2021 House of Delegates Virtual Meeting

Order of Business

Saturday, May 1, 2021

9:00 – 10:30 am

- Opening Remarks from the Speakers – Theodore B. Jones, MD; and Phillip G. Wise, MD
- Candidate Forum – Theodore B. Jones, MD
- Address of the President – S. “Bobby” Mukamala, MD
- Address of the President-Elect – Pino D. Colone, MD
- Report from the Chair of the Board of Directors – Anita R. Avery, MD
- Report from the Treasurer of the Board of Directors – John A. Waters, MD

Join from a PC, Mac, iPad, iPhone or Android device:

Please click this URL to join.
https://us02web.zoom.us/j/82805076046?pwd=Qlh6U0JhTXp1VWJlaDR5NVJwMGM2dz09
Passcode: 383702

Or iPhone one-tap:
+19292056099,,82805076046#,,,,*383702# US (New York)
+13017158592,,82805076046#,,,,*383702# US (Washington DC)

Or join by phone:
Dial(for higher quality, dial a number based on your current location):
US: +1 929 205 6099 or +1 301 715 8592 or +1 312 626 6799 or +1 669 900 6833 or +1 253 215 8782 or +1 346 248 7799
Webinar ID: 828 0507 6046
Passcode: 383702
International numbers available: https://us02web.zoom.us/u/ktC8Koe2D
### OFFICERS, 2020-2021

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<th>Position</th>
<th>Name</th>
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<tbody>
<tr>
<td>President</td>
<td>S. Bobby Mukkamala, MD</td>
<td>Genesee</td>
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<tr>
<td>President-Elect</td>
<td>Pino D. Colone, MD</td>
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<td>Immediate Past President</td>
<td>Mohammed A. Arsiwala, MD</td>
<td>Wayne</td>
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<td>T. Jann Caisson-Sorey, MD, MSA, MBA</td>
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<td>Treasurer</td>
<td>John A. Waters, MD</td>
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<tr>
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<tr>
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### REGIONAL DIRECTORS

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<td>Larry Junck, MD</td>
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<td>Bradley J. Uren, MD</td>
<td>Livingston</td>
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<td>Amit Ghose, MD</td>
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<td>2021</td>
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<td>Belen Amat, MD</td>
<td>Barry</td>
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<td>Independent Small Practice Physician</td>
<td>Donald P. Condit, MD, MBA, Kent</td>
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<td>Physician Leader From Health System</td>
<td>Christopher J. Milback, MD, MBA, Oakland</td>
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<td>Physician Organization Leader</td>
<td>Paul S. Harkaway, MD, Washtenaw</td>
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<td>Physician Serving as DIO/Representing GME Training</td>
<td>Robert F. Flora, MD, MBA, MPH, Genesee</td>
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<td>Physician Serving in Government/Public Health Role</td>
<td>Thomas M. George, MD, Kalamazoo</td>
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### SECTION DIRECTORS

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<td>Young Physicians Section</td>
<td>Michael J. Redinger, MD</td>
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<td>Residents And Fellows Section</td>
<td>Gunjan B. Malhotra, MD</td>
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<td>Medical Students Section</td>
<td>Tabitha E. Moses, MD</td>
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### DELEGATION TO THE AMA

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<td>Christie L. Morgan, MD, Oakland</td>
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<td>Betty S. Chu, MD, MBA, Oakland</td>
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<td>Amit Ghose, MD, Ingham</td>
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<td>Pino D. Colone, MD, Genesee</td>
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<td>John A. Waters, MD, Genesee</td>
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<td>Mark C. Komorowski, MD, Bay</td>
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<td>M. Salim U. Siddiqui, MD, PhD, Wayne</td>
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<td>Courtland Keteyian, MD, Jackson</td>
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<td>David T. Walsworth, MD, Ingham</td>
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<td>Michael J. Redinger, MD, Kalamazoo</td>
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<td>Sanjay K. Das, Medical Student</td>
<td>2021</td>
<td>Sarah A. Gorgis, MD, Wayne, Resident</td>
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Notification of Slate of Offices – 2021 House of Delegates

**REGIONAL DIRECTORS** *(Three-year term to 2024 House of Delegates)*

Region #2 – Oakland and Macomb

**OPEN POSITION** (Adrian J. Christie, MD, Macomb, *resigning effective May 1, 2021*)

**CANDIDATE:** Daniel M. Ryan, MD, Macomb *(Doctor Ryan will fill Doctor Christie’s unexpired term until the 2023 MSMS House of Delegates)*
*(candidate must be from a county other than Oakland)*

Region #4 – Clinton, Eaton, Hillsdale, Ingham, and Jackson

**OPEN POSITION** (Amit Ghose, MD, Ingham, *completed three 3-year terms, ineligible for re-election*)

**CANDIDATE:** David T. Walsworth, MD, Ingham *(candidate must be from a county other than Jackson)*

Region #5 – Allegan, Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, and Van Buren

Mark E. Meyer, MD, Kalamazoo: completed one term

Belen Amat, MD, Barry: approved by the MSMS Board of Directors on July 17, 2020, to fill the unexpired open seat for Region #5.

Region #7 – Arenac, Bay, Gladwin, Gratiot, Isabella-Clare, Midland, and Saginaw

**OPEN POSITION** if Thomas J. Veverka, MD, Saginaw, is elected President-elect.

**CANDIDATE:** Mildred J. Willy, MD, Saginaw *(candidate must be from a county other than Bay)*

Region #8 – Ionia, Kent, Lake, Mason, Mecosta, Montcalm, Muskegon, Newaygo, Oceana, Osceola, and Ottawa

Brian R. Stork, MD, Muskegon: completed one term

**OPEN POSITION** *(Anita R. Avery, MD, Kent, *completed three 3-year terms, ineligible for re-election)*

**CANDIDATE:** Eric L. Larson, MD, Kent *(candidate must be from a county other than Muskegon)*
Region #9 – See Enclosed Map with Counties

**TWO OPEN POSITIONS** (Richard C. Schultz, MD, Grand Traverse, completed three 3-year terms, ineligible for re-election) *(one candidate must be from a county located in the Upper Peninsula)*

**CANDIDATES:** Joel E. Anhalt, DO, Manistee
Melanie S. Manary, MD, Northern Michigan

**SECTION REPRESENTATIVES:** The *MSMS Resident and Fellow Section* and the *MSMS Medical Student Section* will elect one representative each to serve on the MSMS Board of Directors for a one-year term to the 2022 House of Delegates. The *Young Physicians Section* will elect one representative to serve on the MSMS Board of Directors for a two-year term to the 2023 House of Delegates.

**OFFICERS** *(One-year term to 2022 House of Delegates)*

**Speaker:** *OPEN POSITION* (Theodore B. Jones, MD, Wayne, completed four years, ineligible for re-election)

**Candidate to date:** Phillip G. Wise, MD, Kent

**Vice Speaker:** *OPEN POSITION* (Phillip G. Wise, MD, Kent, completed four years, ineligible for re-election)

**Candidate to date:** Bryan W. Huffman, MD, Ottawa

**President-elect Candidate to Date:** Thomas J. Veverka, MD, Saginaw

**MICHIGAN DELEGATION TO THE AMA** *(Two-year term to 2023 House of Delegates)*

*Delegates*
Mohammed A. Arsiwala, MD, Wayne
Betty S. Chu, MD, MBA, Oakland
Pino D. Colone, MD, Genesee
Mark C. Komorowski, MD, Bay
Michael A. Sandler, MD, Wayne
Krishna K. Sawhney, MD, Wayne
David T. Walsworth, MD, Ingham

*Alternate Delegates Incumbents:*
Theodore B. Jones, MD, Wayne
Patricia A. Kolowich, MD, Wayne
M. Salim U. Siddiqui, MD, PhD, Wayne
Kenneth Elmassian, DO, Ingham
Edward C. Bush, MD, Wayne
In Memory

The members of the Michigan State Medical Society remember with respect their colleagues who have passed away since our last annual meeting.

Okezie Aguwa, MD
C Alkema, MD
James Askins, MD
Roger Byrd, DO
Donald Cady, MD
Nicanor Castedo, MD
John Colombo, MD
Julius Combs, MD
Bernardo Danan, MD
Michael Dawson, MD
Samuel Dismond, MD
Ernesto Duterte, MD
Thomas Egleston, MD
Ali Esfahani, MD
John Feilla, MD
Lynn Gray, MD, MPH
Oliver Grin, MD
Alan Hendra, MD
Anita Herald, MD
Victor Hill, MD
Jeffrey Jacobs, MD
Larry Jennings, MD
Julian Joseph, MD
Francis Judge, MD
Zubeda Khan, MD
John Koh, MD, FACS

Kristin Krizmanich-Conniff, MD
Joseph Kroon, MD
Armand LaSorsa, MD
Lawrence Lee, MD
JoAnne Levitan, MD
Philip Margolis, MD
Rodney McFarland, MD
Mark Menning, MD
Richard Oslund, MD
Lawrence Pawl, MD
Daniel Postellon, MD
Minoo Rao, MD
Robert Reed, MD
David Rovner, MD
Charles Safley, MD
Brian Schafer, MD
Courtland Schmidt, MD
Michael Stone, MD
Dennis Tibble, MD
Luis Tomatis, MD
Prabhundha Vanasupa, MD
Gordon VanOtteren, MD
Robert Weber, MD
Burton Wolters, MD
George Zuidema, MD
## Roster of Delegates

### Officers:
- **Theodore Jones**, MD  Speaker
- **Phillip Wise**, MD  Vice-Speaker
- **T. Jann Caison-Sorey**, MD, MSA, MBA  Secretary

### County: Barry
- **Natalia DiPaola**, MD  Delegate

### County: Berrien
- **Dennis Szymanski**, MD  Delegate

### County: Genesee
- **Khalid Ahmed**, MD  Delegate
- **Qazi Azher**, MD  Delegate
- **Laura Carravallah**, MD  Delegate
- **Edward Christy**, MD  Delegate
- **Deborah Duncan**, MD  Delegate
- **Venkat Rao**, MD  Delegate
- **Macksood Aftab**, DO  Alternate Delegate
- **Scott Garner**, MD  Alternate Delegate
- **Asif Ishaque**, MD  Alternate Delegate
- **Paul Kocheril**, MD  Alternate Delegate
- **Rama Rao**, MD  Alternate Delegate
- **Brenda Rogers-Grays**, DO  Alternate Delegate

### County: Grand Traverse - Leelanau - Benzie
- **Sam Copeland**, DO  Delegate
- **Diane Donley**, MD  Delegate
- **Cyrus Ghaemi**, DO  Delegate
- **Bradley Goodwin**, MD  Delegate
- **Scott Monteith**, MD, FAPA  Delegate
- **Kenneth Musson**, MD, MS, FACS  Delegate
- **Edward Rutkowski**, MD  Delegate
- **Bradley Evans**, MD  Alternate Delegate

### County: Ingham
- **Iftiker Ahmad**, MD  Delegate
- **Tyson Burghardt**, MD  Delegate
- **Douglas Edema**, MD, MPA, FACHE  Delegate
- **Kenneth Elmassian**, DO  Delegate
- **Ved Gossain**, MD  Delegate
- **Narasimha Gundamraj**, MD  Delegate
- **Raza Haque**, MD  Delegate
- **Richard Honicky**, MD  Delegate
- **Ronald Horowitz**, MD  Delegate
- **James Richard**, DO  Delegate
- **Dawn Springer**, MD  Delegate
- **David Walsworth**, MD  Delegate
- **Joseph Wilhelm**, MD  Delegate

### County: Jackson
- **Courtland Keteyian**, MD  Delegate
- **Walter Korytowsky**, MD  Delegate
- **Jon Lake**, MD  Delegate
## Roster of Delegates

### County: Kalamazoo
- Ruqiya Tareen MD Delegate

### County: Kent
- Michelle Condon MD Delegate
- Megan Edison MD Delegate
- Eric Larson MD Delegate
- Gerald Lee MD Delegate
- Rose Ramirez MD Delegate
- Brian Roelof MD Delegate
- Adam Rush MD Delegate
- Herman Sullivan MD Delegate
- John VanSchagen MD Delegate
- David Whalen MD Delegate
- Phillip Wise MD Delegate
- John Beernink MD, FACS Alternate Delegate
- Sandra Dettmann MD Alternate Delegate
- Harland Holman MD Alternate Delegate
- John O'Donnell MD Alternate Delegate

### County: Lenawee
- Lawrence Desjarlais MD Delegate

### County: Macomb
- Adrian Christie MD Delegate
- Lawrence Handler MD Delegate
- Ronald Levin MD Delegate
- Vincente Redondo MD Delegate
- Aaron Sable MD Delegate
- Akash Sheth MD Delegate

### County: Midland
- Thomas Johnson MD Delegate
- Thomas Olen DO Delegate

### County: Monroe
- Irving Hwang MD Delegate
- Busharat Ahmad MD Alternate Delegate

### County: Muskegon
- Wayne Fuller MD Delegate
- F. Remington Sprague MD Delegate

### County: Northern Michigan
- Irene Kazmers MD, FACP, RhMSUS Delegate
- Melanie Manary MD Delegate
- Louis Zako MD Alternate Delegate

### County: Oakland
- Jaime Aragones MD Delegate
- Barry Auster MD Delegate
- George Blum MD Delegate
- Betty Chu MD, MBA Delegate
- Peter Duhamel MD Delegate
- Jay Fisher MD Delegate
## Roster of Delegates

### Oakland cont.

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<th>Name</th>
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### County: Saginaw

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### County: St. Clair

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### County: Washtenaw

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County: Wexford-Missaukee

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Delegate-At-Large: Immediate Past President

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Delegate-At-Large: Medical School Dean, Central Michigan University

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Delegate-At-Large: Medical School Dean, Michigan State University

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Delegate-At-Large: Medical School Dean, University of Michigan

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Delegate-At-Large: Medical School Dean, Wayne State University

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Delegate-At-Large: Medical School Dean, Western Michigan University

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Members-At-Large: MDHHS Chief Medical Officer

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Medical Student Section

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### International Medical Graduate Section

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### Resident and Fellow Section

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### Young Physician Section

Vacant

### Specialty Society: MI Society of Addication Medicine

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### Specialty Society: MI Allergy & Asthma Society

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### Specialty Society: MI Society of Anesthesiologists

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### Specialty Society: MI Chapter of the American College of Cardiology

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### Specialty Society: MI Society of Colon and Rectal Surgeons

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<tr>
<th>Name</th>
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<tr>
<td>Shawn Webb MD</td>
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<tr>
<td>Pasithorn Suwanabol MD</td>
<td>Specialty Society Alternate</td>
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<tr>
<td>Specialty Society: MI Dermatological Society</td>
<td>Specialty Society Delegate: Karen Chapel MD, Specialty Society Alternate: Joseph McGoey MD</td>
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<td>Specialty Society: MI College of Emergency Physicians</td>
<td>Specialty Society Delegate: Sara Chakel MD</td>
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<td>Specialty Society: MI Society of Eye Physicians and Surgeons</td>
<td>Specialty Society Delegate: Patrick Droste MD</td>
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<td>Specialty Society: MI Academy of Family Physicians</td>
<td>Specialty Society Delegate: Loretta Leja MD, Specialty Society Alternate: Brandon Karmo DO</td>
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<td>Specialty Society: MI Neurological Association</td>
<td>Specialty Society Delegate: Amit Sachdev MD</td>
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<td>Specialty Society: MI Association of Neurological Surgeons</td>
<td>Specialty Society Delegate: Hazem Eltahawy MD, PhD, MHCM, FRCS, F/ Specialty Society Alternate: Jason Schwalb MD</td>
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<td>Specialty Society: MI Orthopaedic Society</td>
<td>Specialty Society Delegate: Christopher Betzle MD</td>
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<td>Specialty Society Delegate: Joshua Meyerson MD</td>
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<td>Specialty Society Delegate: Martha Gray MD</td>
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<td>Specialty Society Delegate: Carmen McIntyre MD, Specialty Society Alternate: Duane DiFranco MD</td>
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<td>Specialty Society Delegate: Sarah Lee MD, Specialty Society Alternate: Heidi Flori MD</td>
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<td>Specialty Society Delegate: Robert Jones MD</td>
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Reference Committee A – Medical Care Delivery
Sherwin P. T. Imlay, MD, Chair, Oakland
Patrick J. Droste, MD, MI Society of Eye Physicians and Surgeons
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Phillip G. Wise, MD, Kent
Mara Darian, Wayne State University

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Jennifer L. Finney

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Loretta M. Leja, MD, MI Academy of Family Physicians
James C. Mitchiner, MD, MPH, Washtenaw
Rama D. Rao, MD, Genesee
Dawn E. Springer, MD, Ingham
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Samuel Borer, Central Michigan University

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Staff:
Dara J. Barrera
Mary Kate Barnauskas

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Katharine A. Scharer, MD, MI Radiological Society
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Staff:
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Ronald B. Levin, MD, Macomb
Venkat K. Rao, MD, Genesee
Edward J. Rutkowski, MD, Grand Traverse
Barbara A. Threatt, MD, Washtenaw

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Kaitlyn D. Dobesh, MD, JD, Resident and Fellow Section
Martha L. Gray, MD, American College of Physicians, MI Chapter
Bryan W. Huffman, MD, Ottawa
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Rose M. Ramirez, MD, Kent
Caroline G. M. Scott, MD, Saginaw
David T. Walsworth, MD, Ingham
Phillip G. Wise, MD, Kent
Sanjay Das, Central Michigan University

Staff:
Rebecca J. Blake
Carrie J. Wheeler

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Title: Suspend and Abolish the Medicaid Work Requirement

Introduced by: Annette Mercatante, MD, for the St. Clair County Delegation

Original Author: Annette Mercatante, MD

Referred To: Reaffirmation Calendar

Whereas, Michigan’s Medicaid work requirement affects people enrolled in the Healthy Michigan Plan (HMP), Michigan’s Medicaid expansion plan, and

Whereas, pursuant to the requirement, people age 19 to 62 who depend on the plan must certify to the state that they have spent at least 80 hours per month either working, or getting trained to work, and

Whereas, approximately 670,000 Michigan residents (approximately five percent of the state population) get health care through the HMP, which covers low-income adults, and

Whereas, about twenty percent (130,000) of HMP enrollees would be exempt from the work requirement, while the other 80 percent (540,000) would not be exempt, and

Whereas, approximately five to ten percent of the non-exempt population is expected to lose coverage per the Michigan House Fiscal Agency’s estimate that up to 54,000 Michiganders would lose Medicaid coverage through implementation of the state’s proposal to take Medicaid away from people who do not meet the work requirement, and

Whereas, the Kaiser Family Foundation has estimated that, if a work requirement were implemented at the national level, approximately 1.4 to 4 million enrollees (six to seventeen percent of non-elderly, non-disabled adult Medicaid enrollees) would lose coverage, and

Whereas, Michigan’s Medicaid expansion has been extremely successful, extending coverage and access to care to more than one million low-income adults in Michigan since April 2014, and improving their physical and financial health, and

Whereas, the HMP currently provides coverage to more than 668,000 low-income Michiganders while also providing economic benefits to the state and reducing uncompensated care for hospitals and other safety net providers, and

Whereas, the HMP has cut Michigan’s uninsured rate in half since expansion began in April 2014. Half of non-working adults reported that having Medicaid made it easier to look for work, and nearly 70 percent of those already working said Medicaid made it easier to work or made them better at their job, and
Whereas, most Medicaid adults are already working; among those who are not working, most report barriers to work, and

Whereas, those in better health and with more education are more likely to be working. Even when working, adults with Medicaid face high rates of financial and food insecurity, as they are still living in or near poverty. Half report that they are very or moderately worried that they will not have enough money to pay normal monthly bills, and more than four in ten say they are very or moderately worried about having enough money for housing, rates similar to non-working adults with Medicaid. While income gained from work can improve financial security, this pattern shows that low-income workers still face substantial insecurity given the nature of their jobs. Additionally, people who meet Medicaid work requirements through participating in volunteer activities will not gain income to improve their financial security, and

Whereas, there are high rates of functional disability and serious medical conditions among Medicaid adults, especially among those not working. More than a third (34 percent) of those not working live with multiple chronic medical conditions such as hypertension, high cholesterol, arthritis, or heart disease, and half (51 percent) have a functional limitation, including mobility, physical, or emotional limitations, and

Whereas, many adult Medicaid beneficiaries do not use computers, the internet, or e-mail, which could be a barrier in finding a job and in complying with work reporting requirements. More than a quarter (26 percent) of adult Medicaid beneficiaries report that they never use a computer, 25 percent do not use the internet, and 40 percent do not use e-mail, which may pose a barrier to gaining a job and complying with reporting requirements under state waivers, and

Whereas, an earlier analysis of potential nationwide reductions in Medicaid coverage if all states implemented work requirements estimated that most disenrollment would be among individuals who would remain eligible, but lose coverage due to new administrative burdens or red tape, and only a minority would lose eligibility due to not meeting new work requirements, and

Whereas, work requirements may not result in increased employment or employer-based health coverage. Arkansas enrollees reported that new work requirements did not provide an additional incentive to work, beyond economic pressures to pay for food and other bills. Another study found that work requirements in Arkansas did result in significant changes in employment. Among individuals who may find work, low-income jobs are not likely to come with employer-sponsored insurance (ESI). ESI offer rates are low among poor (below 100 percent FPL) and low-income (between 100 and 250 percent FPL) workers who work full-time (25 percent and 42 percent, respectively). Very few part-time workers, especially those with low-incomes, receive an employer-sponsored offer of health benefits, and

Whereas, several state-adopted Medicaid work requirements have been challenged in court including Michigan's policy, and

Whereas, federal judges have blocked Medicaid work requirements in Arkansas, Kentucky, New Hampshire, and, most recently, Michigan, further raising the question of whether the issue will be taken up by the Supreme Court; therefore be it

RESOLVED: That MSMS continue to advocate for the elimination of Medicaid work requirements, as well as other barriers to state Medicaid insurance plans.
WAYS AND MEANS COMMITTEE FISCAL NOTE: None

Relevant MSMS Policy:

**Opposition to Medicaid Work Requirements**
MSMS opposes work requirements as a criterion for Medicaid eligibility. (Res22-19)

Relevant AMA Policy:

**Opposition to Medicaid Work Requirements H-290.961**
Our AMA opposes work requirements as a criterion for Medicaid eligibility.

**Sources:**
3. Center for Health and Research Transformation, Ann Arbor MI
WHEREAS, the Affordable Care Act, which beneficially expanded health insurance coverage in the United States, allowed states to determine if they wished to enact Medicaid Expansion, and

WHEREAS, lack of insurance coverage has devastating effects on the health of all persons, affecting them, their families, and society in general, and

WHEREAS, Medicaid expansion in the states in which it has been enacted has been demonstrated to have beneficial effects on the health status of enrollees and to save money; therefore be it

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to advocate strongly for expansion of the Medicaid program to all states; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to produce informational brochures and other communications that can be distributed by health care providers to inform the public of the importance of expanded health insurance coverage to all.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Name

Relevant MSMS Policy:

Medicaid Expansion
MSMS supports the expansion of Medicaid under the Affordable Care Act.

Relevant AMA Policy:

Affordable Care Act Medicaid Expansion H-290.965
1. Our AMA encourages state medical associations to participate in the development of their state’s Medicaid access monitoring review plan and provide ongoing feedback regarding barriers to access.
2. Our AMA will continue to advocate that Medicaid access monitoring review plans be required for services provided by managed care organizations and state waiver programs, as well as by state Medicaid fee-for-service models.
3. Our AMA supports efforts to monitor the progress of the Centers for Medicare and Medicaid Services (CMS) on implementing the 2014 Office of Inspector General’s recommendations to improve access to care for Medicaid beneficiaries.
4. Our AMA will advocate that CMS ensure that mechanisms are in place to provide robust access to specialty care for all Medicaid beneficiaries, including children and adolescents.
5. Our AMA supports independent researchers performing longitudinal and risk-adjusted research to assess the impact of Medicaid expansion programs on quality of care.
6. Our AMA supports adequate physician payment as an explicit objective of state Medicaid expansion programs.
7. Our AMA supports increasing physician payment rates in any redistribution of funds in Medicaid expansion states experiencing budget savings to encourage physician participation and increase patient access to care.
8. Our AMA will continue to advocate that CMS provide strict oversight to ensure that states are setting and maintaining their Medicaid rate structures at levels to ensure there is sufficient physician participation so that Medicaid patients can have equal access to necessary services.
9. Our AMA will continue to advocate that CMS develop a mechanism for physicians to challenge payment rates directly to CMS.
10. Our AMA supports extending to states the three years of 100 percent federal funding for Medicaid expansions that are implemented beyond 2016.
11. Our AMA supports maintenance of federal funding for Medicaid expansion populations at 90 percent beyond 2020 as long as the Affordable Care Act’s Medicaid expansion exists.
12. Our AMA supports improved communication among states to share successes and challenges of their respective Medicaid expansion approaches.
13. Our AMA supports the use of emergency department (ED) best practices that are evidenced-based to reduce avoidable ED visits.

Medicaid Expansion D-290.979
Our AMA, at the invitation of state medical societies, will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133% (138% FPL including the income disregard) of the Federal Poverty Level as authorized by the ACA and will advocate for an increase in Medicaid payments to physicians and improvements and innovations in Medicaid that will reduce administrative burdens and deliver healthcare services more effectively, even as coverage is expanded.

Medicaid Expansion Options and Alternatives H-290.966
1. Our AMA encourages policymakers at all levels to focus their efforts on working together to identify realistic coverage options for adults currently in the coverage gap.
2. Our AMA encourages states that are not participating in the Medicaid expansion to develop waivers that support expansion plans that best meet the needs and priorities of their low income adult populations.
3. Our AMA encourages the Centers for Medicare & Medicaid Services to review Medicaid expansion waiver requests in a timely manner, and to exercise broad authority in approving such waivers, provided that the waivers are consistent with the goals and spirit of expanding health insurance coverage and eliminating the coverage gap for low-income adults.
4. Our AMA advocates that states be required to develop a transparent process for monitoring and evaluating the effects of their Medicaid expansion plans on health insurance coverage levels and access to care, and to report the results annually on the state Medicaid web site.
Title: “Red Flag” Law to Enhance Safe Gun Ownership

Introduced by: John Pelachyk, MD, for the St. Clair County Delegation

Original Author: Raj Makim, MD

Referred To: Reaffirmation Calendar

House Action:

Whereas, in the United States, a “red flag” law is a gun control law that permits family members, law enforcement, and sometimes others relevant in the circle of the person in question, to petition a state court to order the temporary removal (of up to 12 months) of firearms from a person who may present a danger to themselves or others, and

Whereas, “red flag” laws have been passed in 17 other states and the District of Columbia and pending legislation for “red flag” laws are being considered in four more states, and

Whereas, research has shown “red flag” laws can affect a significant mitigation of the risk posed by that small proportion of legal gun owners who may pose a threat to themselves or others, and

Whereas, in an Annals of Internal Medicine 2019 study, a case series indicated that California’s “red flag” law has been found to be a factor in efforts to prevent mass shootings, and

Whereas, suicides accounted for 62 percent of U.S. gun deaths from 2008 to 2017, which implies that “red flag” laws may have significant value in preventing some of these deaths, and

Whereas, Everytown for Gun Safety conducted a nationwide study showing that the perpetrators of mass shootings showed warning signs before the event 42 percent of the time, and

Whereas, an April 2018 poll found that 85 percent of registered voters support laws that would “allow the police to take guns away from people who have been found by a judge to be a danger to themselves or others” (71 percent "strongly supported" while 14 percent "somewhat supported" such laws); therefore be it

RESOLVED: That MSMS advocate for and recommend the adoption of “red flag” legislation to enhance safe gun ownership in Michigan.

WAYS AND MEANS COMMITTEE FISCAL NOTE: None

Relevant MSMS Policy:

Firearm Regulations
MSMS opposes the liberalization of concealed gun laws and efforts to weaken current laws regarding the manufacture, importation, and/or ownership of assault weapons and/or handguns. MSMS supports policies that 1) prohibit acquisition of firearms by high-risk persons; 2) require firearm owners to have firearm safety certification which includes but is not limited to basic education in the care and handling of firearms; 3) limit ownership and use of assault weapons; and, 4) ban the sale of assault weapons and large-capacity ammunition magazines.

Relevant AMA Policy:

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.

Sources:
Title: Promote NBPAS as Board Recertification in Michigan

Introduced by: Rose Ramirez, MD, for the Kent County Delegation

Original Author: Rose Ramirez, MD

Referred To: Reaffirmation Calendar

House Action:

Whereas, the American Board of Medical Specialties (ABMS) holds monopoly power over physician board recertification in Michigan and the United States, and

Whereas, ABMS recertification is an expensive, time consuming, high cost requirement to maintain board certification (MOC), and

Whereas, the requirements of the ABMS are often irrelevant to a particular physician’s practice, and

Whereas, the National Board of Physicians and Surgeons (NBPAS) is committed to providing certification that ensures physician compliance with national standards and promotes lifelong learning, and

Whereas, NBPAS will provide recertification in the event that previous certification was obtained through an ABMS or American Osteopathic Association member board, and

Whereas, the NBPAS is relevant, lower cost, and does not require many extra hours of time beyond continuing medical education already obtained; therefore be it

RESOLVED: That MSMS actively lobby hospitals and insurers about the rational approach to board recertification that National Board of Physicians and Surgeons can provide for maintenance of certification.

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

Relevant MSMS Policy:

Review Board Recertification and Maintenance of Certification Process
MSMS supports Maintenance of Certification (MOC) only under all of the following circumstances:
1. MOC must be voluntary
2. MOC must not be a condition of licensure, hospital privileges, health plan participation, or any other function unrelated to the specialty board requiring MOC
3. MOC should not be the monopoly of any single entity. Physicians should be able to access a range of alternatives from different entities.
4. The status of MOC should be revisited by MSMS if it is identified that the continuous review of physician competency is objectively determined to be a benefit for patients. If that benefit is determined to be present by objective data regarding value and efficacy, then MSMS should support the adoption of an evidence based process that serves only to improve patient care. (Res73-15) - Reaffirmed (Res10-19)

**Relevant AMA Policy:**

**Continuing Board Certification D-275.954**

Our AMA will:

1. Continue to monitor the evolution of Continuing Board Certification (CBC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for CBC, and prepare a yearly report to the House of Delegates regarding the CBC process.
2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council’s ongoing efforts to critically review CBC issues.
3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of CBC, and encourage the ABMS to report its research findings on the issues surrounding certification and CBC on a periodic basis.
4. Encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and CBC.
5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of CBC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.
6. Work with interested parties to ensure that CBC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that CBC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.
7. Recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.
8. Work with the ABMS to eliminate practice performance assessment modules, as currently written, from CBC requirements.
9. Encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting CBC and certifying examinations.
10. Encourage the ABMS to ensure that CBC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle.
11. Work with the ABMS to lessen the burden of CBC on physicians with multiple board certifications, particularly to ensure that CBC is specifically relevant to the physician’s current practice.
12. Work with key stakeholders to (a) support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for CBC; (b) support ABMS member board activities in facilitating the use of CBC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement; (c) encourage ABMS member boards to enhance the consistency of quality improvement programs across all boards; and (d) work with specialty societies and ABMS member boards to develop tools and services that help physicians meet CBC requirements.
13. Work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.
14. Work with the ABMS to study whether CBC is an important factor in a physician’s decision to retire and to determine its impact on the US physician workforce.
15. Encourage the ABMS to use data from CBC to track whether physicians are maintaining certification and share this data with the AMA.
16. Encourage AMA members to be proactive in shaping CBC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and CBC Committees.
17. Continue to monitor the actions of professional societies regarding recommendations for modification of CBC.
18. Encourage medical specialty societies’ leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant CBC process for its members.
19. Continue to work with the ABMS to ensure that physicians are clearly informed of the CBC requirements for their specific board and the timelines for accomplishing those requirements.
20. Encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.
21. Recommend to the ABMS that all physician members of those boards governing the CBC process be required to participate in CBC.
22. Continue to participate in the National Alliance for Physician Competence forums.
23. Encourage the PCPI Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of CBC.
24. Continue to assist physicians in practice performance improvement.
25. Encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty board’s CBC and associated processes.
26. Support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the CBC program.
27. Oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Continuing Board Certification.
28. Ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on continuing board certification activities relevant to their practice.
29. Call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.
30. Support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician’s practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.
31. Continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam.
32. Continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.
33. Through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Continuing Board Certification not be a requirement for: (a) medical staff membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure.
34. Increase its efforts to work with the insurance industry to ensure that continuing board certification does not become a requirement for insurance panel participation.
35. Advocate that physicians who participate in programs related to quality improvement and/or patient safety receive credit for CBC Part IV.
36. Continue to work with the medical societies and the American Board of Medical Specialties (ABMS) member boards that have not yet moved to a process to improve the Part III secure, high-stakes examination to encourage them to do so.
37. Our AMA will, through its Council on Medical Education, continue to work with the American Board of Medical Specialties (ABMS), ABMS Committee on Continuing Certification (3C), and ABMS Stakeholder Council to pursue opportunities to implement the recommendations of the Continuing Board Certification: Vision for the Future Commission and AMA policies related to continuing board certification.
RESOLUTION 39-20

Title: End Time Limited Board Certification

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

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

Referred To: Reaffirmation Calendar

House Action:

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

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

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

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

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

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

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

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

Whereas, the MOC product is not academically superior to other forms of CME in terms of patient outcomes and is jurisdictionally inferior to local forms of professional accountability and discipline, rendering it a duplicative burden upon younger physicians, at best, and
Whereas, loss of initial board certification status for not participating and purchasing the MOC product results in significant financial and professional harm to time-limited physicians as they are removed from insurance panels and hospitals; thereby, forcing many physicians to comply with MOC, and

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

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

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

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

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

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

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

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

Relevant MSMS Policy:

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

Relevant AMA Policy:

**Continuing Board Certification H-275.924**

Continuing Board Certification AMA Principles on Continuing Board Certification

1. Changes in specialty-board certification requirements for CBC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in CBC must be reasonable and take into consideration the time needed to develop the proper CBC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the CBC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for CBC.
4. Any changes in the CBC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. CBC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of CBC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for CBC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of CBC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with CBC participation.
9. Our AMA affirms the current language regarding continuing medical education (CME): “Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for CBC Part II. The content of CME and self-assessment programs receiving credit for CBC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 Credit", American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A).”
10. In relation to CBC Part II, our AMA continues to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.
11. CBC is but one component to promote patient safety and quality. Health care is a team effort, and changes to CBC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.
12. CBC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.
13. The CBC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.
14. CBC should be used as a tool for continuous improvement.
15. The CBC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.
16. Actively practicing physicians should be well-represented on specialty boards developing CBC.
17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.
18. CBC activities and measurement should be relevant to clinical practice.
19. The CBC process should be reflective of and consistent with the cost of development and administration of the CBC components, ensure a fair fee structure, and not present a barrier to patient care.
20. Any assessment should be used to guide physicians' self-directed study.
21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.
22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.
23. Physicians with lifetime board certification should not be required to seek recertification.
24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in CBC.
25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.
26. The initial certification status of time-limited diplomates shall be listed and publicly available on all American Board of Medical Specialties (ABMS) and ABMS Member Boards websites and physician certification databases. The names and initial certification status of time-limited diplomates shall not be removed from ABMS and ABMS Member Boards websites or physician certification databases even if the diplomate chooses not to participate in CBC.
27. Our AMA will continue to work with the national medical specialty societies to advocate for the physicians of America to receive value in the services they purchase for Continuing Board Certification from their specialty boards. Value in CBC should include cost effectiveness with full financial transparency, respect for physicians' time and their patient care commitments, alignment of CBC requirements with other regulator and payer requirements, and adherence to an evidence basis for both CBC content and processes.
Title: Long-Acting Reversible Contraception Access in Michigan

Introduced by: Mara Darian, for the Medical Student Section

Original Authors: John Dewey, Megan Sandberg, Emma Swayze, and Alangoya Tezel

Referred To: Reaffirmation Calendar

House Action:

Whereas, Long-Acting Reversible Contraceptives (LARCs) have been demonstrated to be a highly effective method of birth control, with failure rates as low as 0.05 percent, and

Whereas, LARCs have a very limited and safe adverse event profile, and

Whereas, LARCs are available in a variety of forms, allowing patients to choose a method that works best for them, and

Whereas, LARCs are designed to be functional for months to years at a time with little to no maintenance, which reduces the error introduced by reliance on consistent adherence to medication regimens, and

Whereas, a program that provided LARCs and relevant provider training to Title X clinics at a reduced cost has been established in Colorado, known as the Colorado Family Planning Initiative (CFPI), and

Whereas, the CFPI resulted in more than 36,000 LARCs being administered from 2009 to 2015, with a majority of those recipients being in the age bracket of 15-24, and

Whereas, during the course of the CFPI, unintended pregnancy rates among 15-19 year olds in the state of Colorado went from 35 percent in 2009 to 21 percent in 2014, and

Whereas, during the course of the CFPI, abortion rates decreased almost 50 percent in the age group of 15-19, and decreased by 18 percent in the age group of 20-24, and

Whereas, the CFPI contributed toward an increase in the average age of first pregnancy by 1.2 years between 2009 and 2014, and

Whereas, an increase in age of first pregnancy is associated with better outcomes for the mother and the child, and

Whereas, rapid repeat births are here defined as a childbirth that takes place less than 24 months postpartum, and

Whereas, rapid repeat births are associated with worse perinatal health outcomes, and
Whereas, the CFPI contributed to a reduction in rapid repeat births by 12 percent between 2009 and 2014, and

Whereas, the CFPI resulted in an estimated avoidance in federal and state costs of between $66.1 and $69.6 million for women aged 15 to 24, off of an initial $27.3 million investment; therefore be it

RESOLVED: That MSMS support legislation that increases access to Long-Acting Reversible Contraceptives for populations with barriers to contraceptive access and is consistent with the clinical management guidelines provided by the American College of Obstetricians and Gynecologists.

