA asks whether, if it issues a product standard, it should require a standard method of product testing to analyze the nicotine levels in products subject to the standard. Adoption of a standard method of product testing would be helpful to ensure that all products are subject to the same standard and that the standard is actually being adhered to. FDA correctly observes that, “it is critical that the results from the test method used demonstrate a high level of specificity, accuracy, and precision in measuring a range of nicotine levels across a wide variety of tobacco blends and methods.”⁸⁵ In addition, FDA should require manufacturers to sample their products in a consistent manner to ensure that products do not contain excess levels of nicotine and to test each manufactured batch to ensure compliance.

⁸⁵

83 Fed. Reg. at 11820.

V. Possible Countervailing Effects

A. The Product Standard Should Prohibit the Sale or Distribution of Liquid Nicotine or Any Other Tobacco Product Designed to Supplement the Nicotine Content of Combusted Tobacco Products. (ANPRM Section F, Question 2)

FDA should assess the extent to which it would be feasible for smokers to supplement the nicotine content of combusted tobacco products through the use of liquid nicotine or another tobacco product. If such supplementation is feasible in a substantial number of cases, FDA should include in the rule a prohibition on the sale or distribution of liquid nicotine or any other tobacco product designed to supplement the nicotine content of combusted tobacco products.

B. Illicit Trade (ANPRM Section F, Questions 3, 6, 7, 9)

These comments incorporate by reference the Comments filed by the undersigned organizations in Docket No. FDA-2018-N-0529, “Draft Concept Paper: Illicit Trade in Tobacco Products After Implementation of a Food and Drug Administration Product Standard,” 83 Fed. Reg. 11754 (March 16, 2018).

VI. Other Considerations

A. The Potential Consumer Surplus or Utility Loss from the Removal of Nicotine from Combusted Tobacco Products is Minimal in Light of the Availability of Other Sources of Nicotine and the Continued Availability of Tobacco Products. (ANPRM, Section G, Question 2)

The measurement of consumer surplus or utility loss in the context of the regulation of an addictive product, such as cigarettes, has been the subject of considerable debate. In 2014, a group of distinguished health economists presented to the U.S. Department of Health and Human Services and subsequently published a proposed formulation for the measurement of such consumer surplus or utility loss in this context.⁸⁶ After citing the fact that the large majority of smokers started smoking before the legal purchase age, regret the fact that they had started smoking and become addicted, and wished they could quit, the paper concluded:

“Indeed, the data strongly suggest that many smokers do not find smoking pleasurable, and that they derive little consumer surplus from smoking. Instead, most are struggling with or avoiding the withdrawal they would experience if they were able to stop smoking

⁸⁶ Chaloupka FJ, et al., “An Evaluation of the FDA’s Analysis of the Costs and Benefits of the Graphic Warning Label Regulation,” *Tobacco Control*, 24:112-119, 2015.

and break an addiction they regret having ever started, facing psychological costs from being addicted and lacking the self-control to quit.”⁸⁷

Accordingly, the paper recommended that, “nearly all of the lost pleasure from tobacco use, as represented by conventionally measured consumer surplus, should not be included as a cost in FDA analysis of the economic impact of its tobacco regulations.”⁸⁸ To the extent that measurement of consumer surplus or utility loss is required in the evaluation of regulations involving tobacco products, the undersigned organizations urge FDA to adopt the methods described in that paper.

In this case, there are further reasons why consumer surplus or utility loss, to the extent the concepts are relevant at all, would be minimal. If it is true that smokers smoke in order to obtain nicotine (an underlying premise of a nicotine products standard), to the extent that nicotine will remain available to them in other forms, either through appropriately regulated e-cigarettes, NRT products, or otherwise, means that the “pleasure” of receiving nicotine is not being denied to them. To the extent that these products satisfy the need for nicotine, there is no “lost pleasure.” Moreover, to the extent that smokers can satisfy the need for nicotine at a far lower cost to their health indicates that individual smokers will realize a large net economic gain.

Moreover, cigarettes and other combusted tobacco products will remain available for sale. To the extent that smokers derive pleasure from smoking apart from satisfying their need for nicotine, they will continue to be able to purchase cigarettes and other combusted products. Having access to both nicotine and combusted tobacco products, it is questionable whether smokers will experience any loss of consumer surplus, even assuming that such surplus is generated by smoking.

B. FDA Should Consider Externalities, Such as the Reduction in Secondhand Smoke, in Evaluating the Consequences of the Rule (ANPRM Section G, Question 6)

If, as expected, a product standard reducing the level of nicotine in cigarettes and other combusted products substantially reduces the number of cigarettes and other combusted tobacco products smoked, there will be a corresponding reduction in environmental tobacco smoke and in the death and disease resulting from non-smokers’ exposure to such smoke. FDA estimates that from 2005 to 2009, an estimated 7,330 lung cancer and 33,950 heart disease deaths were attributable to secondhand smoke and that secondhand tobacco smoke causes premature death and disease in children and adults who do not smoke.⁸⁹ It is apparent that a reduction in environmental tobacco smoke would reduce the burden of death and disease for non-smokers and provide a substantial public health benefit. Any analysis of the effects of such a rule should

⁸⁷ *Id.*

⁸⁸ *Id.*

⁸⁹ 83 Fed. Reg. at 11825.

consider the benefits to non-smokers that would result through a reduction in death and disease attributable to environmental tobacco smoke.

C. Post-market Surveillance is Critical

Critical to the success of a nicotine reduction policy is a rigorous and comprehensive post-market surveillance and product-testing program to monitor for any unintended tobacco use patterns and to identify any changes in product design that may limit the effectiveness of reduced nicotine content.

Respectfully submitted,

Action on Smoking and Health
American Academy of Family Physicians
American Academy of Oral and
Maxillofacial Pathology
American Association for Dental Research
American Association for Respiratory Care
American Cancer Society Cancer Action
Network
American College of Cardiology
American College of Physicians
American College of Preventive Medicine
American Heart Association
American Lung Association
American Medical Association
American Medical Student Association
American Psychological Association
American Public Health Association
American School Health Association
American Society of Addiction Medicine
American Society of Clinical Oncology
Americans for Nonsmokers' Rights
Association of State and Territorial Health
Officials
Big Cities Health Coalition
Campaign for Tobacco-Free Kids
Community Anti-Drug Coalitions of
America
Counter Tools

Eta Sigma Gamma - National Health
Education Honorary
Mesothelioma Applied Research Foundation
National Association of County and City
Health Officials
National Hispanic Medical Association
National Network of Public Health Institutes
Oncology Nursing Society
Oral Health America
Prevention Institute
Public Health Law Center | Tobacco Control
Legal Consortium
Public Health Solutions
Society for Cardiovascular Angiography and
Interventions
Society for Public Health Education
Students Against Destructive Decisions
The Society for State Leaders of Health and
Physical Education
Trust for America's Health
Truth Initiative



JAMES L. MADARA, MD
EXECUTIVE VICE PRESIDENT, CEO

ama-assn.org
t (312) 464-5000

July 16, 2018

Scott Gottlieb, MD
Commissioner
U.S. Food and Drug Administration
10903 New Hampshire Avenue
Silver Spring, MD 20993

Re: Docket No. FDA-2017-N-6189; APRM; Tobacco Product Standard for Nicotine Level of Certain Tobacco Products

Dear Commissioner Gottlieb:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to provide comments on the Food and Drug Administration's (FDA) advance notice of proposed rulemaking (APRM) titled, "Tobacco Product Standard for Nicotine Level of Combusted Cigarettes," as referenced above.

Tobacco use is the leading preventable cause of death in the United States. The AMA applauds the FDA's decision to gather information regarding the development and implementation of a regulation that would reduce nicotine levels in cigarettes to non-addictive levels. This step toward reducing the addictive power of cigarettes is in line with AMA policy, which has for years encouraged the FDA and other appropriate agencies to study how tobacco products might be modified to facilitate cessation of use, including elimination of nicotine and other additives that enhance addictiveness.

The AMA has joined other medical and public health organizations in submitting comments in this docket (see letter submitted by the Campaign for Tobacco-Free Kids, American Cancer Society Cancer Action Network, American Heart Association, and American Lung Association). These comments outline the public health impact of reducing nicotine in combustible tobacco products, application of the nicotine standard to other combustible tobacco products, implementation considerations, technical achievability, possible countervailing effects, as well as other considerations. In addition to those comments, the AMA believes the scope of the APRM should be expanded to cover all tobacco products.

The AMA calls on the FDA to create a non-addictive nicotine level standard for all tobacco products, not just cigarettes. This includes smokeless tobacco, electronic nicotine delivery systems (ENDS), "heat not burn products," and any other tobacco products containing nicotine for recreational use. Cigarettes are not the only addictive form of tobacco, and applying this standard across all tobacco products is essential to combating the leading cause of preventable death. If FDA reduces nicotine content in combustible tobacco products without already having a regulatory strategy in place that appropriately addresses ENDS, it will miss a critical opportunity to reduce overall nicotine addiction and use of tobacco products. Comprehensive and specific regulations are necessary to prevent new products that may circumvent the nicotine level requirement.

The Honorable Scott Gottlieb, MD

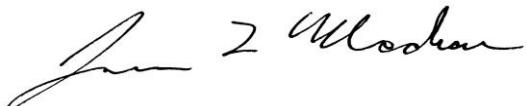
July 16, 2018

Page 2

The AMA acknowledges that all tobacco products (including, but not limited to, cigarettes, smokeless tobacco, chewing tobacco, and hookah/water pipe tobacco) are harmful to health. Furthermore, the use of ENDS is not harmless and increases youth risk of using combustible tobacco cigarettes. We recognize that the use of products containing nicotine in any form among youth, including ENDS, is unsafe and can cause addiction.

In summary, we greatly appreciate the FDA's effort to develop a product standard for a maximum nicotine level for cigarettes, and urge the FDA to extend this rulemaking to all tobacco products, including noncombustible products like ENDS. We thank you for your consideration of these comments, and look forward to a final rule that prioritizes the health of the public. If we may provide further assistance, please contact Margaret Garikes, Vice President, Federal Affairs at 202-789-7409 or margaret.garikes@ama-assn.org.

Sincerely,



James L. Madara, MD

REPORT 4 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-19)
Vector-borne Diseases
(Resolution 430-A-18, first and second Resolves)
(Reference Committee D)

EXECUTIVE SUMMARY

Background. This report responds to Resolution 430-A-18, “Vector-borne Diseases” introduced by the American Academy of Dermatology along with 24 state and national medical specialty societies, and referred by the House of Delegates. This resolution asked the AMA to study the emerging epidemic of vector-borne diseases.

Methods. English language reports were selected from searches of the PubMed, Google Scholar, and Cochrane Library databases from January 2014 to January 2019 using the search terms “vector-borne disease,” “tick-borne disease,” “mosquito-borne disease,” “Lyme disease,” “post treatment Lyme disease,” “chronic Lyme disease,” “West Nile virus,” and “Zika virus.” Additional articles were identified by manual review of the reference lists of pertinent publications. Websites managed by federal, state, and local agencies and applicable national public health, entomology, and mosquito control organizations also were reviewed for relevant information.

Results. In the United States, nearly 650,000 cases of vector-borne diseases (VBD) were reported from 2004–2016. Reported cases of tick-borne disease (TBD) doubled in the 13-year analysis period. TBDs account for more than 75 percent of VBDs reports throughout the continental United States and Lyme disease accounts for the majority (82 percent) of cumulative reported TBD. West Nile Virus was the most commonly transmitted mosquito-borne disease (MBD) in the continental United States from 2004–2016. Epidemics of dengue, chikungunya, and Zika viruses were mostly confined to the U.S. territories. This report focuses broadly on the prevention of VBDs, followed by specific discussions on the diagnosis and treatment of the most prevalent TBDs and MBDs – Lyme disease and West Nile Virus (WNV), respectively.

Conclusion. VBDs are a growing health threat in the United States and one that climate change is expected to exacerbate. The most common VBDs in the United States are Lyme disease, Rocky Mountain spotted fever, WNV, dengue, and Zika virus disease. From a public health perspective, to effectively reduce transmission and respond to VBD outbreaks, improvements in surveillance, reporting, and adequate vector control will be necessary, but as a nation we currently have limited capacity to respond to vector-borne diseases. With approximately 80 percent of our nation’s vector control organizations lacking critical prevention and control capacities, sustained investment in improving these capabilities is needed as are investments in our public health infrastructure and workforce.

For health professionals to adequately care for patients infected with VBDs, clinical research is needed to improve their diagnosis and treatment. Educating health professionals and the public about existing and emerging VBDs will be critical to addressing both prevention and treatment efforts. Lyme disease should be an area of focus in these efforts since it is the most common VBD in the United States. Furthermore, with there being only one nationally notifiable VBD with an FDA approved vaccine available, vaccine development for VBDs should be prioritized. To accomplish these goals, additional and sustained funding for VBDs will be necessary.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 4-A-19

Subject: Vector-borne Diseases
(Resolution 430-A-18, first and second Resolves)

Presented by: Robyn F. Chatman, MD, MPH, Chair

Referred to: Reference Committee D
(Diana Ramos, MD, MPH, Chair)

1 The first and second resolves of Resolution 430-A-18, introduced by the American Academy of
2 Dermatology along with 24 state and national medical specialty societies, and referred by the
3 House of Delegates asks:

4
5 That our American Medical Association (AMA) study the emerging epidemic of vector-borne
6 diseases including an analysis of currently available testing and treatment standards and their
7 effectiveness, and issue a white paper on vector-borne diseases (VBD) for the purpose of
8 increasing awareness of the epidemic of vector-borne diseases.
9

10 METHODS

11
12 English language reports were selected from searches of the PubMed, Google Scholar, and
13 Cochrane Library databases from January 2014 to January 2019 using the search terms “vector-
14 borne disease,” “tick-borne disease,” “mosquito-borne disease,” “Lyme disease,” “post treatment
15 Lyme disease,” “chronic Lyme disease,” “West Nile virus,” and “Zika virus.” Additional articles
16 were identified by manual review of the reference lists of pertinent publications. Websites managed
17 by federal, state, and local agencies and applicable national public health, entomology, and
18 mosquito control organizations also were reviewed for relevant information.
19

20 CURRENT AMA POLICY

21
22 Existing AMA policy on VBD urges the AMA to support educating the medical community on the
23 potential adverse public health effects, including VBDs, of global climate change. Policy also calls
24 on the AMA to advocate for local, state and national research, education, reporting, and tracking
25 on VBDs. Our policy on zoonotic diseases asks the AMA to collaborate with the American
26 Veterinary Medical Association and other stakeholders to take the lead in establishing a robust,
27 coordinated, and effective global surveillance system of zoonotic diseases in humans and
28 syndromic outbreaks in animals. In terms of policy on specific VBDs, existing policy addresses
29 Zika virus by calling for funding and the development of strategies to limit the spread and impact
30 of the virus as well as approaches to minimize the transmission to potentially pregnant women.
31

32 BACKGROUND

33
34 Vectors are blood-feeding insects and ticks capable of transmitting pathogens between hosts. Wide
35 varieties of pathogens have evolved to exploit vector transmission, including some viruses,
36 bacteria, rickettsia, protozoa, and helminths.¹ Mosquitos, ticks, and fleas are the most common

1 vectors in the United States. Diseases from mosquito and tick bites occur in every U.S. state and
2 territory.² The growing incidence of Lyme disease and recent outbreaks of Zika virus and
3 chikungunya points to the need for comprehensive VBD programs and for increased awareness of
4 these diseases by clinicians and patients. Climate change creates additional concern about the
5 spread of VBDs as changing temperatures may expand the geographic range of disease-carrying
6 insects.

7

8 EPIDEMIOLOGY

9

10 VBDs are a major cause of death and illness worldwide. Every year, VBDs such as malaria,
11 dengue, and yellow fever, account for more than 700,000 deaths globally.³ The burden of these
12 diseases is highest in tropical and subtropical areas and they disproportionately affect poor
13 populations.³ In the United States, 16 VBDs are reportable to state and territorial health
14 departments and the National Notifiable Disease Surveillance System. The most common VBDs in
15 the United States are Lyme disease, Rocky Mountain spotted fever, West Nile virus (WNV),
16 dengue, and Zika virus disease.² Malaria and yellow fever are no longer transmitted in the United
17 States, but are monitored because they have potential to re-emerge. As a group, VBDs in the
18 United States are notable for their wide distribution and resistance to control.¹ Yellow fever is the
19 only nationally notifiable VBD for which there is an FDA-approved vaccine available.²

20

21 In the United States, nearly 650,000 cases of VBD were reported from 2004–2016.¹ Reported cases
22 of tick-borne disease (TBD) doubled in the 13-year analysis period.¹ TBDs account for more than
23 75 percent of VBDs reports throughout the continental United States and Lyme disease accounts
24 for the majority (82 percent) of cumulative reported TBD.¹ In addition to Lyme disease, other
25 common illnesses caused by ticks are Rocky Mountain spotted fever, babesiosis, ehrlichiosis,
26 anaplasmosis, tularemia, Colorado tick fever, tick-borne relapsing fever, and Powassan disease.
27 While TBDs are prevalent throughout the country, they are predominately found along the
28 northeastern coast, in the upper Midwest, and along the Pacific coast.

29

30 WNV was the most commonly transmitted mosquito-borne disease (MBD) in the continental
31 United States from 2004–2016, with the largest outbreak occurring in 2012.¹ Epidemics of dengue,
32 chikungunya, and Zika viruses were mostly confined to the U.S. territories. Travelers infected in
33 the territories and Latin America accounted for more than 90 percent of the dengue, chikungunya,
34 and Zika virus cases identified in the continental United States.¹ Limited local transmission of
35 dengue occurred in Florida, Hawaii, and Texas, and of chikungunya and Zika viruses in Texas and
36 Florida.¹ Malaria was diagnosed in approximately 1,500 travelers yearly, but no local transmission
37 was documented from 2004–2016.¹

38

39 Given the broad range of VBDs, CSAPH decided to focus the scope of this report broadly on the
40 prevention of VBDs, followed by specific discussions on the most prevalent TBDs and MBDs –
41 Lyme disease and WNV, respectively.

42

43 PREVENTION OF VBDs

44

45 *Vector Control Programs*

46

47 Vector control programs vary by jurisdiction. These responsibilities may fall to the local health
48 department, mosquito control district, or a variety of other local agencies (public works, streets and
49 sanitation, parks and recreation, or other environmental health services).⁴ The result is differing
50 capabilities across the country. The Centers for Disease Control and Prevention (CDC) has outlined
51 core competencies for vector control programs. The competencies include: (1) routine mosquito

1 surveillance through standardized trapping and species identification; (2) treatment decisions using
2 surveillance data; (3) larvicing, adulticiding, or both; (4) routine vector control activities (i.e.,
3 chemical, biological, source reduction, or environmental management); and (5) pesticide resistance
4 testing. There are five supplemental competencies, these include (1) licensed pesticide application;
5 (2) vector control other than chemical control (i.e., biological, source reduction, or water
6 management); (3) community outreach and education campaigns regarding mosquito-borne
7 diseases, how they spread, and how to prevent infection; (4) regular communication with local
8 health departments regarding surveillance and epidemiology; and (5) outreach (i.e., communication
9 and/or cooperation).

10
11 A survey of vector control organizations in the United States (n=1,083) found that based on the
12 CDC competencies, 34 percent of mosquito control districts perform all core competencies versus
13 6 percent and 7 percent of local health departments and other organizations, respectively.⁴ Of the
14 competencies that vector control programs ranked as “needs improvement,” nearly all of them (98
15 percent) lacked the capability or capacity to perform pesticide resistance testing.⁴ More than half
16 also lack the ability to perform routine surveillance and species identification.⁴

17
18 Another approach to vector control that is being considered to prevent VBDs is the use of novel
19 technologies. One example is the use of genetically engineered mosquitos to prevent the spread of
20 Zika virus. Specifically, the male *Aedes aegypti* mosquitos are genetically engineered to express a
21 gene that encodes a conditional or repressible lethality trait and a red fluorescent marker protein to
22 aid in the identification of these mosquitoes.²⁶ If a female *Aedes* mosquito mates with a sterile male
23 then it will have no offspring, reducing the next generation’s population.²⁶ Repeated release of
24 insects can reduce the insect population to very low levels. The Environmental Protection Agency
25 (EPA) has been considering a pilot to determine the efficacy of these genetically engineered
26 mosquitos in the Florida Keys.

27
28 *Personal Protection from Vectors*

29
30 For mosquitos, personal protection from vectors involves using an EPA-registered insect repellent
31 with one of the following active ingredients: DEET, Picaridin, IR3535, oil of lemon eucalyptus or
32 para-methane-diol, or 2-undecanone.⁵ Individuals should also treat items such as boots, pants,
33 socks, and tents with permethrin or purchase permethrin-treated clothing and gear.⁵ Homes should
34 also be mosquito-proofed by using screens on windows and doors and repairing holes in screens to
35 keep mosquitos outside.⁵ It is also recommended to use air conditioning when available and to
36 eliminate standing water outside your home to keep mosquitos from laying eggs.⁵ It is important to
37 remember that vector-borne diseases affect the poor disproportionately. Overall, changes in living
38 conditions in the United States have resulted in decreased local transmission of MBD such as
39 yellow fever, malaria, and dengue.²²

40
41 For ticks, the use of EPA-registered insect repellents and permethrin treating clothing and gear is
42 also recommended. Individuals are encouraged to avoid contact with ticks by avoiding wooded and
43 brushy areas with high grass and leaf litter, and walk in the center of trails.⁶ Once indoors,
44 individuals should check their clothing and body for ticks after being outdoors. Showering within
45 two hours of coming indoors has been shown to reduce the risk of Lyme disease as it may help
46 wash off unattached ticks.⁶ If a tick is attached to the skin the key is to remove it as soon as
47 possible by using fine-tipped tweezers to grasp the tick as close to the skin’s surface as possible
48 and pull upward.⁷ Testing of ticks for evidence of infection is not recommended.⁷

1 DISCUSSION

2
3 Once an individual has been bit by an infected vector and/or suspects they may have been exposed
4 to a VBDs, health care professionals may be consulted for diagnosis and treatment. The CDC has
5 developed a reference manual for health care providers on tick-borne diseases in the United States
6 that provides an overview of ticks and the infections they transmit.⁶ The manual also provides
7 information on incubation periods, signs and symptoms, diagnosis, and treatment.⁶ A similar
8 manual for MBDs and other VBDs does not currently exist.

9
10 *Lyme Disease*

11
12 Lyme disease, the leading VBD in the United States, is caused by *Borrelia burgdorferi*, which is
13 transmitted by the bite of the tick species *Ixodes scapularis* and *Ixodes pacificus*. In 2017, a total of
14 42,743 confirmed and probable cases of Lyme disease were reported to CDC, nearly 9 percent
15 more than the previous year.⁸ The geographic distribution of Lyme disease appears to be
16 expanding. The number of counties with an incidence of ≥ 10 confirmed cases per 100,000 persons
17 increased from 324 in 2008 to 454 in 2017.⁸

18
19 Signs and Symptoms. The majority (70 to 80 percent) of patients with Lyme disease develop the
20 characteristic skin lesion, erythema migrans (EM).¹² The rash begins at the site of the tick bite and
21 expands. It sometimes has a target or “bull’s-eye” appearance. Other early signs include flu like
22 symptoms – fever, chills, headache, fatigue, muscle and joint aches, and swollen lymph nodes.⁹
23 Longer-term symptoms include severe headaches and neck stiffness, additional EM rashes,
24 arthritis, facial palsy, Lyme carditis, nerve pain, and inflammation of the brain and spinal cord.⁹
25 Recurrent large-joint arthritis signals late disseminated disease (more than six months post bite).¹⁰
26 Late neurologic Lyme disease signaled by peripheral neuropathy, encephalopathy, or
27 encephalomyelitis is uncommon in the United States.¹⁰

28
29 Diagnosis. There are 3 stages of *B. burgdorferi* infection: early localized, early disseminated, and
30 late disseminated.¹⁰ Patients with an EM lesion and epidemiologic risk can receive a Lyme
31 diagnosis without laboratory testing. However, for all other patients, laboratory testing is necessary
32 to confirm the diagnosis.¹⁰

33
34 Serological assays that detect antibodies against *B. burgdorferi* are the only lab test cleared by FDA
35 and recommended by CDC for diagnosis of Lyme disease. A two-step process is used to diagnose
36 Lyme disease (See Figure 1.) The first required test is the Enzyme Immunoassay (EIA) or
37 Immunofluorescence Assay (IFA). If this test yields negative results, the provider should consider
38 an alternative diagnosis; or in cases where the patient has had symptoms for less than or equal to 30
39 days, the provider may treat the patient and follow up with a convalescent serum. If the first test
40 yields positive or equivocal results, two options are available: (1) If the patient has had symptoms
41 for less than or equal to 30 days, an IgM Western Blot is performed; and (2) if the patient has had
42 symptoms for more than 30 days, the IgG Western Blot is performed. The IgM should not be used
43 if the patient has been sick for more than 30 days. The sensitivity of 2-tiered testing is low (30–40
44 percent) during early infection while the antibody response is developing.¹⁰ For disseminated Lyme
45 disease, sensitivity is 70–100 percent. Specificity is high (>95 percent) during all stages of
46 disease.¹⁰

47
48 Since serological tests measure a person’s past or present immune response to infection, they can
49 be negative during first several days to weeks of infection. This results in patients not being
50 diagnosed with appropriate diseases or receiving proper treatment. Serologic tests also cannot
51 distinguish active infection, past infection, or reinfection. In cases of reinfection, it may be helpful

1 to conduct acute-phase and convalescent-phase serologic analysis to detect an increase in EIA titer
2 or an increase in the number of antibody bands that might indicate active infection.¹⁰ When
3 determining whether to test for Lyme disease, clinicians must consider a patient's pretest
4 probability as false-positive results can occur when tests are performed for patients with low pretest
5 probability.¹⁰

6
7 There have been recent proposals to change the recommended 2-tier algorithm for serologic testing
8 for Lyme disease from the current standard to one in which a second-tier EIA would be used
9 instead of a Western blot.^{10,11} This approach would make the tests easier to perform, results would
10 be available sooner, costs would be reduced, and it would eliminate the subjective element inherent
11 in interpretation of Western blots.¹¹ Further research is needed.^{10,11}

12
13 Treatment. Patients treated during the early stages of Lyme disease typically recover rapidly and
14 have good outcomes. Treatment guidelines developed by the Infectious Diseases Society of
15 America recommend that early localized disease be treated with oral antibiotics.²³ Doxycycline 100
16 mg orally twice daily for 10–21 days, or cefuroxime axetil 500 mg orally twice daily or amoxicillin
17 500 mg orally 3 times daily for 14–21 days, has been shown to be effective in resolving early Lyme
18 disease and in preventing progression.²³ People with certain neurological or cardiac forms of illness
19 may require intravenous treatment with antibiotics such as ceftriaxone or penicillin.²³

20
21 While most patients diagnosed with early acute Lyme disease who are treated with appropriate
22 courses of antimicrobial therapy become symptom free, 10–20 percent of patients continue to
23 experience symptoms that can persist for six months or longer. Post-treatment Lyme Disease
24 (PTLD) or “chronic Lyme disease” commonly refers to the continuation of such symptoms as
25 fatigue, myalgia, arthralgia, memory loss, and headache after antibiotic therapy for Lyme disease.
26 Whether chronic disease is a legitimate clinical entity has become highly controversial.^{12-15,23,30} The
27 mechanism behind this persistence in some patients is unknown, but has been suggested to be due
28 to preexisting damage from the inflammatory response to infection, from persistent low-level
29 infection, or to an autoimmune response.¹³ Trials examining the effect of repeated antibiotic
30 treatment in PTLD have shown no significant sustained benefit.^{13,23} The Infectious Diseases Society
31 of America is currently in the process of updating their guidelines on Lyme disease, with a project
32 publication date of Winter 2020.

33
34 Costs. A comprehensive understanding of the full economic and societal costs of Lyme disease
35 remains unknown. The total direct medical costs attributable to Lyme disease and PTLD are
36 estimated to be somewhere between \$712 million - \$1.3 billion each year in the United States.²⁸

37
38 Vaccine. LYMErix™, a noninfectious recombinant vaccine for Lyme disease, was available in the
39 United States from 1998-2002.²¹ The Food and Drug Administration approved vaccine, which
40 reduced new infections in vaccinated adults by nearly 80 percent, was voluntarily withdrawn from
41 the market because of media coverage, fears of vaccine side-effects, and declining sales.²⁷

42
43 *West Nile Virus*

44
45 WNV is the leading cause of mosquito-borne disease in the continental United States. In 2018, 49
46 states and the District of Columbia reported WNV infections in people, birds, or mosquitoes. 2,544
47 cases of WNV in people were reported to CDC last year.²⁵ Of these, 1,594 (63 percent) were
48 classified as neuroinvasive disease and 950 (37 percent) were classified as non-neuroinvasive
49 disease.²⁵ In 2018, 137 deaths were reported.²⁵

1 Signs and Symptoms. Most people infected with WNV do not develop any symptoms.¹⁶
2 Approximately 1 in 5 people will develop a fever as well as headache, body aches, joint pains,
3 vomiting, diarrhea, or rash.¹⁶ About 1 in 150 people who are infected develop a severe illness
4 affecting the central nervous system such as encephalitis or meningitis.¹⁶ Symptoms of severe
5 illness include high fever, headache, neck stiffness, stupor, disorientation, coma, tremors,
6 convulsions, muscle weakness, vision loss, numbness and paralysis.¹⁶
7

8 Diagnosis. Diagnosis of WNV is generally accomplished through laboratory testing of serum or
9 cerebrospinal fluid (CSF) to detect WNV-specific IgM antibodies, which are usually detectable
10 three to eight days after onset of illness and persist for 30 to 90 days.¹⁶ Positive results obtained
11 with these assays should be confirmed by neutralizing antibody testing of acute- and convalescent-
12 phase serum specimens at a state public health laboratory or CDC. WNV IgG antibodies generally
13 are detected shortly after IgM antibodies and persist for many years. Therefore, the presence of IgG
14 antibodies alone is only evidence of previous infection.¹⁶
15

16 Viral cultures and tests to detect viral RNA (i.e., reverse transcriptase-polymerase chain reaction
17 can be performed on serum, CSF, and tissue specimens that are collected early in the course of
18 illness and, if results are positive, can confirm an infection. Immunohistochemistry can detect
19 WNV antigen in formalin-fixed tissue.¹⁶ Negative results of these tests do not rule out WNV
20 infection.¹⁶
21

22 Treatment. There is no specific treatment for WNV disease. Patients with severe meningeal
23 symptoms may require pain control for headaches and antiemetic therapy and rehydration for
24 associated nausea and vomiting.¹⁶ Patients with encephalitis require close monitoring for the
25 development of elevated intracranial pressure and seizures.¹⁶ Patients with encephalitis or
26 poliomyelitis should be monitored for inability to protect their airway.¹⁶ Acute neuromuscular
27 respiratory failure may develop rapidly and prolonged ventilatory support may be required.¹⁶
28

29 Costs. Data suggests the total cumulative costs of reported WNV hospitalized case-patients during
30 1999–2012 were \$778 million, which is an average of approximately \$56 million per year.²⁹
31

32 Vaccines. There are no WNV vaccines licensed for use in humans.
33

34 EMERGING AND RE-EMERGING VBDs
35

36 Since 2004, the United States has seen an increasing number of new or re-emerging vector-borne
37 pathogens.^{1,20} This includes previously unknown tick-borne RNA viruses, a tick-borne relapsing
38 fever agent, and two tick-borne spotted fever species as well as the introduction of mosquito
39 viruses, chikungunya and Zika, introduced in Puerto Rico in 2014 and 2015, respectively.¹
40

41 Zika virus disease
42

43 Zika virus is a Flavivirus, which is transmitted to humans primarily through the bite of an
44 infected Aedes species mosquito (*Ae. aegypti* and *Ae. albopictus*).¹⁷ In 2015 and 2016, outbreaks of
45 Zika virus occurred in the Americas, resulting in travel-associated cases in the United States,
46 widespread transmission in the U.S. territories, and limited local transmission in Florida and
47 Texas.¹⁸ Zika virus infection during pregnancy has been demonstrated to cause birth defects such
48 as microcephaly and other severe brain defects.¹⁸ From January 15 through December 27, 2016, a
49 total of 1,297 pregnancies with possible Zika virus infection were reported to the U.S. Zika
50 Pregnancy Registry.²⁴ Birth defects were reported for 51 (5 percent) of the 972 completed

1 pregnancies with laboratory evidence of possible recent Zika virus infection.²⁴ Zika is the only
2 arbovirus known to be transmitted sexually.

3

4 *Longhorned Tick (Haemaphysalis longicornis)*

5

6 *Haemaphysalis longicornis* is indigenous to eastern Asia and is an important vector of human and
7 animal disease agents, including Rickettsia, Borrelia, Ehrlichia, Anaplasma, Theileria, and several
8 important viral agents such as Heartland and Powassan viruses.¹⁹ *Haemaphysalis longicornis* was
9 discovered on a sheep in New Jersey in August 2017. From August 2017 through September 2018,
10 vector and animal surveillance efforts resulted in 53 reports of *Haemaphysalis longicornis* in the
11 United States, including 38 from animal species (23 from domestic animals, 13 from wildlife, and
12 two from humans), and 15 from environmental sampling of grass or other vegetation.¹⁹ Most of
13 these reports have come from the eastern portion of United States.¹⁹ No cases of illness in humans
14 or other species have been reported to date.¹⁹

15

16 CONCLUSION

17

18 VBDs are a growing health threat in the United States and one that climate change is expected to
19 exacerbate. The most common VBDs in the United States are Lyme disease, Rocky Mountain
20 spotted fever, WNV, dengue, and Zika virus disease. From a public health perspective, to
21 effectively reduce transmission and respond to VBD outbreaks, improvements in surveillance,
22 reporting, and adequate vector control will be necessary, but as a nation we currently have limited
23 capacity to respond to vector-borne diseases. With approximately 80 percent of our nation's vector
24 control organizations lacking critical prevention and control capacities, sustained investment in
25 improving these capabilities is needed as are investments in our public health infrastructure and
26 workforce.

27

28 For health professionals to adequately care for patients infected with VBDs, clinical research is
29 needed to improve their diagnosis and treatment. Educating health professionals and the public
30 about existing and emerging VBDs will be critical to addressing both prevention and treatment
31 efforts. Lyme disease should be an area of focus in these efforts since it is the most common VBD
32 in the United States. Furthermore, with there being only one nationally notifiable VBD with an
33 FDA approved vaccine available, vaccine development for VBDs should be prioritized. To
34 accomplish these goals, additional and sustained funding for VBDs will be necessary.

35

36 RECOMMENDATIONS

37

38 The Council recommends that the following statements be adopted in lieu of Resolution 403-A-18,
39 and the remainder of the report be filed.

40

41 1. That Policy H-440.820, "Vector-Borne Diseases," be amended by addition and deletion to read
42 as follows:

43

44 H-440.820 Vector-Borne Diseases

45 Due to the increasing threat and limited capacity to respond to vector-borne diseases, ~~Our~~ our
46 AMA ~~supports and~~ will advocate for local, state and national research, education, reporting and
47 tracking on vector borne diseases.

48

49 (1) Improved surveillance for vector-borne diseases to better understand the geographic
50 distribution of infectious vectors and where people are at risk;

- 1 (2) The development and funding of comprehensive and coordinated vector-borne disease
2 prevention and control programs at the state and local level;
3 (3) Investments that strengthen our nation's public health infrastructure and the public health
4 workforce;
5 (4) Education and training for health care professionals and the public about the risk of vector-
6 borne diseases and prevention efforts as well as the dissemination of available information;
7 (5) Research to develop new vaccines, diagnostics, and treatments for existing and emerging
8 vector-borne diseases, including Lyme disease;
9 (6) Research to identify novel methods for controlling vectors and vector-borne diseases; and
10 (7) Increased and sustained funding to address the growing burden of vector-borne diseases in
11 the United States. (Modify Current HOD Policy)
- 12 2. That Policy H-135.938, "Global Climate Change and Human Health" and Policy, D-440.940,
13 "Global Tracking System of Zoonotic Diseases," be reaffirmed. (Reaffirm HOD Policy)

Less than \$500.

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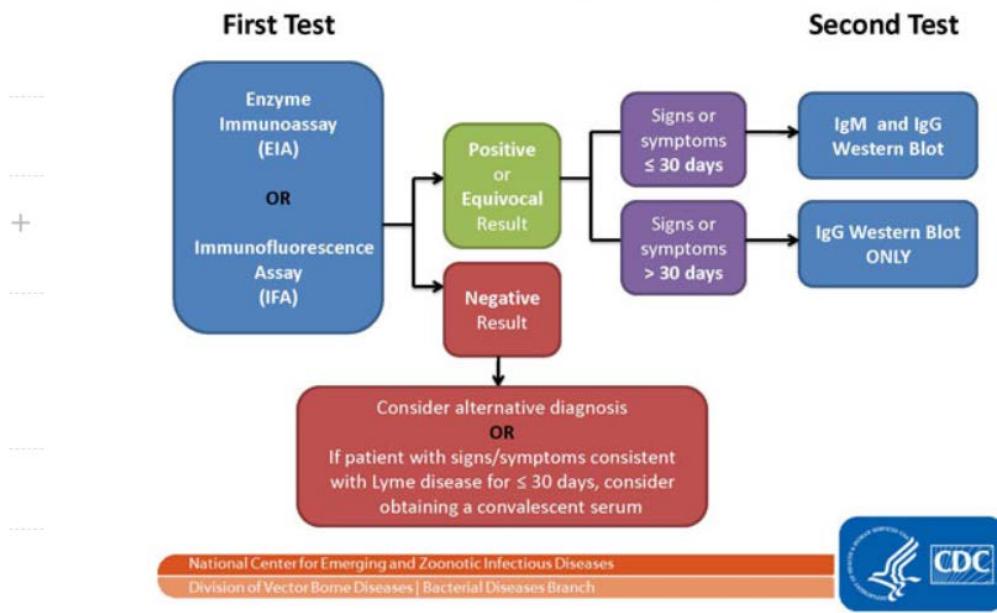
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Figure 1

Two-Tiered Testing for Lyme Disease



AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 401
(A-19)

Introduced by: Oregon

Subject: Support Pregnancy Intention Screenings to Improve the Discussion of Pregnancy Intention, Promote Preventive Reproductive Health Care and Improve Community Health Outcomes by Helping Women Prepare for Healthy Pregnancies and Prevent Unintended Pregnancies

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

- 1 Whereas, Almost half (51%) of all pregnancies in the United States are unintended, which has
- 2 significant physical and socio-economic consequences for women and their families, with a real
- 3 cost in lives and public health; and
- 4
- 5 Whereas, Rates of unintended pregnancies disproportionately impact women of color, women in
- 6 poverty, and women with less education; and
- 7
- 8 Whereas, Women with unintended pregnancies are unlikely to have taken folic acid before
- 9 conceiving and are less likely to receive early prenatal care, thus increasing the risk of babies
- 10 born with health challenges; and
- 11
- 12 Whereas, Women need comprehensive information, services and referrals in order to have
- 13 optimal health, healthy pregnancies, and the best possible birth outcomes; and
- 14
- 15 Whereas, Providers want to use pregnancy intention screening as a routine and proactive
- 16 intervention to address pregnancy intention with patients and have requested a consistent and
- 17 efficient way to document care in their electronic health records; therefore be it
- 18
- 19 RESOLVED, That our American Medical Association support the use of pregnancy intention
- 20 screening, such as One Key Question®, PATH, or the Centers for Disease Control and
- 21 Prevention (CDC) reproductive life planning, as part of routine well care and recommend it be
- 22 built in electronic health records so that providers can document intention screening and
- 23 services provided based on a woman's response. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000.

Received: 03/04/19

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Committee on Health Care for Underserved Women, " Committee Opinion: Reproductive Life Planning to Reduce Unintended Pregnancy," *The American College of Obstetricians and Gynecologists Number 654* (February 2016): 1. <https://www.acog.org-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co654.pdf?dmc=1&ts=20160131T1016396951>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 402
(A-19)

Introduced by: Young Physicians Section
Subject: Bullying in the Practice of Medicine
Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

1 Whereas, Bullying and disrespectful behavior within the practice of medicine in the U.S. and
2 overseas has been well demonstrated in prior studies,^{2,4,6,7,9,12,16} and that perpetrators of bullying
3 within medicine can be other physician colleagues, superior ranking colleagues in training,
4 ancillary staff, and patients^{7,9,2}; and
5
6 Whereas, "Bullying or aggressive behavior has been defined by criteria such as: intention to
7 cause harm or distress, imbalance of power between the bully (perpetrator, aggressor) and the
8 victim (target), and repeatability over time,"² and the British Medical Association defines bullying
9 as "persistent behaviour against an individual that is intimidating, degrading, offensive or
10 malicious and undermines the confidence and self-esteem of the recipient"¹⁰; and
11
12 Whereas, Disrespectful behavior "encompasses a broad array of conduct, from aggressive
13 outbursts to subtle patterns of disruptive behavior so embedded in our culture that they seem
14 normal,"¹⁷ and disrespectful behavior can also be considered "any behavior that influences the
15 willingness of staff or patients to speak up or interact with an individual because he or she
16 expects the encounter will be unpleasant or uncomfortable"⁸; and
17
18 Whereas, A survey published in 2008 found in the United States "A total of 77% of the
19 respondents reported that they had witnessed disruptive behavior in physicians at their
20 hospitals"¹³; and
21
22 Whereas, A 2013 survey from Institute for Safe Medication Practices exposed "healthcare's
23 continued tolerance of and indifference to disrespectful behavior. Despite more than a decade
24 of emphasis on safety, little improvement has been made"⁸; and
25
26 Whereas, One U.S. longitudinal survey of medical students published in 2006 demonstrated
27 that "most medical students in the U.S. reported having been harassed or belittled during their
28 training,"⁷; and
29
30 Whereas, Fnais et al in a 2014 meta-analysis found that "59.4% of medical trainees had
31 experienced at least one form of harassment or discrimination during their training, with verbal
32 harassment being the most commonly cited form of harassment"⁵; and
33
34 Whereas, "Workplace bullying is associated with stress, depression, and intention to leave"⁹ and
35 increased "absenteeism, career damage, poorer job performance, and lower productivity
36 resulting in poorer quality of healthcare services and patient care"²; and
37
38 Whereas, "Victims of bullying suffer from anxiety, loss of self-control, depression, lower self-
39 confidence, occupational job stress, job dissatisfaction, dissatisfaction with life, burnout

1 syndrome, musculoskeletal complaints, increased risk of cardiovascular disease, suicide
2 attempts, and drug abuse”² and disrespectful behaviors “have been linked to adverse events,
3 medical errors, compromises in patient safety, and even patient mortality”^{2,8}; and
4
5 Whereas, The Joint Commission in 2008 issued an alert “warning that offensive and hostile
6 behavior among healthcare professionals not only makes for an unpleasant working
7 environment but can also pose a considerable threat to patient safety”¹²; and
8
9 Whereas, Creswell et al describe how British medical schools are integrating curricula to teach
10 students how to differentiate undermining and destructive bullying behavior from constructive
11 and supportive firm supervision, and how take action against bullying³ and positive teaching
12 methods have been recommended within medical education,^{12,16} and formal procedures to
13 safely, accurately, and freely report bullying are needed in order to protect bullying victims and
14 address the issue^{2,9}; therefore be it
15
16 RESOLVED, That our American Medical Association help establish a clear definition of
17 professional bullying, establish prevalence and impact of professional bullying, and establish
18 guidelines for prevention of professional bullying with a report back at the 2020 Annual Meeting.
19 (Directive to Take Action)

Fiscal Note: Minimal - less than \$1,000.

Received: 04/04/19

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RELEVANT AMA POLICY

Teacher-Learner Relationship In Medical Education H-295.955

The AMA recommends that each medical education institution have a widely disseminated policy that: (1) sets forth the expected standards of behavior of the teacher and the learner; (2) delineates procedures for dealing with breaches of that standard, including: (a) avenues for complaints, (b) procedures for investigation, (c) protection and confidentiality, (d) sanctions; and (3) outlines a mechanism for prevention and education. The AMA urges all medical education programs to regard the following Code of Behavior as a guide in developing standards of behavior for both teachers and learners in their own institutions, with appropriate provisions for grievance procedures, investigative methods, and maintenance of confidentiality.

CODE OF BEHAVIOR

The teacher-learner relationship should be based on mutual trust, respect, and responsibility. This relationship should be carried out in a professional manner, in a learning environment that places strong focus on education, high quality patient care, and ethical conduct.

A number of factors place demand on medical school faculty to devote a greater proportion of their time to revenue-generating activity. Greater severity of illness among inpatients also places heavy demands on residents and fellows. In the face of sometimes conflicting demands on their time, educators must work to preserve the priority of education and place appropriate emphasis on the critical role of teacher. In the teacher-learner relationship, each party has certain legitimate expectations of the other. For example, the learner can expect that the teacher will provide instruction, guidance, inspiration, and leadership in learning. The teacher expects the learner to make an appropriate professional investment of energy and intellect to acquire the knowledge and skills necessary to become an effective physician. Both parties can expect the other to prepare appropriately for the educational interaction and to discharge their responsibilities in the educational relationship with unfailing honesty.

Certain behaviors are inherently destructive to the teacher-learner relationship. Behaviors such as violence, sexual harassment, inappropriate discrimination based on personal characteristics must never be tolerated. Other behavior can also be inappropriate if the effect interferes with professional development. Behavior patterns such as making habitual demeaning or derogatory remarks, belittling comments or destructive criticism fall into this category. On the behavioral level, abuse may be operationally defined as behavior by medical school faculty, residents, or students which is consensually disapproved by society and by the academic community as either exploitive or punishing. Examples of inappropriate behavior are: physical punishment or physical threats; sexual harassment; discrimination based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; repeated episodes of psychological punishment of a student by a particular superior (e.g., public humiliation, threats and intimidation, removal of privileges); grading used to punish a student rather than to evaluate objective performance; assigning tasks for punishment rather than educational purposes; requiring the performance of personal services; taking credit for another individual's work; intentional neglect or intentional lack of communication.

On the institutional level, abuse may be defined as policies, regulations, or procedures that are socially disapproved as a violation of individuals' rights. Examples of institutional abuse are: policies, regulations, or procedures that are discriminatory based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; and requiring individuals to perform unpleasant tasks that are entirely irrelevant to their education as physicians.