WAYS AND MEANS COMMITTEE FISCAL NOTE: None

Relevant MSMS Policy:

Coverage and Billing of Postpartum LARC Services
MSMS supports AMA policy H-75.984, Increasing Availability and Coverage for Immediate Postpartum Long-Acting Reversible Contraceptive Placement, in effect on April 29, 2018, which recognizes efficacy of postpartum long-acting reversible contraceptives placement as a way of reducing future unintended pregnancies and the need to increase availability and coverage by Medicaid, Medicare, and private insurers, as well as to bill and pay these devices separately from the obstetrical global fee.

Family Planning Services
MSMS supports the concept that family planning services are a basic health service and funds should be earmarked to support those services. Universal family planning is an essential element of responsible parenthood, stable family life and social harmony. The very personal nature of advice and counseling in family planning makes it mandatory that consideration be given to the patient’s wishes and desires, and to ethnic and religious background. The professional must be prepared to counsel on all aspects of family planning, either in assisting a couple to have a family, or postponing additions to their family. Expert counseling in all techniques, such as rhythm, barrier, hormone or tubal ligation must be available. Consistent with responsible preventive medicine and in the interest of reducing the incidence of teenage pregnancy, the following is recommended: a. The teenage minor whose sexual behavior exposes her to possible conception should have access to medical consultation and the most effective contraceptive advice and methods consistent with her physical and emotional needs. b. The physician so consulted should be free to prescribe or withhold contraceptive advice in accordance with his or her best medical judgment in the best interests of the patient.

Preserve Access to Contraceptives
MSMS supports the preservation of access to contraceptive services, including through Title X funds.

Relevant AMA Policy:

Increasing Availability and Coverage for Immediate Postpartum Long-Acting Reversible Contraceptive Placement H-75.984
1. Our AMA: (a) recognizes the practice of immediate postpartum and post pregnancy long-acting reversible contraception placement to be a safe and cost effective way of reducing future unintended pregnancies; and (b) supports the coverage by Medicaid, Medicare, and private insurers for immediate postpartum long-acting reversible contraception devices and placement, and that these be billed separately from the obstetrical global fee.
2. Our AMA encourages relevant specialty organizations to provide training for physicians regarding (a) patients who are eligible for immediate postpartum long-acting reversible contraception, and (b) immediate postpartum long-acting reversible contraception placement protocols and procedures.

Sources:
7. CFPI Report, Page 19
8. CFPI Report, Page 26
9. CFPI Report, Page 25
10. CFPI Report, Page 30
15. CFPI Report, Page 34 16. CFPI Report, Page 47
Whereas, 73 percent of medical students graduated with debt in 2017, and

Whereas, in the United States, the average medical school loan debt in 2017 was $192,000, as opposed to $50,000 in 1992, representing a 220 percent increase in debt, and

Whereas, subsidized, interest free loans were previously available prior to the 2011-2012 academic year for up to $34,000 dollars, but are no longer available to medical students, and

Whereas, Stafford unsubsidized loans prior to 2006 had an interest rate of 1.87 percent while in medical school to a current fixed and capitalizing rate of 6.8 percent, and

Whereas, the current interest rate on Graduate Plus Loans, used to supplement the cost of medical education outside the Stafford loan has a fixed interest rate of 7.9 percent, and

Whereas, medical school debt is negatively associated with mental well-being, and academic outcomes, as well as an association with seeking higher paying specialties as opposed to primary care, and

Whereas, the American Medical Association (AMA) recognizes the shortage of physicians across specialties, including primary care, and to explore other innovative solutions to the recognized shortage, and

Whereas, the funding for graduate medical education has not increased consistent with the number of medical school graduates, creating further financial risk for medical students, and

Whereas, MSMS policy dictates the pursing of immediate debt relief for medical students and the analysis of novel solutions to the medical student debt crisis, and

Whereas, the bipartisan H.R. 1554, “The Resident Education Deferred Interest Act,” currently in the United States House of Representatives Education and Labor Committee aims to make interest free deferment on loans during medical or dental internships or residency, and

Whereas, AMA policy supports advocacy for legislation and regulation that would lead to more favorable terms and conditions for borrowing and loan repayment, as well as the self-managed low interest loan programs, and
Whereas, the AMA supports taking an active role in the reauthorization of the Higher Education Act, and similar legislations to expanding loan deferment and other concerns regarding medical school debt, and

Whereas, AMA policy states the AMA will collaborate to advocate for reduction of Stafford and Graduate Plus Loan program interest rates; therefore be it

RESOLVED: That MSMS advocate for the passage of the bipartisan Resident Education Deferred Interest Act, H.R. 1554; and be it further

RESOLVED: That Michigan Delegation to the American Medical Association (AMA) ask our AMA to strongly advocate for the passage of the bipartisan Resident Education Deferred Interest Act, H.R. 1554 and adoption of an amendment to include conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate medical education.

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

Relevant MSMS Policy:

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

Financial Aid for Medical Students
Adequate financial aid systems should be available for financially needy medical students.

Resolution 46-08
RESOLVED: That MSMS pursue immediate debt relief for medical students at the statewide level by advocating for tuition freezes upon matriculation at state medical schools, pursuing scholarship and loan repayment options for students who stay to train and practice in the state, and continue to advocate at the state and national level for medical student debt relief; and be it further
RESOLVED: That the Michigan Delegation to the AMA ask the AMA to pursue long-term solutions to the student debt crisis by hiring an economic consulting firm to analyze the feasibility of novel solutions including; 1) competency-based curriculums that shorten the length of undergraduate education and medical school, 2) work-study opportunities, 3) paid rotating internships for fourth-year students who have passed initial licensing exams and have the training equivalents of mid-level providers, 4) financial investment funds that match parental savings, 5) relief for dual degrees not covered by the National Institute of Health, 6) pursuit of government Medicare funding for undergraduate medical education funding, and 7) implementing international medical student tuition models, among other viable options.

Relevant AMA Policy:

Reduction in Student Loan Interest Rates D-305.984
1. Our AMA will actively lobby for legislation aimed at establishing an affordable student loan structure with a variable interest rate capped at no more than 5.0%.
2. Our AMA will work in collaboration with other health profession organizations to advocate for a reduction of the fixed interest rate of the Stafford student loan program and the Graduate PLUS loan program.
3. Our AMA will consider the total cost of loans including loan origination fees and benefits of federal loans such as tax deductibility or loan forgiveness when advocating for a reduction in student loan interest rates.
4. Our AMA will advocate for policies which lead to equal or less expensive loans (in terms of loan benefits, origination fees, and interest rates) for Grad-PLUS loans as this would change the status quo of high-borrowers paying higher interest rates and fees in addition to having a higher overall loan burden.
5. Our AMA will work with appropriate organizations, such as the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges, to collect data and report on student indebtedness that includes total loan costs at completion of graduate medical education training.

Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925

The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:
1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs—such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector—to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the “20/220 pathway,” and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all
government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.

13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.

14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the “cost of attendance”; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.

16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short- and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.

17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.

18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to: (a) Provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) Work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) Share innovative approaches with the medical education community.

19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.

20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer; (f) Advocate that the profit status of a physicians training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in
service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.

21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.

22. Formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new policies and novel approaches to prevent debt from influencing specialty and subspecialty choice.

Sources:


   doi:10.1136/bmjopen-2019-029980


RESOLUTION 01-21

Title: Stop Continuous CME Mandates

Introduced by: Martha Gray, MD, for the Washtenaw County Delegation

Original Author: Martha Gray, MD

Referred To: Reaffirmation Calendar

House Action:

Whereas, the definition of continuing medical education (CME) is “the process by which physicians and other health professionals engage in activities designed to support their continuing professional development,” and

Whereas, all physicians must adhere to multiple educational credentialing mandates through their specialty boards and societies, and

Whereas, all physicians must meet state board of medicine requirements to maintain a license to practice in Michigan, and

Whereas, Michigan has one of the highest CME requirements compared to other states in our country, and

Whereas, the state and payers continue to add new mandates regarding CME for physicians poorly correlative with value to patient care by physicians, and

Whereas, Blue Cross Blue Shield of Michigan added a required implicit bias training mandate in 2020 for primary care physicians connected to loss of reimbursement if not fulfilled, and

Whereas, this was done in response to unequal societal COVID-19 disease effect but after state law that uncoupled maintenance of certification with payor credentialling and reimbursement, and

Whereas, MSMS has developed CME opportunities and educational training on implicit bias and racial inequities, and

Whereas, new CME mandates arising now are adding to the clinical burden of caring for patients and to the current economic struggle of clinical practice in the time of the COVID-19 pandemic, and

Whereas, MSMS and the AMA are here to support patient care such that physicians are not overburdened by credentialing criteria and MSMS readily responds to changes in the educational needs of its physicians as challenges and new credentialing needs arise; therefore be it
RESOLVED: That MSMS work with the Michigan Board of Medicine and Board of Osteopathic Medicine to stop CME mandates by Michigan legislators and payers such that the physicians are able to self-credential and focus on caring for patients.

WAYS AND MEANS COMMITTEE FISCAL NOTE: None

STATEMENT OF URGENCY: New CME requirements have come out during COVID-19, time is of the essence.

Relevant MSMS Policy:

Opposition to Compulsory Content of Mandated Continuing Medical Education
MSMS opposes any attempt to introduce compulsory content of mandated Continuing Medical Education (CME) in the state of Michigan. (Res67-07A) - Reaffirmed (Sunset Report 2020)

Relevant AMA Policy:
None

Sources:
1. https://www.aafp.org/about/policies/all/continuing-medical-education-definition.html
Title: Maternal Levels of Care Standards of Practice

Introduced by: Federico G. Mariona, MD, MBA, FACOG, FACS, for the Wayne County Delegation

Original Authors: Federico Mariona, MD, and Brianna Sohl

Referred To: Reaffirmation Calendar

Whereas, severe maternal morbidity and maternal-infant mortality continue to be a serious national public health and physicians’ concern, and

Whereas, in the last five years the Centers for Disease Control and Prevention (CDC), the American College of Obstetricians and Gynecologists (ACOG), the Society for Maternal Fetal Medicine (SMFM) and the Joint Commission, supported by other national professional organizations, have recommended the implementation of initiatives to reduce severe maternal morbidity and avoid preventable pregnancy-related maternal deaths, and

Whereas, several states and specific geographic areas where maternal care is provided have implemented collaborative programs to ensure optimal care to pregnant women and decrease or avoid inequality in maternal care, an issue that more severely affects minorities, and

Whereas, maternity care with standardized and established levels of care appears conducive to provide optimal obstetrical and perinatal care and improve clinical outcomes, and

Whereas, due to the increasing demand in clinical care added by the coronavirus 19 (COVID-19) pandemic this resolution requires urgent attention; therefore be it

RESOLVED: That MSMS support statewide initiatives to help improve maternal care in the state of Michigan; and be it further

RESOLVED: That MSMS advocate for the implementation of standards consistent with the Maternal Levels of Care at all birthing centers in the state; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association ask our AMA to support national standards of practice to help improve maternal health at birthing centers across the country.

WAYS AND MEANS COMMITTEE FISCAL NOTE:

Relevant MSMS Policy:

Michigan Maternal Health Safety and Quality Care Initiative – Resolution 24-14
RESOLVED: That MSMS join efforts with the Michigan Department of Community Health, the Michigan Section of the ACOG, the Keystone OB initiative, and all professional societies in the state involved in the care of pregnant women by advocating for the implementation of a standard risk assessment clinical protocol for the identification and standardized treatment of postpartum hemorrhage in all Michigan institutions that offer maternity services.

**Relevant AMA Policy:**

**Disparities in Maternal Mortality D-420.993**

Our AMA: (1) will ask the Commission to End Health Care Disparities to evaluate the issue of health disparities in maternal mortality and offer recommendations to address existing disparities in the rates of maternal mortality in the United States; (2) will work with the CDC, HHS, state and county health departments to decrease maternal mortality rates in the US; (3) encourages and promotes to all state and county health departments to develop a maternal mortality surveillance system; and (4) will work with stakeholders to encourage research on identifying barriers and developing strategies toward the implementation of evidence-based practices to prevent disease conditions that contribute to poor obstetric outcomes, maternal morbidity and maternal mortality in racial and ethnic minorities.

**Infant Mortality D-245.994**

1. Our AMA will work with appropriate agencies and organizations towards reducing infant mortality by providing information on safe sleep positions and preterm birth risk factors to physicians, other health professionals, parents, and child care givers. 2. Our AMA will work with Congress and the Department of Health and Human Services to improve maternal outcomes through: (a) maternal/infant health research at the NIH to reduce the prevalence of premature births and to focus on obesity research, treatment and prevention; (b) maternal/infant health research and surveillance at the CDC to assist states in setting up maternal mortality reviews; modernize state birth and death records systems to the 2003-recommended guidelines; and improve the Safe Motherhood Program; (c) maternal/infant health programs at HRSA to improve the Maternal Child Health Block grant; (d) comparative effectiveness research into the interventions for preterm birth; (e) disparities research into maternal outcomes, preterm birth and pregnancy-related depression; and (f) the development, testing and implementation of quality improvement measures and initiatives.

**Maternal and Child Health Care H-420.986**

The AMA opposes any further decreases in funding levels for maternal and child health programs; encourages more efficient use of existing resources for maternal and child health programs; encourages the federal government to allocate additional resources for increased health planning and program evaluation within Maternal and Child Health Block Grants; and urges increased participation of physicians through advice and involvement in the implementation of block grants.

**Sources:**

12. Texas Office of the Secretary of State, Department of state Health Services. Texas administrative code; Title 25, part 1, Chapter 133, subchapter K. https://texreg.sos.state.tx.us/public/readtac$ext_ViewTAC?tac_view=5&ti=25&pt=1&ch=133&sch=K&rl=Y
Whereas, Michigan citizens experienced the deliberate lethal threat against our neighbors and public officials by persons carrying firearms and/or explosive devices in the Michigan State Capitol on April 30, 2020, and in various instances since, and

Whereas, members of the group(s) who invaded Michigan’s Capitol in April and threatened our elected officials and public servants were among those who went on to threaten to kidnap and harm various elected leaders, including Governor Gretchen Whitmer and Attorney General Dana Nessel, and

Whereas, private unauthorized militias are illegal in Michigan, and

Whereas, the Armed Conflict Location & Event Data Project states that far-right groups have taken an increasing part in demonstrations against the election result, demonstrations are more likely to turn violent if militia members are present, and these groups have not just started attending more protests, they are also ramping up training and recruitment events, and

Whereas, members of Michigan militant groups are known to have participated in the insurrection attempt at the U.S. Capitol in Washington, DC on January 6, 2021, making it clear that violence against the U.S., its people, and its institutions may just be beginning, and

Whereas, the act of threatening and intimidating with firearms, and/or explosive devices through open carry in the Michigan State Capitol only became expressly prohibited in January 2021, but concealed carry is still permissible, and

Whereas, there is increasing bipartisan support from lawmakers on banning the open carry of firearms in the Michigan legislature, and

Whereas, the latest U.S. public opinion on carrying firearms in public places from the American Journal of Public Health shows that fewer than one in three U.S. adults supported gun carrying in any of the specified venues, and support for carrying in public was lowest for schools (19%; 95% confidence interval [CI] = 16.7, 21.1), bars (18%; 95% CI = 15.9, 20.6), and sports stadiums (17%; 95% CI = 15.0, 19.5), and
Whereas, carrying firearms has been used to threaten individuals and impose physiologic and psychological harm to persons exposed making this a medical issue worthy of consideration by our medical societies, and

Whereas, in Michigan, those who carry firearms and explosive devices in public incite unnecessary fear, stress, and safety risks to fellow citizens and public officials; therefore be it

RESOLVED: That MSMS advocate that firearms and explosive devices of all kinds, with a carry exception for law enforcement officials, be prohibited from state government buildings and public spaces.

WAYS AND MEANS COMMITTEE FISCAL NOTE: None

STATEMENT OF URGENCY: Gun violence is a daily epidemic and there was increased unrest and violence in 2020-2021 in Michigan and Washington.

Relevant MSMS Policy:

Address Gun Violence Using a Public Health Approach
MSMS supports physicians working with local and state public health agencies, law enforcement agencies, and other community organizations and leaders to identify, develop and evaluate strategies to increase firearm safety and prevent firearm injury and death.

Firearm Regulations
MSMS opposes the liberalization of concealed gun laws and efforts to weaken current laws regarding the manufacture, importation, and/or ownership of assault weapons and/or handguns. MSMS supports policies that 1) prohibit acquisition of firearms by high-risk persons; 2) require firearm owners to have firearm safety certification which includes but is not limited to basic education in the care and handling of firearms; 3) limit ownership and use of assault weapons; and, 4) ban the sale of assault weapons and large-capacity ammunition magazines.

Firearm-Related Injury and Death: Adopt A Call to Action
MSMS endorses the specific recommendations made in the publication “Firearm-Related Injury and Death in the United States: A Call to Action From 8 Health Professional Organizations and the American Bar Association,” which is aimed at reducing the health and public health consequences of firearms.

Handgun Control and Education
MSMS recommends effective controls on the assembly, manufacture, distribution and possession of handguns.

MSMS supports distribution of educational materials to firearm purchasers. The materials should address the use of lock boxes, trigger locks, childproof safety catches and loading indicators.

Oppose Imposition of Penalties on Local Units of Government and/or Officials and Staff
MSMS opposes the prohibition of local units of government and/or their elected or appointed officials or staff from imposing restrictions on the ownership, registration, purchase, sale, transfer, transportation, or possession of guns within their area of jurisdiction and/or punishment for the imposition of such restrictions.
Relevant AMA Policy:

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.

Firearm Related Injury and Death: Adopt a Call to Action H-145.973
Our AMA endorses the specific recommendations made by an interdisciplinary, inter-professional group of leaders from the American Academy of Family Physicians, American Academy of Pediatrics, American College of Emergency Physicians, American College of Obstetricians and Gynecologists, American College of Physicians, American College of Surgeons, American Psychiatric Association, American Public Health Association, and the American Bar Association in the publication "Firearm-Related Injury and Death in the United States: A Call to Action From 8 Health Professional Organizations and the American Bar Association," which is aimed at reducing the health and public health consequences of firearms and lobby for their adoption.

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997
1. 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:
(A) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;
(B) 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;
(C) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;
(D) 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;
(E) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;
(F) 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
(G) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.

2. Our AMA will advocate for firearm safety features, including but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or misappropriation of the weapon by a non-registered user; and support legislation and regulation to standardize the use of these firearm safety features on weapons sold for non-military and non-peace officer use within the U.S.; with the aim of establishing manufacturer liability for the absence of safety features on newly manufactured firearms.

Sources:
Title: Insurance Coverage of Adverse Childhood Experiences Screening

Introduced by: Laura Carravallah, MD

Original Authors: Elizabeth Anteau, Aleena Hajek, Rachel Hollander, and Laura Carravallah, MD

Referred To: Reaffirmation Calendar

Whereas, adverse childhood experiences (ACEs) are events in childhood that are potentially stressful and traumatic, such as experiencing abuse or neglect, witnessing violence, or being in a household with substance abuse or instability, and

Whereas, ACEs have been proven to negatively impact health outcomes and have lasting effects associated with injuries, mental health, maternal health, infectious disease, chronic disease, risky behaviors, and social opportunities, and

Whereas, of those investigated in the Kaiser ACEs study, approximately two-thirds reported one or more ACEs, and more than 20 percent reported experiencing more than three, and

Whereas, early detection of ACEs can help to decrease their negative health effects by providing earlier intervention and increasing access to resources, and

Whereas, existing MSMS policy on Routine ACE Screening in Pediatric Appointments states, “That MSMS supports screening for adverse childhood experiences in annual pediatric appointments and shall advocate for such screening,” and

Whereas, a 2016 study found that physicians listed “inadequate reimbursement” as a moderate/severe barrier to ACEs screening, and

Whereas, in October 2019, the California Department of Health Care Services and California Office of the Surgeon General adopted the goal of reducing ACEs and “toxic stress by half in one generation,” and

Whereas, California has recently adopted a reimbursement plan via Medi-cal of $29 per ACEs screening for primary care physicians in order to accomplish the previously stated goal; therefore be it

RESOLVED: That MSMS support and advocate for insurance reimbursement for Adverse Childhood Events (ACEs) screening of the pediatric population.

WAYS AND MEANS COMMITTEE FISCAL NOTE: None
Relevant MSMS Policy:

**Routine ACE Screening in Pediatric Appointments**
MSMS supports screening for adverse childhood experiences in annual pediatric appointments.
(Board Action Report #2, 2019 HOD, re Res29-18)

Relevant AMA Policy:

**Adverse Childhood Experiences and Trauma-Informed Care H-515.952**
1. Our AMA recognizes trauma-informed care as a practice that recognizes the widespread impact of trauma on patients, identifies the signs and symptoms of trauma, and treats patients by fully integrating knowledge about trauma into policies, procedures, and practices and seeking to avoid re-traumatization. 2. Our AMA supports:  
   a. evidence-based primary prevention strategies for Adverse Childhood Experiences (ACEs);  
   b. evidence-based trauma-informed care in all medical settings that focuses on the prevention of poor health and life outcomes after ACEs or other trauma at any time in life occurs;  
   c. efforts for data collection, research and evaluation of cost-effective ACEs screening tools without additional burden for physicians;  
   d. efforts to educate physicians about the facilitators, barriers and best practices for providers implementing ACEs screening and trauma-informed care approaches into a clinical setting; and  
   e. funding for schools, behavioral and mental health services, professional groups, community and government agencies to support patients with ACEs or trauma at any time in life.

Sources:
5. Trauma screenings and Trauma-Informed care Provider Trainings. Retrieved February 08, 2021, from https://www.dhcs.ca.gov/provgovpart/Pages/TraumaCare.aspx#:~:text=Detecting%20ACEs%20early%20and%20connecting,adults%20with%20Medi%20Cal%20coverage
REFERENCE COMMITTEE A – MEDICAL CARE DELIVERY

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

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

Original Author: Megan Edison, MD

Referred To: Reference Committee A

House Action:

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

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

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

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

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

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

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

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

Relevant AMA Policy:

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

13. Work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.

14. Work with the ABMS to study whether CBC is an important factor in a physician’s decision to retire and to determine its impact on the US physician workforce.

15. Encourage the ABMS to use data from CBC to track whether physicians are maintaining certification and share this data with the AMA.

16. Encourage AMA members to be proactive in shaping CBC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and CBC Committees.

17. Continue to monitor the actions of professional societies regarding recommendations for modification of CBC.

18. Encourage medical specialty societies’ leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant CBC process for its members.

19. Continue to work with the ABMS to ensure that physicians are clearly informed of the CBC requirements for their specific board and the timelines for accomplishing those requirements.

20. Encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.

21. Recommend to the ABMS that all physician members of those boards governing the CBC process be required to participate in CBC.

22. Continue to participate in the National Alliance for Physician Competence forums.

23. Encourage the PCPI Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of CBC.

24. Continue to assist physicians in practice performance improvement.

25. Encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty board’s CBC and associated processes.

26. Support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the CBC program.

27. Oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Continuing Board Certification.

28. Ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on continuing board certification activities relevant to their practice.

29. Call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.

30. Support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician’s practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.

31. Continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high-stakes exam.

32. Continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.

33. Through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Continuing Board Certification not be a requirement for: (a) medical staff membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure.

34. Increase its efforts to work with the insurance industry to ensure that continuing board certification does not become a requirement for insurance panel participation.
35. Advocate that physicians who participate in programs related to quality improvement and/or patient safety receive credit for CBC Part IV.
36. Continue to work with the medical societies and the American Board of Medical Specialties (ABMS) member boards that have not yet moved to a process to improve the Part III secure, high-stakes examination to encourage them to do so.
37. Our AMA will, through its Council on Medical Education, continue to work with the American Board of Medical Specialties (ABMS), ABMS Committee on Continuing Certification (3C), and ABMS Stakeholder Council to pursue opportunities to implement the recommendations of the Continuing Board Certification: Vision for the Future Commission and AMA policies related to continuing board certification.
Whereas, the 2020 COVID-19 pandemic and restrictions brought unprecedented financial strain upon physicians, with the most recent Physician Foundation survey showing 12 percent of physicians either closing or planning to close their practice within the next year (75 percent of those physicians are in private practice), and nearly 75 percent of physicians reported lost income, and

Whereas, in the middle of this crisis, the new AMA Current Procedural Terminology® (CPT®) Evaluation and Management coding system went live on January 1, 2021, completely changing the Evaluation and Management (E&M) coding system and reimbursement for the first time in 24 years, and

Whereas, the timing of this change could not have come at a worse time for physicians still reeling from the pandemic and new insurance contracts not yet negotiated, and

Whereas, each patient encounter and experience is unique, and attempts to create a system to accurately reflect the care given within hundreds of specialties and thousands of patient visits is very difficult and likely to be inadequate, and

Whereas, failure to account for all patient interactions and care within a medical coding system will financially harm physicians in these overlooked areas of medicine, and

Whereas, the adverse consequences of the new CPT® system have not been studied, but early feedback among physicians shows this new CPT® system focuses on chronic care, thereby excluding nearly every pediatric diagnosis, and

Whereas, the new CPT® system rewards ordering prescriptions, lab tests, and studies, rather than watchful waiting and counseling, and

Whereas, the new CPT® system prevents private practice physicians from counting in-house labs and studies towards the complexity of care, but allows hospital employed physicians to do so, and

Whereas, the new CPT® system awards higher levels of reimbursement for curb siding a specialist, thereby encouraging and codifying a system of uncompensated care by specialists, and
Whereas, while the intent of this coding change may have been noble, the fallout and failures need to be studied and modified to create a fair system among private and employed physicians, reflective of the complexity of care within all specialties, and respectful of uncompensated care by our specialist colleagues, and

Whereas, the physicians in this country deserve to know the finances behind the AMA CPT® coding system that we are required to participate in; therefore be it

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) request that our AMA study and report the financial impact of the new 2021 CPT® Evaluation and Management coding system upon physicians, among all specialties, in private and employed practices; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to publicly disclose all revenue generated by the proprietary CPT® program in a transparent fashion, including but not limited to licensing fees, royalties, electronic health record fees, government and institutional licensing fees, handbooks, training programs, coding apps, and print-based coding resources in a yearly report.

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

STATEMENT OF URGENCY: The 2021 American Medical Association (AMA) Current Procedural Terminology® (CPT®) Evaluation and Management went live on January 1, 2021. It is currently affecting physician reimbursement. Failure to address any potential harm in a timely manner will result in more practice closures and worsen patient access to physicians. This resolution asks the AMA to study and provide fiscal transparency on an issue that is very pertinent to practicing physicians right now.

Relevant MSMS Policy:
None

Relevant AMA Policy:

**AMA CPT Editorial Panel and Process H-70.973**
The AMA will continue (1) to work to improve the CPT process by encouraging specialty societies to participate fully in the CPT process; (2) to enhance communications with specialty societies concerning the CPT process and subsequent appeals process; and (3) to assist specialty societies, as requested, in the education of their members concerning CPT coding issues.

**Preservation of Evaluation/Management CPT Codes H-70.985**
It is the policy of the AMA to (1) oppose the bundling of procedure and laboratory services within the current CPT Evaluation/Management (E/M) services; (2) oppose the compression of E/M codes and support efforts to better define and delineate such services and their codes; (3) seek feedback from its members on insurance practices that advocate bundling of procedures and laboratory services with or the compression of codes in the CPT E/M codes, and express its views to such companies on behalf of its members;
(4) continue to work with the PPRC and all other appropriate organizations to insure that any modifications of CPT E/M codes are appropriate, clinically meaningful, and reflective of the considered views of organized medicine; and
(5) work to ensure that physicians have the continued opportunity to use CPT as a coding system that is maintained by the medical profession.

**Use of CPT Editorial Panel Process H-70.919**
Our AMA reinforces that the CPT Editorial Panel is the proper forum for addressing CPT code set maintenance issues and all interested stakeholders should avail themselves of the well-established and documented CPT Editorial Panel process for the development of new and revised CPT codes, descriptors, guidelines, parenthetic statements and modifiers.

**CPT Coding System H-70.974**
1. The AMA supports the use of CPT by all third party payers and urges them to implement yearly changes to CPT on a timely basis.
2. Our AMA will work to ensure recognition of and payment for all CPT codes approved by the Centers for Medicare & Medicaid Services (CMS) retroactive to the date of their CMS approval, when the service is covered by a patient's insurance.

**Physicians' Current Procedural Terminology H-70.972**
The AMA (1) continues to seek ways to increase its efforts to communicate with specialty societies and state medical associations concerning the actions and deliberations of the CPT Maintenance process; (2) urges the national medical specialty societies to ensure that their representatives to the CPT process are fully informed as to their association's policies and coding preferences; and (3) urges those specialty societies that have not nominated individuals to serve on the CPT Advisory Committee to do so.

**Source:**
Title: Medicaid Dialysis Policy for Undocumented Patients

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

Original Authors: Michelle Condon, MD, FACP, and David Whalen, MD

Referred To: Reference Committee A

Whereas, in most states undocumented migrants with end stage kidney disease (ESKD) are ineligible for public assistance and rely on sessions of emergency dialysis when symptoms become intolerable, and

Whereas, in most states, undocumented migrants access to care is limited to safety-net providers, including hospital Emergency Departments (EDs) that are required to provide emergency care under federal Emergency Medical Treatment and Labor Act (EMTALA), and then have to wait until their symptoms qualify for ED admission for care to be reimbursed by emergency Medicaid program funding, and

Whereas, the five year mortality rate on emergency dialysis is 14 times higher than standard care, and costs up to $400,000 per patient annually compared to $100,000 in the outpatient setting, and

Whereas, undocumented ESKD patients are often younger with fewer comorbidities than other ESKD patients, making them often ideal candidates for transplantation, but usually they cannot qualify due to lack of insurance to cover the high cost of immunosuppressive therapy, and

Whereas, caring for these patients exerts a toll on physicians resulting in signs of burnout stemming from the feeling that they were being forced to provide substandard care, and

Whereas, undocumented patients can purchase commercial plans at full price due to a provision in the Affordable Care Act (ACA) forbidding companies from denying coverage based on preexisting conditions, and

Whereas, some states have allowed patients to automatically qualify for outpatient dialysis care after presenting to a hospital; therefore be it

RESOLVED: That MSMS ask the State of Michigan to develop a dialysis policy for undocumented patients with end stage kidney disease as an emergency condition covered under Medicaid; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask the AMA to work with the Center for Medicare and Medicaid Services and other state Medicaid programs to develop a dialysis policy for undocumented patients with end stage kidney disease as an emergency condition covered under Medicaid.
WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions requesting governmental advocacy - $25,000+

STATEMENT OF URGENCY: This is a timely issue that should be addressed promptly for physicians and underserved, low-income patients. It is an access-to-care issue for many patients.

Relevant MSMS Policy:
None

Relevant AMA Policy:
None
Title: Medical and Dental Care for Prisoners

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

Original Author: Patrick J. Droste, MS, MD

Referred To: Reference Committee A

House Action:

Whereas, prisoners in correctional facilities have the right to receive timely medical and dental care, and

Whereas, prisoners in correctional facilities frequently have medical and dental problems that are not addressed by prison authorities, and

Whereas, prisoners do not have internal prison advocates to support their quest for medical and/or dental care, and

Whereas, prisoners get charged for each request of medical or dental service and may not have the funds to pay for such visits, and

Whereas, prisoners have no recourse to request second opinion or specialty evaluation for unresolved medical or dental concerns, and

Whereas, family members of prisoners, serving as an advocate, find it difficult to facilitate appropriate medical care or obtain information regarding a prisoner’s condition(s), and

Whereas, prisoners are frequently transferred to multiple prison facilities throughout their sentence, which leads to lack of continuity of care; therefore be it

RESOLVED: That MSMS work with the Michigan Department of Corrections to establish viable and effective protocols to allow prisoners to present their medical concerns and receive timely responses to their request for medical and dental care; and be it further

RESOLVED: That MSMS support the development of a Review Board, composed of correctional officials, medical professionals such as physicians, nurses, or physician assistants and prisoners, to review inmates concerns regarding medical and dental diagnosis and treatment.

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

STATEMENT OF URGENCY: We feel that the MSMS-HOD should hear and act on this resolution in 2021 and give it highest consideration, because prisoners are being denied timely and affordable
medical and dental care during their period of confinement. This neglect of care makes it more difficult for them to rehabilitate both inside the correction facilities and after their discharge.

Relevant MSMS Policy:
None

Relevant AMA Policy:
None

Source:
Kimberly Norris, MD, of Barry County
Whereas, adolescents believe that all health care should be confidential and report it as one of the most important aspects of their health care, yet many express concerns regarding privacy and worry that their providers will tell parents about their conversations, and

Whereas, the Academy of Pediatrics recommends providing confidential and private health care to adolescents by allowing sufficient opportunities for adolescents to discuss sensitive issues with physicians without a parent present, and

Whereas, the COVID-19 pandemic has not affected adolescents' needs for confidential services, and the early shift from in-person visits to telehealth visits demonstrated that 85 percent of adolescent primary care visits occurred for sensitive issues including sexual and reproductive health, eating disorders, and substance use, and

Whereas, recent studies report that only 38 percent of adolescents spent any time alone with a provider within the last year, yet adolescents who experience portions of their visits unaccompanied by a parent are more likely to discuss sensitive topics such as sexual and reproductive health, and

Whereas, only 27 percent of adolescents reported that they had any alone time with their provider during recent telehealth visits, potentially limiting access to confidential services, and

Whereas, a unique challenge of providing confidential care over telehealth includes finding quiet and private spaces in adolescents' homes that are separate from other household members to discuss sensitive topics without fear of the conversation being overheard, and

Whereas, the American Academy of Pediatrics, Pediatric Health Network, Michigan Medicine, and other organizations have developed frameworks recommending that physicians continue providing confidential and private care to adolescents through telehealth, and

Whereas, the organizations above provide recommendations unique to telehealth to ensure private and confidential visits, including asking the parent to leave for part of the visit and gaining parent buy-in regarding the importance of this privacy, and

Whereas, additional suggestions to provide confidential care to adolescents through telehealth include asking the adolescent to move to a more private area of the home, providing suggestions on unique areas that patients may go to ensure privacy, the use of headphones and
chat features, the use of yes or no answers, asking the adolescent for a 360 degree video view to understand who is in the room, and having the parent and adolescent call from separate devices to easily facilitate the transition to confidential discussions, and

Whereas, AMA Policies H-60.938 and H-60.965 recommend providing confidential care to adolescent patients, but do not address the unique confidentiality concerns of adolescents and their parents accessing telehealth, nor the challenges associated with finding private spaces in an adolescents' home; therefore be it

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to amend AMA policy H-60.965 by addition to read as follows:

Confidential Health Services for Adolescents H-60.965

Our AMA:
(1) reaffirms that confidential care for adolescents is critical to improving their health;
(2) encourages physicians to allow emancipated and mature minors to give informed consent for medical, psychiatric, and surgical care without parental consent and notification, in conformity with state and federal law;
(3) encourages physicians to involve parents in the medical care of the adolescent patient, when it would be in the best interest of the adolescent. When, in the opinion of the physician, parental involvement would not be beneficial, parental consent or notification should not be a barrier to care;
(4) urges physicians to discuss their policies about confidentiality with parents and the adolescent patient, as well as conditions under which confidentiality would be abrogated. This discussion should include possible arrangements for the adolescent to have independent access to health care (including financial arrangements);
(5) encourages physicians to offer adolescents an opportunity for examination and counseling apart from parent. The same confidentiality will be preserved between the adolescent patient and physician as between the parent (or responsible adult) and the physician;
(6) encourages state and county medical societies to become aware of the nature and effect of laws and regulations regarding confidential health services for adolescents in their respective jurisdictions. State medical societies should provide this information to physicians to clarify services that may be legally provided on a confidential basis;
(7) urges undergraduate and graduate medical education programs and continuing education programs to inform physicians about issues surrounding minors' consent and confidential care, including relevant law and implementation into practice;
(8) encourages health care payers to develop a method of listing of services which preserves confidentiality for adolescents; and
(9) encourages medical societies to evaluate laws on consent and confidential care for adolescents and to help eliminate laws which restrict the availability of confidential care; and
(10) encourages physicians to recognize the unique confidentiality concerns of adolescents’ and their parents associated with telehealth visits; and
(11) encourages physicians in a telehealth setting to offer examination and counseling apart from others in the home and to ensure that the adolescent is in a private space.
WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions only requesting new or revised MSMS or AMA policy - $500

Relevant MSMS Policy:
None

Relevant AMA Policy:
See above.