While criticism is part of the learning process, in order to be effective and constructive, it should be handled in a way to promote learning. Negative feedback is generally more useful when delivered in a private setting that fosters discussion and behavior modification. Feedback should focus on behavior rather than personal characteristics and should avoid pejorative labeling.

Because people's opinions will differ on whether specific behavior is acceptable, teaching programs should encourage discussion and exchange among teacher and learner to promote effective educational strategies. People in the teaching role (including faculty, residents, and students) need guidance to carry out their educational responsibilities effectively.

Medical schools are urged to develop innovative ways of preparing students for their roles as educators of other students as well as patients.

Citation: (BOT Rep. ZZ, I-90; Reaffirmed by CME Rep. 9, A-98; Reaffirmed: CME Rep. 2, I-99; Modified: BOT Rep. 11, A-07; Reaffirmed: CME Rep. 9, A-13

Violence and Abuse Prevention in the Health Care Workplace H-515.966

Our AMA encourages all health care facilities to: adopt policies to reduce and prevent all forms of workplace violence and abuse; develop a reporting tool that is easy for workers to find and complete; develop policies to assess and manage reported occurrences of workplace violence and abuse; make training courses on workplace violence prevention available to employees and consultants; and include physicians in safety and health committees.

Citation: Res. 424, I-98; Reaffirmation I-99; Reaffirmed: CSAPH Rep. 1, A-09; Modified: BOT Rep. 2, I-12; Reaffirmed in lieu of Res. 423, A-13; Modified: CSAPH Rep. 07, A-16

Reduction of Online Bullying H-515.959

Our AMA urges social networking platforms to adopt Terms of Service that define and prohibit electronic aggression, which may include any type of harassment or bullying, including but not limited to that occurring through e-mail, chat room, instant messaging, website (including blogs) or text messaging.

Citation: Res. 401, A-12

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 403
(A-19)

Introduced by: Young Physicians Section

Subject: White House Initiative on Asian Americans and Pacific Islanders

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

1 Whereas, The Asian American and Pacific Islander (AAPI) community is the fastest-growing
2 racial group in the country, growing from 46% from 2000-2010, and projected to double to over
3 47 million by 2060¹; and

4 Whereas, There are approximately 18.9 million AAPIs and Native Hawaiians residing in the
5 U.S., representing over 30 countries and ethnic groups that speak over 100 different languages
6 and dialects¹; and

7 Whereas, Some AAPI subgroups have staggering educational needs and health disparities that
8 are often overlooked or masked by aggregated data; and

9 Whereas, According to the 2010 U.S. Census Bureau, 34% of Laotians, 38.5% of Cambodians,
10 and 39.6% of Hmong adults do not have a high school diploma; and

11 Whereas, The 2006-2008 American Community Survey showed that 65.8% of Cambodian,
12 66.5% of Laotian, 63.2% of Hmong, and 51.1% of Vietnamese Americans have not attended
13 college² and only 18.2% of Native Hawaiians have a bachelor's degree³; and

14 Whereas, There are differences in health outcomes among AAPIs when compared to other U.S.
15 racial and ethnic groups, including:

16 (1) Vietnamese women experience the highest incidence rate of invasive cervical cancer;
17 however, cancer screening rates are dramatically lower among Vietnamese American
18 women compared to women in other ethnic and racial subgroups, with one study
19 reporting that 1 in 3 Vietnamese-American women had never had a Papanicolaou (Pap)
20 smear.⁴

21 (2) Native Hawaiians/Pacific Islanders are 2.4 times more likely to be diagnosed with
22 diabetes, compared to non-Hispanic whites.⁵

23 (3) Native Hawaiians/Pacific Islanders were 3 times more likely to be obese than the overall
24 Asian American population in 2015.⁶

25 (4) South Asians in the U.S. have higher hospitalization and mortality rates from
26 atherosclerotic cardiovascular disease compared with other racial/ethnic minority groups,
27 including a 2-fold higher prevalence of Type 2 Diabetes and a higher mortality from
28 ischemic heart disease compared with non-Hispanic whites⁸; and

29 Whereas, President Bill Clinton signed Executive Order 13125 to establish the first White House
30 Initiative on Asian Americans and Pacific Islanders "in order to improve the quality of life of
31 Asian Americans and Pacific islanders through increased participation in federal programs
32 where they may be underserved (e.g., health, human services, education, housing, labor,
33 transportation and economic and community development)"¹³; and

1 Whereas, President George W. Bush signed Executive Order 13216 to renew the Initiative and
2 changed the title to “Increasing Opportunity and Improving Quality of Life of Asian Americans
3 and Pacific Islanders,” and moved the Initiative from the U.S. Department of Health and Human
4 Services to the U.S. Department of Commerce to focus on economic development¹; and
5

6 Whereas, President Barack Obama signed Executive Order 13515, re-establishing the Initiative
7 and moving the Initiative from the Department of Commerce to the Department of Education^{1, 14};
8 and
9

10 Whereas, President Donald Trump issued Executive Order 13811 to re-establish the President’s
11 Advisory Commission on AAPIs¹⁵; and
12

13 Whereas, According to the “Healthcare and Housing” section of the website on the White House
14 Initiative on Asian Americans and Pacific Islanders¹⁶:

- 15 (1) 21.4% of Pacific Islanders have low or very low food security, compared to 8.9% of the
16 general population; and
- 17 (2) One in 12 AAPIs are living with chronic hepatitis B, making up 50% of Americans with
18 chronic hepatitis B; and
- 19 (3) The tuberculosis rate for Native Hawaiians and Pacific Islanders is 18.2 per 100,000,
20 compared with 0.6 per 100,000 in non-Hispanic Whites; and
21

22 Whereas, Previous iterations of the White House Initiative Asian Americans and Pacific
23 Islanders have worked extensively on data disaggregation and published best practices on
24 providing disaggregated AAPI data from federal surveys, including the needs to:

- 25 (1) Conduct outreach activities with AAPI community organizations, advocates, and
26 respected leaders;
- 27 (2) Oversample the AAPI population to ensure adequate representation; and
- 28 (3) Develop language assistance programs to account for limited English proficiency; and
29

30 Whereas, Our AMA has policy that “urges existing federal agencies, commissions and Asian
31 American and Pacific Islander health organizations to study how to improve the collection,
32 analysis and dissemination of public health data on Asian Americans and Pacific Islanders” but
33 does not have any specific policy regarding disaggregation of AAPI data by subgroups; and
34

35 Whereas, President Obama stated in his executive order on the AAPI Initiative: “Some Asian
36 American and Pacific Islanders, particularly new Americans and refugees, still face language
37 barriers...And then there are the disparities that we don’t even know about because our data
38 collection methods still aren’t up to par. Too often, Asian American and Pacific Islanders are all
39 lumped into one category, so we don’t have accurate numbers reflecting the challenges of each
40 individual community. Smaller communities in particular can get lost, their needs and concerns
41 buried in a spreadsheet¹⁷; therefore be it
42

43 RESOLVED, That our American Medical Association advocate for restoration of webpages on
44 the Asian American and Pacific Islander (AAPI) initiative (similar to those from prior
45 administrations) that specifically address disaggregation of health outcomes related to AAPI
46 data (Directive to Take Action); and be it further
47

48 RESOLVED, That our AMA support the disaggregation of data regarding AAPIs in order to
49 reveal the AAPI ethnic subgroup disparities that exist in health outcomes (Directive to Take
50 Action); and be it further

1 RESOLVED, That our AMA support the disaggregation of data regarding AAPIs in order to
2 reveal the AAPI ethnic subgroup disparities that exist in representation in medicine, including
3 but not limited to leadership positions in academic medicine (Directive to Take Action); and be it
4 further

5
6 RESOLVED, That our AMA report back at the 2020 Annual Meeting on the issue of
7 disaggregation of data regarding AAPIs (and other ethnic subgroups) with regards to the ethnic
8 subgroup disparities that exist in health outcomes and representation in medicine, including
9 leadership positions in academic medicine. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 04/04/19

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RELEVANT AMA POLICY

Health Initiatives on Asian-Americans and Pacific Islanders H-350.966

Our AMA urges existing federal agencies, commissions and Asian American and Pacific Islander health organizations to study how to improve the collection, analysis and dissemination of public health data on Asian Americans and Pacific Islanders.

Citation: (Res. 404, A-00; Reaffirmed: CSAPH Rep. 1, A-10

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 404
(A-19)

Introduced by: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont, American Academy of Dermatology, Society for Investigative Dermatology, American Society of Dermatopathology

Subject: Shade Structures in Public and Private Planning and Zoning Matters

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

1 Whereas, Malignant melanoma is now the fifth most common cancer in the United States, and
2 its incidence has increased 33-fold since 1935, with sun exposure being the principle
3 cause,^{1,2,3,4} and

4
5 Whereas, The Surgeon General's "Call to Action to Prevent Skin Cancer" of 2014⁵ concisely
6 outlined the magnitude of the public health problem which skin cancer represents in this
7 country, and recommended multiple strategies to decrease the risk of this preventable cancer,
8 including special attention to the provision of shade structures in the planning of public and
9 private spaces; and

10
11 Whereas, Shade structures are often treated as accessory buildings in planning and zoning
12 matters, and this can result in the denial of reasonable shade protection in public and private
13 spaces; therefore be it

14
15 RESOLVED, That our American Medical Association support sun shade structures (such as
16 awnings, gazebos and other structures providing shade) in the planning of public and private
17 spaces, as well as in zoning matters and variances in recognition of the critical importance of
18 sun protection as a public health measure. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000.

Received: 04/12/19

References

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5. *The Surgeon Generals Call to Action to Prevent Skin Cancer* 2014

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 405
(A-19)

Introduced by: California

Subject: Gun Violence Prevention: Safety Features

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

1 Whereas, The ongoing tragedy of gun violence in the United States has been labeled a public
2 health crisis by the AMA and others, with huge attendant financial costs to hospitals, health
3 systems, insurers, and many others; and
4
5 Whereas, In 2016, more than 38,000 deaths were caused by firearms; and
6
7 Whereas, The economic burden of firearm death and injury is substantial, reaching
8 approximately \$229 billion in aggregate costs and representing about 1.4 percent of U.S. gross
9 domestic product for costs associated with health care, criminal justice, loss of income, pain,
10 suffering and loss of quality of life; and
11
12 Whereas, Some companies are working on gun safety technologies, such as magazine
13 discharge mechanisms, and indicators that show a gun is loaded, to reduce the danger of
14 firearms for gun owners and their families; there is also federal legislation to require all gun-
15 makers in five years to retrofit guns with personalization technology that would only allow the
16 owners to shoot the guns; and
17
18 Whereas, It has been well established that the gun industry and gun advocacy groups, such as
19 the National Rifle Association, have successfully fought virtually any proposed safety features,
20 regulatory proposals, or epidemiological research that could lessen gun-related accidents and
21 violence; and
22
23 Whereas, The federal government holds manufacturers to strict safety standards regarding
24 almost every consumer product built within U.S. borders, such as toys, cars and medications –
25 which allows consumers to reasonably assume that the products we buy and use every day are
26 safe. But with guns, there are no federal regulations regarding the safety standards of firearms
27 produced within the U.S. – an oversight in consumer protection that often proves deadly; and
28
29 Whereas, From 2005-2010, 3,800 people were killed and more than 95,000 injured (42,000
30 under the age of 25) from unintended shootings that could have been prevented through better
31 gun safety standards and safety testing for mechanical defects; and
32
33 Whereas, Public health organizations have produced many evidence-based materials and
34 recommendations to lessen gun-related harms, but many experts believe that, as with the
35 tobacco industry in the past, the gun industry escapes true responsibility and liability for the
36 harms and costs caused by their products; therefore be it

1 RESOLVED, That our American Medical Association advocate for gun safety features, including
2 but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or
3 misappropriation of the weapon by a non-registered user; and support legislation and regulation
4 to standardize the use of these gun safety features on weapons sold for non-military and non-
5 peace officer use within the U.S.; with the aim of establishing manufacturer liability for the
6 absence of safety features on newly manufactured guns. (Directive to Take Action)

Fiscal Note: Minimal - less than \$1,000.

Received: 04/29/19

RELEVANT AMA POLICY

Gun Violence as a Public Health Crisis D-145.995

Our AMA: (1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and
(2) will actively lobby Congress to lift the gun violence research ban.

Citation: Res. 1011, A-16; Reaffirmation: A-18; Reaffirmation: I-18

Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975

1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.

2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.

3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.

Citation: Sub. Res. 221, A-13; Appended: Res. 416, A-14; Reaffirmed: Res. 426, A-16; Reaffirmed: BOT Rep. 28, A-18; Reaffirmation: A-18; Modified: CSAPH Rep. 04, A-18; Reaffirmation: I-18

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997

Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths. Therefore, the AMA: (1) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms; (2) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths; (3) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns; (4) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;

(6) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;

(7) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and

(8) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.

Citation: CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appended: Res. 403, I-99; Reaffirmation A-07; Reaffirmation A-13; Appended: Res. 921, I-13; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmation: A-18; Reaffirmation: , I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 406
(A-19)

Introduced by: California

Subject: Reduction in Consumption of Processed Meats

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

1 Whereas, Processed meats include (but are not limited to) bacon, sausages, hot dogs, salami,
2 corned beef, beef jerky, ham, canned meat, ground beef processed with ammonia and other
3 cured meat; and

4
5 Whereas, The International Agency for Research on Cancer (IARC) part of the World Health
6 Organization (WHO) has classified processed meats as a Group 1 carcinogen after reviewing
7 over 800 research studies; and

8
9 Whereas, Processed meats are associated with diabetes, hypertension, chronic obstructive
10 pulmonary disease (COPD) and coronary artery disease 2; therefore be it

11
12 RESOLVED, That our American Medical Association support reduction of processed meat
13 consumption, especially for patients diagnosed or at risk for coronary artery disease, type 2
14 diabetes and colorectal cancer (New HOD Policy); and be it further

15
16 RESOLVED, That our AMA support initiatives to reduce processed meats consumed in public
17 schools, hospitals, food markets and restaurants while promoting healthy alternatives such as a
18 whole foods and plant-based nutrition (New HOD Policy); and be it further

19
20 RESOLVED, That our AMA support public awareness of the risks of processed meat
21 consumption, including research that better defines the health risks imposed by different
22 methods of meat processing (New HOD Policy); and be it further

23
24 RESOLVED, That our AMA support educational programs for health care professionals on the
25 risks of processed meat consumption and the benefits of healthy alternatives. (New HOD
26 Policy)

Fiscal Note: Minimal - less than \$1,000.

Received: 04/29/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 407
(A-19)

Introduced by: California

Subject: Evaluating Autonomous Vehicles as a Means to Reduce Motor Vehicle Accidents

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

1 Whereas, Motor vehicle accidents are responsible for significant morbidity and mortality in the
2 U.S. In 2015, there were 3,176 deaths in California alone; and
3
4 Whereas, Over 90% of all motor vehicle accidents are primarily attributable to driver error, and
5 over 40% of fatal accidents involve substance use, fatigue, or a distracted driver; and
6
7 Whereas, Existing partially automated systems, such as autonomous emergency braking,
8 demonstrably reduce the incidence of collision-related injury; and
9
10 Whereas, Fully autonomous vehicles have the potential to prevent a significant proportion of
11 motor vehicle accidents by substantially reducing driver error, which could in turn reduce injury,
12 death, healthcare resource utilization, and healthcare spending; and
13
14 Whereas, The U.S. National Highway Traffic Safety Administration has voiced optimism for the
15 potential of autonomous vehicles to play a significant role in improving transportation safety, and
16 has published a guidance for the automobile industry accordingly; and
17
18 Whereas, Age-related loss in the ability to operate motor vehicles increases individuals' risk for
19 depression; therefore be it
20
21 RESOLVED, That our American Medical Association monitor the development of autonomous
22 vehicles, with particular focus on the technology's impact on motor vehicle related injury and
23 death (Directive to Take Action); and be it further
24
25 RESOLVED, That our AMA promote driver, pedestrian, and general street and traffic safety as
26 key priorities in the development of autonomous vehicles. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 04/29/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 408
(A-19)

Introduced by: Illinois

Subject: Banning Edible Cannabis Products

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

1 Whereas, In general, children have more severe symptoms from cannabis toxicity (with
2 leukocytosis and elevated lactic acid levels); and
3
4 Whereas, The pharmacology of edible cannabis makes this a poorly viable medicinal agent due
5 to its low oral bioavailability (under 25%) and slow peak absorption (almost 3 hours); and
6
7 Whereas, Toddlers are increasingly accessing edible cannabis products with subsequent
8 severe neurotoxicity and cardiotoxicity; and
9
10 Whereas, No antidote exists for cannabis toxicity, and activated charcoal is apparently not
11 effective; and
12
13 Whereas, Unintentional cannabis ingestion by adults can lead to unintended medical and
14 forensic consequences (such as a positive drug test leading to job termination); and
15
16 Whereas, There is no US Food and Drug Administration oversight on medicinal edible cannabis
17 products; and
18
19 Whereas, Colorado studies along with National Poison Data System encounters due to
20 unintentional pediatric cannabis exposures have increased substantially in legalized cannabis
21 states; and
22
23 Whereas, Some states and localities have restricted or outlawed the sale of flavored tobacco
24 products because of the concern that they increase pediatric initiation, i.e., first use of the
25 product; and
26
27 Whereas, There is much more risk of initiation with candy marijuana than with flavored tobacco
28 products; and
29
30 Whereas, Consumers often do not understand toxic hazards of edible cannabis and may
31 consume a greater than intended amount; therefore be it
32
33 RESOLVED, That our American Medical Association adopt policy supporting a total ban on
34 recreational edible cannabis products (New HOD Policy); and be it further

1 RESOLVED, That our AMA support or cause to be introduced legislation to ban all recreational
2 edible cannabis products. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 04/25/19

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 409
(A-19)

Introduced by: New York

Subject: Addressing the Vaping Crisis

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

1 Whereas, Vaping / E-cigarettes may be useful in helping smokers stop smoking; and
2
3 Whereas, Vaping has no other healthful purposes and these devices will, on rare occasion,
4 explode; and
5
6 Whereas, Vaping is highly addictive, and is marketed to children, and often leads to smoking;
7 therefore be it
8
9 RESOLVED, That our American Medical Association advocate to the Food and Drug
10 Administration that vaping devices should be available only by prescription for smokers who are
11 trying to quit smoking. (Directive to Take Action)

Fiscal Note: Minimal - less than \$1,000.

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 410
(A-19)

Introduced by: New York

Subject: Reducing Health Disparities Through Education

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

- 1 Whereas, The favorable direct impact of education on health outcomes has been well
- 2 documented for years, with improved outcomes at each additional level obtained from high
- 3 school graduation to post graduate degrees; and
- 4
- 5 Whereas, The high school graduation rate in the lower socioeconomic group is <30% compared
- 6 to an overall U.S. graduation rate of >80%; and
- 7
- 8 Whereas, The cost of a college degree is constantly rising with the average cost of a 4-year
- 9 degree in the U.S. is presently on average \$28,000 to \$34,000. The former for public college,
- 10 the latter for private colleges; and
- 11
- 12 Whereas, There are many environmental factors that impact health outcomes (e.g. a safe out
- 13 door space to exercise, the concentration of fast food restaurants, the availability of fresh,
- 14 affordable fruits and vegetables) in poor neighborhoods etc., in spite of the environmental
- 15 circumstances educational attainment helps to mitigate the negative impact of these
- 16 circumstances; and
- 17
- 18 Whereas, Personal behaviors informed by education leads to a decrease in unhealthy behaviors
- 19 (e.g. smoking); and
- 20
- 21 Whereas, Educational attainment leads to improved rates of secondary prevention (e.g. age
- 22 appropriate screenings); therefore be it
- 23
- 24 RESOLVED, That our American Medical Association work with the Health and Human Services
- 25 Department (HHS) and Department of Education (DOE) to raise awareness about the health
- 26 benefits of education (Directive to Take Action); and be it further
- 27
- 28 RESOLVED, That our AMA work with HHS and DOE to establish a meaningful health
- 29 curriculum (including nutrition) for grades kindergarten through 12 which is required for high
- 30 school graduation (Directive to Take Action); and be it further
- 31
- 32 RESOLVED, That our AMA work nationally toward the same goals and strategies to reduce
- 33 health disparities. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 411
(A-19)

Introduced by: New York

Subject: AMA to Analyze Benefits / Harms of Legalization of Marijuana

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

1 Whereas, Rates of marijuana use among the US population has increased in the past decade;
2 and
3
4 Whereas, Marijuana is a complex botanical with many different compounds with potential
5 pharmacological activity; and
6
7 Whereas, There is some high quality evidence for efficacy of some marijuana compounds for
8 treatment of disease or alleviation of symptoms; and
9
10 Whereas, There are structural impediments to high quality research due to marijuana being
11 classified as a Schedule I substance by the Food and Drug Administration; and
12
13 Whereas, There is accumulating evidence about harms associated with marijuana use in
14 regards to accidents, impaired driving, psychosis, depression, and suicide; and
15
16 Whereas, There is little long term data on the efficacy and potential harms associated with
17 medical or non-medical use; and
18
19 Whereas, Practicing clinicians could provide better recommendations for medicinal use with
20 high quality research; and
21
22 Whereas, There is emerging data from the states which have legalized marijuana use; and
23
24 Whereas, Review and analysis of the emerging data would be helpful to state medical societies
25 as they provide advice to their governmental representatives and regulators as they formulate
26 policies toward marijuana; therefore be it
27
28 RESOLVED, That our American Medical Association review pertinent data from those states
29 that have legalized marijuana. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 412
(A-19)

Introduced by: New York

Subject: Regulating Liquid Nicotine and E-Cigarettes

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

1 Whereas, Warnings have been placed on liquid nicotine as "poisonous if swallowed, inhaled or
2 if it comes in contact with skin"; and
3
4 Whereas, Warnings to "keep out of children's reach" as liquid nicotine can be addictive, may
5 increase heart rate, blood pressure, cause dizziness, nausea, and aggravate respiratory
6 conditions; and
7
8 Whereas, Warnings that "ingestion of liquid nicotine may be fatal"; and
9
10 Whereas, Many states have prohibited the sale of tobacco products, liquid nicotine, e-cigarettes
11 and smoking paraphernalia to persons under 21 years of age; and
12
13 Whereas, According to the NIH- National Institute on Drug Abuse: teens are more likely to use
14 e-cigarettes than cigarettes (eighth grade 3.6% vs 9.5%) and teen e-cigarette users are more
15 likely to start smoking (8.1% vs 30.7%) and 66% of teens claim "just flavoring" is in their e-
16 cigarettes; and
17
18 Whereas, According to the NIH- National Institute on Drug Abuse: "more than 1 in 10 eighth
19 graders say they vaped nicotine in the last year and surveys show vaping among high school
20 seniors increased from 11% in 2017 to 20.9% in 2018; therefore be it
21
22 RESOLVED, That our American Medical Association seek legislation or regulations that limit
23 higher concentration nicotine salts (greater than 10mg) in nicotine vaping pods and restrict bulk
24 sale of vaping products and associated paraphernalia. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 413
(A-19)

Introduced by: New York

Subject: End the Epidemic of HIV Nationally

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

1 Whereas, In 2014, Governor Andrew Cuomo announced a New York State (NYS) initiative to
2 End the HIV Epidemic by 2020 (EtE 2020) with the goal of fewer than 750 new HIV infections
3 statewide by 2020; and

5 Whereas, EtE 2020 is built on New York State's public health leadership since the emergence
6 of AIDS in 1988; and

8 Whereas, EtE 2020 has a 3-point plan that:

- 9 1) Identifies persons with HIV who remain undiagnosed and link them to health care;
- 10 2) Links and retains persons diagnosed with HIV in health care to maximize virus
- 11 suppression so they remain healthy and prevent further transmission; and
- 12 3) facilitates access to Pre-Exposure Prophylaxis (PrEP) for high-risk persons to keep
- 13 them HIV negative; and

15 Whereas, The NYS initiative is at the forefront of similar efforts nationwide and globally as
16 evidenced by a detailed 2015 Blueprint to End the AIDS Epidemic (health.ny.gov/ete) that
17 includes recommendations that address health care and the social determinants of health; and

19 Whereas, NYS 2017 surveillance data shows a decrease in incidence of new HIV infections
20 statewide; and

22 Whereas, New York's End the Epidemic is an example of state's efforts that can be replicated
23 on the national level; and

25 Whereas, The are similar state efforts underway to curtail the epidemic; and

27 Whereas, Federal funds are critical to this effort; therefore be it

29 RESOLVED, That our American Medical Association advocate that the federal budget include
30 provisions to End the HIV epidemic and that such a plan be structured after New York State's
31 EtE 2020 or other similar state programs. (Directive to Take Action)

Fiscal Note: Minimal - less than \$1,000.

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 414
(A-19)

Introduced by: Oklahoma

Subject: Patient Medical Marijuana Use in Hospitals

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

1 Whereas, By 2018, 33 states, the District of Columbia, Guam, and Puerto Rico, have passed
2 legislation to legalize medical marijuana, including Oklahoma; and
3
4 Whereas, There are many legal implications due to the passage of state medical marijuana laws
5 and the associated regulations passed by State Departments of Health; and
6
7 Whereas, Many community facilities continue to ban marijuana on their campuses pursuant to
8 the Federal Drug-Free Schools and Communities Act, the Drug-Free Workplace Act, and the
9 Federal Controlled Substance Act; and
10
11 Whereas, Hospital medical staffs are struggling when patients with medical marijuana licenses
12 report non-FDA approved marijuana products as home medication and bring these products into
13 their facilities; and
14
15 Whereas, American Medical Association Council on Science and Public Health Report 5, I-17,
16 "Clinical Implications and Policy Considerations of Cannabis Use," does not address patient
17 non-FDA approved medical marijuana use in hospitals; therefore be it
18
19 RESOLVED, That our American Medical Association offer guidance to medical staffs regarding
20 patient use of non-US Food and Drug Administration approved medical marijuana and
21 cannabinoids on hospital property, including product use, storage in patient rooms, nursing
22 areas and/or pharmacy, with report back to the House of Delegates at the 2019 Interim Meeting.
23 (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 04/15/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 415
(A-19)

Introduced by: Oklahoma

Subject: Distracted Driver Legislation

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

1 Whereas, National Highway Traffic Safety Administration, primarily uses distracted driving to
2 mean “the inattention that occurs when drivers divert their attention away from the driving task
3 to focus on another activity”¹; and
4
5 Whereas, Oklahoma has laws that restrict cell phone use while driving in an effort to reduce
6 distracted driving accidents. Oklahoma is like most states in that many drivers either don’t know
7 the applicable distracted driving laws or choose to ignore them; and
8
9 Whereas, Nearly one-third of all U.S. drivers 18 to 64 years old read or send text or email
10 messages while driving²; and
11
12 Whereas, Reading or sending text or email messages while driving and other distracted driving
13 behaviors leads to more than 420,000 injuries and more than 3,100 deaths every year in the
14 United States³; and
15
16 Whereas, Simply knowing the risks of distracted driving has not yet translated into reducing the
17 behavior⁴; and
18
19 Whereas, In 2015, Oklahoma became the 46th state to ban texting while driving. The Oklahoma
20 law, Trooper Nicholas Dees and Trooper Keith Burch Act of 2015 , prohibits texting and some
21 other forms of electronic communication--such as taking photos or video and posting to social
22 media--while operating a motor vehicle; and
23
24 Whereas, Some states’ laws prohibit drivers from talking on hand-held devices all together;
25 some laws apply only to vehicles in motion whereas others also apply to drivers stopped in a
26 travel lane. Laws focused specifically on electronic communication, or “texting,” also vary in
27 prohibited conduct. Some statutes prohibit particular behaviors, such as composing, viewing, or
28 transmitting electronic communications, but do not outlaw other actions such as entering a
29 phone number or entering GPS data; and
30
31 Whereas, All states put a legal responsibility on drivers to operate in a safe manner, distracted
32 driving laws vary across the United States in what they prohibit and how they can be enforced;
33 and
34
35 Whereas, Federal law bans cell phone use while operating commercial motor vehicles or
36 transporting hazardous materials. Specifically, in 2010 and 2011, Federal law banned
37 commercial truck drivers, bus drivers, and drivers transporting hazardous materials from using
38 hand-held cell phones and messaging on electronic devices⁵; and

1 Whereas, Current AMA Policy, H-15.952, "The Dangers of Distraction While Operating Hand-
2 Held Devices," merely states "Our AMA will endorse legislation that would ban the use of hand-
3 held devices while driving"; therefore be it

4
5 RESOLVED, That our American Medical Association actively lobby for federal legislation to
6 decrease distracted driving injuries and fatalities by banning the use of electronic
7 communication such as texting, taking photos or video and posting on social media while
8 operating a motor vehicle; (Directive to Take Action) and be it further

9
10 RESOLVED, That our AMA actively lobby for federal legislation to require automobile
11 manufacturers to integrate hands-free technology into new automobiles. (Directive to Take
12 Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 04/15/19

RELEVANT AMA POLICY

The Dangers of Distraction While Operating Hand-Held Devices H-15.952

1. Our American Medical Association encourages physicians to educate their patients regarding the public health risks of text messaging while operating motor vehicles or machinery and will advocate for state legislation prohibiting the use of hand held communication devices to text message while operating motor vehicles or machinery.
2. Our AMA will endorse legislation that would ban the use of hand-held devices while driving.
3. Our AMA: (A) recognizes distracted walking as a preventable hazard and encourages awareness of the hazard by physicians and the public; and (B) encourages research into the severity of distracted walking as a public health hazard as well as ways in which to prevent it.
4. Our AMA supports public education efforts regarding the dangers of distracted driving, particularly activities that take drivers' eyes off the road, and that the use of earbuds or headphones while driving is dangerous and illegal in some states.
5. Our AMA: (A) supports education on the use of earbuds or headphones in both ears during outdoor activities requiring auditory attention, including but not limited to biking, jogging, rollerblading, skateboarding and walking; and (B) supports the use of warning labels on the packaging of hand-held devices utilized with earbuds or headphones, indicating the dangers of using earbuds or headphones in both ears during outdoor activities requiring auditory attention, including but not limited to biking, jogging, rollerblading, skateboarding and walking.

Citation: (Res. 217, I-08; Appended: Res. 905, I-09; Appended: BOT Rep. 10, A-13; Appended: Res. 416, A-13; Modified in lieu of Res. 414, A-15

References

- ¹ National Highway Traffic Safety Administration. (2010, April). Overview of the National Highway Traffic Safety Administration's driver distraction program (Report No. DOT HS 811 299). Washington, DC: Author. Available at www.nhtsa.gov/staticfiles/nti/distracted_driving/pdf/811299.pdf
- ² Centers for Disease Control and Prevention. Mobile Device Use While Driving – United States and Seven European Countries, 2011. Morbidity and Mortality Weekly Report, March 15, 2013/62(10); 177-182.
- ³ National Center for Statistics and Analysis. (2016, April). Distracted driving 2014 (Traffic Safety Facts Research Note. Report No. DOT HS 812 260). Washington, DC: National Highway Traffic Safety Administration. Available at <https://crashstats.nhtsa.dot.gov/Api/Public/ViewPublication/812260>
- ⁴ Atchley, P., Hadlock, C., & Lane, S. (2012). Stuck in the 70s: The role of social norms in distracted driving, Accident Analysis & Prevention, 40, 279-284.
- ⁵ 49 CFR § 392.80 and § 392.82. <https://www.fmcsa.dot.gov/regulations>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 416
(A-19)

Introduced by: Oklahoma

Subject: Non-Medical Exemptions from Immunizations

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

1 Whereas, Non-medical exemptions from immunizations endanger the health of unvaccinated
2 individuals, medically exempt patients, and the health of those in his or her group and the
3 community at large; and
4
5 Whereas, Vaccinations are critical to protect the health and welfare of Oklahomans; and
6
7 Whereas, The Oklahoma State Medical Association supports all efforts to increase vaccination
8 of Oklahoma children; and
9
10 Whereas, Oklahoma State Medical Association endorses requiring day care centers and homes
11 to use the recommendations of the Advisory Committee on Immunization Practices as the rules
12 and regulations governing the specific number of vaccine doses required and frequency of their
13 administration to attend day care; and
14
15 Whereas, AMA public health policy encourages state medical associations to seek removal of
16 non-medical exemption in statutes requiring mandatory immunizations, including for childcare
17 and school attendance and encourages physicians to grant vaccine exemption requests only
18 when medical contraindications are present (AMA Policy H-440.970); and
19
20 Whereas, All states require immunizations for children to attend school. Forty-seven states, all
21 but California, Mississippi, and West Virginia, allow parents to opt out of immunizations if they
22 have religious beliefs against immunizations; and
23
24 Whereas, Oklahoma is one of 18 states that allow parents to opt out of vaccines if they have a
25 personal, moral or philosophical belief against immunizations; and
26
27 Whereas, In 2016 American Academy of Pediatrics took a stance that personal and religious
28 exemptions should end; and
29
30 Whereas, According to the World Health Organization, there has been a 30% increase in
31 measles worldwide in 2017; and
32
33 Whereas, The World Health Organization issued a report in January 2019 that said “vaccine
34 hesitancy” has become a global health threat; and
35
36 Whereas, In 2019 a measles outbreak has prompted a public health emergency in Washington
37 State; therefore be it

1 RESOLVED, That our American Medical Association actively advocate for federal legislation
2 that incentivizes states to eliminate non-medical exemptions to mandated pediatric
3 immunizations. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 04/15/19

RELEVANT AMA POLICY

Nonmedical Exemptions from Immunizations H-440.970

Our American Medical Association believes that nonmedical (religious, philosophic, or personal belief) exemptions from immunizations endanger the health of the unvaccinated individual and the health of those in his or her group and the community at large. Therefore, our AMA (1) supports the immunization recommendations of the Advisory Committee on Immunization Practices (ACIP) for all individuals without medical contraindications; (2) supports legislation eliminating nonmedical exemptions from immunization; (3) encourages state medical associations to seek removal of nonmedical exemptions in statutes requiring mandatory immunizations, including for childcare and school attendance; (4) encourages physicians to grant vaccine exemption requests only when medical contraindications are present; (5) encourages state and local medical associations to work with public health officials to develop contingency plans for controlling outbreaks in medically-exempt populations and to intensify efforts to achieve high immunization rates in communities where nonmedical exemptions are common; and (6) recommends that states have in place: (a) an established mechanism, which includes the involvement of qualified public health physicians, of determining which vaccines will be mandatory for admission to school and other identified public venues (based upon the recommendations of the ACIP); and (b) policies that permit immunization exemptions for medical reasons only.

Citation: (CSA Rep. B, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: Res. 10, A-15; Modified: CSAPH Rep. 1, I-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 417
(A-19)

Introduced by: Pennsylvania

Subject: Improved Health in the United States Prison System through Hygiene and Health Educational Programming for Inmates and Prison Staff

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

1 Whereas, Overcrowding, poor hygiene, and poor-quality food predispose inmates to many
2 preventable diseases; and

3
4 Whereas, Lapses in food safety by prison staff have made United States prisoners six times
5 more likely to contract a foodborne illness, such as Clostridium perfringens or Salmonella, than
6 the general population according to a study from the Centers for Disease Control and
7 Prevention (CDC);² and

8
9 Whereas, Preventing inmates from transmitting illnesses by contact with prison staff, health care
10 providers, and visitors from the community through increased health awareness can contribute
11 to improved community health; and

12
13 Whereas, A research study showed that increased hand hygiene was associated with a 24%
14 reduction in the risk of MRSA acquisition. This risk decreased significantly (by 48%) with hand
15 hygiene compliance levels above 80%. Two additional clinical studies supported this data,
16 showing lower incidence rates of MRSA, resistant E. coli and carbapenem resistant P.
17 aeruginosa when achieving compliance levels higher than 70%;³ and

18
19 Whereas, Existing AMA-MSS policy recognizes the importance of oral health as a part of overall
20 patient care and supports an increase in access to oral health services (440.058MSS); and

21
22 Whereas, Poor oral health may contribute to the development of endocarditis, cardiovascular
23 disease, and premature birth or low birth weight, and it is typically affected by existing conditions
24 such as diabetes, HIV/AIDS, osteoporosis, and Alzheimer's disease. Risk for poor oral hygiene
25 is high in prison inmates as 1.5% of all inmates in state and federal prisons have HIV or AIDS
26 (21,987 persons), which is 4 times the prevalence rate of HIV in the general populace;^{4,5} and

27
28 Whereas, Existing AMA policy focuses on increasing health literacy among populace to remove
29 barriers to effective medical diagnosis and treatment through the development of literacy
30 appropriate, culturally diverse, health-related patient education materials (H-160.931); and

31
32 Whereas, Adults with limited literacy skills are less likely to manage their chronic diseases and
33 more likely to be hospitalized than people with stronger literacy skills. Only 12 percent of adults
34 have proficient health literacy, according to the National Assessment of Adult Literacy. In other
35 words, nearly 9 out of 10 adults may lack the skills needed to manage their health and prevent
36 disease;¹ therefore be it

1 RESOLVED, That our American Medical Association collaborate with state medical societies to
2 emphasize the importance of hygiene and health literacy information sessions for both inmates
3 and staff in state and local prison systems. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 04/26/19

References:

- ¹ America's Health Literacy. Office of Disease Prevention and Health Promotion. 2007. <https://health.gov/communication/literacy/issuebrief/>.
- ² Fassler, J. Prison food is making U.S. inmates disproportionately sick. The Atlantic. 2017 Dec. <https://www.theatlantic.com/health/archive/2017/12/prison-food-sickness-america/549179/>.
- ³ Girou E, et al. Association between hand hygiene compliance and methicillin-resistant Staphylococcus aureus prevalence in a French rehabilitation hospital. Infect Control Hosp Epidemiol. 2006 Oct;27(10):1128-1130.
- ⁴ Maruschak, L. et al. HIV in Prisons, 2007-2008. Department of Justice: Bureau of Justice Statistics Bulletin. 2010.
- ⁵ Oral health: a window to overall health. Mayo Clinic. 2016 Apr. <https://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/dental/art-2004747>.
- ⁶ Rennie, D. et al. Evaluation of Food Hygiene Education. British Food Journal. 1994;96(11):20-25. doi: 10.1108/00070709410074650.

RELEVANT AMA AND AMA-MSS POLICY:

Health Literacy H-160.931

Our AMA:

- (1) recognizes that limited patient literacy is a barrier to effective medical diagnosis and treatment;
- (2) encourages the development of literacy appropriate, culturally diverse health-related patient education materials for distribution in the outpatient and inpatient setting;
- (3) will work with members of the Federation and other relevant medical and nonmedical organizations to make the health care community aware that approximately one fourth of the adult population has limited literacy and difficulty understanding both oral and written health care information;
- (4) encourages the development of undergraduate, graduate, and continuing medical education programs that train physicians to communicate with patients who have limited literacy skills;
- (5) encourages all third party payers to compensate physicians for formal patient education programs directed at individuals with limited literacy skills;
- (6) encourages the US Department of Education to include questions regarding health status, health behaviors, and difficulties communicating with health care professionals in all future National Assessment of Adult Literacy studies;
- (7) encourages the allocation of federal and private funds for research on health literacy;
- (8) recommends all healthcare institutions adopt a health literacy policy with the primary goal of enhancing provider communication and educational approaches to the patient visit;
- (9) recommends all healthcare and pharmaceutical institutions adopt the USP prescription standards and provide prescription instructions in the patient's preferred language when available and appropriate; and
- (10) encourages the development of low-cost community- and health system resources, support state legislation and consider annual initiatives focused on improving health literacy.

Citation: (CSA Rep. 1, A-98; Appended: Res. 415, I-99; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Appended: Res. 718, A-13

Health Information and Education H-170.986

- (1) Individuals should seek out and act upon information that promotes appropriate use of the health care system and that promotes a healthy lifestyle for themselves, their families and others for whom they are responsible. Individuals should seek informed opinions from health care professionals regarding health information delivered by the mass media self-help and mutual aid groups are important components of health promotion/disease and injury prevention, and their development and maintenance should be promoted.
- (2) Employers should provide and employees should participate in programs on health awareness, safety and the use of health care benefit packages.
- (3) Employers should provide a safe workplace and should contribute to a safe community environment. Further, they should promptly inform employees and the community when they know that hazardous

substances are being used or produced at the worksite.

(4) Government, business and industry should cooperatively develop effective worksite programs for health promotion and disease and injury prevention, with special emphasis on substance abuse.

(5) Federal and state governments should provide funds and allocate resources for health promotion and disease and injury prevention activities.

(6) Public and private agencies should increase their efforts to identify and curtail false and misleading information on health and health care.

(7) Health care professionals and providers should provide information on disease processes, healthy lifestyles and the use of the health care delivery system to their patients and to the local community.

(8) Information on health and health care should be presented in an accurate and objective manner.

(9) Educational programs for health professionals at all levels should incorporate an appropriate emphasis on health promotion/disease and injury prevention and patient education in their curricula.

(10) Third party payers should provide options in benefit plans that enable employers and individuals to select plans that encourage healthy lifestyles and are most appropriate for their particular needs. They should also continue to develop and disseminate information on the appropriate utilization of health care services for the plans they market.

(11) State and local educational agencies should incorporate comprehensive health education programs into their curricula, with minimum standards for sex education, sexual responsibility, and substance abuse education. Teachers should be qualified and competent to instruct in health education programs.

(12) Private organizations should continue to support health promotion/disease and injury prevention activities by coordinating these activities, adequately funding them, and increasing public awareness of such services.

(13) Basic information is needed about those channels of communication used by the public to gather health information. Studies should be conducted on how well research news is disseminated by the media to the public. Evaluation should be undertaken to determine the effectiveness of health information and education efforts. When available, the results of evaluation studies should guide the selection of health education programs.

Citation: (BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmation A-07; Reaffirmation A-15

20.002MSS AIDS Education: AMA-MSS: (1) encourages public school instruction, appropriate for a student's age and grade, on the nature of HIV and the prevention of its transmission starting at the earliest age at which health and hygiene are taught; (2) asks the AMA to encourage the training of appropriate school personnel to assure a basic knowledge of the nature of HIV, the prevention of its transmission, the availability of appropriate resources for counseling and referral, and other information that may be appropriate considering the ages and grade levels of pupils. (MSS Sub Res 4, A-87) (Reaffirmed: MSS Rep D, I-97) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12)

440.058MSS Importance of Oral Health in Medical Practice: AMA-MSS (1) recognizes the importance of managing oral health as a part of overall patient care; (2) supports efforts to educate physicians on oral condition screening and management, as well as the consequences of poor oral hygiene on mental and physical health; (3) supports closer collaboration of physicians with dental providers to provide comprehensive medical care; and (4) support efforts to increase access to oral health services. (MSS Res 22, I-16)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 418
(A-19)

Introduced by: Washington

Subject: Eliminating the Death Toll from Combustible Cigarettes

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

1 Whereas, The United States has made great progress in decreasing cigarette smoking since
2 the first Surgeon General's report in 1964; and
3
4 Whereas, Combustible cigarettes continue to kill between 450,000 and 500,000 people each
5 year in the United States; and
6
7 Whereas, The death toll from all other forms of nicotine is very small and not statistically
8 measurable; and
9
10 Whereas, There are many other nicotine-delivering products available to U.S. consumers; and
11
12 Whereas, The level of measurable toxins in non-combustible nicotine products is much lower
13 than in combustible products; and
14
15 Whereas, Safety concerns (real or imagined) have inhibited smokers' understanding of the
16 benefits of product switching; and
17
18 Whereas, Wise regulation and medically accurate labeling can address safety concerns about
19 non-combustible nicotine products; therefore be it
20
21 RESOLVED, That our American Medical Association study and report on the conditions under
22 which our country could successfully eliminate the manufacture, distribution, and sale of
23 combustible cigarettes and other combustible tobacco products at the earliest feasible date.
24 (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 04/26/19

RELEVANT AMA POLICY

Sales and Distribution of Tobacco Products and Electronic Nicotine Delivery Systems (ENDS) and E-cigarettes H-495.986

H-495.986 Tobacco Product Sales and Distribution

Our AMA:

- (1) recognizes the use of e-cigarettes and vaping as an urgent public health epidemic and will actively work with the Food and Drug Administration and other relevant stakeholders to counteract the marketing and use of addictive e-cigarette and vaping devices, including but not limited to bans and strict restrictions on marketing to minors under the age of 21;
- (2) encourages the passage of laws, ordinances and regulations that would set the minimum age for purchasing tobacco products, including electronic nicotine delivery systems (ENDS) and e-cigarettes, at 21 years, and urges strict enforcement of laws prohibiting the sale of tobacco products to minors;
- (3) supports the development of model legislation regarding enforcement of laws restricting children's access to tobacco, including but not limited to attention to the following issues: (a) provision for licensure to sell tobacco and for the revocation thereof; (b) appropriate civil or criminal penalties (e.g., fines, prison terms, license revocation) to deter violation of laws restricting children's access to and possession of tobacco; (c) requirements for merchants to post notices warning minors against attempting to purchase tobacco and to obtain proof of age for would-be purchasers; (d) measures to facilitate enforcement; (e) banning out-of-package cigarette sales ("loosies"); and (f) requiring tobacco purchasers and vendors to be of legal smoking age;
- (4) requests that states adequately fund the enforcement of the laws related to tobacco sales to minors;
- (5) opposes the use of vending machines to distribute tobacco products and supports ordinances and legislation to ban the use of vending machines for distribution of tobacco products;
- (6) seeks a ban on the production, distribution, and sale of candy products that depict or resemble tobacco products;
- (7) opposes the distribution of free tobacco products by any means and supports the enactment of legislation prohibiting the disbursement of samples of tobacco and tobacco products by mail;
- (8) (a) publicly commends (and so urges local medical societies) pharmacies and pharmacy owners who have chosen not to sell tobacco products, and asks its members to encourage patients to seek out and patronize pharmacies that do not sell tobacco products; (b) encourages other pharmacists and pharmacy owners individually and through their professional associations to remove such products from their stores; (c) urges the American Pharmacists Association, the National Association of Retail Druggists, and other pharmaceutical associations to adopt a position calling for their members to remove tobacco products from their stores; and (d) encourages state medical associations to develop lists of pharmacies that have voluntarily banned the sale of tobacco for distribution to their members; and
- (9) opposes the sale of tobacco at any facility where health services are provided; and
- (10) supports that the sale of tobacco products be restricted to tobacco specialty stores.