Sources:

# RESOLUTIONS BY COMMITTEE

## REFERENCE COMMITTEE B – LEGISLATION

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Title: Medication-Assisted Treatment in Physician Health Programs

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

Original Authors: Clara Hwang, MD, and Tabitha Moses, MS

Referred To: Reference Committee B

House Action:

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

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

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

Whereas, the majority of state PHP treatment programs adhere to abstinence only policies for physicians diagnosed with a SUD and will not refer physicians to addiction treatment programs that include medications for addiction treatment (MAT) as part of their program, and

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

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

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

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

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

Whereas, for physicians with SUD who are denied MAT, relapses and recurrences are common, and
Whereas, a 2019 report from the National Academies of Sciences, Engineering, and Medicine stated that “there is no scientific evidence that justifies withholding medications from OUD patients in any setting” and that such practices amount to “denying appropriate medical treatment,” and that such practices amount to “denying appropriate medical treatment”, and

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

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

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

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

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

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

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

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

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

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

Relevant AMA Policy:

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

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

Introduced by: Mara Darian, for the Medical Student Section

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

Referred To: Reference Committee B

House Action:

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

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

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

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

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

Whereas, arrests for marijuana possession, regardless of whether the person was later convicted on these charges, have been shown to negatively impact opportunities such as finding employment, housing, and obtaining student loans, which can lead to widespread and multifactorial individual health consequences; furthermore, criminalization of drug use is associated with increased stigma and discrimination of drug users and that stigma and discrimination is also a causal factor for decreased mental and physical health, and
Whereas, nationally, African Americans are three times more likely to be arrested for marijuana possession than Whites, a difference mirrored in Michigan where African Americans are 2.6 times more likely to be arrested, a finding that cannot be explained by differences in use, and

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

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

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

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

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

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

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

Whereas, efforts to set up expungement laws for marijuana-based offenses have come through Bills 4890-85 and 5120 in the Michigan House of Representatives which passed with bipartisan support in November 2019, these bills are currently under review by the Senate
Committee on Judiciary and Public Safety and a Senate Bill to this same end (SB-416) is still pending; and

Whereas, in October 2020, Governor Gretchen Whitmer signed a bill to expand expungement of misdemeanor marijuana charges that would not be considered crimes after legalization of recreational marijuana; and,

Whereas, at the federal level, the Marijuana Opportunity Reinvestment and Expungement (MORE) Act asks that marijuana be removed from the Controlled Substances Act and create an opportunity for individuals with marijuana law convictions to petition for expungement and resentencing; this act was passed in the House in December 2020 (H.R. 3884) and is also under consideration by the Senate (S. 2227); and

Whereas, The Marijuana Opportunity Reinvestment and Expungement Act defines “eligible State of Locality” as a “State or locality that has taken steps to— (i) create an automatic process, at no cost to the individual, for the expungement, destruction, or sealing of criminal records for cannabis offenses; and (ii) eliminate violations or other penalties for persons under parole, probation, pre-trial, or other State or local criminal supervision for a cannabis offense”; therefore be it

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

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

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

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

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

Relevant MSMS Policy:

43-19 - Resentencing for People Convicted of Marijuana-Based Offenses - DISAPPROVE

Rationale: The Committee agreed with the underlying intent to decriminalize low-level offenses associated with marijuana possession; however, Committee members determined that the resolution entails a complex legal matter and not within the purview of MSMS.
Relevant AMA Policy:

Cannabis Legalization for Adult Use (commonly referred to as recreational use) H-95.924
Our AMA: (1) believes that cannabis is a dangerous drug and as such is a serious public health concern; (2) believes that the sale of cannabis for adult use should not be legalized (with adult defined for these purposes as age 21 and older); (3) discourages cannabis use, especially by persons vulnerable to the drug’s effects and in high-risk populations such as youth, pregnant women, and women who are breastfeeding; (4) believes states that have already legalized cannabis (for medical or adult use or both) should be required to take steps to regulate the product effectively in order to protect public health and safety including but not limited to: regulating retail sales, marketing, and promotion intended to encourage use; limiting the potency of cannabis extracts and concentrates; requiring packaging to convey meaningful and easily understood units of consumption, and requiring that for commercially available edibles, packaging must be child-resistant and come with messaging about the hazards about unintentional ingestion in children and youth; (5) laws and regulations related to legalized cannabis use should consistently be evaluated to determine their effectiveness; (6) encourages local, state, and federal public health agencies to improve surveillance efforts to ensure data is available on the short- and long-term health effects of cannabis, especially emergency department visits and hospitalizations, impaired driving, workplace impairment and worker-related injury and safety, and prevalence of psychiatric and addictive disorders, including cannabis use disorder; (7) supports public health based strategies, rather than incarceration, in the handling of individuals possessing cannabis for personal use; (8) encourages research on the impact of legalization and decriminalization of cannabis in an effort to promote public health and public safety; (9) encourages dissemination of information on the public health impact of legalization and decriminalization of cannabis; (10) will advocate for stronger public health messaging on the health effects of cannabis and cannabinoid inhalation and ingestion, with an emphasis on reducing initiation and frequency of cannabis use among adolescents, especially high potency products; use among women who are pregnant or contemplating pregnancy; and avoiding cannabis-impaired driving; (11) supports social equity programs to address the impacts of cannabis prohibition and enforcement policies that have disproportionately impacted marginalized and minoritized communities; and (12) will coordinate with other health organizations to develop resources on the impact of cannabis on human health and on methods for counseling and educating patients on the use cannabis and cannabinoids.

Sources:
5. R. Snyder and J. J. Walsh, “EXECUTIVE BUDGET STATE OF MICHIGAN.”
30. S. Stutzky et al., "Ballot Proposal 1 of 2018."
Title: Oppose Routine Use of Gonad Shields

Introduced by: Aparna Joshi, MD, and Gunjan Malhotra, MD

Original Authors: Aparna Joshi, MD, and Gunjan Malhotra, MD

Referred To: Reference Committee B

Whereas, the Image Gently Alliance was formed in late 2006 led by the Society of Pediatric Radiology (SPR) with the goal of “changing practice by raising awareness of the opportunities to lower radiation dose in the imaging of children,” and

Whereas, the SPR recruited other organizations/members of the imaging team into the alliance in 2007 including the American College of Radiology (ACR), American Association of Physicists in Medicine (AAPM), and American Society of Radiologic Technologists (ASRT), and

Whereas, the practice of shielding reproductive organs and in utero fetuses began about 70 years ago in the 1950s in response to potential concerns about the long term effects of radiation and the potential for passing on genetic mutations through genetic inheritance, and

Whereas, in response to these concerns, regulation by entities such as the FDA and legislation at the state and federal level exist requiring the use of gonad shields in medical imaging studies, and

Whereas, through technological advances, medical physicists estimate the dose from routine diagnostic imaging to reproductive organs has reduced by 95 percent without compromising diagnostic quality, and

Whereas, technological advances and optimization have resulted in marginal hereditary risk reduction from gonad shielding ranging from 1x10^-6 in women and 5x10^-6 in men, and

Whereas, research on radiation dosing has shown that routine diagnostic imaging does not produce harmful levels of radiation to patients and fetuses, and

Whereas, technological advances such as automatic exposure control (AEC) (meant to optimize imaging parameters) are negatively affected by shielding, and

Whereas, the gonad shield results in decreased activity on the detector triggering AEC to increase the radiation tube to increase output, exposure, and patient dose and also degrades image quality, and

Whereas, the gonad shield produces artifacts and can obscure relevant anatomy and diagnostic information, and
Whereas, non-diagnostic or obscured images may need to be repeated increasing patient dose when shields are used, and

Whereas, the gonad surface shield is ineffective at reducing internal scatter, and

Whereas, studies have shown that gonad shields are incorrectly placed for females in 91 percent of radiographs and for males in 66 percent of radiographs, rendering them ineffective, and

Whereas, on January 12, 2021, the National Council on Radiation Protection and Measurements issued a statement that the risks of utilizing gonad shields far outweigh the negligible benefits to reproductive organs and therefore they should not be routinely used, and

Whereas, similar statements opposing routine or mandatory use of gonadal shields were released by the ACR and the AAPM in 2019 and by the ASRT in 2021; therefore be it

RESOLVED: That MSMS advocate for state legislation and regulatory changes to oppose mandatory use of gonad shields in medical imaging; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to advocate that the FDA amend the code of federal regulations to oppose the routine use of gonad shields in medical imaging; and be it further

RESOLVED: That the Michigan Delegation to the AMA in conjunction with state medical societies, develop model state and national legislation to oppose mandatory use of gonadal shields in medical imaging.

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

STATEMENT OF URGENCY: This resolution is urgent and time sensitive because recent research and statements from organizations that optimize radiation in imaging protocols have recommended legislative changes regarding the use of gonadal shields. We need urgent legislative and regulatory changes to decrease the radiation doses for medical imaging in children. Without these changes children are receiving unnecessary radiation and creating poor diagnostic quality images. The National Council on Radiation Protection and Measurements (NCRP) released a statement on this issue in January 2021.

Relevant MSMS Policy:
None

Relevant AMA Policy:
None

Sources:
1. https://www.imagegently.org/About-Us/Campaign-Overview
6. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7005227/
8. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3292647/
Title: Electronic Prescribing Waiver for Michigan’s Free Clinics

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

Original Author: Michelle M. Condon, MD, FACP

Referred To: Reference Committee B

WHEREAS, there are 57 free clinics for patients who obtain medical care from non-profit charitable medical clinics mostly because they do not have health insurance in Michigan, and

WHEREAS, approximately one-third of these clinics, have not had sufficient funds to switch to electronic medical records, and

WHEREAS, these clinics are largely run with all volunteer personnel and are financed by donations and the occasional grant, and

WHEREAS, many clinics are open less than 25 hours per week, and

WHEREAS, some volunteer retired physician personnel have resigned from these clinics rather than learn a (or another) medical records system, and

WHEREAS, patients generally shop multiple pharmacies to find the least expensive source for their medications thus requiring additional valuable staff time to discontinue electronic prescriptions sent to pharmacies in order to support patients’ efforts to source their medication at a lower price, perhaps having found it at an alternative pharmacy; therefore be it

RESOLVED: That MSMS supports the Free Clinics of Michigan in asking the Michigan Department of Licensing and Regulatory Affairs (LARA) and the Michigan Board of Pharmacy to change the initial proposed language of Michigan Administrative Code Section R, 338.3162a (5)(a)(v), not yet posted for public comment, to allow a waiver for non-profit charitable medical clinics excusing them from being required to submit all prescriptions to pharmacies in electronic form.

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

STATEMENT OF URGENCY: The business of the MSMS HOD addresses issues of physicians from all over Michigan, in a timely fashion, to improve the delivery of care, patient care issues and important policy and legislative issues affecting our members. Listening to the voice of physicians is paramount in organized medicine and is why many of our members participate at the county and state levels. Physician authors have taken the time during this busy and stressful time to articulate the issues. It is time to get back to the business of medicine for the sake of over-stressed
colleagues and their patients to address what is important to them, our members. The result can be improved transparency, updated physicians, or improved issues that affect patients in Michigan and/or across the country.

**Relevant MSMS Policy:**
None

**Relevant AMA Policy:**
None
Title: Expanding Access to Medication for the Treatment of Opioid Use Disorder

Introduced by: Mara Darian, for the Medical Student Section

Original Authors: May Chammaa and Brianna Sohl

Referred To: Reference Committee B

House Action:

Whereas, in 2017, there were 21.2 opioid overdose deaths per 100,000 persons in Michigan, which is higher than the national rate of 14.6 deaths per 100,000 persons; nationally, more than 21 million people have an opioid use disorder (OUD) but fewer than 10 percent have accessed treatment, and

Whereas, medications for opioid use disorder (MOUD), which includes the full agonist methadone and the partial agonist buprenorphine, are evidence-based, gold standard, effective treatments for OUD that lessen the harmful health and societal effects of such substance use disorders, and

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

Whereas, the Drug Addiction Treatment Act of 2000 (DATA-2000) allows physicians to obtain a waiver from the Narcotic Addict Treatment Act registration requirements to treat OUD with Schedule III, IV, and V drugs or a combination of them (including buprenorphine); physicians are eligible to prescribe buprenorphine-based medications if they pass an eight-hour course, and after obtaining their current state medical license and a valid DEA registration number, they then apply for a waiver, and

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

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

Whereas, implementing point of care initiation of buprenorphine treatment and referral such as within the emergency department is hindered by factors including the buprenorphine
waiver and thus loses a significant setting for intervention that, when utilized, has shown to reduce one-year mortality, and

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

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

Whereas, buprenorphine has a higher safety profile compared to commonly prescribed, full opioid agonists, which physicians are able to prescribe to patients with no additional training and a 2015 survey of 706 people who used opioids in San Francisco found that less than one percent of those prescribed buprenorphine reported using it to get high, serving as evidence of the low misuse potential of buprenorphine in the U.S., and

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

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

Whereas, in an effort to increase treatment availability, the U.S. Department of Health and Human Services (HHS) announced new guidelines in January 2021, to exempt DEA-registered physicians from the waiver requirements; however, these new guidelines were rapidly halted, and

Whereas, many medical organizations including the AMA supported the new HHS guidelines, and Patrice Harris, MD, Chair of the AMA's Opioid Task Force and Immediate Past President, stated: "With this change, office-based physicians and physician-led teams working with patients to manage their other medical conditions can also treat them for their opioid use disorder without being subjected to a separate and burdensome regulatory regime," and

Whereas, experts believe that the X-waiver will continue to overregulate buprenorphine, a medication with a high safety profile and low misuse potential, continue to discourage physicians from prescribing it even in the midst of a worsening opioid epidemic, and continue to stigmatize OUDs and disregard them as chronic medical conditions which needs evidence based medication treatment, and

Whereas, in light of current legislation discussions, it is vital that all medical organizations and societies have explicit policy and advocacy regarding education requirements for treatments for OUD; our AMA has policy (D-95.972) that explicitly calls for the elimination of the waiver to prescribe buprenorphine for the treatment of OUD but MSMS has no such policy; therefore be it
RESOLVED: That MSMS advocates for the elimination of the requirement for obtaining a waiver to prescribe buprenorphine for the treatment of opioid use disorder; and be it further

RESOLVED: That MSMS oppose all non-evidence based barriers to the prescription of medications for the treatment of opioid use disorder; and be it further

RESOLVED: That MSMS encourages all undergraduate medical institutions to incorporate into their curricula education on prescribing medications to treat opioid use disorders.

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

Relevant MSMS Policy:
None

Relevant AMA Policy:

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

Sources:
1. Center for Behavioral Health Statistics, "Results from the 2017 national survey on drug use and health: detailed tables," Rockville, MD, 2018


19. A. Bohnert, J. Erb-Downward, and T. Ivacko, "OPIOID ADDICTION: MEETING THE NEED FOR TREATMENT IN MICHIGAN"


23. L. Kuntz, "Dropping the X-Waiver for Buprenorphine," Psychiatric Times, 18-Jan-2021
Title: Decarceration During an Infectious Disease Pandemic

Introduced by: Sanjay Das, for the Medical Student Section

Original Authors: Jennifer Byk, Arjun Chadha, Moustafa Hadi, Jessyca Judge, Man Yee Keung, Remonda Khalil, Darian Mills, Chan Nguyen, Melanie Valentin, Will Vander Pols, and Francis Yang

Referred To: Reference Committee B

House Action:

Whereas, the United States has the highest incarceration rate in the world, with nearly 700 prisoners per 100,000 people and Michigan has an incarceration rate of 641 per 100,000 people, including prisons, jails, immigration detention, and juvenile justice facilities, and

Whereas, the 2018 Bureau of Justice Statistics estimates that of the number of people incarcerated in local jails per 100,000 people in each racial or ethnic category, incarceration rates are much higher in Black individuals (592) compared to other racial/ethnic categories: American Indian (401), White (187), Hispanic (182), Other (50), and Asian (26), and

Whereas, the 2017 Bureau of Justice Statistics estimates that the pretrial jail population has disproportionately affected Black and Hispanic populations and nearly doubled in the past 15 years, and

Whereas, as of December 2020, confirmed case rates of COVID-19 in United States prisons were 3.7 times higher than the national confirmed case rate, and case fatality rate was double what was expected given the age, gender, and race/ethnicity of the prison population, and

Whereas, 61 percent of Michigan’s prison population has tested positive for COVID-19, while only 6.2 percent of Michigan’s general population has tested positive for COVID-19, and

Whereas, inmates are discouraged from reporting symptoms due to penal measures aimed at limiting spread of infectious agents, thus contributing to further spread of infectious agents, and

Whereas, high rates of preexisting health conditions and limited access to quality health care exacerbate the impact of COVID-19 in incarceration systems, and inability to social distance due to crowding in prisons prevents compliance with infection prevention protocols, and

Whereas, as of May 1, 2020, Michigan prisons were operating at 94 percent capacity, making it difficult for safety protocols to be followed, and

Whereas, a 2020 report from a consensus panel of the National Academy of Sciences, Engineering, and Medicine recognized that reducing the size of the incarcerated population could
help increase the penetration and effectiveness of standard prevention measures in jails and
prisons, such as testing, quarantining, and medical isolation for those who remain, and

Whereas, decarceration is not associated with an increase in crime, as the states of New
York and Connecticut have cut their overall prison and jail populations in half since reaching their
peak population levels, and have since had crime rates below the national average, and

Whereas, nearly every major city in the United States which decreased jail population in
response to COVID-19 experienced no subsequent increase in crime, and

Whereas, individuals older than 55 years are at low risk of reincarceration and are at high
risk of severe complications and mortality due to COVID-19, and

Whereas, rates of incarceration have decreased approximately 11 percent as a result of
restricted admission and expedited release of pre-trial detainees to reduce overall prison capacity
in coordinated efforts to curb impact of COVID-19 on prison health systems, and

Whereas, compassionate release, a legal provision that allows people with terminal illnesses
to be released before their sentences have been served, could be a lever for protecting many high-
risk patients from harm, as clinicians can assist by providing medical attestations to the release of
individual patients during COVID-19 and future pandemics, and

Whereas, as recommended by the American Bar Association, directive MCL-801.51a allowed
the compassionate release of inmates in Michigan county jails; therefore be it

RESOLVED: That MSMS support reducing the incarcerated population during an infectious
disease pandemic by way of restricted admission of pre-trial detainees, expedited release of pre-
trial detainees, and compassionate release of individuals at low risk of reincarceration.

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

Relevant MSMS Policy:
None

Relevant AMA Policy:

**Compassionate Release for Incarcerated Patients H-430.980**
Our AMA supports policies that facilitate compassionate release for incarcerated patients on the basis of
serious medical conditions and advanced age; will collaborate with appropriate stakeholders to develop clear,
evidence-based eligibility criteria for timely compassionate release; and promote transparent reporting of
compassionate release statistics, including numbers and demographics of applicants, approvals, denials, and
revocations, and justifications for decisions.

**Support Public Health Approaches for the Prevention and Management of Contagious Diseases in
Correctional and Detention Facilities H-430.979**
1. Our AMA, in collaboration with state and national medical specialty societies and other relevant
stakeholders, will advocate for the improvement of conditions of incarceration in all correctional and
immigrant detention facilities to allow for the implementation of evidence-based COVID-19 infection prevention and control guidance.

2. Our AMA will advocate for adequate access to personal protective equipment and SARS-CoV-2 testing kits, sanitizing and disinfecting equipment for correctional and detention facilities.

3. Our AMA will advocate for humane and safe quarantine protocols for individuals who are incarcerated or detained that test positive for or are exposed to SARS-CoV-2, or other contagious respiratory pathogens.

4. Our AMA supports expanded data reporting, to include testing rates and demographic breakdown for SARS-CoV-2 and other contagious infectious disease cases and deaths in correctional and detention facilities.

5. Our AMA recognizes that detention center and correctional workers, incarcerated persons, and detained immigrants are at high-risk for COVID-19 infection and therefore should be prioritized in receiving access to safe, effective COVID-19 vaccine in the initial phases of distribution, and that this policy will be shared with the Advisory Committee on Immunization Practices for consideration in making their final recommendations on COVID-19 vaccine allocation.

**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 Congress, the Centers for Medicare & Medicaid Services (CMS), and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from adult and juvenile correctional facilities in order to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism.

7. Our AMA advocates for 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.

8. Our AMA will collaborate with state medical societies and federal regulators to emphasize the importance of hygiene and health literacy information sessions for both inmates and staff in correctional facilities.

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

**Sources:**

   Published September 2, 2020. Accessed February 12, 2021


9. Prison Policy Initiative. Since you asked: Just how overcrowded were prisons before the pandemic, and at this time of social distancing, how overcrowded are they now? Prison Policy Initiative. [https://www.prisonpolicy.org/blog/2020/12/21/overcrowding/](https://www.prisonpolicy.org/blog/2020/12/21/overcrowding/) Accessed February 12, 2021


ACTION REPORT #01-21 OF THE BOARD OF DIRECTORS

SUBJECT: Resolution 50-20
Remove Clinic-Specific Caps on Buprenorphine

REFERRED TO: Reference Committee B

HOUSE ACTION:

RECOMMENDATION: That the 2021 House of Delegates approve Resolution 50-20, “Remove Clinic-Specific Caps on Buprenorphine,” as amended to read:

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

RESOLVED: That MSMS advocate the Michigan Bureau of Community and Health System Substance Use Disorder Service Programs Administrative Rules be amended to remove the cap on the number of patients receiving buprenorphine or naltrexone prescriptions from a single site or group practice as a condition of licensure and instead rely on appropriate federal guidelines for the safe and effective provision of Substance Use Disorder services.

Resolution 50-20 was referred to the MSMS Board of Directors for study. The Board referred the resolution to the Committee on State Legislation and Regulations for review and recommendation.

Resolution 50-20 asked that “MSMS oppose state legislation that attempts to limit the prescription of medication for opioid use disorder beyond those regulations set forth by federal laws; and that MSMS advocate the Michigan Bureau of Community and Health System Substance Use Disorder Service Programs Administrative Rules be amended to remove the cap on the number of patients receiving buprenorphine prescriptions from a single site or group practice as a condition of licensure.”

Resolution 50–20 was introduced in response to concerns regarding the adoption of Michigan Administrative Rules governing substance use disorder programs. Under these rules, individuals or individuals in group practices who provide buprenorphine or naltrexone treatment to more than 100 individuals at any one time at a specific property

(continued)
must apply for a substance use disorder service program license. Licensure triggers additional requirements under the rules that would be difficult to meet for most physician group practices. The authors of the Resolution argue the 100 individual cap or threshold is a deterrent to increased access to buprenorphine prescribing as medically necessary for persons diagnosed with opioid use disorder.

Therefore, Resolution 50-20 directs MSMS to 1) oppose any legislative attempts to impose limits on the prescription of medication for opioid use disorder beyond those regulations set forth by federal laws, and 2) to advocate for the removal of the 100 individual cap/threshold in the Administrative Rules so that medical practice groups can manage their patients in need of MAT without having to be licensed.

The Administrative Rule prompting the introduction of Resolution 50-20 is as follows:

R 325.1303 Application; licensing requirement; review process; licensure.
Rule 1303. (1) As authorized in article 6 of the public health code and chapter 2a of the mental health code, MCL 330.1260 to 330.1287, an application for initial licensure or licensure change, including change in ownership, relocation of the program, addition or deletion of service levels, change in bed or RDT positions, shall be made on the most recent applicable form authorized and provided by the department.
(2) A person offering substance use disorder services shall be licensed under article 6 of the public health code, except as provided in subrule (3) or (4) of this rule.
(3) A substance use disorder services program license is not required for an individual licensed under article 15 of the public health code to provide psychological, medical, or social services if all of the following are met:
(a) An individual is offering psychological, medical, or social services within the scope of his or her individual professional license and not under a group or organization offering substance use disorder services, unless exempt under subdivision (c) of this subrule.
(b) An individual is offering psychological or medical services and not providing methadone treatment. Methadone treatment requires a license under article 6 of the public health code, for the group or organization, not for the individual licensed under article 15 of the public health code.
(c) An individual, or individuals in a group practice, is offering psychological or medical services and does not provide buprenorphine or naltrexone treatment to more than 100 individuals at any 1 time at a specific property. As a result of not meeting subdivision (c) of this subrule, a license shall be maintained until the licensee can demonstrate to the satisfaction of the department that the specific property will only provide treatment equal to or less than 100 unique recipients at any 1 time for each of the next 2 consecutive calendar years.

(continued)
The Administrative Rules in question were updated by the Michigan Department of Licensing and Regulatory Affairs (LARA) a few years ago. LARA has acknowledged that the Rules have created some unintended consequences and intends to revise the rules.

In recommending referral to the Board of Directors, the Reference Committee indicated it was supportive of the intent of this resolution. However, the issues surrounding the administrative rules versus the legislation referred to in the first Resolved, as well as a discussion around removing or increasing the cap, led the Committee to decide additional expertise was needed. The MSMS Committee on State Legislation and Regulations considered Resolution 50-20 at its meeting on February 2, 2021. One of the Resolution’s authors was present and provided the Committee with the rationale for introduction and the related “asks” of MSMS. After much discussion, the Committee agreed the first Resolved should remain as currently written, but the second Resolved should be amended to clarify MSMS advocate Michigan’s Administrative Rules for substance use disorder programs should be consistent with federal guidelines.

The Committee on State Legislation and Regulations unanimously approved a motion to support Resolution 50-20, as amended

At its virtual meeting on Wednesday, March 31, 2021, the MSMS Board of Directors approved the recommendation of the Committee on State Legislation and Regulations to approve Resolution 50-20, as amended.

Attachment
   Resolution 50-20
Title: Remove Clinic-Specific Caps on Buprenorphine Prescriptions

Introduced by: Nabiha Hashmi for the Medical Student Section

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

Referred To: Reference Committee B

House Action:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Relevant MSMS Policy:

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

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

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

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

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

**Sources:**


MICHIGAN STATE MEDICAL SOCIETY  
2021 HOUSE OF DELEGATES  

RESOLUTIONS BY COMMITTEE  

REFERENCE COMMITTEE C – INTERNAL AFFAIRS AND BYLAWS  

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<tr>
<td>20-21</td>
<td>Designated Directors Serving as Chair of the MSMS Board of Directors</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BOARD ACTION REPORT</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>#2-21</td>
<td>Revisions to the MSMS Policy Manual and the 2021 Sunset Policy</td>
</tr>
</tbody>
</table>
Title: Dissemination of Information to County Medical Societies

Introduced by: Joseph Wilhelm, MD, for the Ingham County Delegation, Christopher J. Allen, MD, for the Saginaw County Medical Society, and Evelyn Eccles, MD, for the Washtenaw County Delegation

Original Author: Christopher J. Allen, MD

Referred To: Reference Committee C

House Action:

Whereas, the County Medical Societies (CMS) are duly chartered component societies of MSMS, and membership is required in CMS and MSMS, and

Whereas, over time, MSMS has retained the statewide database of members and nonmembers (including nonpaid members, physicians who have moved, and the deceased) as it hosts the online membership platform and database, CRM, and

Whereas, the CMS are tasked with maintaining a roster of members, but the majority of CMS do not maintain an independent electronic database of members and nonmembers as MSMS hosts a comprehensive, statewide version, and

Whereas, the CMS have previously used this shared information exclusively for official membership business including the verification of membership and to aid MSMS in recruitment and retention efforts, and

Whereas, CMS and MSMS work hand-in-hand in providing services to their physician and medical student members, and

Whereas, MSMS ceased providing statewide membership information to CMS stating the practice was not in compliance with MSMS Bylaws and policies beginning in October 2020, and

Whereas, MSMS began citing a Website Privacy Policy Information Sharing and Disclosure policy in February 2021, noting the prohibition of the release of this information to CMSs moving forward, and

Whereas, the Information and Sharing Disclosure states “the Michigan State Medical Society is committed to protecting your personal information. We will not disclose your personally identifiable information to third parties without your consent;” and

Whereas, the newly cited MSMS policy suggests CMS are “third parties” and not component partners in unified membership efforts; therefore be it
RESOLVED: That MSMS amend its Website Privacy Policy Information Sharing and Disclosure policy to affirm the County Medical Societies as component societies, and continue the transparent process of providing member and nonmember information to the Secretary and Executive Director/Administrator, if applicable, of the duly chartered County Medical Societies as requested without regard to the members’ or nonmembers’ county of origin; and be it further

RESOLVED: That any membership or information sharing policy shall be discussed and approved with the County Medical Societies and/or the House of Delegates before implementation or finalization moving forward.

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

STATEMENT OF URGENCY: The Saginaw, Ingham, and Washtenaw County Medical Society Delegations and Boards of Directors affirm this resolution is important and needs immediate action by the House of Delegates. In order for the county medical societies to survive, thrive and serve their members, it is imperative the county medical societies receive the requested information from MSMS which has been available to the county medical societies in the past, but has been withheld by MSMS for various unsubstantiated reasons as dictated by MSMS. The county medical societies are trusted partners, not third parties, and work hand-in-hand with MSMS to provide services to our dual members. The requested information is also needed to maintain and ensure the integrity and transparency of both the county medical societies and MSMS. The 2018 and 2019 HOD voted to maintain unification of MSMS and the county medical societies, therefore, the HOD needs to address the issue of MSMS staff withholding necessary information from the counties which is needed to maintain that unification.

Relevant MSMS Policy:
Over the past year, MSMS has deployed several strategies to address issues raised by county medical societies regarding state society operations and procedures relative to membership, advocacy, communications and the House of Delegates. Those strategies include weekly (spring 2020) and then bi-weekly (summer 2020) virtual meetings between the MSMS CEO and county society staff, monthly meetings between MSMS departmental heads and county society staff (which have been ongoing since 2010), and a facilitator-led series of meetings to research state and county perspectives and host a series of meetings to work through how various issues will be handled going forward. The consultant work is ongoing, and the topic raised in this resolution has been part of that process. In addition, county concerns have been discussed broadly at MSMS Board meetings, the Chair and Vice Chair hosted a virtual meeting with Regional Directors representing five counties raising concerns, and the MSMS Executive Committee has also met to support strategies to establish best practices between state and county going forward.

MSMS Website Privacy Policy: At the Michigan State Medical Society, we believe anyone who uses the Internet should be fully aware of how their information is used, and are committed to doing business with the highest ethical standards. The following Privacy Policy outlines how the Michigan State Medical Society gathers and utilizes various sources of information obtained during your visit to www.msms.org, and handles your data.

Definitions: “Non-Personal Information” is information that is in no way personally identifiable and that is obtained automatically through your use of the Site with a Web browser. “Personally Identifiable Information” is non-public information that is personally identifiable and obtained in connection with providing a product or service to you. It may include information such as name and address.
Information collected: When you enter the Site, we collect Non-Personal Information, such as your browser type and IP address. Likewise, in order to offer you meaningful products and services and for other reasons, we may collect personally identifiable Information about you from the following sources: Information you give us on applications or other forms on the Site; or Information you send us via any medium, including, but not limited to email, telephone, and social media interaction. If you are a non-registered visitor to the Site, the only information we collect will be Non-Personal Information through the use of cookies and/or pixels. Information you provide to third-party websites is not within the control of the Michigan State Medical Society and you provide such information at your own risk. The terms and conditions of use and the privacy policies of those websites that you provide information to will govern their use of such information.

Cookies & Pixels: The Site may send a "cookie" to your computer. A cookie, or pixel, is a small piece of data that is sent to your browser from a Web server and stored on your computer's hard drive. A cookie or pixel cannot read data off your hard disk or read cookie and pixel files created by other sites. Cookies and pixels do not damage your system. Cookies and pixels allow us to recognize you as a user when you return to the Michigan State Medical Society website using the same computer and Web browser. We use cookies and pixels to identify which areas of our site you have visited, so the next time you visit the site, those pages may be readily accessible. We may also use this information to better personalize the content that you see on the Site. In the course of optimizing service to our users, we may allow authorized third parties to recognize a unique cookie or pixel on your browser. Any information provided to third parties through cookies or pixels will not be personally identifiable, but may provide general segment information for the enhancement of your user experience by providing more relevant advertising. The Michigan State Medical Society uses third-party vendor re-marketing tracking cookies and pixels, through sites like Facebook and Google. This means we have the ability to show ads to you on Facebook, or other websites across the Internet. As always, we respect your privacy and are not collecting any identifiable information through Facebook, or any other third-party remarketing system. The third-party vendors, including Facebook, whose services we use, will place cookies on Web browsers in order to serve ads based on past visits to our website. Third party vendors, including Facebook, use cookies to serve ads based on a user's prior visits to your website. This type of advertising is designed to provide you with a selection of products and offers based on what you're viewing on www.msms.org, and allows us to make special offers and continue to market our services to those who have shown interest in our service.

Managing Cookies: Most browser software can be set to reject cookies. If you'd prefer to restrict, block or delete cookies from www.msms.org or any other website, you can use your browser to do this. Each browser is different; so check the 'Help' menu of your particular browser to learn how to change your Cookie preferences. Alternatively, you can opt out of a third-party vendor’s use of cookies by visiting the Network Advertising Initiative opt-out page. Please keep in mind that if cookies aren’t enabled, certain functionality on the Site may not work properly and your experience may be limited.

Information Sharing And Disclosure: The Michigan State Medical Society is committed to protecting your personal information. We will not disclose your personally identifiable information to third parties without your consent.