Citation: CSA Rep. 3, A-04; Appended: Res. 413, A-04; Reaffirmation A-07; Amended: Res. 817, I-07; Reaffirmation A-08; Reaffirmation I-08; Reaffirmation A-09; Reaffirmation I-13; Reaffirmation A-14; Reaffirmation I-14; Reaffirmation A-15; Modified in lieu of Res. 421, A-15; Modified in lieu of Res. 424, A-15; Reaffirmation I-16; Appended: Res. 926, I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 419
(A-19)

Introduced by: Washington

Subject: Universal Access for Essential Public Health Services

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

1 Whereas, We have not gained a general consensus on what are the essential public health
2 services that everyone in our country are entitled to receive; and
3
4 Whereas, Public health governance structures and funding sources greatly vary by region,
5 state, and jurisdiction across the country; and
6
7 Whereas, Compartmentalized, competitive, unpredictable, and inflexible funding leaves many
8 health departments without financing for all essential public health services and necessary
9 capabilities; and
10
11 Whereas, Hospitals play an important role in local public health systems and possess enormous
12 capacity to provide essential public health services in a cost-effective manner; and
13
14 Whereas, We have no means to accurately capture capabilities and spending on essential
15 public health services in every jurisdiction in order to determine if there is a current lack of
16 universal access; and
17
18 Whereas, We have no means of collecting outcome data in order the monitor the access to and
19 cost effectiveness of our public health interventions; therefore be it
20
21 RESOLVED, That our American Medical Association study the options and/or make
22 recommendations regarding the establishment of:
23
24 1. A list of all essential public health services that should be provided in every jurisdiction in
25 the United States.
26 2. A federal data system that can capture the amount of federal, state, and local public
27 health capabilities and spending that occurs in every jurisdiction to assure that their
28 populations have universal access to all essential public health services.
29 3. A federal data system that can capture actionable evidence-based outcomes data from
30 public health activities in every jurisdiction (Directive to Take Action); and be it further
31
32 RESOLVED, That our AMA prepare and publicize annual reports on current efforts and
33 progress to achieve universal access to all essential public health services. (Directive to Take
34 Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 04/26/19

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3. Foundational Public Health Services Model Version 1.0. Public Health National Center for Innovations. Access at: https://phnci.org/uploads/resource-files/PHNCI-FPHS-Factsheet_FINAL-1.pdf
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RELEVANT AMA POLICY

Federal Block Grants and Public Health H-440.912

- (1) Our AMA should collaborate with national public health organizations to explore ways in which public health and clinical medicine can become better integrated; such efforts may include the development of a common core of knowledge for public health and medical professionals, as well as educational vehicles to disseminate this information.
- (2) Our AMA urges Congress and responsible federal agencies to: (a) establish set-asides or stable funding to states and localities for essential public health programs and services, (b) provide for flexibility in funding but ensure that states and localities are held accountable for the appropriate use of the funds; and (c) involve national medical and public health organizations in deliberations on proposed changes in funding of public health programs.
- (3) Our AMA will work with and through state and county medical societies to: (a) improve understanding of public health, including the distinction between publicly funded medical care and public health; (b) determine the roles and responsibilities of private physicians in public health, particularly in the delivery of personal medical care to underserved populations; (c) advocate for essential public health programs and services; (d) monitor legislative proposals that affect the nation's public health system; (e) monitor the growing influence of managed care organizations and other third party payers and assess the roles and responsibilities of these organizations for providing preventive services in communities; and (f) effectively communicate with practicing physicians and the general public about important public health issues.
- (4) Our AMA urges state and county medical societies to: (a) establish more collegial relationships with public health agencies and increase interactions between private practice and public health physicians to develop mutual support of public health and clinical medicine; and (b) monitor and, to the extent possible, participate in state deliberations to ensure that block grant funds are used appropriately for health-related programs.
- (5) Our AMA urges physicians and medical societies to establish community partnerships comprised of concerned citizens, community groups, managed care organizations, hospitals, and public health agencies to: (a) assess the health status of their communities and determine the scope and quality of population- and personal-based health services in their respective regions; and (b) develop performance objectives that reflect the public health needs of their states and communities.
6. Our AMA: (a) supports the continuation of the Preventive Health and Health Services Block

Grant, or the securing of adequate alternative funding, in order to assure preservation of many critical public health programs for chronic disease prevention and health promotion in California and nationwide, and to maintain training of the public health physician workforce; and (b) will communicate support of the continuation of the Preventive Health and Health Services Block Grant, or the securing of adequate alternative funding, to the US Congress.

Citation: (CSA Rep. 3, A-96; Reaffirmation A-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed in lieu of Res. 424, A-11; Appended: Res. 935, I-11; Reaffirmation A-15

Support for Public Health D-440.997

1. Our AMA House of Delegates request the Board of Trustees to include in their long range plans, goals, and strategic objectives to support the future of public health in order "to fulfill society's interest in assuring the conditions in which people can be healthy." This shall be accomplished by AMA representation of the needs of its members? patients in public health-related areas, the promotion of the necessary funding and promulgation of appropriate legislation which will bring this to pass.
2. Our AMA: (A) will work with Congress and the Administration to prevent further cuts in the funds dedicated under the Patient Protection and Affordable Care Act to preserve state and local public health functions and activities to prevent disease; (B) recognizes a crisis of inadequate public health funding, most intense at the local and state health jurisdiction levels, and encourage all medical societies to work toward restoration of adequate local and state public health functions and resources; and (C) in concert with state and local medical societies, will continue to support the work of the Centers for Disease Control and Prevention, and the efforts of state and local health departments working to improve community health status, lower the risk of disease and protect the nation against epidemics and other catastrophes.
3. Our AMA recognizes the importance of timely research and open discourse in combatting public health crises and opposes efforts to restrict funding or suppress the findings of biomedical and public health research for political purposes.

Res. 409, A-99 Modified CLRDPD Rep. 1, A-03 Reaffirmed: CSAPH Rep. 1, A-13 Appended: Res. 206, A-13 Reaffirmation A-15 Appended: Res. 902, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 420
(A-19)

Introduced by: Resident and Fellow Section

Subject: Coordinating Correctional and Community Healthcare

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

1 Whereas, The United States has the highest rate of incarceration in the world¹ with an
2 estimated 6,899,000 individuals held under the supervision of the correctional system at year
3 end 2013²; and

4 Whereas, The incarcerated population has higher rates of many chronic diseases, including
5 tuberculosis, HIV, hepatitis, asthma, mental health disorders, and substance abuse than the
6 general public³; and

7 Whereas, The increased aging of the prison population will only increase the rates of chronic
8 medical conditions⁴; and

9 Whereas, The health benefits gained through incarceration, such as food, housing, medication,
10 and access to healthcare are lost upon release, as shown by the increased rate of all-cause
11 mortality in the two weeks following release, as well as the increased rate of hospitalization
12 among recently released inmates compared to the general public and the increased utilization of
13 the emergency department and acute care settings⁵⁻⁶; and

14 Whereas, Health benefits have been demonstrated from the linkage of care from correctional
15 institutions to community health clinics and resources, with poorer chronic health outcomes
16 seen in those not linked to care on reentry compared to those linked to care, as well as
17 decreased utilization of emergency department in those linked to community health care upon
18 release⁷⁻⁸; therefore be it

¹ Cloud DH, Parsons J, Delany-Brumsey A. Addressing mass incarceration: a clarion call for public health. *Am J Public Health*. 2014;104(3):389-391.

² Glaze LE, Kaeble D. Correctional populations in the United States, 2013. Bureau of Justice Statistics; 2014. Available at [http://www.bjs.gov/index.cfm?ty=pb&detail&id=5177\(www.bjs.gov\)](http://www.bjs.gov/index.cfm?ty=pb&detail&id=5177(www.bjs.gov)). Accessed April 1, 2016.

³ Marks JS and Turner N. The critical link between health care and jails. *Health Affairs*. 2014; 33(3): 443-447.

⁴ Williams BA, Goodwin JS, Baillargeon J, Ahalt C, Walter LC. Addressing the aging crisis in U.S. criminal justice health care. *J Am Geriatr Soc*. 2012;60(6):1150-1156.

⁵ Binswanger IA, Stern MF, Deyo RA, et al. Release from prison--a high risk of death for former inmates. *N Engl J Med*. 2007;356(2):157-165.

⁶ Frank JW, Linder JA, Becker WC, Fiellin DA, Wang, E. Increased hospital and emergency department utilization by individuals with recent criminal justice involvement: results of a national survey. *JGIM*. 29(9): 12256-33.

⁷ Montague BT, Rosen DL, Sammartino C, et al. Systematic Assessment of Linkage to Care for Persons with HIV Released from Corrections Facilities Using Existing Datasets. *AIDS Patient Care STDs*. 2016;30(2):84-91.

⁸ Montague BT, Rosen DL, Sammartino C, Costa M, Gutman R, Solomon L, Rich J. Systemic assessment of linkage to care of persons with HIV released from corrections facilities using existing databases. *AIDS Patient Care and STDs*. 2016; 30(2): 84-91.

23 RESOLVED, That our American Medical Association support linkage of those incarcerated to
24 community clinics upon release in order to accelerate access to primary care and improve
25 health outcomes among this vulnerable patient population, as well as adequate funding (New
26 HOD Policy); and be it further
27
28 RESOLVED, That our AMA support the collaboration of correctional health workers and
29 community health care providers for those transitioning from a correctional institution to the
30 community. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000.

Received: 05/01/19

RELEVANT AMA POLICY

Standards of Care for Inmates of Correctional Facilities H-430.997

Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance misuse care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism.

Citation: (Res. 60, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Amended: Res. 416, I-99; Reaffirmed: CEJA Rep. 8, A-09; Reaffirmation I-09; Modified in lieu of Res. 502, A-12; Reaffirmation: I-12

Health Care While Incarcerated H-430.986

1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA supports partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. That our AMA encourage state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
5. Our AMA encourages states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal justice system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA urges the Centers for Medicare & Medicaid Services (CMS) and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from correctional facilities in order to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism.
7. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of incarcerated women and adolescent females, including gynecological care and obstetrics care for pregnant and postpartum women.

Citation: CMS Rep. 02, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 421
(A-19)

Introduced by: Resident and Fellow Section

Subject: Contraception for Incarcerated Women

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

1 Whereas, The United States accounts for over 30% of the world's population of incarcerated
2 women¹ and currently houses more than 200,000 female prisoners²; and
3
4 Whereas, The population of females in jail or prison worldwide has risen 53% since the year
5 2003; and
6
7 Whereas, The majority of incarcerated women in the United States are between the ages of 18
8 and 44, and therefore are within reproductive age⁴; and
9
10 Whereas, Up to 84% of incarcerated women have had a prior unintended pregnancy⁵, 77-84%
11 of incarcerated women plan to be sexually active within six months of release⁶ and 72% of
12 incarcerated women were not using a regular form of contraception prior to incarceration; and
13
14 Whereas, The majority of women incarcerated have multiple barriers to accessing healthcare
15 upon release from jail, and incarceration provides a unique opportunity to provide healthcare to
16 a resource poor population; and
17
18 Whereas, Our AMA has policy which advocates for necessary programs and staff training to
19 address the distinctive health care needs of incarcerated women and adolescent females and
20 encourages improved access to comprehensive physical and behavioral health care services to
21 adults and juveniles while incarcerated; and
22
23 Whereas, Our AMA has policy that advocates for necessary programs and staff training to
24 address the distinctive health care needs of incarcerated women and adolescent females,
25 including gynecological care and obstetrics care for pregnant and postpartum; therefore be it
26
27 RESOLVED, That our American Medical Association support incarcerated persons' access to
28 evidence-based contraception counseling, access to all contraceptive methods and autonomy
29 over contraceptive decision-making prior to release. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000.

Received: 05/01/19

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1 Kajstura, Alexis. (2018), "States of Women's Incarceration: The Global Context 2018" Prison Policy Initiative. URL
<https://www.prisonpolicy.org/global/women/2018.html>, accessed August 31, 2018.

2 Walmsley, R (2017). World Female Imprisonment List, Fourth Edition. Institute for Criminal Policy Research.

3 Kajstura, Alexis (2017), "Women's Mass Incarceration: The Whole Pie 2017". Prison Policy Initiative. URL
<https://www.prisonpolicy.org/reports/pie2017women.html> Accessed August 31, 2018.

4 Carson, AE (2018), "Prisoners in 2016" (No. NCJ 251149), Department of Justice, Bureau of Justice Statistics, Washington DC.

- 5 Clarke, JG; Hebert, MR; Rosengard, C; et al. "Reproductive healthcare and family planning needs among incarcerated women", Am Journal Public Health, Vol 96, p. 834-839.
- 6 Larocelle, F; Castro, C; Goldenson, J; Tulsky, JP; et al. (2012), "Contraceptive use and barriers to access among newly arrested women", J Correct Health Care, Vol 18, p. 111-119.
- 7 Oswalt, K; Hale, GJ; Cropsey, KL; et al. (2010), "The contraceptive needs for STD protection among women in jail", Health Educ. Behav. Off. Publ. Soc. Health Educ., Vol 37, p. 568-579.

RELEVANT AMA POLICY

Health Care While Incarcerated H-430.986

1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA supports partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. That our AMA encourage state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
5. Our AMA encourages states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal justice system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA urges the Centers for Medicare & Medicaid Services (CMS) and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from correctional facilities in order to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism.
7. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of incarcerated women and adolescent females, including gynecological care and obstetrics care for pregnant and postpartum women.

Citation: CMS Rep. 02, I-16

Standards of Care for Inmates of Correctional Facilities H-430.997

Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance misuse care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism.

Citation: (Res. 60, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Amended: Res. 416, I-99; Reaffirmed: CEJA Rep. 8, A-09; Reaffirmation I-09; Modified in lieu of Res. 502, A-12; Reaffirmation: I-12

Reducing Unintended Pregnancy H-75.987

Our AMA: (1) urges health care professionals to provide care for women of reproductive age, to assist them in planning for pregnancy and support age-appropriate education in esteem building, decision-making and family life in an effort to introduce the concept of planning for childbearing in the educational process; (2) supports reducing unintended pregnancies as a national goal; and (3) supports the training of all primary care physicians and relevant allied health professionals in the area of preconception counseling, including the recognition of long-acting reversible contraceptives as efficacious and economical forms of contraception.

Citation: Res. 512, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmation A-15; Appended: Res. 502, A-15; Reaffirmation I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 422
(A-19)

Introduced by: Resident and Fellow Section

Subject: Promoting Nutrition Education Among Healthcare Providers

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

1 Whereas, The prevalence of obesity in the United States is on the continuous rise unchecked,
2 with more than one-third of the population being obese; and
3
4 Whereas, The growing burden of obesity is enormous, with about \$68 billion direct medical
5 costs and 280,000 deaths each year¹; and
6
7 Whereas, Millions of people in the US file for disability each year²; and
8
9 Whereas, Clinicians tend to focus more on the complications of obesity such as hypertension,
10 Type II Diabetes and coronary artery disease. However, the importance of primary prevention in
11 early identification and intervention of obesity is seldom discussed by physicians; and
12
13 Whereas, The common misconception that nutrition counseling is not their role, but rather the
14 function of dieticians, is still prevalent among healthcare providers; and
15
16 Whereas, Some of the important barriers to counseling include lack of nutrition knowledge and
17 skills in nutrition counseling among the medical practitioners.³ Physicians often do not feel
18 comfortable, confident, or adequately prepared in discussing their patients' diet³; and
19
20 Whereas, Targeting the dietary habits of our patients and preventing obesity offers a
21 tremendous opportunity to optimize the overall quality of patient care, improve clinical
22 outcomes, and reduce overall healthcare costs; and
23
24 Whereas, Nutrition knowledge appears confined largely to books and exams. In fact, according
25 to one study, doctors engage in nutrition counseling with patients only 11% of the time³; and
26
27 Whereas, In teaching hospitals, where residents work closely with patients, it is crucial that
28 residents develop a comprehensive knowledge of nutrition science and apply that knowledge to
29 clinical practice; therefore be it
30
31 RESOLVED, That American Medical Association Policy H-150.995, "Basic Courses in Nutrition,"
32 be reaffirmed (Reaffirm HOD Policy); and be it further
33
34 RESOLVED, That AMA Policy H-150.953, "Obesity as a Major Public Health Problem," be
35 reaffirmed. (Reaffirm HOD Policy)

Fiscal Note: Minimal - less than \$1,000.

Received: 05/01/19

References:

1. Tremmel M, Gerdtham U-G, Nilsson PM, Saha S. Economic burden of obesity: A systemic literature review. *Int J Environ Res Public Health.* 2017; 14(4):435.
2. Lazarus K, Weinsier RL, Boker JR. Nutrition knowledge and practices of physicians in a family-practice residency program: the effect of an education program provided by a physician nutrition specialist. *Am J Clin Nutr.* 1993; 58:319-25.
3. Vetter ML, Herring SJ, Sood M, Shah NR, Kalet AL. What do resident physicians know about nutrition? An evaluation of attitudes, self-perceived proficiency and knowledge. *J Am Coll Nutr.* 2008; 27(2):287-298.

RELEVANT AMA POLICY

Basic Courses in Nutrition H-150.995

Our AMA encourages effective education in nutrition at the undergraduate, graduate, and postgraduate levels.

Citation: (Sub. Res. 116, A-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-11

Obesity as a Major Public Health Problem H-150.953

Our AMA will: (1) urge physicians as well as managed care organizations and other third party payers to recognize obesity as a complex disorder involving appetite regulation and energy metabolism that is associated with a variety of comorbid conditions;

(2) work with appropriate federal agencies, medical specialty societies, and public health organizations to educate physicians about the prevention and management of overweight and obesity in children and adults, including education in basic principles and practices of physical activity and nutrition counseling; such training should be included in undergraduate and graduate medical education and through accredited continuing medical education programs;

(3) urge federal support of research to determine: (a) the causes and mechanisms of overweight and obesity, including biological, social, and epidemiological influences on weight gain, weight loss, and weight maintenance; (b) the long-term safety and efficacy of voluntary weight maintenance and weight loss practices and therapies, including surgery; (c) effective interventions to prevent obesity in children and adults; and (d) the effectiveness of weight loss counseling by physicians;

(4) encourage national efforts to educate the public about the health risks of being overweight and obese and provide information about how to achieve and maintain a preferred healthy weight;

(5) urge physicians to assess their patients for overweight and obesity during routine medical examinations and discuss with at-risk patients the health consequences of further weight gain; if treatment is indicated, physicians should encourage and facilitate weight maintenance or reduction efforts in their patients or refer them to a physician with special interest and expertise in the clinical management of obesity;

(6) urge all physicians and patients to maintain a desired weight and prevent inappropriate weight gain;

(7) encourage physicians to become knowledgeable of community resources and referral services that can assist with the management of overweight and obese patients; and

(8) urge the appropriate federal agencies to work with organized medicine and the health insurance industry to develop coding and payment mechanisms for the evaluation and management of obesity.

Citation: (CSA Rep. 6, A-99; Reaffirmation A-09; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmation A-12; Reaffirmed in lieu of Res. 434, A-12; Reaffirmation A-13; Reaffirmed: CSAPH Rep. 3, A-13

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 423
(A-19)

Introduced by: American Academy of Pediatrics

Subject: Mandatory Immunizations for Asylum Seekers

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

1 Whereas, The current recommended process for immunization of asylum seekers to the United
2 States involves immunization assessment and as indicated vaccine administration in overseas
3 camps prior to embarkment to the US; and
4
5 Whereas, Refugees are currently not legally required to get vaccinations before US
6 resettlement; and
7
8 Whereas, There currently exists a partnership between the CDC, the Bureau of Population,
9 Migration, and Refugees, and the Department of State; and
10
11 Whereas, The vaccinations are provided at reduced price through the Unicef Program; and
12
13 Whereas, The increase in asylum seekers who are entering the US by foot without prior
14 positioning in an overseas camp situation makes vaccination prior to arrival impossible; and
15
16 Whereas, There remains a resurgence of vaccine-preventable diseases being disseminated
17 during the asylum seeker's journey and processing, in addition to that among current US
18 residents; and
19
20 Whereas, Current US residents are eligible to receive Vaccine for Children (VFC) immunizations
21 at considerably reduced cost; and
22
23 Whereas, Immunizations remain one of the greatest health promotion accomplishments of our
24 time; therefore be it
25
26 RESOLVED, That our American Medical Association call for asylum seekers to receive all
27 medically-appropriate vaccinations upon presentation for asylum regardless of country of origin.
28 (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 05/09/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 424
(A-19)

Introduced by: American Academy of Physical Medicine and Rehabilitation

Subject: Physician Involvement in State Regulations of Motor Vehicle Operation and/or Firearm Use by Individuals with Cognitive Deficits Due to Traumatic Brain Injury

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

1 Whereas, Approximately 6,000 individuals per day sustain a traumatic brain injury (TBI) in the
2 US¹; and
3
4 Whereas, In 2017, approximately 1.4 million people made at least one suicide attempt and of
5 those successful, 50.57% were achieved by firearms²; and
6
7 Whereas, People with TBI are twice as likely to commit suicide; and Veterans, a large
8 population of whom have a TBI are also twice as likely to commit suicide^{3,4,5,6}; and
9
10 Whereas, A systematic review has found that 18% of persons affected by brain injury have
11 attempted suicide and were successful 3–4 times more often than the general population¹; and
12
13 Whereas, Federal law (49 USC 31113(a)(8), 49 CFR 391.41-49) states that medical clearance
14 is required for interstate commercial travel along with numerous states having laws promoting or
15 legally requiring physicians to report patients with medical issues that would impair driving; and
16
17 Whereas, Many states have specific agencies or committees tasked with aiding the state in
18 determining the safety of individuals based on their medical conditions and/or ability to exercise
19 sound judgment in relation to driving, and in some instances, proper use and storage of a
20 handgun^{7,8}; and
21
22 Whereas, The AMA has policy focused on decreasing gun related violence and deaths through
23 public campaigning, generalized advocacy, and requests to the US Surgeon General, and has
24 declared gun violence a public health emergency; and
25
26 Whereas, The AMA supports physician reporting of impaired or possibly impaired patients to
27 state agencies when relating to their driving abilities; therefore be it

¹ Zafonte, Ross D., et al. Brain Injury Medicine, 2nd Edition: Principles and Practice. Vol. 2nd ed, Demos Medical, 2013.

² American Foundation for Suicide Prevention . Suicide Statistics. <https://afsp.org/about-suicide/suicide-statistics/>. Accessed March 18, 2019.

³ Goldstein L, Diaz-Arrastia R. Traumatic Brain Injury and Risk of Suicide. JAMA. 2018;320(6):554–556. doi:10.1001/jama.2018.10825.

⁴ Madsen T, Erlangsen A, Orlovska S, Mofaddy R, Nordentoft M, Benros ME. Association Between Traumatic Brain Injury and Risk of Suicide. JAMA. 2018;320(6):580–588. doi:10.1001/jama.2018.10211.

⁵ Teasdale TW, Engberg AW. Suicide after traumatic brain injury: a population study. J Neurol Neurosurg Psychiatry. 2001; 71(4): 436–440.

⁶ Simpson G, Tate R. Suicidality in people surviving a traumatic brain injury: prevalence, risk factors and implications for clinical management. Brain Inj. 2007; 21(13–14): 1335–1351.271.

⁷ Berger JT, Rosner F, Kark P, Bennett AJ. Reporting by physicians of impaired drivers and potentially impaired drivers. The Committee on Bioethical Issues of the Medical Society of the State of New York. J Gen Intern Med. 2000 Sep;15(9):667-72.

⁸ Texas Department of State Health Services. Duties of the Medical Advisory Board. Texas Department of State Health Services. <https://dshs.texas.gov/medical-advisory-board/>. Published March 7, 2019. Accessed March 18, 2019.

1 RESOLVED, That our American Medical Association reaffirm current AMA policy,
2 H-145.999, "Gun Regulation," stating it supports stricter enforcement of current federal and
3 state gun legislation (Reaffirm HOD Policy); and be it further
4
5 RESOLVED, That our AMA advocate for physician-led committees in each state to give further
6 recommendations to the state regarding driving and/or gun use by individuals who are
7 cognitively impaired and/or a danger to themselves or others. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 05/02/19

RELEVANT AMA POLICY

Ban Realistic Toy Guns H-145.995

The AMA supports (1) working with civic groups and other interested parties to ban the production, sale, and distribution of realistic toy guns; and (2) taking a public stand on banning realistic toy guns by various public appeal methods.

Citation: Sub. Res. 140, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CSAPH Rep. 01, A-18

Gun Regulation H-145.999

Our AMA supports stricter enforcement of present federal and state gun legislation and the imposition of mandated penalties by the judiciary for crimes committed with the use of a firearm, including the illegal possession of a firearm.

Citation: Sub. Res. 31, I-81; Reaffirmed: CLRPD Rep. F, I-91; Amended: BOT Rep. I-93-50; Reaffirmed: Res. 409, A-00; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Modified: Res. 401, A-17; Reaffirmation: I-18

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997

Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths. Therefore, the AMA: (1) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;

(2) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths; (3) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;

(4) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible; (6) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;

(7) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and (8) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.

Citation: CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appended: Res. 403, I-99; Reaffirmation A-07; Reaffirmation A-13; Appended: Res. 921, I-13; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmation: A-18; Reaffirmation: I-18

Gun Safety H-145.978

Our AMA: (1) recommends and promotes the use of trigger locks and locked gun cabinets as safety precautions; and (2) endorses standards for firearm construction reducing the likelihood of accidental discharge when a gun is dropped and that standardized drop tests be developed.

Citation: (Res. 425, I-98; Reaffirmed: Res. 409, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmation A-13

Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975

1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.
2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.
3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.

Citation: Sub. Res. 221, A-13; Appended: Res. 416, A-14; Reaffirmed: Res. 426, A-16; Reaffirmed: BOT Rep. 28, A-18; Reaffirmation: A-18; Modified: CSAPH Rep. 04, A-18; Reaffirmation: I-18

Gun Violence as a Public Health Crisis D-145.995

Our AMA: (1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and (2) will actively lobby Congress to lift the gun violence research ban.

Citation: Res. 1011, A-16; Reaffirmation: A-18; Reaffirmation: I-18

Firearm Availability H-145.996

1. Our AMA: (a) advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.
2. Our AMA supports requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms.
3. Our AMA supports “gun violence restraining orders” for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as “red-flag” laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and “red-flag” laws, we also support the importance of due process so that individuals can petition for their rights to be restored.

Citation: Res. 140, I-87; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: BOT Rep. 12, A-16; Appended: Res. 433, A-18; Reaffirmation: I-18; Modified: BOT Rep. 11, I-18

Physicians and the Public Health Issues of Gun Safety D-145.997

Our AMA will request that the US Surgeon General develop a report and campaign aimed at reducing gun-related injuries and deaths.

Citation: (Res. 410, A-13

AMA Campaign to Reduce Firearm Deaths H-145.988

The AMA supports educating the public regarding methods to reduce death and injury due to keeping guns, ammunition and other explosives in the home.

Citation: (Res. 410, A-93; Reaffirmed: CLRDPD Rep. 5, A-03; Reaffirmation A-13; Modified: CSAPH Rep. 1, A-13

Firearms and High-Risk Individuals H-145.972

Our AMA supports: (1) the establishment of laws allowing family members, intimate partners, household members, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms; (3) expanding domestic violence restraining orders to include dating partners; (4) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons; (5) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and (6) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals.

Citation: CSAPH Rep. 04, A-18; Reaffirmed: BOT Rep. 11, I-18

Waiting Period Before Gun Purchase H-145.992

The AMA supports legislation calling for a waiting period of at least one week before purchasing any form of firearm in the U.S.

Citation: Res. 171, A-89; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Reaffirmation: A-18

E-8.2 Impaired Drivers & Their Physicians

A variety of medical conditions can impair an individuals ability to operate a motor vehicle safely, whether a personal car or boat or a commercial vehicle, such as a bus, train, plane, or commercial vessel. Those who operate a vehicle when impaired by a medical condition pose threats to both public safety and their own well-being. Physicians have unique opportunities to assess the impact of physical and mental conditions on patients ability to drive safely and have a responsibility to do so in light of their professional obligation to protect public health and safety. In deciding whether or how to intervene when a patients medical condition may impair driving, physicians must balance dual responsibilities to promote the welfare and confidentiality of the individual patient, and to protect public safety.

Not all physicians are in a position to evaluate the extent or effect of a medical condition on a patients ability to drive, particularly physicians who treat patients only on a short-term basis. Nor do all physicians necessarily have appropriate training to identify and evaluate physical or mental conditions in relation to the ability to drive. In such situations, it may be advisable to refer a potentially at-risk patient for assessment.

To serve the interests of their patients and the public, within their areas of expertise physicians should:

- (a) Assess at-risk patients individually for medical conditions that might adversely affect driving ability, using best professional judgment and keeping in mind that not all physical or mental impairments create an obligation to intervene.
- (b) Tactfully but candidly discuss driving risks with the patient and, when appropriate, the family when a medical condition may adversely affect the patients ability to drive safely. Help the patient (and family) formulate a plan to reduce risks, including options for treatment or therapy if available, changes in driving behavior, or other adjustments.
- (c) Recognize that safety standards for those who operate commercial transportation are subject to governmental medical standards and may differ from standards for private licenses.
- (d) Be aware of applicable state requirements for reporting to the licensing authority those patients whose impairments may compromise their ability to operate a motor vehicle safely.
- (e) Prior to reporting, explain to the patient (and family, as appropriate) that the physician may have an obligation to report a medically at-risk driver:
 - (i) when the physician identifies a medical condition clearly related to the ability to drive;
 - (ii) when continuing to drive poses a clear risk to public safety or the patients own well-being and the patient ignores the physicians advice to discontinue driving; or
 - (iii) when required by law.
- (f) Inform the patient that the determination of inability to drive safely will be made by other authorities, not the physician.

(g) Disclose only the minimum necessary information when reporting a medically at-risk driver, in keeping with ethics guidance on respect for patient privacy and confidentiality.

[AMA Principles of Medical Ethics: I, III, IV, VII](#)

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Issued: 2016

See also:

Brain Injury in Boxing H-470.984

Reduction of Sports-Related Injury and Concussion H-470.954

Boxing Safety H-470.963

Ban on Handguns and Automatic Repeating Weapons H-145.985

Safety of Nonpowder (Gas-Loaded/Spring-Loaded) Guns H-145.989

Waiting Period Before Gun Purchase H-145.992 (Recently Modified)

School Violence H-145.983

Increasing Toy Gun Safety H-145.974

Guns in School Settings H-60.947

Guns in Hospitals H-215.977

Prevention of Ocular Injuries from BB and Air Guns H-145.982

Ocular Injuries from Air Guns H-10.961

Prevention of Unintentional Shooting Deaths Among Children H-145.979

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 425
(A-19)

Introduced by: Georgia

Subject: Distracted Driver Education and Advocacy

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

1 Whereas, A higher percentage of U.S. drivers text or use hand-held cell phones while driving
2 compared to drivers in European countries; and

4 Whereas, The CDC states that in 2016, 3,450 people were killed in crashes involving a
5 distracted driver; and

7 Whereas, The CDC also found that in 2015, 391,000 people were injured in motor vehicle
8 crashes involving a distracted driver; and

10 Whereas, One-fourth of all traffic accidents are associated with cell phone use; and

12 Whereas, Sixteen states and the District of Columbia have laws in place banning hand-held cell
13 phone use and texting; therefore be it

15 RESOLVED, That our American Medical Association make it a priority to create a national
16 education and advocacy campaign on distracted driving in collaboration with the Centers for
17 Disease Control and other interested stakeholders (Directive to Take Action); and be it further

19 RESOLVED, That our AMA explore developing an advertising campaign on distracted driving
20 with report back to the House of Delegates at the 2019 Interim Meeting. (Directive to Take
21 Action)

Fiscal Note: Estimated cost of \$65,000 to implement resolution.

Received: 05/09/19

RELEVANT AMA POLICY

The Dangers of Distraction While Operating Hand-Held Devices H-15.952

1. Our American Medical Association encourages physicians to educate their patients regarding the
public health risks of text messaging while operating motor vehicles or machinery and will advocate for
state legislation prohibiting the use of hand held communication devices to text message while operating
motor vehicles or machinery.

2. Our AMA will endorse legislation that would ban the use of hand-held devices while driving.
3. Our AMA: (A) recognizes distracted walking as a preventable hazard and encourages awareness of
the hazard by physicians and the public; and (B) encourages research into the severity of distracted
walking as a public health hazard as well as ways in which to prevent it.
4. Our AMA supports public education efforts regarding the dangers of distracted driving, particularly
activities that take drivers' eyes off the road, and that the use of earbuds or headphones while driving is
dangerous and illegal in some states.
5. Our AMA: (A) supports education on the use of earbuds or headphones in both ears during outdoor

activities requiring auditory attention, including but not limited to biking, jogging, rollerblading, skateboarding and walking; and (B) supports the use of warning labels on the packaging of hand-held devices utilized with earbuds or headphones, indicating the dangers of using earbuds or headphones in both ears during outdoor activities requiring auditory attention, including but not limited to biking, jogging, rollerblading, skateboarding and walking.

Citation: (Res. 217, I-08; Appended: Res. 905, I-09; Appended: BOT Rep. 10, A-13; Appended: Res. 416, A-13; Modified in lieu of Res. 414, A-15

Distracted Driver Reduction D-15.993

Our AMA will develop model state legislation to limit cell phone use to hands-free use only while driving.

Citation: Res. 220, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 426
(A-19)

Introduced by: Minority Affairs Section
American Association of Public Health Physicians

Subject: Health Care Accreditation of Correctional, Detention and Juvenile Facilities

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

1 Whereas, In 1976, the Supreme Court of the United States¹ and other courts ruled that all
2 persons incarcerated in the United States are entitled to "reasonably adequate health care,
3 meaning "services at a level reasonably commensurate with modern medical science and a
4 quality acceptable within prudent professional standards"; and
5

6 Whereas, The American Medical Association developed a set of standards for health care
7 provided to prisoners of jails, prisons, and juvenile detention facilities during the 1970s which
8 were later adopted by the National Commission on Correctional Health Care; and
9

10 Whereas, There are organizations that have created standards of correctional health care
11 services and support and regularly survey facilities; and
12

13 Whereas, Correctional facilities voluntarily seek NCCHC accreditation which involves a review
14 of the facility's condition by external clinical professionals to determine whether they meet
15 NCCHC accreditation; and
16

17 Whereas, The American Correctional Association (ACA) provides similar guidelines and an
18 opportunity for voluntary accreditation and compliance monitoring; and
19

20 Whereas, Being an accredited facility has distinct advantages including: 1) ensuring proper
21 health care is provided, 2) demonstrating to the public that the facility has taken steps to care
22 for those incarcerated, 3) promoting the health of a vulnerable segment of society and 4)
23 contributing to the welfare of the public by lessening its financial health care burden; and
24

25 Whereas, At the present time, only approximately 15% of the nearly 7,000 penal facilities in the
26 United States are accredited; and
27

28 Whereas, The Federal government has enacted the First Step Act (Formerly Incarcerated
29 Reenter Society Transformed Safely Transitioning Every Person Act) in its recognition of
30 concerns of incarceration; therefore be it

1 RESOLVED, That our American Medical Association work with an accrediting organization,
2 such as National Commission on Correctional Health Care (NCCHC), American Correctional
3 Association (ACA) and others with accreditation expertise, in developing a strategy to accredit
4 all correctional, detention and juvenile facilities (Directive to Take Action); and be it further
5
6 RESOLVED, That our AMA advocate that all correctional, detention and juvenile facilities be
7 accredited by a national accrediting organization, such as the NCCHC or ACA, no later than
8 2025. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 05/09/19

RELEVANT AMA POLICY

Health Care While Incarcerated H-430.986

1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA supports partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. That our AMA encourage state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
5. Our AMA encourages states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal justice system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA urges the Centers for Medicare & Medicaid Services (CMS) and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from correctional facilities in order to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism.
7. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of incarcerated women and adolescent females, including gynecological care and obstetrics care for pregnant and postpartum women.

Citation: CMS Rep. 02, I-16

Support for Health Care Services to Incarcerated Persons D-430.997

Our AMA will:

- (1) express its support of the National Commission on Correctional Health Care Standards that improve the quality of health care services, including mental health services, delivered to the nation's correctional facilities
- (2) encourage all correctional systems to support NCCHC accreditation
- (3) encourage the NCCHC and its AMA representative to work with departments of corrections and public officials to find cost effective and efficient methods to increase correctional health services funding; and
- (4) continue support for the programs and goals of the NCCHC through continued support for the travel expenses of the AMA representative to the NCCHC, with this decision to be reconsidered every two years in light of other AMA financial commitments, organizational memberships, and programmatic priorities.

Citation: Res. 440, A-04; Amended: BOT Action in response to referred for decision Res. 602, A-00; Reaffirmation I-09; Reaffirmation A-11; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: CMS Rep. 02, I-16

Disease Prevention and Health Promotion in Correctional Institutions H-430.989

Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public health systems toward the prevention and control of HIV/AIDS, substance abuse, tuberculosis, and hepatitis. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers and drug treatment center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase in direct referral by correctional systems of parolees with a recent, active history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs as a sentence or in connection with sentencing.

Citation: (CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13

Health Status of Detained and Incarcerated Youth H-60.986

Our AMA (1) encourages state and county medical societies to become involved in the provision of adolescent health care within detention and correctional facilities and to work to ensure that these facilities meet minimum national accreditation standards for health care as established by the National Commission on Correctional Health Care;

(2) encourages state and county medical societies to work with the administrators of juvenile correctional facilities and with the public officials responsible for these facilities to discourage the following inappropriate practices: (a) the detention and incarceration of youth for reasons related to mental illness; (b) the detention and incarceration of children and youth in adult jails; and (c) the use of experimental therapies, not supported by scientific evidence, to alter behavior.

(3) encourages state medical and psychiatric societies and other mental health professionals to work with the state chapters of the American Academy of Pediatrics and other interested groups to survey the juvenile correctional facilities within their state in order to determine the availability and quality of medical services provided.

(4) advocates for increased availability of educational programs by the National Commission on Correctional Health Care and other community organizations to educate adolescents about sexually transmitted diseases, including juveniles in the justice system.

Citation: CSA Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Appended: Res. 401, A-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: Res. 917, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 427
(A-19)

Introduced by: Michigan

Subject: Utility of Autonomous Vehicles for Individuals Who are Visually Impaired or Developmentally Disabled

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

1 Whereas, Individuals who are visually impaired or developmentally disabled rely on public and
2 private means for transportation; and
3
4 Whereas, The functionality of autonomous or “self-driving” vehicles span a range from almost
5 complete driver engagement to no driver engagement whatsoever; and
6
7 Whereas, Implementation of proven autonomous vehicles may result in reduced automobile
8 accidents and occupant injury or death, with the consequence of lower health care costs,
9 improved public safety, and lower automobile insurance cost; and
10
11 Whereas, Most autonomous vehicles currently under development are generally at a level
12 where driver monitoring and engagement is essential for safe driving; and
13
14 Whereas, Individuals who are visually impaired or developmentally disabled may not meet the
15 requirements necessary for monitoring an autonomous vehicle at the current level of
16 automation, and therefore would not qualify to operate such vehicles; therefore be it
17
18 RESOLVED, That our American Medical Association work with the National Transportation
19 Safety Board to support physician input on research into the capability of autonomous or “self-
20 driving” vehicles to enable individuals who are visually impaired or developmentally disabled to
21 benefit from autonomous vehicle technology. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 05/09/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 428
(A-19)

Introduced by: Michigan

Subject: Dangers of Vaping

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

1 Whereas, Electronic nicotine delivery systems (ENDS) produce an aerosol by heating a liquid
2 that usually contains nicotine, flavorings and other harmful chemicals; and
3
4 Whereas, Nicotine is an addictive drug that can harm the developing adolescent brain; and
5
6 Whereas, ENDS aerosol can contain harmful and potentially harmful substances, including
7 nicotine, ultrafine particles, volatile organic compounds, cancer-causing chemicals, and heavy
8 metals such as nickel, tin, and lead; and
9
10 Whereas, The health impacts of inhaling such chemicals is still being investigated but
11 preliminary reports indicate that some ingredients could be harmful to the lungs in the long-term;
12 and
13
14 Whereas, The United States Surgeon General recently declared youth e-cigarette use an
15 epidemic; and
16
17 Whereas, According to the Centers for Disease Control and Prevention, nearly 1 of every 20
18 middle school students (4.9%) reported in 2018 that they used electronic cigarettes in the past
19 30 days and nearly 1 of every 5 high school students (20.8%) reported the same; and
20
21 Whereas, Although the impact of such utilization remains to be fully appreciated, it is clear the
22 health impacts and the potential of creating significant health risks parallels the early years of
23 tobacco; and
24
25 Whereas, Big tobacco markets to youth via sweet flavoring, product design and ads with
26 deliberate intent on addicting future adult users; therefore be it

1 RESOLVED, That our American Medical Association amend existing policy H-495.986, "Sales
2 and Distribution of Tobacco Products and Electronic Nicotine Delivery Systems (ENDS) and
3 E-cigarettes," by addition to read as follows:

4 Our AMA:

5 (1) recognizes the use of e-cigarettes and vaping as an urgent public health epidemic
6 and will actively work with the Food and Drug Administration and other relevant
7 stakeholders to counteract the marketing and use of addictive e-cigarette and vaping
8 devices, including but not limited to bans and strict restrictions on marketing to minors
9 under the age of 21 and requirements to include warning labels on all electronic
10 nicotine delivery systems (ENDS);

11 (2) encourages the passage of laws, ordinances and regulations that would set the
12 minimum age for purchasing tobacco products, including electronic nicotine delivery
13 systems (ENDS) and e-cigarettes, at 21 years and require warning labels on all ENDS,
14 and urges strict enforcement of laws prohibiting the sale of tobacco products to minors;
15 (3) supports the development of model legislation regarding enforcement of laws
16 restricting children's access to tobacco, including but not limited to attention to the
17 following issues: (a) provision for licensure to sell tobacco and for the revocation
18 thereof; (b) appropriate civil or criminal penalties (e.g., fines, prison terms, license
19 revocation) to deter violation of laws restricting children's access to and possession of
20 tobacco; (c) requirements for merchants to post notices warning minors against
21 attempting to purchase tobacco and to obtain proof of age for would-be purchasers; (d)
22 measures to facilitate enforcement; (e) banning out-of-package cigarette sales
23 ("loosies"); and (f) requiring tobacco purchasers and vendors to be of legal smoking
24 age; and (g) requirements for warning labels on all ENDS;

25 (4) requests that states adequately fund the enforcement of the laws related to tobacco
26 sales to minors;

27 (5) opposes the use of vending machines to distribute tobacco products and supports
28 ordinances and legislation to ban the use of vending machines for distribution of
29 tobacco products;

30 (6) seeks a ban on the production, distribution, and sale of candy products that depict
31 or resemble tobacco products;

32 (7) opposes the distribution of free tobacco products by any means and supports the
33 enactment of legislation prohibiting the disbursement of samples of tobacco and
34 tobacco products by mail;

35 (8) (a) publicly commends (and so urges local medical societies) pharmacies and
36 pharmacy owners who have chosen not to sell tobacco products, and asks its
37 members to encourage patients to seek out and patronize pharmacies that do not sell
38 tobacco products; (b) encourages other pharmacists and pharmacy owners individually
39 and through their professional associations to remove such products from their stores;
40 (c) urges the American Pharmacists Association, the National Association of Retail
41 Druggists, and other pharmaceutical associations to adopt a position calling for their
42 members to remove tobacco products from their stores; and (d) encourages state
43 medical associations to develop lists of pharmacies that have voluntarily banned the
44 sale of tobacco for distribution to their members; and

45 (9) opposes the sale of tobacco at any facility where health services are provided; and

46 (10) supports that the sale of tobacco products be restricted to tobacco specialty
47 stores. (Modify Current HOD Policy)

48

Fiscal Note: Minimal - less than \$1,000.

Received: 05/09/19

References:

1. Centers for Disease Control and Prevention. (2018). Quick Facts on the Risks of E-cigarettes for Kids, Teens, and Young Adults. Retrieved from https://www.cdc.gov/tobacco/basic_information/e-cigarettes/Quick-Facts-on-the-Risks-of-E-cigarettes-for-Kids-Teens-and-Young-Adults.html
2. U.S. Department of Health and Human Services. (2018). Surgeon General releases advisory on E-cigarettes epidemic among youth. Retrieved from <https://www.hhs.gov/about/news/2018/12/18/surgeon-general-releases-advisory-e-cigarette-epidemic-among-youth.html> 2015-2016 and 2017-2018
3. Centers for Disease Control and Prevention. Accessed at https://www.cdc.gov/tobacco/data_statistics/fact_sheets/youth_data/tobacco_use/index.htm.

RELEVANT AMA POLICY

Sales and Distribution of Tobacco Products and Electronic Nicotine Delivery Systems (ENDS) and E-cigarettes H-495.986

H-495.986 Tobacco Product Sales and Distribution

Our AMA:

- (1) recognizes the use of e-cigarettes and vaping as an urgent public health epidemic and will actively work with the Food and Drug Administration and other relevant stakeholders to counteract the marketing and use of addictive e-cigarette and vaping devices, including but not limited to bans and strict restrictions on marketing to minors under the age of 21;
- (2) encourages the passage of laws, ordinances and regulations that would set the minimum age for purchasing tobacco products, including electronic nicotine delivery systems (ENDS) and e-cigarettes, at 21 years, and urges strict enforcement of laws prohibiting the sale of tobacco products to minors;
- (3) supports the development of model legislation regarding enforcement of laws restricting children's access to tobacco, including but not limited to attention to the following issues: (a) provision for licensure to sell tobacco and for the revocation thereof; (b) appropriate civil or criminal penalties (e.g., fines, prison terms, license revocation) to deter violation of laws restricting children's access to and possession of tobacco; (c) requirements for merchants to post notices warning minors against attempting to purchase tobacco and to obtain proof of age for would-be purchasers; (d) measures to facilitate enforcement; (e) banning out-of-package cigarette sales ("loosies"); and (f) requiring tobacco purchasers and vendors to be of legal smoking age;
- (4) requests that states adequately fund the enforcement of the laws related to tobacco sales to minors;
- (5) opposes the use of vending machines to distribute tobacco products and supports ordinances and legislation to ban the use of vending machines for distribution of tobacco products;
- (6) seeks a ban on the production, distribution, and sale of candy products that depict or resemble tobacco products;
- (7) opposes the distribution of free tobacco products by any means and supports the enactment of legislation prohibiting the disbursement of samples of tobacco and tobacco products by mail;
- (8) (a) publicly commends (and so urges local medical societies) pharmacies and pharmacy owners who have chosen not to sell tobacco products, and asks its members to encourage patients to seek out and patronize pharmacies that do not sell tobacco products; (b) encourages other pharmacists and pharmacy owners individually and through their professional associations to remove such products from their stores; (c) urges the American Pharmacists Association, the National Association of Retail Druggists, and other pharmaceutical associations to adopt a position calling for their members to remove tobacco products from their stores; and (d) encourages state medical associations to develop lists of pharmacies that have voluntarily banned the sale of tobacco for distribution to their members; and
- (9) opposes the sale of tobacco at any facility where health services are provided; and
- (10) supports that the sale of tobacco products be restricted to tobacco specialty stores.