Relevant AMA Policy:
None
Title: Upholding the Integrity and Vitality of the State and County Medical Societies

Introduced by: Narasimha Gundamraj, MD, for the Ingham County Delegation, Christopher J. Allen, MD, for the Saginaw County Delegation, and Evelyn Eccles, MD, for the Washtenaw County Delegation

Original Author: Evelyn Eccles, MD

Referred To: Reference Committee C

House Action:

Whereas, MSMS and county medical societies are and always have been interdependent, but supported by separate dues structures, and

Whereas, the health of MSMS depends in large part on the health of the county medical societies, which provide grassroots input, mentorship, coordination, education, leadership, and

Whereas, physician and medical student members are best served when linked to leaders within their respective local, component society communities, and

Whereas, physicians that live in areas where there is no active, staffed county medical society have been allowed to become members of MSMS, and

Whereas, this practice could create an incentive for physicians and/or medical students and/or physician groups regardless of where they live or work to join unstaffed counties or counties without membership dues to reduce their cost, and

Whereas, this option is potentially disruptive and harmful to the integrity and vitality of the county medical societies and MSMS, and

Whereas, the 2019 MSMS House of Delegates overwhelmingly approved continued membership unification between MSMS and the county medical societies via the amended Final MSMS Organizational Remodeling Recommendations, as well as disapproval of Resolution 63-19, and

Whereas, the MSMS Board of Directors considered and approved a motion at the October 2020, Board meeting interpreting the bylaws stating, “that the MSMS Board of Directors acknowledge MSMS Legal Counsel’s interpretation that the MSMS Bylaws do not expressly require a physician to live or work in a county in order to hold membership in that county medical society,” and

Whereas, the county medical societies have become aware of physician(s) and/or physician group(s) that belong to counties in which they potentially do not live and/or work prior to the October 2020, MSMS Board or Directors motion and approval and subsequently since, and
Whereas, the county medical societies have requested and received membership roster(s) within their districts and/or regions previously, but have been informed by MSMS that this is not in accordance with MSMS Bylaws and policies since October 2020; therefore be it

RESOLVED: That the county medical societies and MSMS work as committed partners to uphold the county medical societies and MSMS shared integrity and vitality, as previously approved by the House of Delegates; and be it further

RESOLVED: That the current MSMS state-wide membership roster shall be audited and the results shall be distributed to the county medical societies and the 2022 MSMS House of Delegates to evaluate the extent of the October 2020 bylaws interpretation; and be it further

RESOLVED: That any recruitment and/or retention practice by MSMS, vendors and/or support subsidiaries, and/or county medical societies supported by the October 2020 bylaws interpretation that serves to undermine the integrity and vitality of the medical societies end; and be it further

RESOLVED: That moving forward, all physician and medical student members join the county where they live or work, unless there is written agreement due to mutually agreed upon exception between the medical student, physician and/or physician group, MSMS, and the respective county(ies).

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

STATEMENT OF URGENCY: The membership practice was considered and approved within the last year and the consequences are currently unknown. The HOD should review and remedy this practice before the 2022 membership dues cycle begins.

Relevant MSMS Policy:
Over the past year, MSMS has deployed several strategies to address issues raised by county medical societies regarding state society operations and procedures relative to membership, advocacy, communications and the House of Delegates. Those strategies include weekly (spring 2020) and then bi-weekly (summer 2020) virtual meetings between the MSMS CEO and county society staff, monthly meetings between MSMS departmental heads and county society staff (which have been ongoing since 2010), and a facilitator-led series of meetings to research state and county perspectives and host a series of meetings to work through how various issues will be handled going forward. The consultant work is ongoing, and the topic raised in this resolution has been part of that process. In addition, county concerns have been discussed broadly at MSMS Board meetings, the Chair and Vice Chair hosted a virtual meeting with Regional Directors representing five counties raising concerns, and the MSMS Executive Committee has also met to support strategies to establish best practices between state and county going forward.

Advise Physicians Regarding the Importance of Organized Medicine
MSMS advocates educating Michigan physicians regarding the value of membership in their respective county medical societies, MSMS and the AMA. (Res17-96A)

Relevant AMA Policy:
None
Sources:
3. Source: January 14, 2021 MSMS Board of Directors Meeting Packet
Title: Designated Directors Serving as Chair of the MSMS Board of Directors

Introduced by: Betty S. Chu, MD, MBA

Original Author: Betty S. Chu, MD, MBA

Referred To: Reference Committee C

House Action:

Whereas, the MSMS House of Delegates amended its bylaws in 2019 to create a new category of representatives on the MSMS Board of Directors, titled Designated Directors, and

Whereas, the purpose of the Designated Director was to represent specific physician constituencies and perspectives based on current physician demographics, and

Whereas, the House of Delegates overwhelmingly supported the addition of these seats to complement the Regional Directors that constitute the vast majority of seats on the MSMS Board of Directors, and

Whereas, the House of Delegates forms a Nominating Committee, composed of delegates from each of the nine regions, to review candidates for each of the Designated Director categories to ensure the candidates presented are the most qualified and reflect the diversity of the Society’s membership, and

Whereas, the House of Delegates has the final authority to elect candidates for the Designated Director, and

Whereas, the current Designated Directors approved by the House of Delegates include representatives from a physician organization, health system, independent small practice, government/public health, designated institutional officer/graduate medical education, and an at-large member, and

Whereas, the contribution of these House-elected Designated Directors has already proven to be beneficial to the work of the MSMS Board, and

Whereas, allowing Designated Directors to be candidates to chair MSMS Board Committees, which are elected by the Board annually, would expand the choice of qualified candidates that could serve in Board leadership; therefore be it

RESOLVED: That the MSMS Bylaws be amended as follows. Deletions are indicated by strikethroughs, additions are indicated in bold type.

14.10 ORGANIZATION—The Board of Directors is the executive body of the Society. Subject only to the following, it shall determine the times and places of its meetings. At its first meeting immediately following the Annual Session of the House of
Delegates, the Board of Directors shall elect Secretary and Treasurer, who shall serve for a term of office of one year or until a successor is elected and takes office. At the same meeting, the Board of Directors shall elect a Chair, a Vice-Chair, a Chair of the Finance Committee, a Chair of the Health Care Delivery Committee, a Chair of the Legislative Policy Committee, and a Chair of the Scientific and Educational Affairs Committee, who shall be duly elected Regional Directors or Designated Directors, each to take office immediately and to serve for a term of one year or until a successor is elected and takes office.

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

**Relevant MSMS Policy:**
None

**Relevant AMA Policy:**
None
ACTION REPORT #02-21 OF THE BOARD OF DIRECTORS

SUBJECT: Revisions to the MSMS Policy Manual and the 2021 Sunset Policy

REFERRED TO: Reference Committee C

HOUSE ACTION:

RECOMMENDATION: That the 2021 MSMS House of Delegates approve the additions to the MSMS Policy Manual and the 2021 Sunset report. Upon House approval, the updates will be placed in the Policy Manual on the MSMS website.

The MSMS Policy Manual Review Committee met virtually on February 15, 2021, to review existing policy slated for review pursuant to the MSMS sunset policy; reviewed the 2020 House of Delegates Resolutions and Board Action Reports, as well as the MSMS Board Actions from January through October 2020.

At its virtual meeting on Wednesday, March 31, 2021, the MSMS Board of Directors approved the revisions to the MSMS Policy Manual and the 2021 Sunset Report and that upon House approval the updates will be placed in the Policy Manual on the MSMS website.

Attachments
  MSMS Policy Manual Updates
  Addendum S
  2021 Sunset Report
END OF LIFE CARE
(See also: Long-Term Care; Pain Management)

Hospice Care and the “Adult Failure to Thrive” Diagnosis
MSMS endorses working with the Michigan Home Care and Hospice Association to broaden the diagnosis and/or hospice admission criteria to encourage more focus on the patient’s prognosis and decline in functional status rather than on the primary diagnosis. (Board Action Report #05, 2020 HOD, re Res68-19)

ETHICS
(See also: Discrimination; End of Life Care)

Bioethics
Forced Organ Harvesting
MSMS denounces the practice of forced organ harvesting and programs and policies that assist with the education and research of anyone who participates in organ transplant programs in a country where forced organ harvesting is practiced. (Board Action Report #02, 2020 HOD, re Res52-19)

HEALTH INFORMATION TECHNOLOGY
Anonymous Prescribing Option for Expedited Partner Therapy
MSMS recommends that electronic medical records have the capability of providing an anonymous prescribing option for the purpose of expedited partner therapy. (Res43-20)

MENTAL HEALTH
(See also: Health Care Insurance; Managed Care; Medical Education and Training)

Inter-Facility Transfers of Patients with Serious Mental Illness
MSMS believes community mental health agencies and hospital administrators should, at all times, respect the Emergency Medical Treatment and Labor Act regarding inter-facility transfers of patients with serious mental illness. (Res38-20)

Involuntary Hospitalization
MSMS supports appropriate modification of the Michigan Mental Health Code in order to make involuntary hospitalization more rapidly accessible for mentally ill persons requiring such intervention for the benefit of their safety and the safety of others. (Prior to 1990)
-Reaffirmed Res38-20

Behavioral Health Integration Guiding Principles
MSMS supports the Behavioral Health Integration Guiding Principles listed in Addendum S. (See Addendum S in website version) (Board-March2020)

QUALITY ASSURANCE AND PATIENT SAFETY
Oppose Criminalization of Physicians and Patients for Evidence Based Standard of Medical Care
MSMS opposes the criminalization of a procedure and prosecution of physicians for delivering evidence-based standard of medical care, as well as for refusing to engage in care that is neither safe nor evidence based. (Res41-20)

SUBSTANCE USE AND ADDICTION
Access to Opioid Agonist Treatment for Incarcerated Persons
MSMS recommends the availability of all types of opioid agonist treatment for opioid use disorder, as well as a validated screening tool to identify withdrawal and determine potential need for treatment for opioid use disorder, for incarcerated persons in Michigan. (Res47-20)
Behavioral Health Integration Guiding Principles

MSMS supports the following Behavioral Health Integration Guiding Principles:

1. Whole-person collaborative care across all elements of the health care system is prioritized and supported by training, payment, and care delivery addressing physical, behavioral, and social health together.

2. Efforts to improve behavioral health services address stigma, cultural competency, and disparities.


4. People receive the care they need at the place and time that is right for them.

5. Behavioral health services are covered equally with physical health services.

6. Mental health (including substance use) early intervention is encouraged and routinely available to persons of all ages including, children and adolescents, prior to any functional decline. Screening using valid instruments is supported through outreach and education, availability of screening tools, reimbursement, and infrastructure supporting screening follow up.

7. Promotion of clinical models across the spectrum of symptoms and continuum of care that recognize the importance of:
   a. Physician leadership in team-based care.
   b. Integrating physical and behavioral health, such as that achieved by the collaborative care model.
   c. Access to outpatient and inpatient psychiatric services and related therapies.
   d. Clinician care delivery from primary care through behavioral health through enhanced communication and administrative simplification.
   e. Individualized care plans that identify and address both physical and behavioral health needs, as well as social determinants which may affect health outcomes.
   f. The role of telepsychiatry and telehealth.
   g. Eliminating fragmentation in funding and contracting for physical and behavioral health services.
   h. Acknowledging that patients move across the severity continuum.

8. Core components of effective clinical models include, but are not limited to, patient identification and engagement, patient education and self-management support, medication management and psychotherapy as clinically indicated, team-based care management, systematic follow-up, and effective consultation and supervision for patients who are not improving as expected.
9. Mental health (including substance use conditions), health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization are recognized and addressed at all levels of care.

10. Treatment and services are consistent with standards of care and evidence-based when there is credible research evidence to support their efficacy.

11. Primary care provider (PCP) and Community Mental Health (CMH) Agency communication and collaboration on mutual patients recognizes the PCP to be central in the referral process for specialty or subspecialty mental health care through CMH and provides standing to appeal an adverse determination.

12. Specialty physicians, in coordination with primary care, have the ability to refer their patients for behavioral health care.

13. Governmental programs and all payers support interdepartmental coordination and shared accountability, as well as greater access to timely outpatient treatment, crisis intervention, specialty behavioral health services, inpatient psychiatric hospitalizations, and other medically necessary related therapies on par with non-psychiatric conditions.

14. Billing and coding policies enable physicians, psychiatrists regardless of setting, and other health care providers to be reimbursed for providing team-based integrated care that includes screening, case management, consultation, and other related care. Policies and procedures for referrals, consultations and follow-up are uniform regardless of whether related to physical or behavioral health concerns.

15. Payment for behavioral health care is reflective of the value of care delivered (e.g., total cost of care), not just the volume of care provided.

16. Workforce needs are identified across the continuum of care in order to develop policies and programs supporting team-based care based on individualized patient needs and choices.

17. The sharing of confidential, accurate and timely care documentation between health care providers is supported by useable and interoperable health information technology.

(Created by the MSMS Behavioral Health Integration Task Force and adopted by the MSMS Board of Directors on March 25, 2020.)
At its 2018 Annual Meeting, the Michigan State Medical Society (MSMS) House of Delegates (HOD) established a sunset mechanism for House policies (Resolution 14-18, “Sunset Mechanism MSMS Policy”). Pursuant to this mechanism, a policy established by the HOD ceases to be viable after 10 years unless action is taken by the HOD to retain it.

The objective of the sunset mechanism is to help ensure the MSMS Policy Manual is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of MSMS to communicate and promote its policy positions, as well as contributes to the efficiency and effectiveness of HOD deliberations.

The MSMS Committee to Review the MSMS Policy Manual recommends that the House of Delegates policies listed in this report be acted upon in the manner indicated and the remainder of the report be filed.

<table>
<thead>
<tr>
<th>Policy</th>
<th>Year</th>
<th>Recommendation</th>
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<tbody>
<tr>
<td>Educational Activities Addressing Needs of the Elderly</td>
<td>Prior to 1990</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td>MSMS supports, through existing MSMS committees and programs, educational activities addressing the special medical, social and economic needs of the elderly.</td>
<td></td>
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<tr>
<td>Improving Medical Care in Extended Care Facilities</td>
<td>Prior to 1990</td>
<td>Retain, policy is still relevant.</td>
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<tr>
<td>MSMS supports a requirement for a qualified medical director in every skilled nursing home facility and encourages physicians to continue the care of their patients either directly or by delegation following admission to long term care facilities.</td>
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<tr>
<td>Prevention of Elderly Abuse</td>
<td>Prior to 1990</td>
<td>Retain, policy is still relevant, and modify to read as follows: Prevention of Elderly Abuse</td>
</tr>
<tr>
<td>MSMS urges implementation of current statutes that require providers of health services to report cases of abuse, neglect or exploitation of the elderly to the Michigan Department of Community Health, and urges the provision of appropriate immunity from legal action for those who report such cases in good faith.</td>
<td></td>
<td>MSMS supports mandatory reporting of cases of abuse, neglect, or exploitation of the elderly to the appropriate state department by providers of health services. MSMS believes providers of health care who report such cases in good faith should have appropriate immunity from legal action.</td>
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<td>Policy</td>
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<td><strong>Appropriate End of Life Therapy</strong></td>
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<td><strong>Retain, policy is still relevant.</strong></td>
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<tr>
<td>MSMS will continue to work at all levels for improved pain management and symptom control.</td>
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<td>MSMS will continue education on recognition of depression and its adequate therapy.</td>
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<td>MSMS will continue to promote advance directives.</td>
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<td>MSMS will continue support for hospice including education about hospice and the use of hospice care.</td>
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<td><strong>Clergy Involvement with the Terminally Ill</strong></td>
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<td><strong>Retain, policy is still relevant.</strong></td>
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<tr>
<td>MSMS encourages the inclusion of the clergy in providing care for the terminally ill and in meetings and discussions throughout the state to elicit their views and recommendations on the ethical and practical issues of care of terminal patients.</td>
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<tr>
<td><strong>Compassionate Care and Comfort Guidelines</strong></td>
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<td><strong>Retain, policy is still relevant.</strong></td>
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<tr>
<td>MSMS adopts the Compassionate Care and Comfort Guidelines as being in compliance with the standards of care. (See Addendum A in website version)</td>
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<tr>
<td><strong>Death Notification</strong></td>
<td>Board-July97</td>
<td>Retain, policy is still relevant.</td>
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<tr>
<td>MSMS supports and encourages appropriate death notification by health care facilities in a timely fashion.</td>
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<tr>
<td><strong>Death with Dignity Law</strong></td>
<td>Prior to 1990</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td>An attending physician should be allowed legally to participate with the patient and/or the legally appointed agent in deciding the continuation of medical treatment when faced with terminal illness.</td>
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<tr>
<td>MSMS will work with interested groups to resolve and clarify the legal and ethical dilemmas surrounding the withholding and withdrawal of life support therapy.</td>
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<tr>
<td><strong>Hospice Deaths as Crime Scenes</strong></td>
<td>Res45-03A</td>
<td>Sunset policy. This policy is no longer necessary as Public Act 153 of 2004 addressed this issue by revising the conditions under which an investigation is required when an individual dies while under home hospice care.</td>
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<tr>
<td>MSMS opposes attempts by local law enforcement agencies to regard expected hospice deaths as crime scenes.</td>
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<tr>
<td>MSMS opposes the routine deployment of criminal investigators to expected hospice death scenes.</td>
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<tr>
<td><strong>Living Will</strong></td>
<td>Res92-90A</td>
<td>Retain, policy is still relevant.</td>
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<tr>
<td>MSMS recognizes the validity of Living Will/Durable Power of Attorney forms in Michigan.</td>
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<td></td>
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<tr>
<td>Policy</td>
<td>Year</td>
<td>Recommendation</td>
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<tr>
<td><strong>Oppose Legislative Interference in Patient/Physician Relationship</strong>&lt;br&gt;MSMS opposes any legislation passed in the area of assisted suicide that interferes with the proper patient/physician relationship, particularly as such legislation relates to pain control and the terminally ill, so that physicians may continue to provide compassionate care to their patients in accordance with principles of medical care and ethics.</td>
<td>Res70-93A</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td><strong>Physician Assisted Suicide Legislation</strong>&lt;br&gt;MSMS supports legislation opposing physician assisted suicide, so long as such legislation includes safeguards to protect the legal and ethical rights of physicians and patients.</td>
<td>Res85-98A</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td><strong>Stem Cells</strong>&lt;br&gt;MSMS respects the diversity of opinion amongst Michigan physicians regarding human embryonic stem cell research and adopts a neutral position regarding human embryonic stem cell research.</td>
<td>Res28-08A</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td><strong>Cloning</strong>&lt;br&gt;MSMS supports laws and governmental policies that prohibit human reproductive cloning.</td>
<td>Res60-03A</td>
<td>Retain, policy is still relevant.</td>
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<tr>
<td></td>
<td>Reaffirmed w/Res70-06A</td>
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<tr>
<td>Policy</td>
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<td>--------------------------------------------</td>
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<tr>
<td>&quot;Baby Doe&quot; and Other Handicapped Individuals</td>
<td>Prior to 1990</td>
<td>Retain, policy is still relevant, and modify to read as follows:</td>
</tr>
<tr>
<td>Handicapped individuals, if competent, have the right to choose among treatment alternatives. Incompetent individuals and those unable to express their own opinions have the right to have choices made for them. In these circumstances, families provided with comprehensive information regarding alternatives can best represent the handicapped. When questions with respect to the patient’s best interest are raised by the patient’s physician, or the hospital bioethics committee, protections provided by local agencies and courts may be invoked to evaluate fair choices. Physicians and hospitals can aid by: 1. Providing counsel to patients, families, physicians and agencies charged with individual decisions. 2. Confidential review of decision-making experiences. 3. Aiding in the development of guidelines regarding this process.</td>
<td>Medical Treatment Decisions and Persons with Disabilities</td>
<td>Persons with disabilities, unless they are subject to a guardian or conservator, have the right to make their own medical decisions, including the choice of treatment alternatives. Persons with disabilities and if necessary, a guardian, conservator, or patient advocate, are best served when provided with comprehensive information to assist in making informed decisions. When questions with respect to the patient’s best interest are raised by the patient’s physician, or the hospital bioethics committee, protections provided by local agencies and courts may be invoked to evaluate fair choices. Physicians and hospitals can aid by: 1. Providing counsel to patients, families, physicians, and agencies charged with individual decisions. 2. Confidential review of decision-making experiences. 3. Aiding in the development of guidelines regarding this process.</td>
</tr>
<tr>
<td>Surrogate Parenting</td>
<td>Prior to 1990 Edited 1998</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td>MSMS endorses the need to define and protect the legal status and rights of a child born as a result of surrogate parenting. MSMS endorsement does not extend to the process of surrogate parenting.</td>
<td>Standards for Due Process in Hospital Ethics Committees</td>
<td>MSMS believes hospitals should ensure that the minimum standards for institutional Ethics Committees include input from the patient, and/or a representative chosen by the patient, and/or a guardian ad litem for the patient to protect the patient’s best interests.</td>
</tr>
<tr>
<td>Standards for Due Process in Hospital Ethics Committees</td>
<td>Board-Jan09</td>
<td>Retain, policy is still relevant, but modify to read as follows: Standards for Due Process in Hospital Ethics Committees</td>
</tr>
<tr>
<td>Do Not Compete Clauses</td>
<td>Res30-98A Edited 2005</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td>It is unethical for a teaching institution to seek a non-competition guarantee from its residents or trainees.</td>
<td>Integrity and the Values and Principles Embedded in the Tradition of Medicine</td>
<td>MSMS supports the 1996 House of Delegates resolution on “Statement on Integrity and the Values and Principles Embedded in the Tradition of Medicine.”</td>
</tr>
<tr>
<td>Policy</td>
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<tr>
<td><strong>in the Tradition of Medicine.” (See Addendum E in website version)</strong></td>
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</tr>
<tr>
<td><strong>Physician’s Definition of Terminal Illness</strong></td>
<td>Board-Jan99</td>
<td><strong>Sunset the policy.</strong> <em>This policy is no longer necessary as the identification of common terminal conditions, along with the relevant medical criteria indicative of advanced illness is customary.</em></td>
</tr>
<tr>
<td>MSMS supports a treating physician defining a disease or condition as a terminal illness.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Physician’s Rights in Treatment Decisions</strong></td>
<td>Prior to 1990</td>
<td><strong>Retain, policy is still relevant.</strong></td>
</tr>
<tr>
<td>Neither physicians, hospitals nor hospital personnel shall be required to perform any act that violates good medical judgment or is contrary to moral principles of the individual. In such circumstances, the physician or other professional may withdraw from the case as long as the withdrawal is consistent with good medical practice.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Racism and Sexism in the Practice of Medicine</strong></td>
<td>Res113-99A</td>
<td><strong>Retain, policy is still relevant.</strong></td>
</tr>
<tr>
<td>MSMS opposes racism and sexism in our society.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sexual Harassment Guidelines</strong></td>
<td>Res12-93A</td>
<td><strong>Retain, policy is still relevant.</strong></td>
</tr>
<tr>
<td>MSMS advocates that guidelines for prevention of sexual harassment be integrated into the medical work place.</td>
<td>Edited 1998</td>
<td></td>
</tr>
<tr>
<td><strong>Commercial or Political Exploitation of Officer Titles</strong></td>
<td>Prior to 1990</td>
<td><strong>Retain, policy is still relevant.</strong></td>
</tr>
<tr>
<td>Physicians who hold offices or have held offices in MSMS should guard against commercial or political exploitation of any position or title use in any manner that implies, directly or indirectly, endorsement of a commercial product or service by MSMS.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Choice of Family Planning Method</strong></td>
<td>Prior to 1990</td>
<td><strong>Retain, policy is still relevant.</strong></td>
</tr>
<tr>
<td>Everyone in consultation with a physician should be free to choose his or her own method of family limitation, including sterilization. MSMS supports the policy of third party payment for elective sterilization.</td>
<td>Edited 1998, 2005</td>
<td></td>
</tr>
<tr>
<td><strong>CMS Auditing of Medicare and Medicaid</strong></td>
<td>Res49-98A</td>
<td><strong>Retain, policy is still relevant.</strong></td>
</tr>
<tr>
<td>MSMS opposes arbitrary assessment of audit monies by the Centers for Medicare &amp; Medicaid Services (CMS).</td>
<td>Edited 2005</td>
<td></td>
</tr>
<tr>
<td><strong>Excessive Medical Administrative Costs</strong></td>
<td>Res81-90A</td>
<td><strong>Retain, policy is still relevant.</strong></td>
</tr>
<tr>
<td>MSMS opposes additional regulatory requirements that place a financial burden on the physicians or hospitals without compensation.</td>
<td>Edited 1998</td>
<td></td>
</tr>
<tr>
<td><strong>Government Financed Health Care</strong></td>
<td>Prior to 1990</td>
<td><strong>Retain, policy is still relevant.</strong></td>
</tr>
<tr>
<td>The only purpose of government medical care programs for indigent patients is the delivery of needed quality health care.</td>
<td>Edited 1998</td>
<td></td>
</tr>
<tr>
<td><strong>Limited Antitrust Exemption for Physicians</strong></td>
<td>Res51-07A</td>
<td><strong>Retain, policy is still relevant, but modify to read as follows:</strong></td>
</tr>
</tbody>
</table>

Retain, policy is still relevant, but modify to read as follows:
<table>
<thead>
<tr>
<th>Policy</th>
<th>Year</th>
<th>Recommendation</th>
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<tbody>
<tr>
<td>MSMS supports a limited physician antitrust exemption modeled after the “Quality Health Care Coalition Action” physician organization mechanisms to equilibrate the bargaining position between health care insurance companies and physicians.</td>
<td></td>
<td><strong>Limited Antitrust Exemption for Physicians</strong>&lt;br&gt;MSMS supports a limited physician antitrust exemption to balance the bargaining position between health care insurance companies and physicians and therefore enable fair negotiations.</td>
</tr>
<tr>
<td><strong>National Health Care</strong>&lt;br&gt;MSMS supports voluntary, free-choice methods of medical and health care rather than a system dominated and controlled by the federal government.</td>
<td>Prior to 1990 Edited 1998</td>
<td><strong>Retain, policy is still relevant.</strong></td>
</tr>
<tr>
<td><strong>Physician Input for National Health Care Programs</strong>&lt;br&gt;MSMS supports physician input at all levels in the development of any national health care programs.</td>
<td>Res131-93A</td>
<td><strong>Retain, policy is still relevant.</strong></td>
</tr>
<tr>
<td><strong>Unauthorized Files and Investigations by the Bureau of Occupational and Professional Regulations, Office of Health Services</strong>&lt;br&gt;MSMS is opposed to unauthorized investigations of physicians and the unauthorized development of files against physicians by the administration of Bureau of Occupational and Professional Relations (BOPR), Office of Health Services.</td>
<td>Res106-97A</td>
<td><strong>Retain, policy is still relevant, but modify to read as follows:</strong>&lt;br&gt;<strong>Unauthorized Files and Investigations by the State Regulatory Agency</strong>&lt;br&gt;MSMS is opposed to unauthorized investigations of physicians and the unauthorized development of files against physicians by the state agency with licensing and regulatory oversight of physicians.</td>
</tr>
<tr>
<td><strong>Use of Appropriate Terminology</strong>&lt;br&gt;MSMS encourages federation publications to reverse the trend of using inappropriate terminology when referring to physicians as “providers,” patients as “clients” and medical practices as “businesses.”</td>
<td>Res20-00A</td>
<td><strong>Retain, policy is still relevant.</strong></td>
</tr>
<tr>
<td><strong>Denial of Medical Care to Indigents</strong>&lt;br&gt;Indigents should not be denied medical care that is available to the remainder of society.</td>
<td>Prior to 1990 Edited 1998</td>
<td><strong>Retain, policy is still relevant, but modify to read as follows:</strong>&lt;br&gt;<strong>Denial of Medical Care</strong>&lt;br&gt;Persons who are indigent should not be denied necessary medical care.</td>
</tr>
<tr>
<td><strong>Direct Access to Specialists</strong>&lt;br&gt;MSMS supports direct access to specialty physicians when the specialty physician acts as a primary care physician, such as pediatricians and obstetrician/gynecologists.</td>
<td>Board-July99</td>
<td><strong>Retain, policy is still relevant.</strong></td>
</tr>
<tr>
<td><strong>Ob/Gyn as Primary Care Physician</strong>&lt;br&gt;MSMS supports the designation of the obstetrician/gynecologist as a primary care physician.</td>
<td>Res26-95A</td>
<td><strong>Retain, policy is still relevant.</strong></td>
</tr>
<tr>
<td><strong>Universal Coverage</strong>&lt;br&gt;MSMS supports comprehensive health system reform described in the MSMS Future of Medicine Report. (See Addendum P</td>
<td>Res81-06A</td>
<td><strong>Retain, policy is still relevant.</strong></td>
</tr>
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<tr>
<td>&quot;Guiding Principles for the Future of Medicine and Health Care&quot; in website version)</td>
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</tr>
<tr>
<td><strong>Physician Organization Networks</strong>&lt;br&gt;MSMS supports formation of physician organizations (POs) and PO networks to facilitate the provision of high-quality, efficient care and the communication of information.</td>
<td>Res21-94A</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td><strong>CPT Coding</strong>&lt;br&gt;MSMS supports uniform CPT coding for all medical services provided within the state of Michigan.</td>
<td>Res46-92A&lt;br&gt;Reaffirmed w/Res50-10A</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td><strong>Domination of Health Care Delivery Market</strong>&lt;br&gt;MSMS opposes any single organization dominating the health care delivery market.</td>
<td>Prior to 1990&lt;br&gt;Edited 1998</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td><strong>Economic Aspects of Health Care Delivery System</strong>&lt;br&gt;Statement of Principles and Recommendations re Physician Involvement with Economic Aspects of the Health Care Delivery System:&lt;br&gt;Principles:&lt;br&gt;1. MSMS and its individual members share with the public a concern for the proper distribution, delivery and utilization of health care.&lt;br&gt;2. MSMS has an enduring commitment to the delivery of health care in the most cost-effective manner.&lt;br&gt;3. MSMS believes that physicians have a moral and vital obligation to inform, advise, or assist third parties in deliberations concerning the quality of health care, its utilization and cost.</td>
<td>(Prior to 1990)</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td><strong>Emergency Care for Office Based Procedures</strong>&lt;br&gt;MSMS supports a requirement that a physician, who performs office based procedures, provide access to post-operative physician care consistent with appropriate standards of care (practice).</td>
<td>Res107-99A</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td><strong>Alternative Uses of Hospital Beds</strong>&lt;br&gt;MSMS supports alternative uses of hospital beds and space.</td>
<td>Prior to 1990&lt;br&gt;Edited 1998</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
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<tr>
<td><strong>Blue Cross Blue Shield of Michigan (BCBSM) Restrictions for Ambulatory Surgery Centers</strong>&lt;br&gt;MSMS advocates for the elimination of Blue Cross Blue Shield of Michigan Evidence of Need criteria for ambulatory surgery centers and promotes the more generally accepted guidelines for certification of ambulatory surgery centers set forth by Medicare.</td>
<td>Res48-07A</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td><strong>Closing of Small Community Hospitals</strong>&lt;br&gt;MSMS supports the reduction of financial constraints on small rural hospitals in order to improve access to health care.</td>
<td>Res16-90A Edited 1998</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td><strong>Funding of County Medical Care Facilities</strong>&lt;br&gt;MSMS opposes inappropriate reduction in funding for county medical care facilities.</td>
<td>Res43-91A Edited 1998</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td><strong>Determination of Disability and Impairment</strong>&lt;br&gt;MSMS encourages appropriate agencies adopt the &quot;AMA Guides to the Evaluation of Permanent Impairment&quot; for determining disability and impairment.</td>
<td>Res65-96A</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td><strong>Specialty Society Clinical Care Guidelines</strong>&lt;br&gt;MSMS supports the implementation of clinical care guidelines developed by recognized national medical specialty societies to enhance state-of-the-art, quality care for patients. (See Addendum F in website version)</td>
<td>Res76-90A 1990 Board Annual Report Edited 1998</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td><strong>Determination of Medical Necessity of Medical Case Management</strong>&lt;br&gt;The treating physician shall be the sole determinant of medical case management and medical necessity. MSMS believes that an insurer, a health care corporation or a government agency may not interfere with the patient/physician relationship by determining medical necessity or medical case management without a fair and reasonable appeals process and independent binding arbitration in a timely fashion.</td>
<td>Board Action Report #14, 1994 HOD, re Res121-93A</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td><strong>Breast Thermography</strong>&lt;br&gt;MSMS accepts the American College of Radiology position that thermography has not been demonstrated to have value as a screening, diagnostic, or adjunctive imaging tool.</td>
<td>ACR Res33-90 Edited 1998</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td><strong>Physician Support of Statewide Breast and Cervical Cancer Control Program</strong></td>
<td>Res16-93A</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
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<td>Recommendation</td>
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</tr>
<tr>
<td>MSMS supports and endorses the Breast and Cervical Cancer Control Program and urges members to refer eligible patients to the Program for screening as part of ongoing care.</td>
<td></td>
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</tr>
<tr>
<td><strong>Support of Cholesterol Screening Programs</strong></td>
<td>Prior to 1990</td>
<td><strong>Sunset policy. This policy is no longer necessary as the AMA cholesterol-screening program is no longer operational.</strong></td>
</tr>
<tr>
<td>MSMS supports the AMA cholesterol-screening program.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Continuous Quality Improvement (CQI) Programs</strong></td>
<td>Res111-95A</td>
<td><strong>Retain, policy is still relevant.</strong></td>
</tr>
<tr>
<td>MSMS urges its members to participate in Continuous Quality Improvement (CQI) training programs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Collection and Use of Physician Specific Data</strong></td>
<td>Board-May94</td>
<td><strong>Retain, policy is still relevant.</strong></td>
</tr>
<tr>
<td>MSMS supports the amended &quot;Principles on the Release of Physician-Specific and Physician Group Data.&quot; (See Addendum J in website version)</td>
<td>Reaffirmed by Board-March07</td>
<td></td>
</tr>
<tr>
<td><strong>Access to Psychiatrists</strong></td>
<td>Res92-95A</td>
<td><strong>Retain, policy is still relevant.</strong></td>
</tr>
<tr>
<td>MSMS supports requiring qualified health plans to provide access to psychiatrists.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Automatic and Affordable Health Insurance Coverage for All Americans</strong></td>
<td>Res41-01A</td>
<td><strong>Retain, policy is still relevant.</strong></td>
</tr>
<tr>
<td>MSMS supports affordable health insurance coverage for Americans.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Childhood Obesity as a Covered Benefit</strong></td>
<td>Res88-10A</td>
<td><strong>Retain, policy is still relevant.</strong></td>
</tr>
<tr>
<td>MSMS supports the treatment of childhood obesity a benefit covered by health insurance plans.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Children’s Preventive Care</strong></td>
<td>Board-Nov93)</td>
<td><strong>Retain, policy is still relevant.</strong></td>
</tr>
<tr>
<td>MSMS supports requiring insurance companies to cover well-baby check-ups, pediatric check-ups and child immunizations.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Coverage of Immunization by Third Party Payers</strong></td>
<td>Res51-96A</td>
<td><strong>Retain, policy is still relevant.</strong></td>
</tr>
<tr>
<td>MSMS urges all third party payers, especially fee-for-service health plans, to provide coverage of immunizations recommended by national authorities.</td>
<td></td>
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</tr>
<tr>
<td>MSMS encourages fee-for-service health plans, large businesses and labor organizations in Michigan to include health insurance coverage of recommended immunizations.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Discrimination by Health Insurance Carriers against Breast Reconstruction</strong></td>
<td>Res96-96A</td>
<td><strong>Retain, policy is still relevant, but modify to read as follows:</strong></td>
</tr>
<tr>
<td>MSMS supports the right for all women to have access to breast reconstruction after cancer surgery if they desire it, and that access should be available regardless of timing in relationship to the onset of the deformity or absence of their breast.</td>
<td></td>
<td><strong>Access to Breast Reconstruction</strong></td>
</tr>
<tr>
<td>MSMS supports the right for all women to have access to breast reconstruction after cancer surgery if they desire it, and that access should be available regardless of timing in relationship to the onset of the deformity or absence of their breast.</td>
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</tr>
<tr>
<td>MSMS urges health insurance carriers to provide coverage of costs associated with all stages of the breast reconstruction.</td>
<td></td>
<td>Retain, policy is still relevant, but modify to read as follows:</td>
</tr>
<tr>
<td><strong>Emotional Disorder as a Pre-existing Condition</strong></td>
<td>Res88-95A</td>
<td><strong>Emotional or Behavioral Health Disorder as a Pre-existing Condition</strong></td>
</tr>
<tr>
<td>MSMS believes no applicant should be denied an insurance policy for health care, sickness and accident, and/or life because the applicant has been treated for any current or previous emotional disorder.</td>
<td></td>
<td>MSMS believes no applicant should be denied an insurance policy for health care, sickness and accident, and/or life because the applicant has been treated for any current or previous emotional or behavioral health disorder.</td>
</tr>
<tr>
<td><strong>Evaluation of Health Plan Performance</strong></td>
<td>Res28-95A</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td>MSMS continues to evaluate overall performance of health insurance companies with particular emphasis on patient and provider satisfaction, as well as the proportion of premium dollars spent on administration.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Gender Equity for Prescription Drug Coverage</strong></td>
<td>Res4-03A</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td>MSMS supports Michigan insurance carriers and employers to establish gender equity for prescription drug coverage, i.e. birth control pills.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Genetic Screening Affecting Insurance Policy Rates</strong></td>
<td>Res36-95A</td>
<td>Retain, policy is still relevant, but modify to read as follows:</td>
</tr>
<tr>
<td>MSMS supports prohibiting the health insurance industry from basing coverage and rates on knowledge of genetic risk.</td>
<td></td>
<td><strong>Genetic Screening Affecting Insurance Policy Rates</strong></td>
</tr>
<tr>
<td><strong>Health Insurance for Adopted Children</strong></td>
<td>Res11-91A</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td>There should be no discrimination in health insurance benefits between adopted and biological children.</td>
<td>Edited 1998</td>
<td></td>
</tr>
<tr>
<td><strong>Health Insurers: Domestic Assault Victims</strong></td>
<td>Board-July96</td>
<td>Retain, policy is still relevant, but modify as follows:</td>
</tr>
<tr>
<td>MSMS supports the concept of prohibiting insurers, health maintenance organizations and life insurers, from using a person’s status as a victim of domestic assault to deny or cancel coverage or charge special rates.</td>
<td></td>
<td><strong>Health Insurers: Domestic Assault Victims</strong></td>
</tr>
<tr>
<td><strong>Insurance Coverage</strong></td>
<td>Prior to 1990 Edited 1998</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td>Medical insurance companies should make provision for adequate coverage of abortions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Long-term Care Insurance</strong></td>
<td>Prior to 1990)</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td>MSMS supports the availability of insurance for long-term care for Michigan residents.</td>
<td></td>
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</tr>
<tr>
<td><strong>Mental Health Insurance Benefits</strong></td>
<td>Prior to 1990</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td>Policy</td>
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<td>Recommendation</td>
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<tr>
<td>Mental health benefits should be reimbursed on a par with other health care benefits.</td>
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<tr>
<td><strong>No-Fault Auto Insurance – Coordination of Benefits</strong></td>
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</tr>
<tr>
<td>MSMS supports the requirement that automobile insurance policies with a coordination of benefits clause pay reasonable charges for products, services and accommodations incurred by the insured that are not covered by his/her primary health care policy, if the services are provided by a qualified health care professional.</td>
<td>Board-July97</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td><strong>No-fault Health Insurance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSMS supports the concept that health insurance carriers cover the cost of treatment for illness or injury until the responsible payer is identified in order to ensure continuity of care.</td>
<td>Res60-95A</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td><strong>Over Utilization of Radiologic Studies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSMS recommends that insurers reimburse radiologic procedures fairly and equitably and that over utilization be addressed not by decreasing fees, but by recommending appropriate utilization of radiologic procedures and appropriate credentialing of physicians performing these procedures.</td>
<td>Res67-94A</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td><strong>Patient Choice Between Vaginal Birth after Cesarean Section (VBAC) and Repeat Cesarean Section Procedures</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSMS believes that the choice between Vaginal Birth after Cesarean Section (VBAC) and repeat cesarean section should be a decision between the patient, her partner and her doctor. MSMS requests insurance companies to not withhold reimbursement for a repeat cesarean section if this alternative is the patient’s informed decision.</td>
<td>Res93-94A</td>
<td>Retain, policy is still relevant, but modify to read as follows:</td>
</tr>
<tr>
<td><strong>Patient Informed Choice of Delivery Options</strong></td>
<td></td>
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</tr>
<tr>
<td>MSMS believes that the choice between vaginal birth after cesarean (VBAC) delivery and repeat cesarean sections should be a decision between the patient, her partner, and her doctor utilizing the latest relevant guidelines from the American College of Obstetricians and Gynecologists (AGOG). Insurance companies should not withhold reimbursement for a repeat cesarean section if this alternative is the patient’s informed decision.</td>
<td></td>
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</tr>
<tr>
<td><strong>Physician Penalties for Out-of-Network Services</strong></td>
<td></td>
<td></td>
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<tr>
<td>MSMS vehemently opposes any penalties implemented by insurance companies against physicians when patients independently choose to obtain out-of-network services.</td>
<td>Res25-07A</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td><strong>Pre-existing Conditions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSMS supports prohibiting health and disability insurers and HMOs from denying coverage and from refusing to issue or renew coverage because of pre-existing condition.</td>
<td>Board-Nov93</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td><strong>Promotion and Sale of Medical and Disability Insurance Policies</strong></td>
<td>Prior to 1990</td>
<td>Retain, policy is still relevant.</td>
</tr>
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<tr>
<td>Medical and/or disability insurance policies that contain deceptive exclusionary devices should not be promoted or sold.</td>
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<tr>
<td><strong>Prostate Cancer Screening</strong>&lt;br&gt;MSMS supports third party coverage of prostate cancer screening.</td>
<td>Board-July97</td>
<td><strong>Retain, policy is still relevant.</strong></td>
</tr>
<tr>
<td><strong>Second Opinion</strong>&lt;br&gt;MSMS endorses the concept of “second opinion” when requested by the patient or his or her physician. Mandatory second surgical opinion programs are not in the best interest of the public.</td>
<td>Prior to 1990</td>
<td><strong>Retain, policy is still relevant.</strong></td>
</tr>
<tr>
<td><strong>Tax Deductible Insurance Premiums</strong>&lt;br&gt;All health insurance premiums should be tax deductible.</td>
<td>Prior to 1990&lt;br&gt;Edited 1998</td>
<td><strong>Retain, policy is still relevant.</strong></td>
</tr>
<tr>
<td><strong>Uniform Claim Form</strong>&lt;br&gt;MSMS supports implementation of a uniform claim form for all third party payers.</td>
<td>Prior to 1990&lt;br&gt;Edited 1998</td>
<td><strong>Retain, policy is still relevant.</strong></td>
</tr>
<tr>
<td><strong>Waiting Period for Pre-existing Conditions</strong>&lt;br&gt;MSMS supports coverage of pre-existing conditions by third party payers without a waiting period.</td>
<td>Board-Nov97</td>
<td><strong>Retain, policy is still relevant.</strong></td>
</tr>
<tr>
<td><strong>Acupuncture: Licensure</strong>&lt;br&gt;MSMS opposes the licensure of acupuncturists.</td>
<td>Res30-90A&lt;br&gt;Amended 1993</td>
<td><strong>Retain, policy is still relevant.</strong></td>
</tr>
<tr>
<td><strong>Evaluation of Allied Health Professionals</strong>&lt;br&gt;MSMS supports the evaluation of allied health professional methods of practice.</td>
<td>Prior to 1990</td>
<td><strong>Retain, policy is still relevant.</strong></td>
</tr>
<tr>
<td><strong>Medical Staff Privileges for Allied Health Professionals</strong>&lt;br&gt;MSMS urges (1) Michigan physicians to examine the credentials and privileges of allied health professionals and (2) hospital medical staffs to periodically review their bylaws to ensure they include the appropriate language describing the credentialing of allied health professionals.</td>
<td>Res26-94A</td>
<td><strong>Retain, policy is still relevant.</strong></td>
</tr>
<tr>
<td><strong>Midlevel Provider Use Rules</strong>&lt;br&gt;MSMS supports daily physician supervision of all midlevel providers who provide care to hospitalized patients as documented by a signature.</td>
<td>Board Action Report #7, 2011&lt;br&gt;HOD, Res74-10A</td>
<td><strong>Retain, policy is still relevant, but modify to read as follows:</strong>&lt;br&gt;&lt;br&gt;&lt;strong&gt;Non-Physician Practitioner Use Rules**&lt;br&gt;MSMS supports daily physician supervision of all non-physician practitioners who provide care to hospitalized patients as documented by a signature.</td>
</tr>
<tr>
<td><strong>Midwifery: Protection from Unqualified Practitioners</strong>&lt;br&gt;MSMS supports protection of Michigan women from unqualified practitioners of obstetrics.</td>
<td>Prior to 1990&lt;br&gt;Edited 1998</td>
<td><strong>Retain, policy is still relevant.</strong></td>
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<tr>
<td>Nursing: Direct Reimbursement of Certified Nurse Midwives</td>
<td>Board-Sept94</td>
<td>Retain, policy is still relevant.</td>
</tr>
</tbody>
</table>
| MSMS supports permitting direct reimbursement to certified nurse midwives if the regulations stipulate the following:  
  • An expense-incurred, medical or surgical policy, conversion policy or indemnity policy, that provides coverage for maternity services, shall offer to provide coverage for such services whether performed by a physician or a nurse midwife acting within the scope of his or her license. A certified nurse midwife must include evidence of a collaborative relationship with a physician with obstetrical privileges at the same institution.  
  • A group or non-group certificate or conversion certificate that provides coverage for maternity services, shall offer to provide or shall provide, coverage for such services whether performed by a physician or a nurse midwife acting within the scope of his or her license. A certified nurse midwife must include evident of a collaborative relationship with a physician with obstetrical privileges at the same institution. |            |                                          |
<p>| Nursing: Education                                    | Prior to 1990 | Sunset policy. This policy is no longer timely as hospital-based nursing degree programs are rare, with the majority of individuals receiving their nursing degree at a college or university. |
| Hospital nursing schools should not be “phased out.” The integration of hospital nursing schools and community and state colleges into a unified academic program should be considered. |            |                                          |
| Optometry: Scope of Practice Expansion                | Board-Jan93  | Retain, policy is still relevant.         |
| MSMS opposes allowing optometrists to expand their scope of practice to include the use of therapeutic drugs, and to expand the area that they may examine from the eyeball to the area surrounding the eye. |            |                                          |
| Pharmacy: Cooperation to Insure Patient Medication Safety | Res88-93A  | Retain, policy is still relevant.         |
| MSMS works with the Michigan Pharmacists Association to assure patient safety, confidentiality, and continuity of care. |            |                                          |
| Pharmacy: Cooperation to Insure Patient Medication Safety | Board-July95 | Retain, policy is still relevant.         |
| MSMS works with the Michigan Pharmacists Association to assure patient safety, confidentiality, and continuity of care. (Res88-93A)Physician Assistants and Nursing: Prescription Drugs |            |                                          |
| MSMS supports the concept of permitting physician assistants and registered nurses to order, receive and dispense complimentary starter doses of non-controlled substances. |            |                                          |</p>
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<tr>
<td><strong>Physician’s Relationship with Limited Practitioners</strong></td>
<td>Prior to 1990</td>
<td><em>Retain, policy is still relevant, but modify to read as follows:</em></td>
</tr>
<tr>
<td>A physician should at all times practice a method of healing founded on a scientific basis. A physician may refer a patient for diagnostic or therapeutic services to another physician, licensed limited practitioner, or any other provider of health care services permitted by law to furnish such services whenever the physician believes that this will benefit the patient. As in the case of referrals to physician specialists, referrals to limited practitioners should be based on their individual competence and ability to perform services needed by the patient. Testimonials should not be used in advertising as such claims tend to mislead the public. In addition, the Society supports Section 16265 of the Michigan Public Health code which states: “1) An individual licensed under this article to engage in the practice of chiropractic, dentistry, medicine, optometry, osteopathic medicine and surgery, podiatric medicine and surgery, psychology, or veterinary medicine shall not use the terms doctor or dr. in any written or printed matter or display without adding thereto of chiropractic, of dentistry, of medicine, of optometry, or of osteopathic medicine and surgery, of psychology, of veterinary medicine or a similar term, respectively.”</td>
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<tr>
<td><strong>Physical Therapy: Direct Reimbursement</strong></td>
<td>Board-July95</td>
<td><em>Retain, policy is still relevant.</em></td>
</tr>
<tr>
<td>MSMS opposes direct reimbursement to physical therapists.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Physical Therapy: Reimbursement</strong></td>
<td>Board-Nov93</td>
<td><em>Retain, policy is still relevant.</em></td>
</tr>
<tr>
<td>MSMS opposes requiring commercial payers to directly reimburse physical therapists for their services.</td>
<td></td>
<td></td>
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<tr>
<td><strong>Psychology: Prescribing Medications</strong></td>
<td>Res87-95A</td>
<td><em>Retain, policy is still relevant.</em></td>
</tr>
<tr>
<td>MSMS opposes psychologists prescribing medications.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Psychology: Hospital Staff Privileges</strong></td>
<td>Board-July96</td>
<td><em>Retain, policy is still relevant.</em></td>
</tr>
<tr>
<td>MSMS opposes hospitals credentialing a psychologist to practice independently.</td>
<td></td>
<td></td>
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<tr>
<td><strong>Surgical Assistants: Role and Reimbursement</strong></td>
<td>Res115-90A</td>
<td><em>Retain, policy is still relevant.</em></td>
</tr>
<tr>
<td>MSMS supports the role and reimbursement of surgical assistants in the delivery of health care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>e-Visit Reimbursements</strong></td>
<td>Board-April06</td>
<td><em>Retain, policy is still relevant.</em></td>
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<tr>
<td>MSMS supports and advocates reimbursement of e-visits that involve encounters relating to a patient’s care as a part of</td>
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<tr>
<td>ongoing management and maintains appropriate elements of quality, physician accountability, and confidentiality.</td>
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<tr>
<td><strong>Support Patient Empowerment Controlled Health Records</strong></td>
<td></td>
<td><em>Retain, policy is still relevant.</em></td>
</tr>
<tr>
<td>MSMS supports the development of functional patient-centric information exchange systems to and from a patient-accessible health record that gives patient control to share with others, protects their individual rights to privacy, and supports continuity of care, provider work flow, and provider fulfillment of meaningful use.</td>
<td>Res80-10A</td>
<td></td>
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<tr>
<td><strong>Regionalization</strong></td>
<td>Prior to 1990</td>
<td><em>Retain, policy is still relevant.</em></td>
</tr>
<tr>
<td>The private physician and local medical societies should be involved in planning for regionalization of medical services.</td>
<td></td>
<td></td>
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<tr>
<td><strong>Amending Medical Staff Bylaws</strong></td>
<td></td>
<td><em>Retain, policy is still relevant.</em></td>
</tr>
<tr>
<td>MSMS will assist medical staffs by providing legal help and support, if determined appropriate by the MSMS Board of Directors, when a hospital board of directors unilaterally changes the medical staff bylaws.</td>
<td>Res27-94A</td>
<td></td>
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<tr>
<td><strong>Physician Representation on Hospital Boards of Trustees</strong></td>
<td></td>
<td><em>Retain, policy is still relevant.</em></td>
</tr>
<tr>
<td>MSMS supports the principle that all physicians seated on hospital boards of trustees be elected to their position by the hospital medical staff members.</td>
<td>Res51-06A</td>
<td></td>
</tr>
<tr>
<td><strong>Physician Representation on Hospital Governing Boards</strong></td>
<td></td>
<td><em>Retain, policy is still relevant.</em></td>
</tr>
<tr>
<td>MSMS encourages all physicians to participate on their hospital governing boards and/or boards of trustees, and recommends in addition that elected chiefs of staff be voting members of their hospital governing boards.</td>
<td>Res22-93A</td>
<td>Edited 1998</td>
</tr>
<tr>
<td><strong>Arbitrary Denial or Termination of Medical Staff Privileges</strong></td>
<td></td>
<td><em>Retain, policy is still relevant.</em></td>
</tr>
<tr>
<td>MSMS recognizes hospital medical staff bylaws as a contract that affords due process to all members of the medical staff.</td>
<td>Res14-95A</td>
<td></td>
</tr>
<tr>
<td><strong>Consolidation of Medical Staff and Departments</strong></td>
<td></td>
<td><em>Retain, policy is still relevant.</em></td>
</tr>
<tr>
<td>MSMS supports the concept that consolidation of medical staff and departments and associated bylaws and departmental policies and procedures must require the approval of all medical staffs and/or departments so involved.</td>
<td>Res15-95A</td>
<td></td>
</tr>
<tr>
<td><strong>Guidelines – Applications for Hospital Medical Staff Privileges</strong></td>
<td>Prior to 1990</td>
<td><em>Retain, policy is still relevant.</em></td>
</tr>
<tr>
<td>MSMS endorses the Guidelines on Applications for Hospital Medical Staff Privileges. (See Addendum G in website version)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Guidelines for Medical Staff Funds</strong></td>
<td>Prior to 1990</td>
<td><em>Retain, policy is still relevant.</em></td>
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<tr>
<td>1. Participation in such funds shall be voluntary.</td>
<td></td>
<td>Retain, policy is still relevant, but modify to read as follows:</td>
</tr>
<tr>
<td>2. Control of the use of medical staff funds shall be limited to the physicians who have contributed to the fund.</td>
<td></td>
<td>Guidelines for Physician-Hospital Relations</td>
</tr>
<tr>
<td>3. The constitution, bylaws or other governing rules of the fund shall provide that all elections and votes on major decisions by the membership shall be by secret written ballot.</td>
<td></td>
<td>Prior to 1990</td>
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</table>

Guidelines for Physician-Hospital Relations

1. Hospital-employed physicians should be included as members of the medical staff and should be subject to its bylaws, rules, and regulations. The following provisions should be included in medical staff bylaws:
   “The credentials committee (or other appropriate committee) shall cooperate with the governing board in reviewing the credentials of all physician applicants for employment by the hospital to assure that such employees qualify for regular membership on the medical staff. The procedures followed in processing applications for regular medical staff appointment and for continued staff privileges shall be applicable to and have control over such employed physicians.”

2. The medical staff should include proper safeguards in all appropriate sections of the medical staff bylaws, rules, and regulations to make certain that they apply to all physicians serving on the medical staff, including those employed by the hospital.

3. While medical staff bylaws must be approved by the governing board and, for this reason, are considered to be binding on the governing board, it would appear desirable to include a provision in any contracts with physicians, as well as in the medical staff bylaws, to assure the desired result. The following is suggested:
   “In accordance with and subject to the procedures of the organized medical staff, Doctor ______ is granted and accepts appointment as a member of the medical staff. This Agreement shall terminate automatically if the staff privileges of Doctor _____ are revoked upon recommendation of the organized medical staff.”

4. If there is no organized democratic departmental structure which allows for communication and input, the medical staff
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<tr>
<td>should establish an advisory committee to counsel and assist the administrator in carrying out his or her responsibilities.</td>
<td></td>
<td>should establish an advisory committee to counsel and assist the administrator in carrying out his or her responsibilities.</td>
</tr>
<tr>
<td>5. Where the employment of a full-time physician to carry out departmental administrative and operational functions is being considered, it is recommended that consideration be given to employing this physician as an administrative assistant to the elected chief with the delegated functions appropriately spelled out in the medical staff or departmental bylaws.</td>
<td></td>
<td>5. Where the employment of a full-time physician to carry out departmental administrative and operational functions is being considered, it is recommended that consideration be given to employing this physician as an administrative assistant to the elected chief with the delegated functions appropriately spelled out in the medical staff or departmental bylaws.</td>
</tr>
<tr>
<td>6. Medical staffs in all types of non-federal hospitals should be alert to the potential dangers of governing board dominance over the executive committee and the need for careful bylaw structuring of the executive committee to prevent this.</td>
<td></td>
<td>6. Organized medical staffs in all types of non-federal hospitals should be alert to the potential dangers of governing board dominance over the executive committee and the need for careful bylaw structuring of the executive committee to prevent this.</td>
</tr>
<tr>
<td>7. The American Medical Association should firmly oppose the specific proposals of the American College of Hospital Administrators and the Catholic Hospital Association concerning medical staff structure and medical staff-administrator-board relationships. (Note: The Board has concerned itself only with those specific sections of the documents.)</td>
<td></td>
<td>7. It is emphasized that organized medical staffs should take a firm stand against governing board control of organized medical staff activities related to patient care.</td>
</tr>
<tr>
<td>8. It is emphasized that medical staffs should take a firm stand against governing board control of medical staff activities related to patient care.</td>
<td></td>
<td>8. State and local medical societies are urged to supplement AMA’s effort to assist and offer support to organized medical staffs involved in negotiations with governing boards and administrations.</td>
</tr>
<tr>
<td>9. State and local medical societies are urged to supplement AMA’s effort to assist and offer support to hospital medical staffs involved in negotiations with governing boards and administrations.</td>
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**Hospital Admissions by Allied Health Professionals**

Only physicians and surgeons with staff privileges may admit patients. Allied health professional services may be available, within limits of skill and law, only under direction and supervision of a member of the medical staff qualified in that field. Such services are to be under direction of the department or section responsible for that type of service.

Prior to 1990
Edited 1998

*Retain, policy is still relevant.*

**Hospital Medical Staff Credentialing of Physicians who Provide Electronic and Other Telemedicine Services for Hospital Patients**

Board Action Report #3, 1997
HOD, Res29-3

*Retain, policy is still relevant.*
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<tr>
<td>MSMS supports the requirement of physicians who provide diagnostic or therapeutic services on a regular, ongoing or contractual basis via electronic or other communications to patients in a hospital setting within Michigan to be fully credentialed by that hospital's medical staff in accordance with the medical staff bylaws. MSMS supports the requirement of physicians who provide diagnostic or therapeutic services on a regular ongoing or contractual basis to patients in a hospital setting within Michigan solely via electronic or other distant communications (and so would not otherwise ever have any direct personal interaction with the remainder of the medical staff) be credentialed as active members of that hospital's medical staff and be held to the same standards of requisite responsibilities as other active members of the medical staff.</td>
<td>96A, Res97-96A, &amp; Res98-96A</td>
<td></td>
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<tr>
<td>Medical Doctors and Department Heads of Hospital Staffs</td>
<td>Prior to 1990Edited 1998</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td>It is inappropriate for hospital medical departments in acute care general hospitals to be chaired by persons other than licensed physicians or, when appropriate, dentists.</td>
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<tr>
<td>Medical Staff Reappointment</td>
<td>Prior to 1990</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td>Reappointment of doctors to the active medical staff should not be denied except for medical ineptitude, character deficiency or conviction of unethical conduct, revocation of license by the state, or violation of the hospital medical staff bylaws that have been approved by the medical staff.</td>
<td></td>
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<tr>
<td>Oppose Mandatory “Hospitalist” Care</td>
<td>Res15-99A</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td>MSMS opposes mandatory requirements that a patient’s physician turn over inpatient care to “hospitalists.”</td>
<td></td>
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<tr>
<td>Qualifications for Chief of Medical Staff</td>
<td>Res12-97A</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td>MSMS encourages medical staffs to include in their bylaws a provision that all physicians be eligible for election to chief of staff unless the physicians serve in a major medical administrative position at the hospital.</td>
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<tr>
<td>Unfair Competition by Non-profit and Tax-exempt Organizations</td>
<td>Prior to 1990</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td>MSMS opposes the unfair privilege of non-profit and tax-exempt organizations providing medical care in competition with the private and taxed physicians providing the same services.</td>
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<td>Administration of Immunizations</td>
<td>Prior to 1990</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td>The immunization of children and adults for prophylaxis against</td>
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<td>infectious diseases is best performed at the direction of physicians</td>
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<td>involved in continuing care of the individual, taking into account</td>
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<td>the risks and benefits accruing to the individual. A concerted</td>
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<td>effort should be made by physicians to ensure that patients begin</td>
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<td>pediatric immunizations at the earliest medically appropriate time</td>
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<td>and that patients finish their series. Guidelines and schedules</td>
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<td>produced by scientific groups and/or governmental agencies, while</td>
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<td>often helpful, should not be regarded as overriding the exercise of</td>
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<td>informed decision-making by the physician where the welfare of his</td>
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<td>or her patient is involved. Recognizing that circumstances occur in</td>
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<td>which immunization should be given under other auspices, the common</td>
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<td>good should be served with due regard for the concerns of the</td>
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<td>individual. Immunization programs thus carried out under other</td>
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<td>auspices should be developed with appropriate input from physicians</td>
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<td>and in concert with the laws regulating medical practice. Mass</td>
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<td>programs should, to the greatest possible degree, defer to</td>
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<td>successful and affordable approaches to immunization, which do not</td>
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<td>remove individuals from regular sources of care and should not</td>
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<tr>
<td>scatter the individual’s immunization record. A uniform statewide</td>
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<tr>
<td>record should be utilized and the parent/guardian should be</td>
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<tr>
<td>provided with a cumulative copy of the record. An entry should be</td>
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<td>made into this record at the time of each immunization.</td>
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<tr>
<td>Immunizations and Preventive Health Care for Children</td>
<td>Res91-90A and 54-92A</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td>MSMS supports coverage for preventative health care visits and</td>
<td>Edited 1998</td>
<td></td>
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<tr>
<td>immunizations for all children. MSMS also supports immunization</td>
<td>Reaffirmed w/Res56-01A</td>
<td></td>
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<tr>
<td>records being kept by the child’s physician, parents and schools.</td>
<td></td>
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<tr>
<td>Insurance Coverage for Immunizations</td>
<td>Board Action Report #3, 2009</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td>MSMS urges employers to provide health coverage that includes</td>
<td>HOD, Res27-08A</td>
<td></td>
</tr>
<tr>
<td>coverage of all immunizations that are recommended by the Centers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>for Disease Control and the Advisory Committee on Immunization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practices for persons living in the U.S.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policy</td>
<td>Year</td>
<td>Recommendation</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>----------------</td>
<td>---------------------------------------------------------------------</td>
</tr>
<tr>
<td>Mandatory Immunizations: Physicians Held Harmless</td>
<td>Prior to 1990</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td>MSMS supports physicians being held harmless in the event of a malocurrence not involving negligence encountered during the administration of immunization to patients as required by federal or state governmental agencies.</td>
<td>Edited 1998</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td>Priority Vaccine Distribution to Physician Offices</td>
<td>Res65-10A</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td>MSMS supports physicians receiving their orders for seasonal vaccine before delivery to non-medical venues or retail/urgent care clinics.</td>
<td></td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td>Universal Access to Child Immunizations</td>
<td>Board-Nov93</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td>MSMS supports a policy of universal access to immunizations for all Michigan children. It further supports a strategy whereby the immunizations are purchased by the state at the lowest possible price and made available to all health care providers administering immunizations.</td>
<td></td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td>Elimination of Informed Consent for HIV Testing</td>
<td>Res2-92A &amp;</td>
<td>Retain, policy is still relevant, but modify to read as follows:</td>
</tr>
<tr>
<td>MSMS supports (1) elimination of the informed consent requirements for HIV testing and (2) the ability of physicians to perform HIV tests on patients as they feel it is appropriate for proper medical management of the patient.</td>
<td>Res95-92A</td>
<td>Elimination of Mandatory Consent for HIV Testing</td>
</tr>
<tr>
<td>Reaffirmed</td>
<td>Reaffirmed</td>
<td>MSMS supports (1) elimination of mandatory informed consent</td>
</tr>
<tr>
<td></td>
<td>w/Res98-01A</td>
<td>requirements for HIV testing and (2) the ability of physicians to</td>
</tr>
<tr>
<td></td>
<td>Reaffirmed</td>
<td>perform HIV tests on patients, as indicated by their medical</td>
</tr>
<tr>
<td></td>
<td>w/Board-Oct2009</td>
<td>judgement, for proper</td>
</tr>
<tr>
<td></td>
<td></td>
<td>medical management of the patient.</td>
</tr>
<tr>
<td>Policy</td>
<td>Year</td>
<td>Recommendation</td>
</tr>
<tr>
<td>------------------------------------------------------------</td>
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</tr>
<tr>
<td><strong>MSMS Position on Informed Consent</strong></td>
<td></td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td>MSMS strongly endorses the principle of informed consent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>for medical treatment. Patients have a right to participate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>in decisions regarding their health care to the extent that</td>
<td></td>
<td></td>
</tr>
<tr>
<td>they wish; and they have a right to the information</td>
<td></td>
<td></td>
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<tr>
<td>necessary for meaningful participation. However, a right</td>
<td></td>
<td></td>
</tr>
<tr>
<td>to the information necessary to participate to the extent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>that the patient desires does not imply that patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>should be forced to accept information deemed relevant by</td>
<td></td>
<td></td>
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<tr>
<td>an outside party. Respect for patient’s rights entails</td>
<td></td>
<td></td>
</tr>
<tr>
<td>respecting a patient’s desires to receive or not receive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>particular items of information. In order to respect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>patients’ rights in a compassionate manner, information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>disclosure should be tailored to the particular needs and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>desires of the particular patient. MSMS opposes regulatory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>interference in the physician-patient relationship, either</td>
<td></td>
<td></td>
</tr>
<tr>
<td>to prohibit the physician from discussing certain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>information, or requiring that certain information be</td>
<td></td>
<td></td>
</tr>
<tr>
<td>disclosed in all cases regardless of patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>circumstances. MSMS also believes that current law</td>
<td></td>
<td></td>
</tr>
<tr>
<td>requires informed consent for all medical treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and offers adequate recourse if consent is not</td>
<td></td>
<td></td>
</tr>
<tr>
<td>obtained. Therefore, the Society sees no need for specific</td>
<td></td>
<td></td>
</tr>
<tr>
<td>legislation mandating informed consent for particular</td>
<td></td>
<td></td>
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<tr>
<td>procedures or diseases.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Board-Sept91</td>
<td></td>
</tr>
<tr>
<td><strong>Educational Commission for Foreign Medical Graduates</strong></td>
<td>Res63-94A</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td>(ECFMG) Credentials Verification</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Educational Commission for Foreign Medical Graduates</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ECFMG) verification should be the primary source for</td>
<td></td>
<td></td>
</tr>
<tr>
<td>granting permanent state licensing and hospital privileges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>for international medical graduates.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Res98-90A</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td><strong>Equality of Graduates of Foreign Medical Schools</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSMS is concerned and sensitive toward issues facing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>international medical graduates in Michigan. It will work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>with the AMA to provide, profess and propagate its</td>
<td></td>
<td></td>
</tr>
<tr>
<td>intention to work for equality of IMGs with United States</td>
<td></td>
<td></td>
</tr>
<tr>
<td>medical graduates in training and work places.</td>
<td>Amended 1993</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Edited 1998</td>
<td></td>
</tr>
<tr>
<td>Policy</td>
<td>Year</td>
<td>Recommendation</td>
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<tr>
<td>----------------------------------------------------------------------</td>
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<td>---------------------------------</td>
</tr>
<tr>
<td><strong>J1 Visa Waivers for Specialists</strong></td>
<td>Res5-05A</td>
<td><em>Retain, policy is still relevant.</em></td>
</tr>
<tr>
<td>MSMS supports the distribution of J1 Visa waivers between primary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>care and specialists depending on their own need.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Selection of Residents Based on Skills and Qualifications</strong></td>
<td>Res58-96A</td>
<td><em>Retain, policy is still relevant.</em></td>
</tr>
<tr>
<td>MSMS opposes policies that discriminate against international</td>
<td></td>
<td></td>
</tr>
<tr>
<td>medical graduates for postgraduate medical training programs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Visa Status Changes for International Medical Graduates</strong></td>
<td>Res22-95A</td>
<td><em>Retain, policy is still relevant.</em></td>
</tr>
<tr>
<td>MSMS supports the position that IMG resident physicians with H-1B</td>
<td></td>
<td></td>
</tr>
<tr>
<td>status be allowed to keep their H-1B visas for the duration of their</td>
<td></td>
<td></td>
</tr>
<tr>
<td>current graduate medical education in the United States.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Laboratory as a Medical Practice</strong></td>
<td>Prior to 1990</td>
<td><em>Retain, policy is still relevant.</em></td>
</tr>
<tr>
<td>The operation of a medical laboratory represents the practice of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>medicine and should be actively supervised and directed by a licensed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>physician.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Educational Loans-Physician Licensure</strong></td>
<td>Board-Nov97</td>
<td><em>Retain, policy is still relevant.</em></td>
</tr>
<tr>
<td>MSMS opposes using non-payment of student loans to place physicians'</td>
<td></td>
<td></td>
</tr>
<tr>
<td>licensure at risk.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Examination for State Re-licensure</strong></td>
<td>Res41-96A</td>
<td><em>Retain, policy is still relevant.</em></td>
</tr>
<tr>
<td>MSMS opposes mandatory examination for re-licensure by the state of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Michigan except for re-licensure after forfeiture of the original</td>
<td></td>
<td></td>
</tr>
<tr>
<td>license.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Fees to be Returned</strong></td>
<td>Prior to 1990</td>
<td><em>Retain, policy is still relevant.</em></td>
</tr>
<tr>
<td>All medical licensing fees should be returned to the Michigan Board</td>
<td></td>
<td></td>
</tr>
<tr>
<td>of Medicine.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Interstate Practice of Medicine</strong></td>
<td>Board Action Report #3, 1997</td>
<td><em>Retain, policy is still relevant.</em></td>
</tr>
<tr>
<td>patients to be fully licensed by the state of Michigan; however,</td>
<td>Res98-96A</td>
<td></td>
</tr>
<tr>
<td>MSMS does support occasional and irregular medical consultations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>that are requested by out-of-state physicians who are not licensed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>in the state of Michigan. MSMS policy is that an out-of-state</td>
<td></td>
<td></td>
</tr>
<tr>
<td>physician treating a patient within Michigan be subject to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>jurisdiction at the patient's location.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Language Fluency as Requirement for Licensure</strong></td>
<td>Res57-92A Edited 1998</td>
<td><em>Retain, policy is still relevant.</em></td>
</tr>
<tr>
<td>MSMS opposes requiring individuals to pass a spoken English proficiency test to receive a medical license in Michigan.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Licensing Non-physicians</strong></td>
<td>Res30-90A Amended 1993 Edited</td>
<td><em>Retain, policy is still relevant.</em></td>
</tr>
<tr>
<td>MSMS opposes extending to non-physicians the right to practice</td>
<td>1998</td>
<td></td>
</tr>
<tr>
<td>medicine or surgery without physician supervision.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policy</td>
<td>Year</td>
<td>Recommendation</td>
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<tr>
<td>-----------------------------------------------------------------------</td>
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</tr>
<tr>
<td><strong>Licensure for Health Plan Medical Directors</strong></td>
<td>Board-Sept98</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td>MSMS supports licensure by the state of Michigan for health plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>medical directors, even if they are located outside of the state of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Michigan and are not engaged in active clinical practice.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Licensure of Medical Technologists</strong></td>
<td>Board-July97</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td>MSMS opposes licensure of medical technologists.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pharmacy Licensing Fee</strong></td>
<td>Res59-90A Edited 1998</td>
<td>Sunset policy. The need for this policy is moot as</td>
</tr>
<tr>
<td>MSMS opposes the physician pharmacy license fee in Michigan.</td>
<td></td>
<td>Michigan has required a separate license for</td>
</tr>
<tr>
<td></td>
<td></td>
<td>dispensing prescribers for more than 25 years. All</td>
</tr>
<tr>
<td></td>
<td></td>
<td>licensed physicians, podiatrists, optometrists,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>dentists, and physician’s assistants who wish to</td>
</tr>
<tr>
<td></td>
<td></td>
<td>dispense prescription drugs must obtain a drug</td>
</tr>
<tr>
<td></td>
<td></td>
<td>control license for each location in which the</td>
</tr>
<tr>
<td></td>
<td></td>
<td>storage and dispensing of prescription drugs occur.</td>
</tr>
<tr>
<td>**Suspension of a Physician’s License Following Conviction of a</td>
<td>Res5-95A</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td>Misdemeanor Involving Possession or Use of Alcohol**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSMS is opposed to the discriminatory summary suspension of health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>professionals’ licenses or registrations upon their conviction for a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>misdemeanor involving alcohol.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Definition of Nursing Home</strong></td>
<td>Prior to 1990</td>
<td>Sunset policy. This policy is no longer relevant as</td>
</tr>
<tr>
<td>MSMS believes a nursing home should be a facility providing in-</td>
<td>Edited 1998</td>
<td>the Michigan Public Health Code defines nursing</td>
</tr>
<tr>
<td>patient care for persons requiring nursing care and related services</td>
<td></td>
<td>homes in MCL 333.20109. (1) “Nursing home” means a</td>
</tr>
<tr>
<td>not available at home, but not requiring the services of acute</td>
<td></td>
<td>nursing care facility, including a county medical</td>
</tr>
<tr>
<td>general hospital care.</td>
<td></td>
<td>care facility, that provides organized nursing care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>and medical treatment to 7 or more unrelated</td>
</tr>
<tr>
<td></td>
<td></td>
<td>individuals suffering or recovering from illness,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>injury, or infirmity. As used in this subsection,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“medical treatment” includes treatment by an employee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>or independent contractor of the nursing home who is</td>
</tr>
<tr>
<td></td>
<td></td>
<td>an individual licensed or otherwise authorized to</td>
</tr>
<tr>
<td></td>
<td></td>
<td>engage in a health profession under part 170 or</td>
</tr>
<tr>
<td></td>
<td></td>
<td>175. Nursing home does not include any of the</td>
</tr>
<tr>
<td></td>
<td></td>
<td>following:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(a) A unit in a state correctional facility.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(b) A hospital.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(c) A veterans facility created under 1885 PA 152,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MCL 36.1 to 36.12.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(d) A hospice residence that is licensed under this</td>
</tr>
<tr>
<td></td>
<td></td>
<td>article.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(e) A hospice that is certified under 42 CFR 418.100</td>
</tr>
<tr>
<td>**No Cardiopulmonary Resuscitation (CPR) Orders in Adult Foster</td>
<td>Res24-97A</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td>Care and Assisted Living Settings**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSMS supports do-not-resuscitate orders, as well as other advanced</td>
<td></td>
<td></td>
</tr>
<tr>
<td>directives, for residents of adult foster care facilities, nursing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>homes and other non-hospital settings.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policy</td>
<td>Year</td>
<td>Recommendation</td>
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<td>-------------------------------------------------</td>
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</tr>
<tr>
<td><strong>Separation of Physician Services from Day Rates</strong>&lt;br&gt; All fees for physicians’ services and medicines should be kept entirely separate from day rates for nursing home care, since the establishment of an all-inclusive rate might lead to poor and inadequate medical care and tend to separate the patient from his/her physician.</td>
<td>Prior to 1990</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td><strong>Shortage of Nursing Home Beds</strong>&lt;br&gt; MSMS supports attempts to resolve the shortage of basic and skilled nursing home beds.</td>
<td>Res89-90A, Edited 1998</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td><strong>Therapeutic Intervention</strong>&lt;br&gt; MSMS supports regulations regarding therapeutic interventions for nursing home patients accommodating patient and family choice for treatment of an individual on a case by case basis.</td>
<td>Res92-96A</td>
<td>Retain, policy is still relevant.</td>
</tr>
</tbody>
</table>
**RESOLUTIONS BY COMMITTEE**

**REFERENCE COMMITTEE D – PUBLIC HEALTH**

<table>
<thead>
<tr>
<th>RESOLUTION</th>
<th>DESCRIPTION</th>
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</thead>
<tbody>
<tr>
<td>46-20</td>
<td>Depression Screening in Adolescents after Sport-Related Concussion</td>
</tr>
<tr>
<td>61-20</td>
<td>9-1-1 Dispatcher Telephone CPR Training</td>
</tr>
<tr>
<td>11-21</td>
<td>Updates to Organ Donation and Transplant Policies</td>
</tr>
<tr>
<td>24-21</td>
<td>Improved Outreach to Minority Communities Regarding the COVID-19 Vaccine</td>
</tr>
<tr>
<td>25-21</td>
<td>Public Health Considerations to Reduce Harm in Encampment Removals</td>
</tr>
<tr>
<td>35-21</td>
<td>COVID-19 Vaccine Distribution Regarding People Experiencing Homelessness</td>
</tr>
</tbody>
</table>
Whereas, the estimated lifetime prevalence of concussion in middle school and high school students is 20 percent, and

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

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

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

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

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

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

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

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

Whereas, the Patient Health Questionnaire Modified for Teens (PHQ-9) is a rating scale used for depression screening in adolescents age 12-18 and its use is supported by the American Academy of Child and Adolescent Psychiatry; therefore be it
RESOLVED: That MSMS supports the screening of student athletes participating in Michigan High School Athletic Association sports for depression after concussion by physicians, physician assistants, or nurse practitioners using a screening tool such as the Patient Health Questionnaire Modified for Teens; and be it further

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

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

Relevant MSMS Policy:
None

Relevant AMA Policy:

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

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

3. Our AMA will work with interested agencies and organizations to: (a) identify harmful practices in the sports training of children and adolescents; (b) support the establishment of appropriate health standards for sports training of children and adolescents; (c) promote evidenced-based educational efforts to improve knowledge and understanding of concussion and other sport injuries among youth athletes, their parents, coaches, sports officials, school personnel, health professionals, and athletic trainers; and (d) encourage further research to determine the most effective educational tools for the prevention and management of pediatric/adolescent concussions.