Citation: CSA Rep. 3, A-04; Appended: Res. 413, A-04; Reaffirmation A-07; Amended: Res. 817, I-07; Reaffirmation A-08; Reaffirmation I-08; Reaffirmation A-09; Reaffirmation I-13; Reaffirmation A-14; Reaffirmation I-14; Reaffirmation A-15; Modified in lieu of Res. 421, A-15; Modified in lieu of Res. 424, A-15; Reaffirmation I-16; Appended: Res. 926, I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 429
(A-19)

Introduced by: Medical Student Section

Subject: Support for Children of Incarcerated Parents

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

1 Whereas, The United States has the highest rate of incarceration in the world with 2,162,400
2 incarcerated persons as of year-end 2016¹⁻²; and

3
4 Whereas, The imprisoned population demographics are disproportionate with the U.S.
5 population, comprised of 30.1% White non-Hispanic, 33.3% Black, and 23.3% Hispanic
6 compared to the U.S. population at 60.7% White non-Hispanic, 13.4% Black/African American,
7 and 18.1% Hispanic³⁻⁴; and

8
9 Whereas, An estimated 2.7 million children in the United States have at least one parent
10 incarcerated at any given time and approximately 10 million children have experienced parental
11 incarceration at some point in their lives⁵; and

12
13 Whereas, Worse health outcomes as a result of parental incarceration disproportionately impact
14 minorities, where 1 in 9 children with incarcerated parents are African American, 1 in 18 are
15 Hispanic, and 1 in 57 are White⁵; and

16
17 Whereas, Parental incarceration has been found to be a strong risk factor for long-lasting
18 psychopathology in children, including antisocial behaviors, high risk behaviors, substance use
19 and abuse, and health problems including depression, post-traumatic stress disorder, anxiety,
20 hyperlipidemia, obesity, asthma, migraines, HIV/AIDS, and overall fair/poor health⁶⁻⁹; and

21
22 Whereas, The number of adverse childhood event (ACE) exposures has been shown to be
23 directly correlated to increased likelihoods of specific negative health outcomes such as
24 coronary disease, diabetes, asthma, disability, and mental distress¹⁰; and

25
26 Whereas, Children with incarcerated parents experience up to five times as many additional
27 ACEs as their counterparts without incarcerated parents, such as financial hardship and
28 exposure to drug and alcohol abuse¹¹⁻¹²; and

29
30 Whereas, Early childhood interventions, such as high quality education programs which support
31 parent-child relationships, improve health outcomes and health behaviors, particularly in at-risk
32 youth¹³; and

33
34 Whereas, Providing children with coping strategies and additional emotional resources, such as
35 mentors, trained teachers, skilled counselors, and strong foster families can help children feel
36 comforted and secure throughout a parent's incarceration¹⁴; and

37
38 Whereas, Established intervention programs aimed at improving the interactions between
39 children and their incarcerated parents include interventions such as having parents record

themselves reading their child a book and providing incarcerated parents, their children, and the child's interim caregiver with in-person visits, individual counseling and family skill sessions; and

Whereas, Established intervention programs have shown to increase student performance and interest in school, improve familial functioning, and improve parental mental health¹⁵⁻¹⁶; and

Whereas, Even increased telephone and written letter contact between children and their incarcerated parents resulted in fewer child behavioral problems and improved mental health¹⁷⁻¹⁸; and

Whereas, Established intervention programs identify arranging visits, the privacy of the parent-child interactions, the need for more interaction with case workers, and the lack of sufficient training for program providers as barriers to providing better services¹⁹; and

Whereas, The AMA policy H-430.990 has previously supported further research on and implementation of programs to promote maternal/child bonding among incarcerated mothers²⁰; and

Whereas, The 115th Congress introduced a House of Representatives resolution (H.Res.623) that recognizes the importance of providing services to children of incarcerated parents²¹; and

Whereas, The House of Representatives passed H.Res.5682 passed which requires that federal prisoners to be placed within 500 miles of their families in an attempt to improve parental-child contact with the aim of reducing recidivism²²; therefore be it

RESOLVED, That our American Medical Association support legislation and initiatives that provide resources and support for children of incarcerated parents. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000.

Received: 05/09/19

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RELEVANT AMA POLICY

Family Violence-Adolescents as Victims and Perpetrators H-515.981

The AMA (1) (a) encourages physicians to screen adolescents about a current or prior history of maltreatment. Special attention should be paid to screening adolescents with a history of alcohol and drug misuse, irresponsible sexual behavior, eating disorders, running away, suicidal behaviors, conduct disorders, or psychiatric disorders for prior occurrences of maltreatment; and (b) urges physicians to consider issues unique to adolescents when screening youths for abuse or neglect. (2) encourages state medical society violence prevention committees to work with child protective service agencies to develop specialized services for maltreated adolescents, including better access to health services, improved foster care, expanded shelter and independent living facilities, and treatment programs. (3) will investigate research and resources on effective parenting of adolescents to identify ways in which physicians can promote parenting styles that reduce stress and promote optimal development. (4) will alert the national school organizations to the increasing incidence of adolescent maltreatment and the need for training of school staff to identify and refer victims of maltreatment. (5) urges youth correctional facilities to screen incarcerated youth for a current or prior history of abuse or neglect and to refer maltreated youth to appropriate medical or mental health treatment programs. (6) encourages the National Institutes of Health and other organizations to expand continued research on adolescent initiation of violence and abuse to promote understanding of how to prevent future maltreatment and family violence.

Citation: (CSA Rep. I, A-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13

Bonding Programs for Women Prisoners and their Newborn Children H-430.990

Because there are insufficient data at this time to draw conclusions about the long-term effects of prison nursery programs on mothers and their children, the AMA supports and encourages further research on the impact of infant bonding programs on incarcerated women and their children. The AMA recognizes the prevalence of mental health and substance abuse problems among incarcerated women and continues to support access to appropriate services for women in prisons. The AMA recognizes that a large majority of female inmates who may not have developed appropriate parenting skills are mothers of children under the age of 18. The AMA encourages correctional facilities to provide parenting skills training to all female inmates in preparation for their release from prison and return to their children. The AMA supports and encourages further investigation into the long-term effects of prison nurseries on mothers and their children.

Citation: CSA Rep. 3, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17

Long-Term Care Residents With Criminal Backgrounds H-280.948

1. Our AMA encourages the long-term care provider and correctional care communities, including the American Medical Directors Association, the Society of Correctional Physicians, the National Commission on Correctional

Health Care, the American Psychiatric Association, long-term care advocacy groups and offender advocacy groups, to work together to develop national best practices on how best to provide care to, and develop appropriate care plans for, individuals with violent criminal backgrounds or violent tendencies in long-term care facilities while ensuring the safety of all residents of the facilities.

2. Our AMA encourages more research on how to best care for residents of long-term care facilities with criminal backgrounds, which should include how to vary approaches to care planning and risk management based on age of offense, length of incarceration, violent tendencies, and medical and psychiatric history.
3. Our AMA encourages research to identify and appropriately address possible liabilities for medical directors, attending physicians, and other providers in long-term care facilities caring for residents with criminal backgrounds.
4. Our AMA will urge the Society of Correctional Physicians and the National Commission on Correctional Health Care to work to develop policies and guidelines on how to transition to long-term care facilities for individuals recently released from incarceration, with consideration to length of incarceration, violent tendencies, and medical and psychiatric history.

Citation: (CMS Rep. 8, I-13

Disease Prevention and Health Promotion in Correctional Institutions H-430.989

Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public health systems toward the prevention and control of HIV/AIDS, substance abuse, tuberculosis, and hepatitis. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers and drug treatment center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase in direct referral by correctional systems of parolees with a recent, active history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs as a sentence or in connection with sentencing.

Citation: (CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13

Improving Pediatric Mental Health Screening H-345.977

Our AMA: (1) recognizes the importance of, and supports the inclusion of, mental health (including substance use, abuse, and addiction) screening in routine pediatric physicals; (2) will work with mental health organizations and relevant primary care organizations to disseminate recommended and validated tools for eliciting and addressing mental health (including substance use, abuse, and addiction) concerns in primary care settings; and (3) recognizes the importance of developing and implementing school-based mental health programs that ensure at-risk children/adolescents access to appropriate mental health screening and treatment services and supports efforts to accomplish these objectives.

Citation: Res. 414, A-11; Appended: BOT Rep. 12, A-14; Reaffirmed: Res. 403, A-18

Drug Abuse in the United States - Strategies for Prevention H-95.978

Our AMA: (1) Urges the Substance Abuse and Mental Health Administration to support research into special risks and vulnerabilities, behavioral and biochemical assessments and intervention methodologies most useful in identifying persons at special risk and the behavioral and biochemical strategies that are most effective in ameliorating risk factors.

(2) Urges the Center for Substance Abuse Prevention to continue to support community-based prevention strategies which include: (a) Special attention to children and adolescents, particularly in schools, beginning at the pre-kindergarten level. (b) Changes in the social climate (i.e., attitudes of community leaders and the public), to reflect support of drug and alcohol abuse prevention and treatment, eliminating past imbalances in allocation of resources to supply and demand reduction. (c) Development of innovative programs that train and involve parents, educators, physicians, and other community leaders in "state of the art" prevention approaches and skills.

(3) Urges major media programming and advertising agencies to encourage the development of more accurate and prevention-oriented messages about the effects of drug and alcohol abuse.

(4) Supports the development of advanced educational programs to produce qualified prevention specialists, particularly those who relate well to the needs of economically disadvantaged, ethnic, racial, and other special populations.

(5) Supports investigating the feasibility of developing a knowledge base of comprehensive, timely and accurate concepts and information as the "core curriculum" in support of prevention activities.

(6) Urges federal, state, and local government agencies and private sector organizations to accelerate their collaborative efforts to develop a national consensus on prevention and eradication of alcohol and drug abuse.

Citation: (BOT Rep. H, A-89; Reaffirmed: CSA Rep. 12, A-99; Reaffirmation I-01; Reaffirmed: CSAPH Rep. 1, A-11

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 430
(A-19)

Introduced by: Medical Student Section

Subject: Compassionate Release for Incarcerated Patients

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

1 Whereas, Compassionate release, sometimes called “early medical parole” or “early medical
2 release” describes a range of policies that allow incarcerated individuals who have a serious or
3 debilitating medical condition and/or advanced age to secure early release from an existing
4 sentence^{1,2}; and
5
6 Whereas, The aging incarcerated population is increasing exponentially, with the number of
7 state prisoners over age 55 quadrupling from 6300 to 25,700 between 1993 and 2013³; and
8
9 Whereas, Cancer and heart disease are the two leading causes of death in prisons and jails,
10 both of which are associated with advanced age⁵; and
11
12 Whereas, Aging incarcerated individuals require medically-appropriate accommodations,
13 including ramps, lower bunks, handicapped-accessible cells, and assistance with feeding, which
14 many facilities are unable to provide due to old infrastructure, overcrowding, and lack of
15 appropriate training for staff^{4,6,7}; and
16
17 Whereas, Few facilities have special units for incarcerated individuals with cognitive
18 impairments, and these individuals must rely on fellow incarcerated people for support⁴; and
19
20 Whereas, Incarcerated people have a constitutional right to adequate medical care;⁸ and
21
22 Whereas, Existing AMA policy affirms that it believes in “preserving dignity and self-respect of
23 all individuals at all ages” (H-25.997); and
24
25 Whereas, Although 49 states and the District of Columbia have laws that permit compassionate
26 release, few incarcerated individuals can receive early release because these state laws are
27 inconsistent, confusing, do not delineate a clear process, or contain overly strict eligibility
28 criteria²; and
29
30 Whereas, For example, Arizona requires compassionate release applicants to be facing
31 “imminent death,” but has three different definitions of “imminent death” among Department of
32 Corrections and Board of Executive Clemency documents;² and
33
34 Whereas, The eligibility criteria in Maryland’s medical parole statute are different from those
35 listed in the Code of Maryland Regulations²; and
36
37 Whereas, Michigan does not have any guidelines for the implementation of its compassionate
38 release policy whatsoever²; and

1 Whereas, Thirty incarcerated individuals died from 2011-2016 while navigating the
2 compassionate release process in Georgia, where there are no guidelines for the processing
3 and referral of eligible patients to the Georgia Board of Pardons and Paroles²; and
4

5 Whereas, In some states including Kansas, eligibility for compassionate release requires a
6 prognosis of only 30 to 60 days to live, even though the review process for compassionate
7 release can take many months²; and
8

9 Whereas, Only 13 states have a statutory or regulatory reporting requirement for their
10 compassionate release programs, and of those states, very few make that information public,
11 making it often impossible to analyze outcomes²; and
12

13 Whereas, Each year over 2,600 incarcerated people appeal to the Federal Bureau of Prisons
14 (BOP) for compassionate release, but 97% of requests are denied^{9,10}; and
15

16 Whereas, The U.S. Department of Justice Office of the Inspector General found that of 142
17 incarcerated individuals approved through the BOP's compassionate release program between
18 2006 and 2011, only five had been re-arrested within a three-year timeframe, a recidivism rate
19 of 3.5% compared to an average rate of recidivism of 68% within the same period for all
20 prisoners^{7,11}; and
21

22 Whereas, In 2016, the United States Sentencing Commission adopted a new set of federal
23 compassionate release eligibility guidelines based on recommendations from medical and policy
24 experts; however, these guidelines are not legally binding for the BOP and many states do not
25 conform to these guidelines¹²; and
26

27 Whereas, Eligibility guidelines for state compassionate release programs rarely account for
28 current medical evidence related to serious illness, health trajectories in the seriously ill and
29 aging, and prognosis¹²; and
30

31 Whereas, Between 2013 and 2017, the BOP received about 5,400 applications for
32 compassionate release, and as of March 2018, 312 of those applicants have been approved,
33 while 266 have died waiting¹³; therefore be it
34

35 RESOLVED, That our American Medical Association support policies that facilitate
36 compassionate release on the basis of serious medical conditions and advanced age (New
37 HOD Policy); and be it further
38

39 RESOLVED, That our AMA collaborate with appropriate stakeholders to draft model legislation
40 that establishes clear, evidence-based eligibility criteria for timely compassionate release
41 (Directive to Take Action); and be it further
42

43 RESOLVED, That our AMA promote transparent reporting of compassionate release statistics,
44 including numbers and demographics of applicants, approvals, denials, and revocations, and
45 justifications for decisions. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 05/09/19

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RELEVANT AMA POLICY

Health Care While Incarcerated H-430.986

1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA supports partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. That our AMA encourage state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
5. Our AMA encourages states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal justice system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA urges the Centers for Medicare & Medicaid Services (CMS) and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from correctional facilities in order to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism.
7. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of incarcerated women and adolescent females, including gynecological care and obstetrics care for pregnant and postpartum women.

Citation: CMS Rep. 02, I-16

Support for Health Care Services to Incarcerated Persons D-430.997

Our AMA will:

- (1) express its support of the National Commission on Correctional Health Care Standards that improve the quality of health care services, including mental health services, delivered to the nation's correctional facilities
- (2) encourage all correctional systems to support NCCHC accreditation

(3) encourage the NCCHC and its AMA representative to work with departments of corrections and public officials to find cost effective and efficient methods to increase correctional health services funding; and
(4) continue support for the programs and goals of the NCCHC through continued support for the travel expenses of the AMA representative to the NCCHC, with this decision to be reconsidered every two years in light of other AMA financial commitments, organizational memberships, and programmatic priorities.

Citation: Res. 440, A-04; Amended: BOT Action in response to referred for decision Res. 602, A-00; Reaffirmation I-09; Reaffirmation A-11; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: CMS Rep. 02, I-16

Dignity and Self Respect H-25.997

The AMA believes that medical care should be available to all our citizens, regardless of age or ability to pay, and believes ardently in helping those who need help to finance their medical care costs.

Furthermore, the AMA believes in preserving dignity and self respect of all individuals at all ages and believes that people should not be set apart or isolated on the basis of age. The AMA believes that the experience, perspective, wisdom and skill of individuals of all ages should be utilized to the fullest.

Citation: AMA President's Address, A-61; Reaffirmed: CLRPD C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Modified: CEJA Rep. 06, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 431
(A-19)

Introduced by: Medical Student Section

Subject: Eliminating Recommendations to Restrict Dietary Cholesterol and Fat

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

1 Whereas, The current government-sponsored guidelines for American no longer recommend
2 restriction of dietary cholesterol or total grams of fat in one's diet¹; and

4 Whereas, Nutrient density refers to the nutrient to energy content ratio of foods and/or diets²;
5 and

7 Whereas, Studies have provided nutrient profile models showing higher nutrient density to
8 energy content is an accurate marker of healthy diets^{3,4}; and

10 Whereas, There are foods with high nutrient content and low energy content (i.e. dairy and
11 eggs) that are currently recommended for diet restriction due to some of their macronutrient
12 components (i.e. saturated fats)^{5,6}; and

14 Whereas, These foods are usually substituted for nutrient-poor and high energy content
15 foods^{5,6}; and

17 Whereas, Consumption of eggs has been shown to improve nutritional status and lower
18 inflammation^{7,8}; and

20 Whereas, Consumption of full fat dairy products been linked to a lower risk of metabolic
21 syndrome, type 2 diabetes, and central obesity, as well as inversely associated with weight
22 gain⁹⁻¹³; therefore be it

24 RESOLVED, That our American Medical Association amend Policy H-150.944, "Combating
25 Obesity and Health Disparities," by addition and deletion to read as follows:

27 **H-150.944 Combating Obesity and Health Disparities**

28 Our AMA supports efforts to: (1) reduce health disparities by basing food assistance
29 programs on the health needs of their constituents; (2) provide vegetables, fruits,
30 legumes, grains, vegetarian foods, and healthful dairy and nondairy beverages in
31 school lunches and food assistance programs; and (3) ensure that federal subsidies
32 encourage the consumption of ~~foods and beverages low in fat, added sugars, and~~
33 ~~cholesterol, healthful foods and beverages.~~ (Modify Current HOD Policy)

Fiscal Note: Minimal - less than \$1,000.

Received: 05/09/19

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RELEVANT AMA POLICY

Combating Obesity and Health Disparities H-150.944

Our AMA supports efforts to: (1) reduce health disparities by basing food assistance programs on the health needs of their constituents; (2) provide vegetables, fruits, legumes, grains, vegetarian foods, and healthful dairy and nondairy beverages in school lunches and food assistance programs; and (3) ensure that federal subsidies encourage the consumption of foods and beverages low in fat, added sugars, and cholesterol.

Citation: Res. 413, A-07; Reaffirmation A-12; Reaffirmation A-13; Modified: CSAPH Rep. 03, A-17

Healthy Food Options in Hospitals H-150.949

1. Our AMA encourages healthy food options be available, at reasonable prices and easily accessible, on hospital premises.
2. Our AMA hereby calls on US hospitals to improve the health of patients, staff, and visitors by: (a) providing a variety of healthy food, including plant-based meals, and meals that are low in fat, sodium, and added sugars; (b) eliminating processed meats from menus; and (c) providing and promoting healthy beverages.
3. Our AMA hereby calls for hospital cafeterias and inpatient meal menus to publish nutrition information.

Citation: Res. 410, A-04; Reaffirmed: CSAPH Rep. 1, A-14; Appended: Res. 406, A-17; Modified: Res. 425, A-18

Improving Nutritional Value of Snack Foods Available in Primary and Secondary Schools H-150.960

The AMA supports the position that primary and secondary schools should follow federal nutrition standards that replace foods in vending machines and snack bars, that are of low

nutritional value and are high in fat, salt and/or sugar, including sugar-sweetened beverages, with healthier food and beverage choices that contribute to the nutritional needs of the students.
Citation: Res. 405, A-94; Reaffirmation A-04; Reaffirmed in lieu of Res. 407, A-04; Reaffirmed: CSA Rep. 6, A-04; Reaffirmation A-07; Reaffirmation A-13; Modified: CSAPH Rep. 03, A-17

Taxes on Beverages with Added Sweeteners H-150.933

1. Our AMA recognizes the complexity of factors contributing to the obesity epidemic and the need for a multifaceted approach to reduce the prevalence of obesity and improve public health. A key component of such a multifaceted approach is improved consumer education on the adverse health effects of excessive consumption of beverages containing added sweeteners. Taxes on beverages with added sweeteners are one means by which consumer education campaigns and other obesity-related programs could be financed in a stepwise approach to addressing the obesity epidemic.
2. Where taxes on beverages with added sweeteners are implemented, the revenue should be used primarily for programs to prevent and/or treat obesity and related conditions, such as educational ad campaigns and improved access to potable drinking water, particularly in schools and communities disproportionately effected by obesity and related conditions, as well as on research into population health outcomes that may be affected by such taxes.
3. Our AMA will advocate for continued research into the potentially adverse effects of long-term consumption of non-caloric sweeteners in beverages, particularly in children and adolescents.
4. Our AMA will: (a) encourage state and local medical societies to support the adoption of state and local excise taxes on sugar-sweetened beverages, with the investment of the resulting revenue in public health programs to combat obesity; and (b) assist state and local medical societies in advocating for excise taxes on sugar-sweetened beverages as requested.

Citation: CSAPH Rep. 5, A-12; Reaffirmation A-13; Reaffirmed: CSAPH Rep. 03, A-17; Appended: Res. 414, A-17

Quality of School Lunch Program H-150.962

1. Our AMA recommends to the National School Lunch Program that school meals be congruent with current U.S. Department of Agriculture/Department of HHS Dietary Guidelines.
2. Our AMA opposes legislation and regulatory initiatives that reduce or eliminate access to federal child nutrition programs.