4. Our AMA supports (a) requiring states to develop and revise as necessary, evidenced-based concussion information sheets that include the following information: (1) current best practices in the prevention of concussions, (2) the signs and symptoms of concussions, (3) the short-and long-term impact of mild, moderate, and severe head injuries, and (4) the procedures for allowing a student athlete to return to athletic activity; and (b) requiring parents/guardians and students to sign concussion information sheets on an annual basis as a condition of their participation in sports.

**Sources:**


15. MHSAA PROTOCOL FOR IMPLEMENTATION OF NATIONAL FEDERATION SPORTS PLAYING RULES FOR CONCUSSIONS.; 2016.
17. Psychiatry AA of C and A. Resources for Clinicians.
RESOLUTION 61-20

Title: 9-1-1 Dispatcher Telephone CPR Training

Introduced by: Mara Darian, for the Medical Student Section

Original Author: Erin Lee Currey

Referred To: Reference Committee D

House Action:

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

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

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

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

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

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

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

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

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

Relevant MSMS Policy:
None

Relevant AMA Policy:
Cardiopulmonary Resuscitation (CPR) and Defibrillators H-130.938

Our AMA:
(1) supports publicizing the importance of teaching CPR, including the use of automated external defibrillation;
(2) strongly recommends the incorporation of CPR classes as a voluntary part of secondary school programs;
(3) encourages the American public to become trained in CPR and the use of automated external defibrillators;
(4) advocates the widespread placement of automated external defibrillators, including on all grade K-12 school campuses and locations at which school events are held;
(5) encourages all grade K-12 schools to develop an emergency action plan for sudden cardiac events;
(6) supports increasing government and industry funding for the purchase of automated external defibrillator devices;
(7) endorses increased funding for cardiopulmonary resuscitation and defibrillation training of community organization and school personnel;
(8) supports the development and use of universal connectivity for all defibrillators;
(9) supports legislation that would encourage high school students be trained in cardiopulmonary resuscitation and automated external defibrillator use;
(10) will update its policy on cardiopulmonary resuscitation and automated external defibrillators (AEDs) by endorsing efforts to promote the importance of AED use and public awareness of AED locations, by using solutions such as integrating AED sites into widely accessible mobile maps and applications;
(11) urges AED vendors to remove labeling from AED stations that stipulate that only trained medical professionals can use the defibrillators; and
(12) supports consistent and uniform legislation across states for the legal protection of those who use AEDs in the course of attempting to aid a sudden cardiac arrest victim.

Sources:
Title: Updates to Organ Donation and Transplant Policies

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

Original Author: Richard Burney, MD

Referred To: Reference Committee D

House Action:

Whereas, living donation provides expanded access to kidney and liver transplants to appropriate candidates, preventing waitlist death and in turn increasing organ availability of other candidates to deceased donor transplants, and

Whereas, living donors often face considerable financial hardships to facilitate donation, including time off employment and travel expenses, which are not able to be directly reimbursed by law, and

Whereas, the Gift of Life Michigan is the state’s only federally designated organ and tissue recovery program, and

Whereas, the Gift of Life Michigan recovers organs from HIV-positive donors, in accordance with the federal HIV Organ Policy Equity Act, or HOPE Act, and

Whereas, in Michigan, policy that was created decades ago during the AIDS crisis prohibits blood and other anatomical gifts from HIV-positive donors to be given to recipients, even those who are HIV-positive, and

Whereas, proposed legislation in Michigan would remove this outdated restriction on organs and as a result, those organs could go to HIV-positive patients, instead of being allocated out-of-state, and

Whereas, transplant programs that do not have waiting recipients who are HIV-positive also will benefit, because more available organs relieves pressure on the waiting list in-state and nationwide; therefore be it

RESOLVED: That MSMS amend MSMS policy, “Payment for Organs,” by addition to read as follows:

MSMS opposes payment in any form to the donor, the donor’s family members, or the donor’s agents for organs used for transplant. Payment does not mean provisions for donation-related expenses incurred by a living organ donor including, but not limited to medical expenses related to the donation or expenses incurred after the donation as a consequence of donation; and be it further
RESOLVED: That MSMS actively advocate for and endorse legislation in Michigan that would enable organ transplants from HIV-positive donors to HIV-positive recipients.

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

STATEMENT OF URGENCY: There is current legislation (sponsor Rep. Felicia Brabec) pending in the Michigan legislature related to organ donation and transplant policies. This is a joint advocacy opportunity supported by the Gift of Life Michigan.

Relevant MSMS Policy:

Payment for Organs
MSMS opposes payment in any form to the donor, the donor’s family members, or the donor’s agents for organs used for transplant. (Res5-93A)

Relieve Burden for Living Organ Donors
MSMS supports efforts to remove financial barriers to living organ donation, such as the provision of paid leave for organ donation. (Res61-17)

Relevant AMA Policy:

6.1.1 Transplantation of Organs from Living Donors
Donation of nonvital organs and tissue from living donors can increase the supply of organs available for transplantation, to the benefit of patients with end-stage organ failure. Enabling individuals to donate nonvital organs is in keeping with the goals of treating illness and relieving suffering so long as the benefits to both donor and recipient outweigh the risks to both.

Living donors expose themselves to harm to benefit others; novel variants of living organ donation call for special safeguards for both donors and recipients.

Physicians who participate in donation of nonvital organs and tissues by a living individual should:
(a) Ensure that the prospective donor is assigned an advocacy team, including a physician, dedicated to protecting the donor’s well-being.
(b) Avoid conflicts of interest by ensuring that the health care team treating the prospective donor is as independent as possible from the health care team treating the prospective transplant recipient.
(c) Carefully evaluate prospective donors to identify serious risks to the individual’s life or health, including psychosocial factors that would disqualify the individual from donating; address the individual’s specific needs; and explore the individual’s motivations to donate.
(d) Secure agreement from all parties to the prospective donation in advance so that, should the donor withdraw, his or her reasons for doing so will be kept confidential.
(e) Determine that the prospective living donor has decision-making capacity and adequately understands the implications of donating a nonvital organ, and that the decision to donate is voluntary.
(f) In general, decline proposed living organ donations from unemancipated minors or legally incompetent adults, who are not able to understand the implications of a living donation or give voluntary consent to donation.
(g) In exceptional circumstances, enable donation of a nonvital organ or tissue from a minor who has substantial decision-making capacity when:
(i) the minor agrees to the donation;
(ii) the minor’s legal guardians consent to the donation;
(iii) the intended recipient is someone to whom the minor has an emotional connection.
(h) Seek advice from another adult trusted by the prospective minor donor when circumstances warrant, or from an independent body such as an ethics committee, pastoral service, or other institutional resource.
(i) Inform the prospective donor:
(i) about the donation procedure and possible risks and complications for the donor;
(ii) about the possible risks and complications for the transplant recipient;
(iii) about the nature of the commitment the donor is making and the implications for other parties;
(iv) that the prospective donor may withdraw at any time before undergoing the intervention to remove the organ or collect tissue, whether the context is paired, domino, or chain donation; and
(v) that if the donor withdraws, the health care team will report simply that the individual was not a suitable candidate for donation.

(j) Obtain the prospective donor’s separate consent for donation and for the specific intervention(s) to remove the organ or collect tissue.

(k) Ensure that living donors do not receive payment of any kind for any of their solid organs. Donors should be compensated fairly for the expenses of travel, lodging, meals, lost wages, and medical care associated with the donation only.

(l) Permit living donors to designate a recipient, whether related to the donor or not.

(m) Decline to facilitate a living donation to a known recipient if the transplantation cannot reasonably be expected to yield the intended clinical benefit or achieve agreed on goals for the intended recipient.

(n) Permit living donors to designate a stranger as the intended recipient if doing so produces a net gain in the organ pool without unreasonably disadvantaging others on the waiting list. Variations on donation to a stranger include:

(i) prospective donors who respond to public solicitations for organs or who wish to participate in a paired donation (“organ swap,” as when donor-recipient pairs Y and Z with incompatible blood types are recombined to make compatible pairs: donor-Y with recipient-Z and donor-Z with recipient-Y);
(ii) domino paired donation;
(iii) nonsimultaneous extended altruistic donation (“chain donation”).

(o) When the living donor does not designate a recipient, allocate organs according to the algorithm that governs the distribution of deceased donor organs.

(p) Protect the privacy and confidentiality of donors and recipients, which may be difficult in novel donation arrangements that involve many patients and in which donation-transplant cycles may be extended over time (as in domino or chain donation).

(q) Monitor prospective donors and recipients in proposed nontraditional donation arrangements for signs of psychological distress during screening and after the transplant is complete.

(r) Support the development and maintenance of a national database of living donor outcomes to support better understanding of associated harms and benefits and enhance the safety of living donation.

AMA Principles of Medical Ethics: I, V, VII, VIII

6.2.2 Directed Donation of Organs for Transplantation

Efforts to increase the supply of organs available for transplant can serve the interests of individual patients and the public and are in keeping with physicians’ obligations to promote the welfare of their patients and to support access to care. Although public solicitations for directed donation—that is, for donation to a specific patient—may benefit individual patients, such solicitations have the potential to adversely affect the equitable distribution of organs among patients in need, the efficacy of the transplant system, and trust in the overall system.

Donation of needed organs to specified recipients has long been permitted in organ transplantation. However, solicitation of organs from potential donors who have no pre-existing relationship with the intended recipient remains controversial. Directed donation policies that produce a net gain of organs for transplantation and do not unreasonably disadvantage other transplant candidates are ethically acceptable.

Physicians who participate in soliciting directed donation of organs for transplantation on behalf of their patients should:

(a) Support ongoing collection of empirical data to monitor the effects of solicitation of directed donations on the availability of organs for transplantation.
(b) Support the development of evidence-based policies for solicitation of directed donation.
(c) Ensure that solicitations do not include potentially coercive inducements. Donors should receive no payment beyond reimbursement for travel, lodging, lost wages, and the medical care associated with donation.

(d) Ensure that prospective donors are fully evaluated for medical and psychosocial suitability by health care professionals who are not part of the transplant team, regardless of any relationship, or lack of relationship, between prospective donor and transplant candidate.

(e) Refuse to participate in any transplant that he or she believes to be ethically improper and respect the decisions of other health care professionals should they choose not to participate on ethical or moral grounds.

AMA Principles of Medical Ethics: VII, VIII, IX

Removing Financial Barriers to Living Organ Donation H-370.965

1. Our AMA supports federal and state laws that remove financial barriers to living organ donation, such as:
   (a) provisions for expenses involved in the donation incurred by the organ donor; (b) providing access to health care coverage of any medical expense related to the donation; (c) provisions for expenses incurred after the donation as a consequence of donation; (d) prohibiting employment discrimination on the basis of living donor status; (e) prohibiting the use of living donor status as the sole basis for denying or limiting health, life, and disability and long-term care insurance coverage; and (f) provisions to encourage paid leave for organ donation.

2. Our AMA supports legislation expanding paid leave for organ donation.

3. Our AMA advocates that live organ donation surgery be classified as a serious health condition under the Family and Medical Leave Act.

Sources:


2. https://www.giftoflifemichigan.org/about-us

Title: Improved Outreach to Minority Communities Regarding the COVID-19 Vaccine

Introduced by: Alangoya Tezel, for the Medical Student Section

Original Author: Sarosh Irani, Hannah Kimmel, Kayla Meyer, and Eric Rosen

Referred To: Reference Committee D

House Action:

Whereas, numerous historic bioethical violations of trust have been enacted upon minority communities by medical institutions in human subjects research, and

Whereas, such violations of trust include the U.S. Public Health Service Syphilis Study at Tuskegee, gynecological experimentation without anesthesia by J. Marion Sims, MD, and the HeLa cell line borne from cells unknowingly and non-consensually taken from Henrietta Lacks by researchers at Johns Hopkins Hospital, which particularly harm the relationship between the African-American/Black community and medical institutions, and

Whereas, these violations are the backdrop to present-day racial discrimination, false racial beliefs, and inequitable medical care allocation, access, and quality of care received by minority communities, furthering the need for medical and governmental institutions to earn the trust of Black and Latinx patients, and

Whereas, data has shown that COVID-19 hospitalization rates have been at least 2.5 times higher in minority populations, and

Whereas, minority population tend to be overrepresented in occupations that are considered "frontline," and therefore at higher risk of contracting COVID-19, and

Whereas, this discrepancy is rooted in years of inequality in housing, transportation, and health care, and

Whereas, a September 2020 study by the NAACP and the COVID Collaborative that two of three in the Black community believe "the government can rarely/never be trusted to look after their interests" and that knowledge of the Tuskegee Syphilis Study is a negative predictor of vaccine uptake, and

Whereas, this same study found that only 14 percent of Black Americans and 34 percent of Latinx Americans "mostly or completely trust that a vaccine will be safe," and

Whereas, a December 2020 survey found that while 58 percent of white Michigan voters plan to get the vaccine, only 33 percent of Black respondents intend to get the vaccine, with 26.1 percent saying "it depends," and
Whereas, the Minnesota Immunization Networking Initiative (MINI) successfully reached vulnerable communities to administer influenza vaccines through building relationships with community leaders, especially in faith communities, and holding clinics in these community-based settings, and

Whereas, similar strategies were implemented in the vaccine development stage to actively recruit and involve populations most affected by COVID-19, specifically racial and ethnic minorities, and

Whereas, the Michigan COVID-19 Vaccination Plan has already addressed key partners for critical populations to engage, including school-based health centers, faith-based leaders, and other services where minority populations in Michigan reside and gather; therefore be it

RESOLVED: That MSMS will encourage evidence-based, community-driven interventions to build trust between minority populations and health care institutions with increased urgency, given the COVID-19 pandemic underscoring the disproportionate impact of longstanding historical violations of trust; and be it further

RESOLVED: That MSMS will support the implementation of proven community-centered strategies, such as collaboration with faith and school-based leaders, for education and dissemination of information, specifically as it pertains to promotion of COVID-19 vaccination uptake and vaccine education to minority populations; and be it further

RESOLVED: That MSMS supports community-centered strategies for annual vaccination efforts, including influenza and childhood vaccine outreach.

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

Relevant MSMS Policy:

MSMS Task Force on Implicit Bias and Health Disparities
Problem Statement: As leaders of change, physicians must be introspective and examine their own unconscious biases, including how those biases may inadvertently influence care decisions, as well as the systemic barriers to health equity within their places of employment and the system as a whole. Collective action is necessary to address institutional factors and social determinants that are roadblocks to achieving true health equity.
Goal: To eliminate health disparities by pursuing health equity throughout society by direct engagement with policymakers, medical schools, health care leaders, members, and other stakeholders to advance policies that lead to a more diverse physician workforce, greater cultural awareness, mitigation of social determinants of health, and transparent and equitable organizational structures.

Relevant AMA Policy:
None

Sources:


Title: Public Health Considerations to Reduce Harm in Encampment Removals

Introduced by: Mara Darian, for the Medical Student Section

Original Authors: Jennifer Byk, Arjun Chadha, Zoey Chopra, Sanjay Das, Moustafa Hadi, Sarosh Irani, Jessyca Judge, Man Yee Keung, Remonda Khalil, Darian Mills, Chan Nguyen, Alangoya Tezel, and Melanie Valentin, Will Vander Pols, and Francis Yang

Referred to: Reference Committee D

House Action:

Whereas, 61,832 Michiganders experienced homelessness in 2019, with numbers growing especially in the past year secondary to the pandemic and its economic crisis, with an estimated 250,000 new people expected to join this year nation-wide, and

Whereas, more people are living in urban encampments with growing income inequality and housing insecurity, with up to 26 percent of Michiganders experiencing homelessness in 2018 living in an unsheltered location such as the street or in a tent camp, and

Whereas, people experiencing homelessness already face significant health disparities and are more than twice as likely to have a chronic physical or mental health condition compared to the general U.S. population, and

Whereas, the majority of current encampment closures fail in offering humane options for individuals experiencing homelessness due to a lack of holistic aftercare support that addresses housing, substance use, family reunification, and autonomy and further separates individuals from those resources, and

Whereas, individuals who have experienced abuse or trauma indoors may choose to live in encampments and avoid shelters because they do not want to relive that trauma and that negative experiences with shelters have not been appropriately addressed by current housing initiatives, and

Whereas, police and sanitation departments largely break up encampments primarily on the grounds that they are visually unsightly and not due to public health concerns, and

Whereas, the threat of unannounced encampment sweeps can lead to individuals being hesitant to access medical care, due to the possibility of their belongings and lifesaving medications being confiscated while they are gone, and is “disruptive to people who are attempting to stabilize their lives and find a pathway to housing, and they may have lasting traumatic psychological and emotional impact,” and

Whereas, the U.S. Interagency Council on Homelessness (USICH) stated in 2015, “The forced dispersal of people from encampment settings is not an appropriate solution or strategy ... and can
make it more difficult to provide such lasting solutions to people who have been sleeping and
living in the encampment" and that “government agencies, service providers, [and] law
enforcement ... should work together to understand the needs of those living in an encampment
while assessing the needs of the service providers themselves,” and

Whereas, clearance of encampments “with little or no support may actually reduce the
likelihood that people will seek shelter because it erodes trust and creates an adversarial
relationship between people experiencing homelessness and law enforcement or outreach
workers,” and

Whereas, rather than removing encampments, the focus should be on improving sanitation
of existing sites to mitigate the environmental health issues such as inadequate waste disposal and
unsafe water, and

Whereas, the Center for Disease Control (CDC) guidelines on Interim Guidance on
Unsheltered Homelessness Coronavirus Disease 2019 (COVID-19) for Homeless Service Providers
and Local Officials states that “if individual housing options are not available, allow people who are
living unsheltered or in encampments to remain where they are,” and that “clearing encampments
can cause people to disperse throughout the community” leading to the increase in “potential for
infectious disease to spread,” and

Whereas, a study conducted in Denver showed that the COVID-19 positivity rate was three
times lower for those living in encampments compared to those living in shelters, and the closure
of homeless encampments during the COVID-19 pandemic is straining the capacity of homeless
shelters, disrupting or altogether halting the continuity of necessary medical care by separating
residents from their health care providers and putting more people at risk for transmission and
infection, and

Whereas, other cities have seen success in preventing and managing the spread of
infectious diseases, such as COVID-19, within encampments following guidelines published by the
U.S. Department of Housing and Urban Development, and

Whereas, there have been numerous encampment removals in Detroit, Lansing, and Grand
Rapids since the pandemic began in defiance of CDC guidelines and the Michigan Department of
Health and Human Services,’ which endorsed encampments as the “most immediate reasonable
alternative to congregate shelters” during COVID-19 and warned against clearing of encampments
without a clear plan for housing and transportation of those individuals, and

Whereas, on July 22, 2020, the city of Detroit adopted interim policy for encampment health
and safety concerns that dictates all relocations are done in collaboration with the Housing and
Revitalization Department, Detroit Health Department, and Detroit Police Department to ensure
CDC guidance is being followed and includes direct coordination with unsheltered individuals,
communication and notice for occupant relocation, and outreach staff to help occupants determine
next steps; therefore it be

RESOLVED: That MSMS oppose the removal and relocation of encampments in Michigan
without the involvement of public health departments to mitigate potential risks and harms to
those living in affected encampments, in following with CDC guidelines; and be it further
RESOLVED: That for any planned encampment sweeps, MSMS advocates for the announcement of the planned removal to affected parties with at least 48-hour notice in order to minimize the disruptive and harmful nature of encampment removal on people experiencing homelessness; and be it further

RESOLVED: That MSMS encourage city governments in Michigan to adopt a similar policy and algorithm as established by the city of Detroit to improve existing encampment sanitation and safety and, in the event of public health recommendation of encampment clearance, establish procedures to safely and humanely remove or relocate encampments.

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

Relevant MSMS Policy:
None

Relevant AMA Policy:

Eradicating Homelessness H-160.903
Our AMA:
(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;
(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;
(6) will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians’ role therein, in addressing these needs;
(7) encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;
(8) encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;
(9) (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; and
(10) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods.


Eradicating Homelessness: 440.048MSS
AMA-MSS will ask the AMA to: (1) support improving the health outcomes and decreasing the health care costs of treating the chronically homeless through
housing first approaches; and (2) support the appropriate organizations in developing an effective national plan to eradicate homelessness. MSS Res 33, A-14; Reaffirmed: MSS GC Rep A, I-19

**Housing Provision and Social Support to Immediately Alleviate Chronic Homelessness in the United States: 440.060MSS**

AMA-MSS will ask that our AMA amend policy H-160.903 by addition and deletion to read as follows:

Eradicating Homelessness H-160.903

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) will work with state medical societies to advocate for legislation implementing stable, affordable housing and appropriate voluntary social services as a first priority in the treatment of chronically-homeless individuals, without mandated therapy or services compliance and (3) supports the appropriate organizations in developing an effective national plan to eradicate homelessness. MSS Res 38, I-16; AMA Res 208, A-17

**Opposition to Measures That Criminalize Homelessness: 440.066MSS**

AMA-MSS will ask the AMA to 1) oppose measures that criminalize necessary means of living among homeless persons, including, but not limited to, sitting or sleeping in public spaces; and (2) advocate for legislation that require nondiscrimination against homeless persons, such as homeless bills of rights. MSS Res 410, A-18

**Sources:**
5. Coffey S. Study confirms serious health problems, high trauma rates among unsheltered people in U.S. UCLA. [https://newsroom.ucla.edu/releases/serious-health-conditions-trauma-unsheltered-homeless](https://newsroom.ucla.edu/releases/serious-health-conditions-trauma-unsheltered-homeless) Published October 7, 2019. Accessed February 14, 2021
Title: COVID-19 Vaccine Distribution Regarding People Experiencing Homelessness

Introduced by: Laura Carravallah, MD

Original Authors: Elizabeth Anteau, Donita Barrameda, Tyler Gresham, Aleena Hajek, Rachel Hollander, Laina Weinman, and Laura Carravallah, MD

Referred To: Reference Committee D

House Action:

Whereas, approximately 8,575 people in Michigan experience homelessness on a given day, where homelessness is defined as “a person sleeping in a place not meant for human habitation (e.g. living on the streets, for example) or living in a homeless emergency shelter,” and

Whereas, people experiencing homelessness have limited access to essential hygiene supplies and lack of resources to safely social distance or self-quarantine without having their basic needs threatened, and

Whereas, people experiencing homelessness are at increased risk to contract COVID-19 due to close contact with varying people and are at increased risk for complications due to high rate of underlying health conditions with an estimated peak infection rate of 40 percent and 4.3 percent requiring hospitalization, compared to an estimated infection rate of less than ten percent in the overall United States population, and

Whereas, people experiencing homelessness are more likely to have difficulty accessing medical services/vaccinations traditionally, due to decreased internet, telephone, and/or transportation access, and

Whereas, public health priorities are to prevent COVID-19 outbreaks in facilities and vaccinate those who are not able to maintain social distance, people experiencing homelessness are not included as a specific group in the phases although the workers of the shelter are, and

Whereas, some states such as North Carolina and Rhode Island have specifically listed people who experience homelessness as part of their vaccine distribution strategy prior to distribution to the general population; therefore be it

RESOLVED: That MSMS support the inclusion of people experiencing homelessness in an earlier phase of COVID-19 vaccine distribution by advocating for them to be included as part of phase 1B of the COVID-19 vaccine distribution plan or in an earlier distribution phase than the general population; and be it further

RESOLVED: That MSMS support increased access to vaccines for people experiencing homelessness by advocating for the provision of vaccines at sites easily accessible to people experiencing homelessness such as shelters, food distribution centers, and community centers.
WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions only requesting new or revised MSMS or AMA policy - $500

**Relevant MSMS Policy:**
None

**Relevant AMA Policy:**
None

**Sources:**
## RESOLUTIONS BY COMMITTEE

### REFERENCE COMMITTEE E – SCIENTIFIC AND EDUCATIONAL AFFAIRS

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<td>31-21</td>
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Whereas, the American Academy of Neurology (AAN) has called for uniform brain death laws, policies, and practices, and
Whereas, a specific, uniform standard for declaring brain death is critical for high quality patient-centered neurologic and end-of-life care, as well as for patient and public trust, and
Whereas, the American Neurological Association and the Child Neurology Society have declared their support for this AAN statement position, and
Whereas, brain death is defined as the death of the individual due to irreversible loss of function of the entire brain and is the equivalent of circulatory death, which is due to irreversible loss of function of the circulatory system, which includes the heart, and
Whereas, the 1981 Uniform Determination of Death Act (UDDA) deferred to the medical profession to identify the “accepted medical standards” regarding death determination, the lack of specificity in most states’ laws and inconsistency among institutional brain death protocols has led to differing interpretations by courts, and
Whereas, brain death policies vary considerably between institutions, states, and other governing bodies, and
Whereas, AAN has published evidence-based guideline recommendations to assist clinicians in determining brain death, and
Whereas, the AAN is unaware of a single case where these guidelines failed to accurately declare brain death, and
Whereas, these guidelines function to clarify ambiguity in the UDDA while presenting a uniform evidence-based protocol to declare brain death, and
Whereas, establishing such a uniform protocol will decrease the burden and reliance on individual clinician judgement in determining brain death and will create consistency in practice; therefore be it
RESOLVED: That MSMS support the American Academy of Neurology in their efforts to establish universal brain death protocols; and be it further
RESOLVED: That MSMS support legislation that defers to current adult and pediatric brain death guidelines and any future updates in the declaration of brain death; and be it further

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

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

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

Relevant MSMS Policy:

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

Relevant AMA Policy:
None

Sources:
Title: Vision Qualifications for Driver’s License

Introduced by: Patrick J. Droste, MD, for the Michigan Society of Eye Physicians & Surgeons

Original Author: Patrick J. Droste, MD

Referred To: Reference Committee E

House Action: 

Whereas, current vision qualifications for operating motor vehicles were derived by various states in the 1920s and 1930s, and

Whereas, the American Medical Association (2003) in its Physician's Guide to Assessing and Counseling Older Drivers stated, "Although many states currently require far visual acuity of 20/40 for an unrestricted license, current research indicates that there is no scientific basis for this cut-off. In fact, studies undertaken in some states have demonstrated that there is no increased crash risk between 20/40 and 20/70 resulting in several new state requirements," and

Whereas, good data exists to recommend reconsideration of visual acuity standards in many states, and

Whereas, it has been well known that some persons with reduced acuity continue to drive safely, and

Whereas, persons with significant visual field defects that violate state licensure requirements can be taught to drive safely, and

Whereas, tests for cognitive well-being are generally not used in motor vehicle licensure testing protocols in most states, and

Whereas, denying drivers licensure without evidence to support that denial frequently causes isolation, depression, and increased expenses for ill-advised and unnecessary medical visits, and

Whereas, crash avoidance systems, unimagined one century ago, are routinely incorporated in automotive and roadway systems, and

Whereas, autonomous vehicle technology is in advanced stages of development and has been supported by MSMS, the AMA, and the National Highway Traffic and Safety Administration (NHTSA), and

Whereas, it is well known that a large proportion of mortality involved auto crashes are accompanied by "driver error," and
Whereas, studies have been performed that show that drivers with the visual acuity less than 20/50 can be safe and competent drivers, and

Whereas, the Michigan Society of Eye Physicians and Surgeons (MiSEPS) has submitted a Council Advisory Recommendation (CAR: 21-03) to the American Academy of Ophthalmology (AAO) urging state ophthalmologic societies to approach their legislators to consider reviewing, perhaps relaxing, the visual acuity / visual field requirements for licensure while simultaneously advocating for simple appropriate tests where cognitive decline is suspected; therefore be it

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) urge our AMA to engage with stakeholders including, but not limited to, the American Academy of Ophthalmology, National Highway Traffic Safety Commission, and interested state medical societies, to make recommendations on standardized vision requirements and cognitive testing, when applicable, for unrestricted and restricted driver’s licensing privileges; and be it further

RESOLVED: That MSMS work with the American Medical Association (AMA) in any efforts by our AMA to seek stakeholder engagement to address standardized vision requirements and cognitive testing, when applicable, for unrestricted and restricted driver’s licensing privileges. MSMS shall communicate any resulting recommendations to the Michigan Secretary of State legislative liaison, Michigan legislators serving on committees with oversight of transportation issues, and other stakeholders as appropriate.

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

STATEMENT OF URGENCY: The Michigan Society of Eye Physicians and Surgeons (MiSEPS) has submitted a Council Advisory Recommendation (CAR: 21-03) to the American Academy of Ophthalmology (AAO) urging state ophthalmologic societies to approach their legislators to consider reviewing, perhaps relaxing, the visual acuity/visual field requirements for licensure while simultaneously advocating for simple appropriate tests where cognitive decline is suspected. Timing is everything. Waiting a year to introduce this resolution could be detrimental to harnessing the momentum that could put Michigan at the forefront of addressing this important national health and safety issue. Current vision qualifications for operating motor vehicles were derived with no firm scientific underpinnings by the various states in the 1920s and 1930s and are outdated. This CAR was cosponsored by 10 state and subspecialty societies showing national momentum and support for this effort. At the state level, legislation to update vision qualifications for operating motor vehicles serves the public good. It also offers a good opportunity for stronger relations, increased credibility and capacity building to be better prepared to stand up to potential threats to medically led vision care including the strong potential of a scope challenge by optometry.

Relevant MSMS Policy:
None

Relevant AMA Policy:
8.2 Impaired Drivers & Their Physicians
A variety of medical conditions can impair an individual’s 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 patient’s 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 patient’s 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 patient’s 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 patient’s own well-being and the patient ignores the physician’s 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.

Sources:
2. American Medical Association, (2003) Physicians guide to assessing and counseling older drivers. pp. 1-49. a. Essential Quote: “Although many states currently require far visual acuity for 20/40 for an unrestricted license, current research indicates that there is no scientific basis for this cut-off. In fact, studies undertaken in some states have demonstrated that there is no increased crash risk between 20/40 and 20/70 resulting in several new state requirements” page 45.
3. Rubin, G., Ng, E., et al., (2007) A prospective, population-based study of the role of visual impairment in motor vehicle crashes among older drivers: the SEE Study. (Investigative Ophthalmology & Visual Sciences) 48, (4):1483-1491. a. Essential Quote: “Conclusions: Glare sensitivity, visual field loss and Ufov (useful field of vision) were significant predictors of crash involvement. Acuity, contrast sensitivity and stereo acuity were not associated with crashes. These results suggest that current vision screening for driver’s licensure, based primarily on visual acuity, may miss important aspects of visual impairment.” Owsley, C., Mc Gwin, G., (2010) Vision and driving. (Vision Research) 50:2348-2361. a. Essential Quote: “Based upon the research to date it is clear that if there is an association between visual acuity and driver safety, it is at best weak,...how does one rectify this conclusion in light of the significant findings from performance-based studies? One important consideration in this regard is that visual acuity related driving skill (e.g., sign recognition many not be crucial to the safe operation of a vehicle. Reading signage may be important for route planning or maintaining regulatory compliance with the "rule of the road" but it may not be critical for collision avoidance.” Owsley, C., Wood, J., et al., (2015). A road map for


Carr, D., (2000), The older adult driver. (American Family Physician)


8. MSMS Resolution #8-2019 AMA Resolution #427, June 2019


Whereas, nationwide approximately 200,000 women are in local jails or state prisons, while
16,000 women are in federal jails and prisons, and

Whereas, the length of stay for incarcerated women in Michigan prisons has increased 15.5
percent between the years of 2007 and 2017 and the number of women incarcerated in Michigan
prisons has increased more than 30 percent between the years of 1978 and 2015, and

Whereas, correctional facilities are severely lacking in providing menstrual products for
female-identifying inmates because they have not adapted to their changing population, as women
are the fastest growing population in the U.S. prison system, and

Whereas, the menstrual cycle affects all women of child-bearing age and inadequate access
to feminine hygiene products poses dire medical consequences such as toxic shock syndrome
(TSS), sepsis, and ovarian cancer, and

Whereas, many women have resorted to using makeshift tampons and pads, which can be
unsanitary and dangerous. In 2015, a woman in a Maryland prison developed toxic shock
syndrome as a result of makeshift products which resulted in an emergency hysterectomy, and

Whereas, basic menstrual products are not always available for women in Michigan prisons
and many women often purchase products with their own wages, and

Whereas, a box of eight tampons in Michigan correctional facilities ranges in price from
$4.97 to $7.10, and

Whereas, the average wage for an individual who is incarcerated in Michigan is between 14
to 56 cents per hour, making it nearly infeasible to purchase feminine hygiene products at their
current cost, and

Whereas, only 13 percent of an approximately $2 billion Michigan state corrections facilities
budget is allocated to health care services for inmates, and
Whereas, 73 percent of women in state prisons struggle with mental health disorders, compared to 12 percent in the general population, and the symptoms of these disorders may be perpetuated when access to menstrual health and hygiene products is limited, and

Whereas, the United Nations declares menstrual health and hygiene a basic human right and is prioritized through its Sustainable Development Goals specifically in Goals 5.1, 5.6, and 6.2, and

Whereas, the practice of restricting access to menstrual health products discriminates on the basis of sex, therefore violating the Equal Protection Clause of the Fourteenth Amendment, and

Whereas, women in federal prisons already receive free hygiene products as mandated by the 2018 First Step Act, and

Whereas, MSMS has previously considered reclassifying feminine products from paper products to medical necessities but did not pass the resolution due to a request to make these products purchasable via federally-funded Bridge cards, and

Whereas, the AMA has existing policy H-525.974 Considering Feminine Hygiene Products as Medical Necessities that the AMA will work with federal, state, and specialty medical societies to advocate for the removal of barriers to feminine hygiene products in state and local prisons and correctional institutions to ensure incarcerated women be provided free of charge, the appropriate type and quantity of feminine hygiene products including tampons for their needs; therefore be it

RESOLVED: That MSMS supports access to free menstrual products at all Michigan state and local correctional facilities, regardless of an institution's private, state, or federal funding source.

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

Relevant MSMS Policy:
None

Relevant AMA Policy:

Considering Feminine Hygiene Products as Medical Necessities H-525.974
Our AMA will: (1) encourage the Internal Revenue Service to classify feminine hygiene products as medical necessities; and (2) work with federal, state, and specialty medical societies to advocate for the removal of barriers to feminine hygiene products in state and local prisons and correctional institutions to ensure incarcerated women be provided free of charge, the appropriate type and quantity of feminine hygiene products including tampons for their needs.

Sources:
http://www.canteenservices.com/commissary-purchase-menus/
Whereas, contraceptive vaginal rings and contraceptive patches have been available for
almost 20 years via prescription, and
Whereas, contraceptive rings and patches are documented to have relatively few side
effects, and
Whereas, these contraceptive methods have been linked to reduced rates of ovarian and
endometrial cancer, and
Whereas, these devices are effective forms of contraception with failure rates comparable to
those of combined oral contraceptive pills, and
Whereas, the United States continues to have the highest rates of unintended pregnancy in
the industrialized world, with 54.7 percent of all pregnancies unplanned in 2011, and
Whereas, unintended pregnancies are associated with delays in initiating prenatal care,
reduced likelihood of breastfeeding, increased risk of maternal depression, and increased risk of
physical violence during pregnancy, and
Whereas, reducing the unintended pregnancy rate is a national priority reflected in the
Healthy People 2020 goal, and
Whereas, unintended pregnancies disproportionately affect low-income women, Black
women, and women who have not completed high school, and
Whereas, cost of medical appointments and access to physicians is commonly cited as
barriers to receiving adequate contraceptive care, and
Whereas, the American College of Obstetricians and Gynecologists (ACOG) are in favor of
making all hormonal contraceptives available over the counter as stated in committee opinion 788,
and
Whereas, MSMS has already supported the ACOG Committee Opinion 544, to make oral
contraceptives available over the counter; therefore be it
RESOLVED: That MSMS supports the American College of Obstetricians and Gynecologists Committee policy to allow contraceptive vaginal rings and contraceptive patches to be available over the counter.

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

Relevant MSMS Policy:

**Oral Contraceptives Available Over-the-Counter**

MSMS supports the American College of Obstetricians and Gynecologists’ committee opinion 544 which supports making oral contraceptives available as over the counter medication. (Res95-16)

**Over the Counter Contraception (The Morning After Pill)**

MSMS supports the concept of making the “morning after” contraceptive pill an over the counter medication. (Res6--06A)

Relevant AMA Policy:

**Over-the-Counter Access to Oral Contraceptives D-75.995**

Our AMA:
1. Encourages manufacturers of oral contraceptives to submit the required application and supporting evidence to the US Food and Drug Administration for the Agency to consider approving a switch in status from prescription to over-the-counter for such products.
2. Encourages the continued study of issues relevant to over-the-counter access for oral contraceptives.

Sources:
Whereas, the 2018 State of Homelessness Annual Report cited there were more than 10,700 people that experienced homelessness in the Detroit continuum in 2018 with 2,231 of them being chronically homeless, and

Whereas, in a given year, homeless individuals are three times more likely to utilize emergency room services than housed individuals and are more likely to be readmitted to inpatient services, and

Whereas, when persons experiencing homelessness are hospitalized, they have longer lengths of stay than housed patients and thus have increased medical costs, and

Whereas, homeless patients are often discharged into a setting, such as a homeless shelter or back on the streets, where they cannot receive adequate care for their medical needs, and

Whereas, medical respite programs are centers staffed by health care providers and nurses that provide medical care and housing to homeless patients who are too sick to be in a shelter or on the streets, but not sick enough to require an inpatient stay, and

Whereas, there are a total of 65 medical respite programs in the United States and 3 respite programs in Michigan located in Detroit, Pontiac, and Ann Arbor, with a total of only 45, 15, and 6 beds, respectively, and

Whereas, access to care in a medical respite center is restricted by limited beds and resources, as well as specific program eligibility requirements, including that patients must be independently mobile, patients have a condition that can be addressed within a relatively short time, and patients must be able to perform their own activities of daily living, and

Whereas, the majority of medical respite programs receive funding from three or more sources, the majority sourced from hospitals and private donations, and 18 percent of programs receive public funding through Medicaid/Medicare, and

Whereas, medical respite care for homeless patients has been shown to reduce hospital re-admittance rates and length of stay, increase outpatient provider visits, and decrease health care charges, and
Whereas, a program in Boston demonstrated that patients discharged to a homeless respite program experienced an approximate 50 percent reduction in readmission rates at 90 days post-discharge, compared to those discharged to streets and shelters, and

Whereas, a two-year study in Durham, North Carolina assessing health care utilization among homeless patients following a homeless medical respite pilot program determined that hospital admissions decreased by 37 percent, inpatient days decreased by 70 percent, and medical system charges for participants decreased by 48.6 percent, and

Whereas, an $800,000 investment in a medical respite program for homeless patients has saved participating hospitals in Santa Rosa, California $17 million in the first three years, and

Whereas, emergency department residents have reported being more likely to admit a homeless patient than a non-homeless patient experiencing the same illness, leading to resource-intensive hospital stays that could be handled at the level of care provided in medical respite centers, and

Whereas, our AMA 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” and “development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to hospital,” and

Whereas, the Board of Trustees recommends that “our AMA should encourage collaborative efforts to address homelessness that do not leave hospitals and physicians alone to bear their costs;” therefore be it

RESOLVED: That MSMS support increased availability of medical respite centers and programs for use by the homeless population; and be it further

RESOLVED: That MSMS support local stakeholders to secure increased funding for medical respite programs, including but not limited to expansion of current facilities in urban areas with large populations of homeless individuals.

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

STATEMENT OF URGENCY: In light of the COVID19 pandemic, the effect of deficiencies in transitional care are even more detrimental to those experiencing homelessness. The WCMS has supported this resolution and we ask that the MSMS do the same.

Relevant MSMS Policy:
None
Relevant AMA Policy:

**Eradicating Homelessness H-160.903**

Our AMA:

(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;

(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;

(6) will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians’ role therein, in addressing these needs;

(7) encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;

(8) encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;

(9) (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; and

(10) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods.

**Sources**


REPORT OF
RESOLUTION REVIEW COMMITTEE
Theodore B. Jones, MD, Chair

09-20 Medication-Assisted Treatment in Physician Health Programs - APPROVE
11-20 Fentanyl Patch for Patch Exchange Program - DISAPPROVE
12-20 Non-Stigmatizing Verbiage - DISAPPROVE
19-20 Medicare-For-All - DISAPPROVE
20-20 Michigan State Medical Society Judicial Commission - DISAPPROVE
23-20 Signage Balancing Patient Safety, Quality of Care, and Patient Dignity - DISAPPROVE
24-20 Prescription Medication Pill Size - DISAPPROVE
25-20 Limit Copay on Emergency Department Visits - DISAPPROVE
26-20 Joint Task Force to Improve Prior Authorization Processes - DISAPPROVE
28-20 ICD-10-CM Code for 'Statin Refusal' - DISAPPROVE
29-20 Enforce AMA Principles on Continuing Board Certification - DISAPPROVE
31-20 Bring Insurance Credentialing into Legal Compliance on Maintenance of Certification - APPROVE
33-20 Access to Direct Primary Care Physicians - DISAPPROVE
40-20 Tuition Cost Transparency - DISAPPROVE
44-20 Uniform Standards for Brain Death Determination - APPROVE
46-20 Depression Screening in Adolescents after Sport-Related Concussion - APPROVE
54-20 Resentencing for Individuals Convicted of Marijuana-Based Offenses - APPROVE
58-20 Use Term “Intellectual Disability” in Lieu of “Mental Retardation” in Academic Texts, Published Literature, and Medical Education - DISAPPROVE
61-20 9-1-1 Dispatcher Telephone CPR Training – APPROVE

02-21 Vision Qualifications for Driver’s License - APPROVE
03-21 Oppose Routine Use of Gonad Shields - APPROVE
04-21 Dissemination of Information to County Medical Societies - APPROVE
05-21 Health Information Card - DISAPPROVE
07-21 COVID-19 Vaccine Entry Into MCIR - DISAPPROVE
09-21 Repeal Safe Harbor Provisions - DISAPPROVE
11-21 Updates to Organ Donation and Transplant Policies - APPROVE
12-21 Standard Practice for Members Joining or Transferring Membership - DISAPPROVE
13-21 Upholding the Integrity and Vitality of the State and County Medical Societies - APPROVE
14-21 Disposition of Complaints - DISAPPROVE
15-21 Electronic Prescribing Waiver for Michigan’s Free Clinics - APPROVE
16-21 Medicaid Dialysis Policy for Undocumented Patients - **APPROVE**
17-21 Surrogacy Options for Michigan Parents - **DISAPPROVE**
18-21 Medical and Dental Care for Prisoners - **APPROVE**
19-21 De-professionalization of the Medical Profession - **DISAPPROVE**
20-21 Designated Directors Serving as Chair of the MSMS Board of Directors - **APPROVE**
21-21 Address Adolescent Telehealth Confidentiality Concerns - **APPROVE**
22-21 Expanding Access to Medication for the Treatment of Opioid Use Disorder - **APPROVE**
23-21 Licensure of Nutritionists and Dietitians - **DISAPPROVE**
24-21 Improved Outreach to Minority Communities Regarding the COVID-19 Vaccine - **APPROVE**
25-21 Public Health Considerations to Reduce Harm in Encampment Removals - **APPROVE**
26-21 Decarceration During an Infectious Disease Pandemic - **APPROVE**
27-21 Pictorial Health Warnings on Alcoholic Beverages - **DISAPPROVE**
28-21 Access to Menstrual Products in Correctional Facilities - **APPROVE**
29-21 Fertility Treatment Coverage - **DISAPPROVE**
30-21 Over the Counter Hormonal Contraception - **APPROVE**
31-21 Availability of Medical Respite Centers - **APPROVE**
32-21 Access to Affordable Housing - **DISAPPROVE**
33-21 Participation in Alliance for Innovation on Maternal Health Safety Bundles - **DISAPPROVE**
34-21 Use Term “Deaf and Hard of Hearing” in lieu of “Hearing Impaired” - **DISAPPROVE**
35-21 COVID-19 Vaccine Distribution Regarding People Experiencing Homelessness - **APPROVE**
The Resolution Review Committee (RRC) was instructed by the House to identify resolutions that are time sensitive and must be acted on yet this year, and those that can be postponed until 2022. The intent of narrowing the number of resolutions is solely due to time constraints and the online format, and not intended to be an assessment of the resolution’s merit. The criteria for determining if a resolution will be reviewed this year will include:

- Is the resolution time sensitive? Is this policy or ask needed before April 2022?
- Is there existing policy that covers all or some of the same intent?
- Is the resolution already being addressed by MSMS or regular staff work?
- Can the resolution be addressed within MSMS in another venue like an MSMS Committee or regular staff work?

Authors do have the opportunity for a second assessment. They will need to submit an appeal by emailing Rebecca Blake at rblake@msms.org by April 8, 2021. New information will be required that is different than what the Committee already reviewed. The Speaker and Vice-Speaker will provide the second evaluation.

09-20 – Medication-Assisted Treatment in Physician Health Programs - APPROVE

11-20 - Fentanyl Patch for Patch Exchange Program - DISAPPROVE

The Committee understands this is an important issue but did not believe the state would be in a position to implement a patch exchange program during the public health emergency. Therefore, the Committee determined this resolution does not been to be addressed before April 2022. This resolution will be forwarded to the 2022 House of Delegates.

12-20 - Non-Stigmatizing Verbiage - DISAPPROVE

After thorough review, the Committee thought this resolution did not meet the criteria for urgency but could be addressed within the MSMS Opioid Stewardship Task Force at a
future, regular scheduled meeting. This resolution will be forwarded to the 2022 House of Delegates unless otherwise completed by the Task Force before then.

** * * * * * * * **

19-20 - Medicare-For-All - DISAPPROVE
The Committee acknowledged resolutions similar to 19-20 are introduced almost annually. This is a resolution that engages a broad dialogue with many strongly held beliefs and opinions. The Committee believes this resolution would benefit best with in an in-person setting to allow for lengthy, open discussion, and debate. This resolution will be forwarded to the 2022 House of Delegates.

** * * * * * * * **

20-20 - Michigan State Medical Society Judicial Commission - DISAPPROVE
The Committee agrees that the bylaws regarding the Judicial Commission should be reviewed but because of the low number of reports every year, it did not meet the criteria to be completed before April 2022. This resolution will be forwarded to the 2022 House of Delegates.

** * * * * * * * **

23-20 - Signage Balancing Patient Safety, Quality of Care, and Patient Dignity - DISAPPROVE
The Committee understands this is an important issue but determined this resolution does not have the urgency to be addressed this year. This resolution will be forwarded to the 2022 House of Delegates.

** * * * * * * * **

24-20 - Prescription Medication Pill Size - DISAPPROVE
The Committee understands this is an important issue but determined this resolution does not have the urgency to be addressed this year. This resolution will be forwarded to the 2022 House of Delegates.
25-20 - Limit Copay on Emergency Department Visits - **DISAPPROVE**

The Committee understands this is an important issue but determined this resolution does not have the urgency to be addressed this year. This resolution will be forwarded to the 2022 House of Delegates.

* * * * * *

26-20 - Joint Task Force to Improve Prior Authorization Processes - **DISAPPROVE**

The Committee reviewed MSMS’ work on prior authorization and determined the intent of this resolution is being addressed by MSMS through regular staff work on prior authorization. This resolution will be forwarded to the 2022 House of Delegates.

* * * * * *

28-20 - ICD-10-CM Code for ‘Statin Refusal' - **DISAPPROVE**

The Committee learned there is a generic ICD-10 code that can be used for statin refusal; therefore, the resolution did not meet the urgency requirement to be addressed this year. This resolution will be forwarded to the 2022 House of Delegates.

* * * * * *

29-20 - Enforce AMA Principles on Continuing Board Certification - **DISAPPROVE**

The Committee supported the resolution but found existing MSMS and AMA policy adequate for this year. This resolution will be forwarded to the 2022 House of Delegates.

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31-20 - Bring Insurance Credentialing into Legal Compliance on Maintenance of Certification - **APPROVE**

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33-20 - Access to Direct Primary Care Physicians - **DISAPPROVE**

The Committee understands this is an important issue, but determined this resolution does not have the urgency to be addressed this year. This resolution will be forwarded to the 2022 House of Delegates.
40-20 - Tuition Cost Transparency - DISAPPROVE

The Committee strongly supported the resolution, but found existing MSMS and AMA policy sufficient for this year. This resolution will be forwarded to the 2022 House of Delegates.

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44-20 - Uniform Standards for Brain Death Determination - APPROVE

*****

46-20 - Depression Screening in Adolescents after Sport-Related Concussion - APPROVE

*****

54-20 - Resentencing for Individuals Convicted of Marijuana-Based Offenses - APPROVE

*****

58-20 - Use Term “Intellectual Disability” in Lieu of “Mental Retardation” in Academic Texts, Published Literature, and Medical Education - DISAPPROVE

The Committee understands this is an important issue, but determined this resolution does not have the urgency to be addressed this year. This resolution will be forwarded to the 2022 House of Delegates.

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61-20 - 9-1-1 Dispatcher Telephone CPR Training - APPROVE

*****

02-21 - Vision Qualifications for Driver’s License - APPROVE

*****

03-21 - Oppose Routine Use of Gonad Shields – APPROVE

*****
04-21 - Dissemination of Information to County Medical Societies - APPROVE

05-21 - Health Information Card – DISAPPROVE

The Committee understands this is an important issue, but determined this resolution does not have the urgency to be addressed this year. This resolution will be forwarded to the 2022 House of Delegates.

07-21 - COVID-19 Vaccine Entry Into MCIR - DISAPPROVE

The Committee was pleased to learn that recent Michigan regulations require COVID-19 vaccines be entered into MCIR within 72 hours, and 24 hours is strongly encouraged. Since the resolution has been completed or accomplished, the Committee recommends that it not be reviewed at this year’s House of Delegates.

09-21 - Repeal Safe Harbor Provisions – DISAPPROVE

The Committee supported the resolution, but found existing policy to be adequate for this year. This resolution will be forwarded to the 2022 House of Delegates.


11-21 - Updates to Organ Donation and Transplant Policies - APPROVE
12-21 - Standard Practice for Members Joining or Transferring Membership - DISAPPROVE

The Committee was sensitive to the nature of this resolution. This is a resolution that will require an extensive dialogue with ample opportunity for questions and input, similar to the most recent remodeling process. Therefore, the Committee believes this resolution would benefit best with in an in-person setting to allow for open discussion and debate. This resolution will be forwarded to the 2022 House of Delegates.

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13-21 - Upholding the Integrity and Vitality of the State and County Medical Societies - APPROVE

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14-21 - Disposition of Complaints - DISAPPROVE

The Committee agrees that the bylaws regarding the Judicial Commission should be reviewed, but because of the low number of reports every year, it did not meet the criteria to be completed before April 2022. This resolution will be forwarded to the 2022 House of Delegates.

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15-21 - Electronic Prescribing Waiver for Michigan’s Free Clinics - APPROVE

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16-21 - Medicaid Dialysis Policy for Undocumented Patients - APPROVE

* * * * * * *

17-21 - Surrogacy Options for Michigan Parents - DISAPPROVE

The Committee understands this is an important issue, but determined this resolution does not have the urgency to be addressed this year. This resolution will be forwarded to the 2022 House of Delegates.

* * * * * * *
18-21 - Medical and Dental Care for Prisoners - APPROVE

19-21 - De-professionalization of the Medical Profession - DISAPPROVE

The Committee supported the resolution, but found existing AMA and MSMS policy to be sufficient for this year. This resolution will be forwarded to the 2022 House of Delegates.

20-21 - Designated Directors Serving as Chair of the MSMS Board of Directors - APPROVE

21-21 - Address Adolescent Telehealth Confidentiality Concerns - APPROVE

22-21 - Expanding Access to Medication for the Treatment of Opioid Use Disorder – APPROVE

23-21 - Licensure of Nutritionists and Dietitians - DISAPPROVE

The Committee determined this resolution is not pressing at this time and can be addressed next year. This resolution will be forwarded to the 2022 House of Delegates.

24-21 - Improved Outreach to Minority Communities Regarding the COVID-19 Vaccine – APPROVE

25-21 - Public Health Considerations to Reduce Harm in Encampment Removals - APPROVE
26-21 - Decarceration During an Infectious Disease Pandemic - APPROVE

The Committee understands this is an important issue but determined this resolution does not have the urgency to be addressed this year. This resolution will be forwarded to the 2022 House of Delegates.

27-21 - Pictorial Health Warnings on Alcoholic Beverages – DISAPPROVE

28-21 - Access to Menstrual Products in Correctional Facilities – APPROVE

29-21 - Fertility Treatment Coverage - DISAPPROVE

30-21 - Over the Counter Hormonal Contraception - APPROVE

31-21 - Availability of Medical Respite Centers - APPROVE

32-21 - Access to Affordable Housing - DISAPPROVE

The Committee determined this resolution did not meet the criteria as time sensitive and can be addressed next year. This resolution will be forwarded to the 2022 House of Delegates.
33-21 - Participation in Alliance for Innovation on Maternal Health Safety Bundles – DISAPPROVE

The Committee agreed this is an important issue but determined this resolution did not meet the criteria as time sensitive. This resolution will be forwarded to the 2022 House of Delegates.

34-21 - Use Term “Deaf and Hard of Hearing” in lieu of “Hearing Impaired” – DISAPPROVE

The Committee understands this is an important issue but determined this resolution does not have the urgency to be addressed this year. This resolution will be forwarded to the 2022 House of Delegates.

35-21 - COVID-19 Vaccine Distribution Regarding People Experiencing Homelessness - APPROVE

Members of the Committee include: *Theodore B. Jones, MD, Chair; Phillip G. Wise, MD; *Barry I. Auster, MD; *Laura A. Caravallah, MD; *Sanjay Das; *Kaitlyn D. Dobesh, MD, JD; *Martha L. Gray, MD; *Bryan W. Huffman, MD; *Charles F. Koopmann, Jr., MD, FACS; *Rose M. Ramirez, MD; *Caroline G. M. Scott, MD; and *David T. Walsworth, MD.

The Committee was staffed by: Rebecca J. Blake and Carrie J. Wheeler.

* Denotes members in attendance
Whereas, fentanyl is a powerful synthetic opioid analgesic and 50-100 times more potent than morphine, and

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

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

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

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

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

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

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

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

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

Whereas, this enables the pharmacist, together with the prescriber, to make an assessment, consider the circumstances, and determine the best course of action and the quantity to be dispensed, and
Whereas, it is the responsibility of the pharmacist to properly store and dispose of used patches, as well as contacting appropriate law enforcement if there is suspected counterfeiting, misuse, and/or tampering; therefore be it

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

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

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

Relevant MSMS Policy:

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

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

Relevant AMA Policy:

Curtailing Prescription Drug Abuse While Preserving Therapeutic Use - Recommendations for Drug Control Policy H-95.979 (see language above)
RESOLUTION 12-20

Title: Non-Stigmatizing Verbiage

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

Original Author: Sandy Dettmann, MD, DABAM, FASAM

Referred To:

House Action:

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

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

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

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

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

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

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

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

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

Relevant MSMS Policy:

Communication, Documentation, and Professionalism
MSMS endeavors to educate physicians and other health care providers about the importance of careful and accurate verbal discussions and written documentation of care provided.
MSMS encourages physicians to demonstrate and maintain high ethical standards to avoid inadvertently discrediting other physicians or other health care providers; thereby, leading by example so that resident physicians and medical students can learn in a supportive environment while providing excellent care for our mutual patients.

**Relevant AMA Policy:**

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

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

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

Original Author: James Mitchiner, MD, MPH

Referred To:

House Action:

RESOLUTION 19-20

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

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

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

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

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

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

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

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

RESOLVED: That MSMS create a Health Care Reform Task Force charged with thoughtful and evidence-based deliberations on Medicare-for-All, with at least four periodic meetings throughout the year, leading to recommendations on MSMS taking a definitive "pro or con" position on Medicare-for-All. The Task Force shall report its recommendations to the 2022 MSMS House of Delegates.
WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions to form or join task forces (internal or external) - $5,000+

Relevant MSMS Policy:

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

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

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

Relevant AMA Policy:

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

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

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

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

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

5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees’ access to out-of-network physicians.
6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician.

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

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

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

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

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

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

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

**Evaluating Health System Reform Proposals H-165.888**

1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles:
   A. Physicians maintain primary ethical responsibility to advocate for their patients’ interests and needs.
   B. Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed.
   C. All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be.
D. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan.

E. Any national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care.

F. Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce an adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system.

G. All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President.

H. True health reform is impossible without true tort reform.

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

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

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

Sources:
2. Collins SR, Bhupal HK, Doty MM. Health insurance coverage eight years after the ACA: fewer uninsured Americans and shorter coverage gaps, but more underinsured (Commonwealth Fund, Feb. 2019), at: [https://www.commonwealthfund.org/publications/issue-briefs/2019/feb/health-insurance-coverage-eight-years-after-aca](https://www.commonwealthfund.org/publications/issue-briefs/2019/feb/health-insurance-coverage-eight-years-after-aca)
Title: Michigan State Medical Society Judicial Commission

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

Original Author: Jayne E. Courts, MD, FACP

Referred To:

House Action:

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

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

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

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

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

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

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

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

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

Relevant MSMS Policy:
Judicial Commission Complaint Process

1. MSMS staff receive inquiries from patients or physicians about filing a complaint for a physician, nurse, hospital, or any other healthcare facility.

2. If the complaint is about a physician, the staff member verifies that the physician is a MSMS member. If the physician is a member, the staff member explains that the Judicial Commission process is a peer review process which starts with the county society peer review committee. We encourage the complainant to personally discuss the issue with the physician. Finally, the staff member explains that the MSMS Judicial Commission does not have jurisdiction to award money damages, revoke, restrict or limit a physician's license.

3. Many times, when the complainant realizes it is a peer review process only, they decide not to proceed. If they decide to proceed, the staff member sends a complaint form to gather further information. The complainant has 30 days to submit the form with the detailed information.

4. Once the form is received by MSMS, the MSMS staff member determines the appropriate county medical society (CMS) who should review the complaint and forwards the information to that CMS. If there is not an active county medical society, the MSMS Judicial Commission reviews the complaint.

5. Each CMS has their own process for reviewing a complaint. The MSMS staff member stays in touch with the CMS staff member asking for updates.

6. Once the CMS peer review process makes their determination, they send information about the final decision to the MSMS staff member.

7. The MSMS staff member notifies the Judicial Commission chair about the decision. The Chair decides how the full Commission will be notified of the complaint.

Statistics on Complaints

<table>
<thead>
<tr>
<th>Year</th>
<th>Forms Mailed</th>
<th>Forms Received</th>
<th>Full Complaint Process</th>
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</tr>
<tr>
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</tr>
<tr>
<td>2020</td>
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</tr>
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</table>

Relevant AMA Policy:

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

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

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

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

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

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

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

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

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

Whereas, any publicly visible identification of residents with a fall risk such as a wristband is deemed to be a violation of patient dignity requirements, rather than as a potential method of ensuring the patient's safety and provision of quality of care, and
Whereas, this requirement to ensure information is not viewable by the public doesn’t even allow a colored dot on the room number by the door to alert SNF staff members to patient care needs such as a dysphagia diet, fluid restrictions, or other patient safety and quality concerns, and

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

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

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

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

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

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

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

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

Relevant MSMS Policy:
None
Relevant AMA Policy:

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

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

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

Referred To:

House Action:

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

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

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

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

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

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

Relevant MSMS Policy:
None

Relevant AMA Policy:
None
Title: Limit Copay on Emergency Department Visits

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

Original Author: Michelle M. Condon, MD, FACP

Referred To:

House Action:

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

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

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

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

Relevant MSMS Policy: None

Relevant AMA Policy: None
Title: Joint Task Force to Improve Prior Authorization Processes

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

Original Author: Richard Burney, MD

Referred To: 

House Action:

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

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

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

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

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

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

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

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

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

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

RESOLVED: That in addition to legislative pursuits, MSMS advocate for a joint task force process facilitated by a neutral, expert party, bringing together health care providers and insurers, to examine ways in which a better mutual understanding of prior authorization processes can be achieved, which can lead to mutually beneficial improvements in prior authorization processes.
WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions requiring external consultants - $50,000+

Relevant MSMS Policy:

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

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

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

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

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

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

Relevant AMA Policy

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

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

Remuneration for Physician Services H-385.951
1. Our AMA actively supports payment to physicians by contractors and third party payers for physician time and efforts in providing case management and supervisory services, including but not limited to coordination of care and office staff time spent to comply with third party payer protocols.

2. It is AMA policy that insurers pay physicians fair compensation for work associated with prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements and that compensates physicians fully for the legal risks inherent in such work.

3. Our AMA urges insurers to adhere to the AMA’s Health Insurer Code of Conduct Principles including specifically that requirements imposed on physicians to obtain prior authorizations, including pre-certifications and prior notifications, must be minimized and streamlined and health insurers must maintain sufficient staff to respond promptly.

**Preauthorization for Payment of Services H-320.961**

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

**Payer Accountability H-320.982**

Our AMA: (1) Urges that state medical associations and national medical specialty societies to utilize the joint Guidelines for Conduct of Prior Authorization Programs and Guidelines for Claims Submission, Review and Appeals Procedures in their discussions with payers at both the national and local levels to resolve physician/payer problems on a voluntary basis.

(2) Reaffirms the following principles for evaluation of preadmission review programs, as adopted by the House of Delegates at the 1986 Annual Meeting: (a) Blanket preadmission review of all or the majority of hospital admissions does not improve the quality of care and should not be mandated by government, other payers, or hospitals. (b) Policies for review should be established by state or local physician review committees, and the actual review should be performed by physicians or under the close supervision of physicians. (c) Adverse decisions concerning hospital admissions should be finalized only by physician reviewers and only after the reviewing physician has discussed the case with the attending physician. (d) All preadmission review programs should provide for immediate hospitalization, without prior authorization, of any patient whose treating physician determines the admission to be of an emergency nature. (e) No preadmission review program should make a payment denial based solely on the failure to obtain preadmission review or solely on the fact that hospitalization occurred in the face of a denial for such admission.

(3) Affirms as policy and advocates to all public and private payers the right of claimants to review by a physician of the same general specialty as the attending physician of any claim or request for prior authorization denied on the basis of medical necessity.

**Sources:**


Title: ICD-10-CM Code for ‘Statin Refusal’

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

Original Author: Rose Ramirez, MD

Referred To:

House Action:

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

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

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

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

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

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

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

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

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

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

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA for the creation of a new specific ‘statin refusal’ code and advocate it be a valid exclusion criterion for patients.
WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions only requesting new or revised MSMS or AMA policy - $500

Relevant MSMS Policy:
None

Relevant AMA Policy:
None
Title: Enforce AMA Principles on Continuing Board Certification

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

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

Referred To:

House Action:

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

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

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

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

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

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

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

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

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

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

Relevant AMA Policy:

Continuing Board Certification H-275.924
Continuing Board Certification AMA Principles on Continuing Board Certification
1. Changes in specialty-board certification requirements for CBC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in CBC must be reasonable and take into consideration the time needed to develop the proper CBC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the CBC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for CBC.
4. Any changes in the CBC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. CBC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of CBC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for CBC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of CBC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with CBC participation.
9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for CBC Part II. The content of CME and self-assessment programs receiving credit for CBC will be relevant to advances within the diplomate’s scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 Credit", American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)."
10. In relation to CBC Part II, our AMA continues to support and promote the AMA Physician’s Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.
11. CBC is but one component to promote patient safety and quality. Health care is a team effort, and changes to CBC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.
12. CBC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.
13. The CBC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.
14. CBC should be used as a tool for continuous improvement.
15. The CBC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.
16. Actively practicing physicians should be well-represented on specialty boards developing CBC.
17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.
18. CBC activities and measurement should be relevant to clinical practice.
19. The CBC process should be reflective of and consistent with the cost of development and administration of the CBC components, ensure a fair fee structure, and not present a barrier to patient care.
20. Any assessment should be used to guide physicians' self-directed study.
21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.
22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.
23. Physicians with lifetime board certification should not be required to seek recertification.
24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in CBC.
25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.
26. The initial certification status of time-limited diplomates shall be listed and publicly available on all American Board of Medical Specialties (ABMS) and ABMS Member Boards websites and physician certification databases. The names and initial certification status of time-limited diplomates shall not be removed from ABMS and ABMS Member Boards websites or physician certification databases even if the diplomate chooses not to participate in CBC.
27. Our AMA will continue to work with the national medical specialty societies to advocate for the physicians of America to receive value in the services they purchase for Continuing Board Certification from their specialty boards. Value in CBC should include cost effectiveness with full financial transparency, respect for physicians’ time and their patient care commitments, alignment of CBC requirements with other regulator and payer requirements, and adherence to an evidence basis for both CBC content and processes.
Title: Access to Direct Primary Care Physicians

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

Original Author: Belen Amat, MD

Referred To:

House Action:

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

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

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

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

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

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

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

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

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

Whereas, the state of Maine recognized this distinction, and passed legislation prohibiting denial of referrals by DPC physicians; therefore be it
RESOLVED: That MSMS educate health insurers on the role of direct primary care physicians in promoting high quality care while decreasing health care costs for patients with health insurance; and be it further

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

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

Relevant MSMS Policy:

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

Relevant AMA Policy:

Direct Primary Care H-385.912
1. Our AMA supports: (a) inclusion of Direct Primary Care as a qualified medical expense by the Internal Revenue Service; and (b) efforts to ensure that patients in Direct Primary Care practices have access to specialty care, including efforts to oppose payer policies that prevent referrals to in-network specialists.
2. AMA policy is that the use of a health savings account (HSA) to access direct primary care providers and/or to receive care from a direct primary care medical home constitutes a bona fide medical expense, and that particular sections of the IRS code related to qualified medical expenses should be amended to recognize the use of HSA funds for direct primary care and direct primary care medical home models as a qualified medical expense.
3. Our AMA will seek federal legislation or regulation, as necessary, to amend appropriate sections of the IRS code to specify that direct primary care access or direct primary care medical homes are not health “plans” and that the use of HSA funds to pay for direct primary care provider services in such settings constitutes a qualified medical expense, enabling patients to use HSAs to help pay for Direct Primary Care and to enter DPC periodic-fee agreements without IRS interference or penalty.
Whereas, in 2018, the Association of American Medical Colleges (AAMC) reported that 76 percent of medical students graduated with a median loan debt of $200,000. Compared to the median medical student debt of $50,000 in 1992, there is an approximate 220 percent increase in medical school debt, even after accounting for the rate of inflation, and

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

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

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

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

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

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

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

Whereas, undergraduate medical students are not provided specific breakdowns of tuition costs or reasons for tuition increases, and
Whereas, the AMA supports improving the systematic reporting of undergraduate medical student expenditures to determine which items are included and the ranges of costs; therefore be it

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

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

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

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

Relevant MSMS Policy:

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

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

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

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

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

Cost and Financing of Medical Education and Availability of First-Year Residency Positions H-305.988

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

The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967

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

11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.

12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.

13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.

14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.

15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.

16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.

17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.

18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.

19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.

20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.

21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.

22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.

23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.
24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.

25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.

26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.

27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.

28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.

29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.

30. Our AMA will monitor the status of the House Energy and Commerce Committee’s response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation’s Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.

31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of “Cap-Flexibility” and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.

32. Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates’ rates of placement into GME as well as GME completion.

33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation’s health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.

Sources:


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

Introduced by: Mara Darian, for the Medical Student Section

Original Author: Samantha Rea

Referred To:

House Action:

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

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

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

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

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

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

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

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

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

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to amend AMA policy H-70.912 by addition to read as follows:
Our AMA recommends that physicians adopt the term “intellectual disability” instead of “mental retardation” in clinical settings, academic texts, published literature, and medical education.

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

Relevant MSMS Policy:
None

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

Sources:
RESOLUTION: 05-21

Title: Health Information Card

Introduced by: Federico G. Mariona, MD, MBA, FACOG, FACS, for the Wayne County Delegation

Original Authors: Mirna Kaafarani and Federico Mariona, MD

Referred To:

House Action:

Whereas, the SARS-CoV-2 novel coronavirus is the third highly transmissible pathogen in its class that has surfaced in the first 20 years of the 21st century and reached the level of a pandemic, causing the clinical disease known as Corona Virus Disease-19 (CoVid-19), and

Whereas, Covid-19 affects the health, society, education, economy, and security of the United States population, and

Whereas, accurate and consistent public information is of critical importance to identify, design, and implement programs and processes that are consistent with the needs of the state public health institutions to provide appropriate means to mitigate and implement statewide solutions to health crises and catastrophic events, and

Whereas, the public lacks confidence in the veracity and the consistency of the health information provided by the health authorities and the media, with conflicting and frequently changing advice increasing the health care, social, and economic uncertainty, and

Whereas, that a state Health Information Card should be implemented and equipped with programmed encrypted microchip technology to protect the identity of the holder. The card will allow for real time entry of health events and provide access to health information changes and contribute to build the state's public health system information network, assist in the implementation of strategic plans for public information, individual evidence-based treatment, guide public health advocacy, economic policies, national security integrity, and advanced planning, and

Whereas, a similar system has been tested, tried, and used in advanced industrialized countries in the world including the United States in Tennessee, and

Whereas, providing accurate information can be achieved, by the implementation of a system that allows for timely obtainment and recording of pertinent data gathering to construct epidemiological models avoiding poor methodology and variable definitions; therefore be it

RESOLVED: That MSMS encourage the state’s public health authorities and the state legislature to work towards the implementation of a state Health Information Card, issued to each citizen in the state to contain the demographic and clinical information needed to allow for the
building of a standard system of health data collection and facilitate reporting of the state’s population health status.