Citation: Sub. Res. 507, A-93; Reaffirmed: CSA Rep. 8, A-03; Reaffirmation A-07; Reaffirmed: CSAPH Rep. 01, A-17; Appended: Res. 206, I-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 432
(A-19)

Introduced by: Medical Student Section

Subject: Decriminalization of Human Immunodeficiency Virus (HIV) Status Non-Disclosure in Virally Suppressed Individuals

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

1 Whereas, Since Human immunodeficiency virus (HIV) is a disease of significant public health
2 importance, states mandate physician reporting of new cases to the health department and/or
3 Centers for Disease Control (CDC)^{1,2}; and,

4
5 Whereas, For all mandated reportable diseases other than HIV, the onus for reporting and
6 disclosure falls on the physician, not the patient²; and

7
8 Whereas, Thirty-two states and two U.S. territories have punitive laws criminalizing individuals
9 who fail to disclose HIV status to sexual partners if HIV-positive, with many of these laws
10 passed before the widespread availability of antiretroviral therapy (ART)³; and

11
12 Whereas, ART results in viral suppression, which is defined as a viral load of <200 copies/mL of
13 blood, virtually eliminating the risk of sexual HIV transmission⁴; and

14
15 Whereas, As of 2015, over one million adults and adolescents in the United States were living
16 with HIV and 49 percent had achieved viral suppression⁵; and

17
18 Whereas, Three prospective studies involving both heterosexual and same-sex male couples of
19 different HIV status showed no cases of sexual transmission of HIV from a person living with
20 HIV with an undetectable viral load suppressed by ART⁶⁻⁸; and

21
22 Whereas, As a result of ART, the CDC described the estimated possibility of HIV transmission
23 from an HIV-positive person with an undetectable viral load as “effectively no risk” based on
24 current scientific literature⁹; and

25
26 Whereas, Data from International Epidemiology Databases to Evaluate AIDS demonstrated that
27 of 26,000 adults on antiretroviral therapy (ART), 90% who remained in care were virally
28 suppressed¹⁰; and

29
30 Whereas, Many state laws do not differentiate between high risk behaviors and low/negligible
31 risk behaviors, and criminalize spitting, biting, or having sex with someone with an undetectable
32 viral load, and in two states--Michigan and Tennessee--one-third of HIV related arrests were
33 associated with low risk behaviors¹¹; and

34
35 Whereas, HIV non-disclosure laws have not been shown to reduce risky sexual behavior and
36 have led to disproportionate convictions among people who live with HIV that belong to minority
37 groups^{11,14}; and

1 Whereas, Studies suggest HIV disclosure laws increase stigma towards people who live with
2 HIV, reduce the likelihood of disclosure to sexual or needle-sharing partners, and reduce
3 frequency of HIV testing since knowledge of status is required for legal liability¹¹⁻¹⁶; and
4
5 Whereas, The REPEAL HIV Discrimination Act was introduced in Congress in 2017, and seeks
6 to provide states with guidance on best practices for revising discriminatory HIV laws, with
7 support from a broad range of stakeholders^{17,18}; and
8
9 Whereas, Ontario, Canada (2017) and North Carolina (2018) have removed punitive policies for
10 HIV non-disclosure in people who live with HIV who are adherent to the treatment plan of an
11 attending physician and are known to be virally suppressed for six months prior to sexual
12 exposure^{11,19, 20,21}; and
13
14 Whereas, California reduced the act of HIV non-disclosure from classification as a felony to a
15 misdemeanor in 2017, making it equivalent with current California law penalizing intentionally
16 exposing another person to contagious, infectious, or communicable disease^{8,22}; and
17
18 Whereas, Current reckless endangerment and battery laws would still maintain punishments for
19 knowingly transmitting HIV even after removal of punitive laws criminalizing HIV non-
20 disclosure³; and
21
22 Whereas, AMA policy H-20.914 emphasizes the importance of addressing discrimination based
23 on HIV status, including stigma arising from criminalization, and also “supports consistency of
24 federal and/or state laws with current medical and scientific knowledge”; therefore be it
25
26 RESOLVED, That our American Medical Association support repealing legislation that
27 criminalizes non-disclosure of Human Immunodeficiency Virus (HIV) status for people living with
28 HIV who have an undetectable viral load. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000.

Received: 05/09/19

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RELEVANT AMA POLICY

Patient Disclosure of HIV Seropositivity H-20.919

Our AMA encourages patients who are HIV seropositive to make their condition known to their physicians and other appropriate health care providers.

Citation: (CSA Rep. 4, A-03; Reaffirmed: CSAPH Rep. 1, A-13

HIV Testing H-20.920

(1) General Considerations

- a) Persons who suspect that they have been exposed to HIV should be tested so that appropriate treatment and counseling can begin for those who are seropositive;
- b) HIV testing should be consistent with testing for other infections and communicable diseases;
- c) HIV testing should be readily available to all who wish to be tested, including having available sites for confidential testing;
- d) The physician's office and other medical settings are the preferred settings in which to provide HIV testing;
- e) Physicians should work to make HIV counseling and testing more readily available in medical settings.

(2) Informed Consent Before HIV Testing

- a) Our AMA supports the standard that individuals should knowingly and willingly give consent before a voluntary HIV test is conducted, in a manner that is the least burdensome to the individual and to those administering the test. Physicians must be aware that most states have enacted laws requiring informed consent before HIV testing;
- b) Informed consent should include the following information: (i) patient option to receive more information and/or counseling before deciding whether or not to be tested and (ii) the patient should not be denied treatment if he or she refuses HIV testing, unless knowledge of HIV status is vital to provide appropriate treatment; in this instance, the physician may refer the patient to another physician for care;
- c) It is the policy of our AMA to review the federal laws including the Veteran's Benefits and Services Act, which currently mandates prior written informed consent for HIV testing within the Veterans Administration hospital system, and subsequently to initiate and support amendments allowing for HIV testing without prior consent in the event that a health care provider is involved in accidental puncture injury or mucosal contact by fluids potentially infected with HIV in federally operated health care facilities;
- d) Our AMA supports working with various state societies to delete legal requirements for

consent to medically indicated HIV testing that are more extensive than requirements generally imposed for informed consent to medical care.

(3) HIV Testing Without Explicit Consent

- a) Explicit consent should not always be required prior to HIV testing. Physicians should be allowed, without explicit informed consent, and as indicated by their medical judgment, to perform diagnostic testing for determination of HIV status of patients suspected of having HIV infection;
- b) General consent for treatment of patients in the hospital should be accepted as adequate consent for the performance of HIV testing;
- c) Model state and federal legislation should be developed to permit physicians, without explicit informed consent and as indicated by their medical judgment, to perform diagnostic testing for determination of HIV status of patients suspected of having HIV infection;
- d) Our AMA will work with the Centers for Disease Control and Prevention, the American Hospital Association, the Federation, and other appropriate groups to draft and promote the adoption of model state legislation and hospital staff guidelines to allow HIV testing of a patient maintaining privacy, but without explicit consent, where a health care worker has been placed at risk by exposure to potentially infected body fluids; and to allow HIV testing, without any consent, where a health care worker has been placed at risk by exposure to body fluids of a deceased patient.

(4) HIV Testing Procedures

- a) Appropriate medical organizations should establish rigorous proficiency testing and quality control procedures for HIV testing laboratories on a frequent and regular basis;
- b) Physicians and laboratories should review their procedures to assure that HIV testing conforms to standards that will produce the highest level of accuracy;
- c) Appropriate medical organizations should establish a standard that a second blood sample be taken and tested on all persons found to be seropositive or indeterminate for HIV antibodies on the first blood sample. This practice is also advised for any unexpected negative result;
- d) Appropriate medical organizations should establish a policy that results from a single unconfirmed positive ELISA test never be reported to the patient as a valid indication of HIV infection;
- e) Appropriate medical organizations should establish a policy that laboratories specify the HIV tests performed and the criteria used for positive, negative, and indeterminate Western blots or other confirmatory procedures;
- f) Our AMA recommends that training for HIV blood test counselors encourage patients with an indeterminate Western blot to be advised that three-to-six-month follow-up specimens may need to be submitted to resolve their immune status. Because of the uncertain status of their contagiousness, it is prudent to counsel such patients as though they were seropositive until such time as the findings can be resolved.

(5) Routine HIV Testing

- a) Routine HIV testing should include appropriately modified informed consent and modified pre-test and post-test counseling procedures;
- b) Hospitals, clinics and physicians may adopt routine HIV testing based on their local circumstances. Such a program is not a substitute for universal precautions. Local considerations may include (i) the likelihood that knowledge of a patient's serostatus will improve patient care and reduce HIV transmission risk; (ii) the prevalence of HIV in patients undergoing invasive procedures; (iii) the costs, liabilities and benefits; and (iv) alternative methods of patient care and staff protection available to the patient;
- c) State medical associations should review and seek modification of state laws that restrict the ability of hospitals and other medical facilities to initiate routine HIV testing programs;
- (d) Encourages a review of the evidence for routine HIV testing by the US Preventive Services Task Force; and
- (e) Supports coverage of and appropriate reimbursement for routine HIV testing by all public

and private payers.

(6) Voluntary HIV Testing

- a) Voluntary HIV testing should be provided with informed consent for individuals who may have come into contact with the blood, semen, or vaginal secretions of an infected person in a manner that has been shown to transmit HIV infection. Such testing should be encouraged for patients for whom the physician's knowledge of the patient's serostatus would improve treatment. Voluntary HIV testing should be regularly provided for the following types of individuals who give an informed consent: (i) patients at sexually transmissible disease clinics; (ii) patients at drug abuse clinics; (iii) individuals who are from areas with a high incidence of AIDS or who engage in high-risk behavior and are seeking family planning services; and (iv) patients who are from areas with a high incidence of AIDS or who engage in high-risk behavior requiring surgical or other invasive procedures;
- b) The prevalence of HIV infection in the community should be considered in determining the likelihood of infection. If voluntary HIV testing is not sufficiently accepted, the hospital and medical staff may consider requiring HIV testing.

(7) Mandatory HIV Testing

- a) Our AMA opposes mandatory HIV testing of the general population;
- b) Mandatory testing for HIV infection is recommended for (i) all entrants into federal and state prisons; (ii) military personnel; (iii) donors of blood and blood fractions; breast milk; organs and other tissues intended for transplantation; and semen or ova for artificial conception;
- c) Our AMA will review its policy on mandatory testing periodically to incorporate information from studies of the unintended consequences or unexpected benefits of HIV testing in special settings and circumstances.

(8) HIV Test Counseling

- a) Pre-test and post-test voluntary counseling should be considered an integral and essential component of HIV testing. Full pre-test and post-test counseling procedures must be utilized for patients when HIV is the focus of the medical attention, when an individual presents to a physician with concerns about possible exposure to HIV, or when a history of high-risk behavior is present;
- b) Post-test information and interpretation must be given for negative HIV test results. All negative results should be provided in a confidential manner accompanied by information in the form of a simple verbal or written report on the meaning of the results and the offer, directly or by referral, of appropriate counseling;
- c) Post-test counseling is required when HIV test results are positive. All positive results should be provided in a confidential face-to-face session by a professional properly trained in HIV post-test counseling and with sufficient time to address the patient's concerns about medical, social, and other consequences of HIV infection.

(9) HIV Testing of Health Care Workers

- a) Our AMA supports HIV testing of physicians, health care workers, and students in appropriate situations;
- b) Employers of health care workers should provide, at the employer's expense, serologic testing for HIV infection to all health care workers who have documented occupational exposure to HIV;
- c) Our AMA opposes HIV testing as a condition of hospital medical staff privileges;
- d) Physicians and other health care workers who perform exposure-prone patient care procedures that pose a significant risk of transmission of HIV infection should voluntarily determine their serostatus at intervals appropriate to risk and/or act as if their serostatus were positive. The periodicity will vary according to locale and circumstances of the individual and the judgment should be made at the local level. Health care workers who test negative for HIV should voluntarily redetermine their HIV serostatus at an appropriate period of time after any significant occupational or personal exposure to HIV. Follow-up tests should occur after a time interval exceeding the length of the "antibody window."

(10) Counseling and Testing of Pregnant Women for HIV

Our AMA supports the position that there should be universal HIV testing of all pregnant women, with patient notification of the right of refusal, as a routine component of perinatal care, and that such testing should be accompanied by basic counseling and awareness of appropriate treatment, if necessary. Patient notification should be consistent with the principles of informed consent.

(11) HIV Home Test Kits

a) Our AMA opposes Food and Drug Administration approval of HIV home test kits. However, our AMA does not oppose approval of HIV home collection test kits that are linked with proper laboratory testing and counseling services, provided their use does not impede public health efforts to control HIV disease;

b) Standardized data should be collected by HIV home collection test kit manufacturers and reported to public health agencies;

c) A national study of HIV home collection test kit users should be performed to evaluate their experience with telephone counseling;

d) A national interagency task force should be established, consisting of members from government agencies and the medical and public health communities, to monitor the marketing and use of HIV home collection test kits.

(12) College Students

Our AMA encourages undergraduate campuses to conduct confidential, free HIV testing with qualified staff and counselors.

Citation: (CSA Rep. 4, A-03; Appended: Res. 515, A-06; Reaffirmed: BOT Rep. 1, A-07; Appended: Res. 506, A-10

HIV/AIDS Reporting, Confidentiality, and Notification H-20.915

(1) Reporting

Our AMA strongly recommends that all states, territories, and the District of Columbia adopt a requirement for the confidential reportability of HIV seropositivity of all patients to appropriate public health authorities for the purpose of contact tracing and partner notification. Strict confidentiality must be maintained by each local and state public health authority.

(2) Confidentiality

a) Our AMA supports uniform protection, at all levels of government, of the identity of those with HIV infection or disease, consistent with public health requirements;

b) Patients should receive general information on the limits of confidentiality of medical records at the initial medical visit. Specific information on the limits of confidentiality should be provided before the patient receives HIV-related services or when the patient is counseled about HIV testing;

c) Physicians should be able, without fear of legal sanction, to confidentially discuss a patient's HIV serostatus only with those other health care providers who need this information to properly plan and provide quality medical care to the patient; and

d) Our AMA will continue to address, through the Council on Ethical and Judicial Affairs, the patient confidentiality and ethical issues raised by known HIV antibody-positive patients who refuse to inform their sexual partners or modify their behavior.

(3) Contact Tracing and Partner Notification

Our AMA:

a) Strongly recommends that states adopt a system for contact tracing and partner notification in each community that, while protecting to the greatest extent possible the confidentiality of patient information, provides clear guidelines for public health authorities who need to trace the unsuspecting sexual or needle-sharing partners of HIV-infected persons;

b) Requests that states make provisions in any contact-tracing and notification program for adequate safeguards to protect the confidentiality of HIV-seropositive persons and their contacts, for counseling of the parties involved, and for the provision of information on

counseling, testing, and treatment resources for partners who might be infected;
c) In collaboration with state medical societies, supports legislation on the physician's right to exercise ethical and clinical judgment regarding whether or not to warn unsuspecting and endangered sexual or needle-sharing partners of HIV-infected patients; and
d) Promulgates the standard that a physician attempt to persuade an HIV-infected patient to cease all activities that endanger unsuspecting others and to inform those whom he/she might have infected. If such persuasion fails, the physician should pursue notification through means other than by reliance on the patient, such as by the Public Health Department or by the physician directly.

Citation: CSA Rep. 4, A-03; Reaffirmation A-07; Reaffirmed: CEJA Rep. 04, A-17

Discrimination and Criminalization Based on HIV Seropositivity H-20.914

Our AMA: (1) Remains cognizant of and concerned about society's perception of, and discrimination against, HIV-positive people; (2) Condemns any act, and opposes any legislation of categorical discrimination based on an individual's actual or imagined disease, including HIV infection; this includes Congressional mandates calling for the discharge of otherwise qualified individuals from the armed services solely because of their HIV seropositivity; (3) Encourages vigorous enforcement of existing anti-discrimination statutes; incorporation of HIV in future federal legislation that addresses discrimination; and enactment and enforcement of state and local laws, ordinances, and regulations to penalize those who illegally discriminate against persons based on disease; (4) Encourages medical staff to work closely with hospital administration and governing bodies to establish appropriate policies regarding HIV-positive patients; (5) Supports consistency of federal and/or state laws with current medical and scientific knowledge including avoidance of any imposition of punishment based on health and disability status; and (6) Encourages public education and understanding of the stigma created by HIV criminalization statutes and subsequent negative clinical and public health consequences.

Citation: (CSA Rep. 4, A-03; Reaffirmed: CSAPH Rep. 1, A-13; Appended: Sub. Res. 2, A-14

AMA Stance on the Interference of the Government in the Practice of Medicine H-270.959

1. Our AMA opposes the interference of government in the practice of medicine, including the use of government-mandated physician recitations.
2. Our AMA endorses the following statement of principles concerning the roles of federal and state governments in health care and the patient-physician relationship:
 - A. Physicians should not be prohibited by law or regulation from discussing with or asking their patients about risk factors, or disclosing information to the patient (including proprietary information on exposure to potentially dangerous chemicals or biological agents), which may affect their health, the health of their families, sexual partners, and others who may be in contact with the patient.
 - B. All parties involved in the provision of health care, including governments, are responsible for acknowledging and supporting the intimacy and importance of the patient-physician relationship and the ethical obligations of the physician to put the patient first.
 - C. The fundamental ethical principles of beneficence, honesty, confidentiality, privacy, and advocacy are central to the delivery of evidence-based, individualized care and must be respected by all parties.
 - D. Laws and regulations should not mandate the provision of care that, in the physician's clinical judgment and based on clinical evidence and the norms of the profession, are either not necessary or are not appropriate for a particular patient at the time of a patient encounter.

Citation: (Res. 523, A-06; Appended: Res. 706, A-13

State Tracking of HIV/AIDS and Other Serious Infectious Diseases H-440.886

1. Our AMA encourages specific statutes be drafted that, while protecting to the greatest extent possible the confidentiality of patient information: (a) provide a method for warning unsuspecting sexual partners, needle-sharing partners, or other close contacts; (b) protect physicians from liability for failure to warn the unsuspecting third party; but (c) establish clear standards for when a physician should inform the public health authorities.

2. Our AMA will assist states in their efforts to take whatever actions are necessary to allow blood banks and health departments to share information for the purpose of locating and informing persons who have any transmissible bloodborne disease.

Citation: CSA Rep. 4, A-03; Reaffirmation A-07; Modified: CSAPH Rep. 01, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 433
(A-19)

Introduced by: Nebraska, West Virginia

Subject: Transformation of Rural Community Public Health Systems

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

1 Whereas, When communities formed governments in the US, most created a public health
2 authority and system with legal authority to monitor environmental hazards and stressors,
3 surveil the health status of the population within its geographic confines and conduct activities to
4 reduce hazards, protect and improve health for their respective population; and

5
6 Whereas, Advances to improve health through enhanced monitoring, surveillance and
7 intervention have greatly expanded, most community public health authorities have not been
8 able to effectively and efficiently incorporate these advances to address changing morbidity
9 resulting from new societal conditions; and

10
11 Whereas, Factors contributing to this failure of optimal rural public health include but are not
12 limited to:

13
14 – Increased prevalence of chronic disease that accompanies an aging population
15 – Increased prevalence of mental health and addiction disorders leading to increased
16 morbidity and mortality
17 – Generational changes in family care dynamics
18 – Limited patient health literacy and understanding of complex disease
19 – Fragmentation and duplication of services as a result of absent systems of
20 coordination within and between physicians, providers and community-based public
21 health personnel
22 – Inadequate funding for community-based approaches to addressing and positively
23 impacting social determinants
24 – Decline of local specialty care for critical specialties that are directly related to the
25 health of a community (e.g., obstetrics)
26 – Inability to attract qualified public health leadership professionals for rural communities;
27 and

28
29 Whereas, Despite these obstacles, the greatest challenge to restoring high quality community
30 public health systems is the ability of local political authorities, health care practitioners and
31 institutions to study and identify these changes and obstacles; and

32
33 Whereas, There is a current lack of accountability between local, state and federal authorities to
34 take ownership of rural public health needs; and

35
36 Whereas, The nature, intensity and scope of needs and resources vary among community
37 systems while the essential functions to address them do not; therefore be it

1 RESOLVED, That our American Medical Association work with other entities and organizations
2 interested in public health to:

3

4 - Identify and disseminate concrete examples of administrative leadership and
5 funding structures that support and optimize local, community-based rural public
6 health

7

8 - Develop an actionable advocacy plan to positively impact local, community-based
9 rural public health including but not limited to the development of rural public health
10 networks, training of current and future rural physicians in core public health
11 techniques and novel funding mechanisms to support public health initiatives that
12 are led and managed by local public health authorities

13

14 - Periodically study efforts to optimize rural public health. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 05/09/19

Attachment: **Factors influencing community public health systems in the last 50-100 years**

- The increased prevalence of chronic disease. Through early population screening, risk stratification and interventions, the ability to realize subsequent reduction in downstream morbidity has dramatically increased if such care is sought and obtained. Dementia and autism continue to increase with limited interventions.
- The aging of the population. Increased “life span” produces a marked increase in the need for educational, case management, hygiene, nutritional, mobility, transportation, social interaction and other services if this population is to spend their ‘extra decade’ happy, productive and comfortable (“health span”), rather than victims of preventable morbidity that results in their “ping ponging” among costly institutional, rehabilitation and home health services. Patient and family understanding of care options in terminal situations is a special challenge.
- Change in family dynamics. The extended nuclear family is rare, with many single parents living alone and the historical child caretaker miles removed or lost to opioids.
- Fragmentation, duplication of services/absence of high tech monitoring and communication networks. Many communities lack any overall organizational structure, as well as monitoring and communication systems, to assure high risk individuals are identified, routinely contacted according to their risk status, as well as assuring all service providers share information and avoid duplicating services.
- Stove pipe funding for addressing social determinants and the use of an “insurance” mechanism rather than an integrated community entity. Most individuals do not have insurance to address the cost of “social determinant” services such as rides to a doctor, air conditioner, grocery delivery and home aides. Former football star Joe Namath encourages on TV certain Medicare recipients to ask their doctor about prescribing such “entitlement” services. Joe and many other on Medicare don’t need these services or can afford them on their own. Such funds are not provided to communities to reach the most isolated and needy. Inadequate resources are a chronic problem, together with numerous categorically funded programs duplicating certain functions and creating “system” inefficiency.
- Increased mental health and addiction morbidity and mortality. Expanded treatment of these maladies and the prevention of associated secondary disease morbidity and mortality is welcome. However, there is a paucity of research and community efforts to “prevent” such conditions, such as occurred with the decreased use of tobacco by youth.
- Poor bi-directional communication between physicians, institutional providers and community health staff. Dr. Ilana Yurkiewicz’s, a Stanford physician, provides a horrifying account of Michael’s journey published in the September 28, 2018 The Atlantic (courtesy of Undark Magazine). Communication among patients, practitioners and institutions is a huge problem leading to repeat readmissions and preventable morbidity
- Loss of close-by specialty care, especially in obstetrics. Hospitals continue to close and often the telemedicine and transportation service to assure continuation of quality care are missing.
- Limited health literacy and assistance accessing the health system. Many patients and care takers have little knowledge and ability to access services for which the patient is eligible, criteria can be very complex and there often is no single community number to call for help.
- Inability to attract and adequately compensate trained public health leadership professionals. In many communities there is an absence of trained public health professionals to lead the system.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 434
(A-19)

Introduced by: New Jersey

Subject: Change in Marijuana Classification to Allow Research

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

1 Whereas, The use of marijuana has increased due to the medical marijuana program and will
2 increase further when marijuana is legalized for recreational use; and
3
4 Whereas, Physicians have to make marijuana related treatment decisions based on data from
5 anecdotal observations and poorly conducted studies; therefore be it
6
7 RESOLVED, That our American Medical Association petition the US Food and Drug
8 Administration / US Drug Enforcement Administration to change the schedule classification of
9 marijuana so that it can be subjected to appropriate research. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 05/09/19