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

STATEMENT OF URGENCY: The SARS-CoV-2 novel coronavirus is the third highly transmissible pathogen in its class that has surfaced in the first 20 years of the 21st century and reached the level of a pandemic, causing the clinical disease known as Corona Virus Disease -19 (CoVid-19). Accurate and consistent public information tracking the virus is of critical importance. This resolution is time sensitive as it deals with developing a standard system of health data collection and facilitate reporting of the state’s population health status regarding COVID-19. Similar systems have already been tested, tried and used in advanced industrialized countries. This identification card will allow for real time entry of health events and provide access to health information changes and contribute to build the state’s public health system information network, assist in the implementation of strategic plans for public information, individual evidence-based treatment, guide public health advocacy, economic policies, national security integrity and advanced planning.

Relevant MSMS Policy:
None

Relevant AMA Policy:
None

Sources:
2. The pharmaceutical record in an emergency department: Assessment of its accessibility and its impact on the level of knowledge of the patient’s treatment. Trinh-Duc A, et al. Ann Pharm Fr. 2016. PMID: 33096907 French. In France, the pharmaceutical record (PR) is a shared professional tool arising from the pharmacists lists of all drugs dispensed during the...
RESOLUTION 07-21

Title: COVID-19 Vaccine Entry Into MCIR

Introduced by: Neeli Thati, MD, for the Wayne County Delegation

Original Author: Neeli Thati, MD

Referred To:

House Action:

Whereas, the Affordable Care Act of 2010 establishes patient-centered outcomes for all ages, and

Whereas, the Patient Centered Medical Home is the vehicle to achieve patient centered outcomes, and

Whereas, the Patient Centered Medical Home is a health care setting where, among others, care is facilitated by registries, information technology, health information exchange, and other means, and

Whereas, the Michigan Care Improvement Registry (MCIR), through the careful tracking of immunization information provided by health care providers and making this information accessible to authorized users online, strives to reduce the occurrence of vaccine preventable illness, and

Whereas, patients typically do not keep records of their immunizations, and

Whereas, immunization information is an integral part of EHRs used in Michigan practices, and

Whereas, adult immunization, in contrast to pediatric immunization, is not mandated to be entered into the MCIR system within 72 hours, and

Whereas, Michigan’s COVID-19 vaccine roll out is primarily through the local county health departments, hospitals and pharmacies. Although the number of doses is carefully being accounted for at each distribution center, efforts should be made to update this information in MCIR; therefore be it

RESOLVED: That MSMS support legislation for Michigan that mandates entry of COVID-19 Vaccine into the Michigan Care Improvement Registry (MCIR) system within 72 hours.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions requesting governmental advocacy – $25,000+
STATEMENT OF URGENCY: Adult immunization, in contrast to pediatric immunization, is not mandated to be entered into the MCIR system within 72 hours. COVID-19 Vaccine roll out is through the local county health departments and pharmacies. Although the number of doses are carefully being accounted for at each distribution center, it is crucial that efforts be made to update this information in MICR. This is a very time sensitive matter.

Relevant MSMS Policy:
None

Relevant AMA Policy:
None
Title: Repeal Safe Harbor Provisions

Introduced by: James Szocik, MD, for the Washtenaw County Delegation

Original Author: James Szocik, MD

Referred To:

House Action:

Whereas, group purchasing organizations (GPO) and pharmacy benefits managers (PBM) act as middlemen between producers of drugs and supplies and the consumers, hospitals and patients, and

Whereas, GPO and PBM propose to add value to the consumers by negotiating contracts, but in reality they extract “rent,” limit innovation distort prices (IV saline is sold at below cost because it is “coupled” with other purchases), and contribute to drug shortage, and

Whereas, GPO and PBM further offer “rebates” to hospital systems and major consumers that would otherwise be categorized as “bribes” or “kick-backs” and are only allowed under special “safe harbor provisions” of U.S. law, and

Whereas, this results in increased costs for the end consumer, and

Whereas, the previous Administration supported and was working on eliminating these safe harbors, the current Administration has suspended all implementation of such changes; therefore be it

RESOLVED: That MSMS advocate for the repeal of the “Safe Harbors” under 42 CFR 1001.952(j), 42 U.S.C. 1320a-7b(b)(3)(C) and any other state or federal statutes that may apply and support the substitution of rebates directly to the consumer and the public; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) urge our AMA to advocate for the repeal of the “Safe Harbors” under 42 CFR 1001.952(j), 42 U.S.C. 1320a-7b(b)(3)(C) and any other state or federal statutes that may apply and support the substitution of rebates directly to the consumer and the public.

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

STATEMENT OF URGENCY: In November 2020, the HHS OIG finalized its previously abandoned 2019 proposal to exclude certain rebates paid by drug manufacturers from the discount safe harbor to the federal anti-kickback statute. The rule is expected to go into effect in January 2021.
Relevant MSMS Policy:
None

Relevant AMA Policy:
None

Sources:
5. https://jamanetwork.com/journals/jama/fullarticle/2708613
Whereas, Article III, Section 1 of the Michigan State Medical Society (MSMS) Constitution states: DEFINITION—Component societies shall consist of those county medical societies which hold charters from this Society, and

Whereas, Article III, Section 2 of the MSMS Constitution states: GEOGRAPHICAL SCOPE—Not more than one component society shall be chartered in any county of the State. The House of Delegates may, however, in its discretion, grant a charter to a component society comprising two or more counties, and

Whereas, Section 2.20 of the MSMS Bylaws states: MEMBERSHIP PREREQUISITE—All members of the several component societies, when in good standing, are thereby and must be members of this Society. All members of this Society must be members of a component medical society or direct members through the Resident and Fellow Section or the Medical Student Section, and

Whereas, Section 2.30 of the MSMS Bylaws states: ACTIVE MEMBERS—To be eligible for active membership in any component society, doctors of medicine must hold an unrevoked, permanent license that is not currently under suspension in Michigan, or if unlicensed, must be engaged in academic teaching, research or administration. To maintain active membership in any component society, doctors of medicine must maintain active membership in this Society and comply with all the provisions of the Bylaws of this Society and the component society, and

Whereas, Section 4.10 of the MSMS Bylaws states: MEMBERSHIP AS PRIVILEGE - NOT RIGHT—Admission to membership in any component society is not a matter of right, but one of privilege, to be accorded or withheld at the sole discretion of such society. Each component society may determine the manner of electing its members and shall be the sole judge of the qualifications of applicants for membership therein. There shall be no discrimination on the basis of race, religion, sex, ethnic origin, or sexual orientation, and

Whereas, Section 4.20 of the MSMS Bylaws states: ADJOINING COUNTY—A doctor of medicine whose principal location of practice is near a county may, with the permission of the Board of Directors of this Society, and upon being duly elected thereto, hold membership in the component society most convenient for the member to attend, and

Whereas, it is the practice of our county medical societies and our MSMS that new members to the Michigan State Medical Society join the component medical society of the county
where they either live or primarily work and the MSMS website states, “When you become a member of MSMS, you also become a member of the county medical society in which you live or work,” and

Whereas, any current member wishing to transfer membership to another county medical society must first receive a good standing certification from the former county medical society and approval from the new county medical society, and

Whereas, the county medical societies became aware in July 2020, of physician(s) and/or physician group(s) being allowed to join and/or to transfer membership to inactive counties (counties with no discernable county medical society leadership, structure, operations, or membership dues requirements) in which they did not live and/or primarily work, and

Whereas, MSMS staff did not notify the county medical societies when these members transferred membership, and

Whereas, the county medical societies initiated discussion about these aberrant situations with MSMS staff on July 20, 2020, and

Whereas, following that discussion, the MSMS Board of Directors considered and approved a motion at the October 2020, Board meeting re-interpreting the bylaws stating “that the MSMS Board of Directors acknowledge MSMS Legal Counsel’s interpretation that the MSMS Bylaws do not expressly require a physician to live or work in a county in order to hold membership in that county medical society,” and

Whereas, this practice of allowing physicians to join and/or transfer to counties in which they do not live and/or primarily work continues to occur since the October 2020, MSMS Board meeting, and

Whereas, this practice creates an incentive for physicians and/or physician groups regardless of where they live or work to join inactive counties without membership dues to reduce their cost, and

Whereas, this practice is disruptive and harmful to the integrity and vitality of the county medical societies and MSMS; therefore be it

RESOLVED: That the MSMS Bylaws be amended as follows: Deletions are indicated by strikethroughs, additions are indicated in bold type.

2.20 MEMBERSHIP PREREQUISITE—All members of the several component societies, when in good standing, are thereby and must be members of this Society. All members of this Society must be members of a component medical society **where they live or primarily work** or direct members through the Resident and Fellow Section or the Medical Student Section.

4.10 MEMBERSHIP AS PRIVILEGE - NOT RIGHT—A doctor of medicine may apply for component membership within the county of their residence or primary location of practice. Any exception would require written, mutual agreement between the physician and/or physician group, the MSMS, and the respective county(ies).
Admission to membership in any component society is not a matter of right, but one of privilege, to be accorded or withheld at the sole discretion of such society. Each component society may determine the manner of electing its members and shall be the sole judge of the qualifications of applicants for membership therein. There shall be no discrimination on the basis of race, religion, sex, ethnic origin, or sexual orientation.

4.20 ADJOINING COUNTY—A doctor of medicine whose residence or principal location of practice is near a county an active, chartered county medical society may, with the permission of the Board of Directors of this Society, and upon being duly elected thereto, hold membership in the nearest active, chartered component county medical society most convenient for the member to attend.

5.10 CHANGE OF LOCATION – PROCEDURE—When a member of a component society, by reason of change of residence or primary practice location, desires to transfer membership to another component society, such member shall make application thereto accompanied by tender of dues for the remaining half of the current year (any major fraction of a half being regarded as a full half and any minor fraction being disregarded). Thereupon, the secretary of the society to which application is made shall request certification of standing from the Society from which the member desires to transfer and upon receipt of such request the secretary of the latter Society shall supply certification of good standing, provided the following requirements have been met:

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

STATEMENT OF URGENCY: The county medical societies became aware in July 2020 of physician(s) and/or physician group(s) being allowed to join and/or to transfer membership to inactive counties (counties with no discernable county medical society leadership, structure, operations, or membership dues requirements) in which they did not live and/or primarily work. MSMS staff did not notify the county medical societies when these members joined or transferred membership. The county medical societies initiated discussion about these aberrant situations with MSMS staff on July 20, 2020 and, following that discussion, the MSMS Board of Directors considered and approved a motion at the October 2020 Board meeting re-interpreting the bylaws stating "that the MSMS Board of Directors acknowledge MSMS Legal Counsel’s interpretation that the MSMS Bylaws do not expressly require a physician to live or work in a county in order to hold membership in that county medical society." This practice of allowing physicians to join and/or transfer to counties in which they do not live and/or primarily work has continued to occur since the October 2020 MSMS Board meeting, creating an incentive for physicians and/or physician groups regardless of where they live or work to join inactive counties without membership dues to reduce their cost. This must be addressed at this House of Delegates as the practice is disruptive and harmful to the integrity and vitality of the county medical societies and MSMS.

**Relevant MSMS Policy:**
Over the past year, MSMS has deployed several strategies to address issues raised by county medical societies regarding state society operations and procedures relative to membership, advocacy, communications and the House of Delegates. Those strategies include weekly (spring 2020) and then bi-
weekly (summer 2020) virtual meetings between the MSMS CEO and county society staff, monthly meetings between MSMS departmental heads and county society staff (which have been ongoing since 2010), and a facilitator-led series of meetings to research state and county perspectives and host a series of meetings to work through how various issues will be handled going forward. The consultant work is ongoing, and the topic raised in this resolution has been part of that process. In addition, county concerns have been discussed broadly at MSMS Board meetings, the Chair and Vice Chair hosted a virtual meeting with Regional Directors representing five counties raising concerns, and the MSMS Executive Committee has also met to support strategies to establish best practices between state and county going forward.

Advise Physicians Regarding the Importance of Organized Medicine
MSMS advocates educating Michigan physicians regarding the value of membership in their respective county medical societies, MSMS and the AMA. (Res17-96A)

Relevant AMA Policy:
None

Sources:
1. https://connect.msms.org/Membership/Join
2. Source: January 14, 2021 MSMS Board of Directors Meeting Packet
Title: Disposition of Complaints

Introduced by: Narasimha Gundamraj MD, for the Ingham County Delegation, Christopher J. Allen, MD, for the Saginaw County Delegation, and Evelyn Eccles, MD, for the Washtenaw County Delegation

Original Author: Evelyn Eccles, MD

Referred To: 

House Action:

Whereas, MSMS and/or county societies have a duty to investigate complaints brought against one of their members involving ethical or medical behavior, and

Whereas, in the event that such a complaint is brought, component societies will initiate such investigation with the understanding that should legal advice be needed, they will have the support of MSMS legal counsel, and that their decisions may be reviewed by the MSMS Judicial Committee, and

Whereas, MSMS and/or county societies do not have a duty to investigate or adjudicate complaints that do not involve one or more of its members, and such complaints if they involve a physician who is not a member of MSMS or county society should be referred to LARA for disposition, and

Whereas, in the event that a complaint is brought against a member but the complaint is unrelated to and does not involve any aspect of that member’s medical practice, it should not be referred for disposition by MSMS to the county society in which the alleged activity occurred, but should be dismissed by MSMS, and

Whereas, referral by MSMS of a complaint to the county society for disposition when the dispute does not involve a county society member or is not related to medical practice or patient care, places an unnecessary expectation, administrative, and financial burden on that society; therefore be it

RESOLVED: That MSMS shall provide legal counsel and knowledgeable staff to the county medical society whenever a complaint is received involving a physician member in said county related to medical practice and/or medical ethics.

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

STATEMENT OF URGENCY: Complaints are considered as regular medical society business. A standard, clear practice should be developed and communicated to protect the medical societies and members.
Relevant MSMS Policy:

Judicial Commission Complaint Process

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

Statistics on Complaints

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Relevant AMA Policy:

None
Title: Surrogacy Options for Michigan Parents

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

Original Author: Adam J. Rush, MD

Referred To:

House Action:

Whereas, the AMA supports surrogate parenting “also termed Third Party Reproduction” as a form of assisted reproduction in which a woman agrees to bear a child on behalf of and relinquish the child to an individual or couple who intend to rear the child, and

Whereas, such arrangements can promote fundamental human values by enabling individuals or couples who are otherwise unable to do so to fulfill deeply held desires to raise a child, and

Whereas, gestational carriers in their turn can take satisfaction in expressing altruism by helping others fulfill such desires, and

Whereas, in the United States, individual states have the power to determine the legality of surrogacy agreements and surrogate compensation, and

Whereas, the state of Michigan is one of only three states that are outliers on surrogacy law, and

Whereas, in the state of Michigan statute prohibits compensated surrogacy contracts, and a birth certificate naming both intended parents cannot be obtained, and

Whereas, the state of New York in February 2021, made compensated surrogacy legal, and

Whereas, in 1998, MSMS endorsed the need to define and protect the legal status and rights of a child born as a result of surrogate parenting, and

Whereas, in 2018, Senator Rebekah Warren (D-Warren) introduced Senate Bill 1082 which to repeal Michigan’s current law and replace it with the Gestational Surrogate Parentage Act, but it failed to advance; therefore be it

RESOLVED: That MSMS work with the Michigan legislature to amend the current law to assist parents and newborns in Michigan, clarify parenting rights, and support compensated surrogacy options.
WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions requesting governmental advocacy - $25,000+

STATEMENT OF URGENCY: This is a timely issue that should be addressed promptly for physicians and patients. In light of recent legislative discussions at the state and/or local level, physicians need to be involved in updating this legislation.

Relevant MSMS Policy:

Surrogate Parenting
MSMS endorses the need to define and protect the legal status and rights of a child born as a result of surrogate parenting. MSMS endorsement does not extend to the process of surrogate parenting. (Prior to 1990)

Relevant AMA Policy:

4.2.4 Third-Party Reproduction
Third-party reproduction is a form of assisted reproduction in which a woman agrees to bear a child on behalf of and relinquish the child to an individual or couple who intend to rear the child. Such arrangements can promote fundamental human values by enabling individuals or couples who are otherwise unable to do so to fulfill deeply held desires to raise a child. Gestational carriers in their turn can take satisfaction in expressing altruism by helping others fulfill such desires.

Third-party reproduction may involve therapeutic donor insemination or use of assisted reproductive technologies, such as in vitro fertilization and embryo transfer. The biological and social relationships among participants in these arrangements can form a complex matrix of roles among gestational carrier, gamete donor(s), and rearing parent(s).

Third-party reproduction can alter social understandings of parenthood and family structure. They can also raise concerns about the voluntariness of the gestational carrier’s participation and about possible psychosocial harms to those involved, such as distress on the part of the gestational carrier at relinquishing the child or on the part of the child at learning of the circumstances of his or her birth. Third-party reproduction can also carry potential to depersonalize carriers, exploit economically disadvantaged women, and commodify human gametes and children. These concerns may be especially challenging when carriers or gamete donors are compensated financially for their services. Finally, third-party reproduction can raise concerns about dual loyalties or conflict of interest if a physician establishes patient-physician relationships with multiple parties to the arrangement.

Individual physicians who care for patients in the context of third-party reproduction should:

(a) Establish a patient-physician relationship with only one party (gestational carriers, gamete donor[s] or intended rearing parent[s]) to avoid situations of dual loyalty or conflict of interest.

(b) Ensure that the patient undergoes appropriate medical screening and psychological assessment.

(c) Encourage the parties to agree in advance on the terms of the agreement, including identifying possible contingencies and deciding how they will be handled.

(d) Inform the patient about the risks of third-party reproduction for that individual (those including individuals), possible psychological harms to the individual(s), the resulting child, and other relationships.

(e) Satisfy themselves that the patient’s decision to participate in third-party reproduction is free of coercion before agreeing to provide assisted reproductive services.
Collectively, the profession should advocate for public policy that will help ensure that the practice of third-party reproduction does not exploit disadvantaged women or commodify human gametes or children.

Sources:
Whereas, physicians attend medical school, complete an internship, and residency training before being credentialed as a fully licensed physician, and

Whereas, physicians complete a rigorous series of board examinations during medical school, internship, and residency to certify their ability to diagnosis and treat patients, and

Whereas, physicians are regarded as the legal entity that is ultimately responsible for patient care, and

Whereas, health care workers are encouraged to address physicians by their first name rather than doctor, in order to lessen the “authority gradient” related to patient safety, and

Whereas, physicians-in-training are being encouraged to perform as active team members in patient care and are not being recognized as medical students or resident physicians, which potentially leads to confusion about leadership and accountability within the team, and

Whereas, medical schools are utilizing Advanced Practice Professionals as educators for future physicians, implying that the training of Advanced Practice Professionals is equivalent to the training of physicians, and

Whereas, physicians are still held professionally and legally accountable for outcomes, including adverse outcomes, of team-based care due to the higher level of training involved and the role as the team leader; therefore be it

RESOLVED: That MSMS supports only the use of titles and descriptors that align with a physician or non-physician provider’s state issued licenses or credentials; and be it further

RESOLVED: That MSMS actively oppose efforts to diminish the qualifications and training of physicians by hospital administrators, insurance companies, and governmental regulatory agencies who require physicians be referenced as medical providers, team members, health care providers, or any other reference in lieu of the legal title of physician or doctor; and be it further

RESOLVED: That MSMS seek legislation which provides that professionals in a clinical health care setting clearly and accurately identify to patients their qualifications and degree(s) attained as follows:
1. Wear an identification badge which indicates the individual's name and credentials as appropriate (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc.), to differentiate between those who have achieved a Doctorate, and those with other types of credentials. The font size of their credentials shall be greater than the front size used for their name for the purpose of role definition and patient safety.

2. Anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a “doctor,” and who has not received a “Doctor of Medicine” or a “Doctor of Osteopathic Medicine” degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine, shall specifically and simultaneously declare themselves a “non-physician” and define the nature of their doctorate degree.

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

STATEMENT OF URGENCY: We encourage the highest consideration for this resolution to be evaluated and acted upon by the Michigan State Medical Society-House of Delegates-2021. The medical profession has been victim of a well-organized downgrading of professional merit and expertise by providers who want to pay less for physician provided medical services by comparing them to advanced practice providers (APP). Hospital administrators want to decrease the “authority gradient” by removing titles in correspondence and video meetings and calling physicians by their first name. Pharmacists, physical therapists and nurses all offer doctorate degrees and want their graduates to be recognized by the public and hospitals as “Doctors.” This creates a very confusing environment for patient satisfaction and safety and a very disturbing environment for physicians. This movement has been growing for over thirty years, with little tangible resistance by the medical profession and we feel that something legislative needs to be started this year by the MSMS to start reversing this overt devaluation of our profession.

Relevant MSMS Policy:

Calling Physicians by their First Name
MSMS discourages policies that require physicians to be called by their first names in professional settings such as their workplace. (Res42-16)

Physician Not Labeled as Provider
MSMS opposes the current custom by government and insurance companies of labeling physicians as providers and encourages proper identification of physicians and/or surgeons. MSMS supports physicians who request they be identified as “physicians” apart from other “providers” on any contracts or documents they are asked to sign. (Res38-90A) – Amended 1993 – Edited 1998 -Reaffirmed (Sunset Report 2020)

Relevant AMA Policy:

"Doctor" as a Title H-405.992
The AMA encourages state medical societies to oppose any state legislation or regulation that might alter or limit the title "Doctor," which persons holding the academic degrees of Doctor of Medicine or Doctor of Osteopathy are entitled to employ.

Clarification of the Title "Doctor" in the Hospital Environment D-405.991
1. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement standards for an identification system for all hospital facility staff who have direct contact with patients which would require that an identification badge be worn which indicates the individual's name and credentials as appropriate (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), to differentiate between those who have achieved a Doctorate, and those with other types of credentials.

2. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement new standards that require anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor," and who is not a "physician" according to the AMA definition (H-405.969, ?that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine?) must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.

3. Our AMA will request the American Osteopathic Association (AOA) to (1) expand their standards to include proper identification of all medical staff and hospital personnel with their applicable credential (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), and (2) Require anyone in a hospital environment who has direct contact with a patient presenting himself or herself to the patient as a "doctor", who is not a "Physician" according to the AMA definition (AMA Policy H-405.969 .. that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine) must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.
Whereas, Michigan is one of three states which has no formal licensing requirements or title protections for nutritionists and dietitians, and

Whereas, licensure assures health insurance companies, state, and federal governments that practitioners who are being reimbursed for nutrition care services meet standards of professional competence, and

Whereas, without proper training, individuals can present fringe nutritional practices as evidence-based, or misinterpret current nutritional research and misapply the findings, and

Whereas, without formal licensing, individuals who claim to have expertise in nutrition cannot be prevented from making misleading claims regarding nutrition supplements or weight loss plans that could be contraindicated with certain medical conditions, and

Whereas, registered dietitians have formal professional, educational, and ethical standards, including continuing professional education, and

Whereas, in previous legislation, licensing requirements and regulation did not apply to business people involved in the distribution of health-related products, so long as they did not identify themselves by the title of “dietitian” or “nutritionist,” and

Whereas, MSMS maintains positions on licensing for other health-related fields, supporting the licensure and definition of scope of practice for legitimate professionals such as genetic counselors and nurse anesthetists, while opposing licensure for unproven health practitioners such as naturopaths; therefore be it

RESOLVED: That MSMS supports formal educational requirements and subsequent licensure of dietitians and nutritionists.
Relevant MSMS Policy:

Licensure and Reimbursement for Certified Genetic Counselors
MSMS supports the licensure of certified genetic counselors. (Res36-16)

Certified Anesthesiologist Assistants
MSMS supports the licensure of "certified anesthesiologist assistants" (CAA), who would practice anesthesiology under the supervision of an anesthesiologist, consistent with other MSMS policy relative to scope of practice. (Board-Oct17)

Licensure of Naturopaths
MSMS opposes the use of licensing as a pathway for expanding the scope of practice of persons practicing naturopathic medicine. (Board-July2018)

Health Profession Boards Need to Protect Patients
MSMS opposes efforts by licensing boards of non physicians to establish their own scope of practice, and expansion in non-physicians scope of practice may only occur with approval of the Boards of Medicine, the respective non-physician licensing board, and the Legislature. (Res20-12)

Oppose Scope of Practice Expansion for Allied Health Care Professionals
MSMS opposes scope of practice changes for non-physician health care professionals that are not supported by their level of education and training. (Res89-16) - Amended (Res59-18)

Relevant AMA Policy:
None

Sources:
Whereas, excessive alcohol use is responsible for more than 95,000 deaths annually, making it a leading cause of preventable death in the U.S., and

Whereas, more than half of alcohol related deaths are linked to a rising number of life-threatening medical conditions - such as liver cirrhosis, cancer, cardiovascular disease, and stroke - with prolonged use of excessive alcohol linked to dementia and neuropathy, and use of excessive alcohol during pregnancy linked to fetal alcohol syndrome, the leading cause of intellectual disability in the U.S., and

Whereas, nationally, excessive alcohol use leads to a shortened lifespan by approximately 29 years, for a total of 2.8 million years of potential life lost, and in Michigan, excessive alcohol use results in 2,945 deaths and 84,215 years of potential life lost each year, and

Whereas, the economic burden of alcohol misuse is significant, costing the U.S. $249 billion in 2010 alone - of which, three-quarters of the total cost was related to binge drinking - and in Michigan, excessive alcohol use cost $8.2 billion, or $2.10 per drink, in 2010 alone - of which, three-quarters of the total cost was related to binge drinking, and

Whereas, in 2018, 5.8 percent of adults ages 18 and older nationally had alcohol use disorder, 26.45 percent of people ages 18 or older reported that they engaged in binge drinking in the past month, and 6.6 percent reported that they engaged in heavy alcohol use in the past month, and

Whereas, binge drinking specifically is responsible for more than half the deaths and two-thirds of the years of potential life lost resulting from excessive alcohol use, and in Michigan, 19.7 percent of adults and 17.8 percent of high school students reported binge drinking in 2011, and

Whereas, in Michigan, the alcohol-induced crude mortality rates have been steadily increasing for the last 40 years, and

Whereas, these numbers remain so despite a congressional "Alcoholic Beverage Labeling Act" (ABLA) passed in 1988 requiring health warning statements to appear on the labels of all containers of alcohol beverages for sale or distribution in the U.S., signifying that this label failed to warn against several of the medical consequences of excessive alcohol consumption, as it was required to only appear in text, and
Whereas, only 35 percent of all adults in the summer of 1991 reported having seen the warning label, signifying that these labels have done little to reduce rates of alcohol-related risky behaviors, rates of consumption, or alcohol-related poor health outcomes during this period, and

Whereas, MSMS current policy supports requiring a text-only warning statement on all advertising for alcoholic beverages regarding fetal alcohol syndrome, and

Whereas, during this same time, studies repeatedly showed that (1) larger pictorial and symbolic health warnings on tobacco packaging were more effective at reducing tobacco use than smaller text-only warnings, and (2) a mixture of health-related and social-related graphic health warnings on tobacco packaging were most effective at reducing tobacco use, and

Whereas, experts have recommended and studies have shown that the use of pictorial health warning on alcoholic beverages lead to improve health outcomes, and

Whereas, in the past decade several studies have predicted and proven that negative pictorial health warnings are associated with significantly increased perceptions of the health risks of consuming alcohol as well as greater intentions to reduce and quit alcohol consumption compared to the control, and

Whereas, though critics cite the somatic benefits of alcohol in moderation and question the need for health warnings on alcoholic beverages, research shows that there are adverse effects related to cancer at any level of alcohol consumption, and though critics argue that alcohol can still be consumed in bars and pubs without drinkers seeing the packaging, research actually shows that alcohol purchased from supermarkets is more than twice the level of alcohol consumed in bars/pubs, and

Whereas, MSMS supports a healthy lifestyle related to nutrition and exercise and the avoidance of alcohol and tobacco; therefore be it

RESOLVED: That MSMS will advocate for the implementation of pictorial health warnings on alcoholic beverages for sale in containers in Michigan, including but not limited to images such as a cirrhotic liver and dilated cardiomyopathy secondary to excessive alcohol use, a car crash, or an animation of a baby in the womb; and be it further

RESOLVED: That MSMS will advocate for the amendment of current MSMS policy, titled Fetal Alcohol Syndrome, Board-May94, to include language advocating for pictorial warnings of fetal alcohol syndrome from alcohol use during pregnancy; and be it further

RESOLVED: That MSMS will continue to support the use of health warnings on alcoholic beverages for sale in Michigan.

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

Fetal Alcohol Syndrome
MSMS supports requiring a warning statement on all advertising for alcoholic beverages regarding fetal alcohol syndrome (FAS). (Board-May94)

Relevant AMA Policy:
None

Sources:


Whereas, infertility is defined as the inability to conceive after one year of regular sexual intercourse without using birth control and can affect any age and sex, and

Whereas, involuntary childlessness due to infertility can profoundly impact people’s lives, causing medical, social, economic, and psychological harm, and

Whereas, lack of insurance coverage often leads some women to take risks that will increase their chances of becoming pregnant such as implanting multiple embryos at one time, and

Whereas, implanting multiple embryos may cause multiple gestations, increasing the risk for maternal and fetal complications, as well as increased medical care expenditures due to these complications, and

Whereas, the majority of patients who wish to undergo fertility treatment, such as IVF, must pay out of pocket due to lack of health insurance or having insurance policies that do not cover infertility treatment, with the median price of a cycle of IVF in the United States, including medications, at $19,200, and

Whereas, Medicaid covers preconception care and contraceptives as part of family planning services, but infertility testing and treatments are rarely considered family planning services and rarely covered by Medicaid, and

Whereas, 16 states (not including Michigan) have passed laws that require insurers to either cover or offer coverage for infertility diagnosis and treatment. Fourteen of these require insurance companies to cover infertility treatment and two requiring insurance companies to offer coverage for infertility treatment; therefore be it

RESOLVED: That MSMS supports that Michigan health plans including Medicaid cover fertility treatment, such as in vitro fertilization and other treatments for fertility preservation.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions only requesting new or revised MSMS or AMA policy - $500
Relevant MSMS Policy:
None

Relevant AMA Policy:
None

Sources:
RESOLVED: That MSMS support and advocate for recognition of homelessness as a social determinant of mental and physical health disparities in Michigan; and be it further
RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) urge
our AMA to support and advocate for recognition of homelessness as a social determinant of
mental and physical health disparities in the United States; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA)
support and advocate for timely review of legislation designed to eliminate or reduce
homelessness; and be it further

RESOLVED: That MSMS support and advocate for creation of a permanent funding source
for the Michigan Housing and Community Development Fund (MHCDF) with at least 66 percent of
that funding allocated for the development, rehabilitation, and maintenance of permanent housing
for Michiganders with disabilities or experiencing homelessness.

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

Relevant MSMS Policy:
None

Relevant AMA Policy:

Eradicating Homelessness H-160.903
Our AMA:
(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;
(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;
(6) will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs
of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and
physicians’ role therein, in addressing these needs;
(7) encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless
patients who present to the emergency department but are not admitted to the hospital;
(8) encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social
service organizations, government, and other stakeholders to develop comprehensive homelessness policies
and plans that address the healthcare and social needs of homeless patients;
(9) (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b)
opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-
sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e.,
eating, sitting, or sleeping) when there is no alternative private space available; and
(10) recognizes that stable, affordable housing is essential to the health of individuals, families, and
communities, and supports policies that preserve and expand affordable housing across all neighborhoods.
Sources:
Whereas, pregnancy-related mortality rate per 100,000 live births (PRMR) has peaked in the
United States over the past decade and hovers at 17 percent, the highest of any industrialized
country, with pregnancy-related mortality defined as “death of a woman while pregnant or within 1
year of the end of pregnancy from any cause related to or aggravated by the pregnancy,” and

Whereas, Michigan ranks as the eighth worst state for maternal mortality rate and third
worst for Black mothers in the entire U.S., with additional disparities existing in age and educational
level, and

Whereas, more than 50 percent of all maternal deaths in Michigan are preventable, with
leading causes of death attributable to obstetric hemorrhage, hypertension, pulmonary embolism,
amniotic fluid embolism, infection, and a worsening of pre-existing chronic conditions, and

Whereas, the Michigan Alliance for Innovation on Maternal Health (MI-AIM), pioneered by
Robert Sokol, MD; Dawn Shanafelt, MPA, BSN, RN; Jody Jones, MD; Mary Schubert; and Michigan
Maternal Mortality Surveillance (MMMS) initiatives have led to the creation of “patient safety
bundles” in 2015 to address leading causes of mortality that have led to a 10.5 percent overall
decrease in maternal death rates in Michigan by participating birthing institutions, and

Whereas, despite success at institutions that have implemented MI-AIM’s safety bundles,
only 50 percent have complete adoption and no standardization of data collection exists to
measure outcomes, and

Whereas, racial/ethnic disparities in maternal mortality and morbidity for Black and
American Native/American Indian mothers in Michigan have improved from five times that of white
mothers in 2007-2010 to 2.7 times in 2013-2017, yet still persist, since the startup of MI-AIM, and

Whereas, Texas has achieved 99 percent of participation from all of its birthing centers into
AIM since expanded Medicaid reimbursement to adopting centers, and

Whereas, California, which currently has the lowest maternal mortality rate, created the
California Maternal Quality Care Collaborative (CMQCC), whose fully implemented programs at 95
percent of their birthing centers include required implicit bias training for all health care workers
involved in perinatal care and ongoing studies assessing racial/ethnic differences in pregnancy
outcomes for those with comorbidities, and
Whereas, the mission of MSMS is to improve the lives of physicians so they may best care for the people they serve in the state of Michigan and advocate on behalf of both physicians and their patients; therefore be it

RESOLVED: That MSMS will support the participation in Michigan Alliance for Innovation on Maternal Health safety bundles by all birthing institutions in the state of Michigan; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) urge the AMA to recognize the need for all birthing institutions in the United States to participate in the Alliance for Innovation on Maternal Health and implement patient safety bundles; and be it further

RESOLVED: That MSMS will support Medicaid coverage for birthing centers who become active members of Michigan Alliance for Innovation on Maternal Health in order to improve full participation rates; and be it further

RESOLVED: That MSMS will support the Michigan requirement of all health care workers to undergo implicit bias training to further close the racial/ethnic gap in maternal mortality.

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

Relevant MSMS Policy:

Opposition to Compulsory Content of Mandated Continuing Medical Education
MSMS opposes any attempt to introduce compulsory content of mandated Continuing Medical Education (CME) in the state of Michigan. (Res67-07A) - Reaffirmed (Sunset Report 2020)

Relevant AMA Policy:
None

Sources:
3. ABEST. Racism and Inequity in Birth Outcomes for Black and Native American Families: A Review of the Literature
5. Houdeshell-Putt, MPH, DrPH L. MI AIM Interview. Published online February 18, 2021
7. Texas Health and Human Services Commission. State Efforts to Address Postpartum Depression | Maternal Mortality and Morbidity in Texas. Published online December 2020
Title: Use Term "Deaf and Hard of Hearing" in lieu of “Hearing Impaired”

Introduced by: Laura Carravallah, MD

Original Authors: Irene Lieu and Laura Carravallah, MD

Referred To:

House Action:

RESOLVED: That MSMS recommends that physicians adopt the term, “deaf and hard of hearing" and/or “persons with hearing loss” instead of “hearing impairment" in clinical settings; and

be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to recommend that physicians adopt the term “deaf and hard of hearing” and/or "persons with hearing loss" instead of “hearing impairment” in clinical settings.
WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions only requesting new or revised MSMS or AMA policy - $500

Relevant MSMS Policy:
None

Relevant AMA Policy:
None

Sources: