2023
HOUSE OF DELEGATES

THE ONE HUNDRED FIFTY-EIGHTH
ANNUAL SESSION

April 22 - 23, 2023
The Henry, Dearborn
Saturday, April 22, 2023

8:00 am – 7:00 pm  Registration – Presidential Ball Room Pre-Function

9:00 am – 10:00 am  County and Section Breakfast Meetings
   Wayne/Oakland – The Gallery
   West Michigan Regions 5 & 8 – Salon VII

10:00 am – 10:30 am  Reference Committee on Ways and Means - Delegate

10:30 am – 12:30 pm  Reference Committee Hearings
   Reference Committee A - Medical Care Delivery – Plaza A
   Reference Committee B – Legislation – Plaza B
   Reference Committee C - Internal Affairs, Bylaws, and Rules – Salon V
   Reference Committee D - Public Health – Salon VI
   Reference Committee E - Scientific and Educational Affairs – Salon VII

12:30 pm  Lunch

12:30 – 2:30 pm  First Meeting of the House – Presidential Ballroom
   Call to Order
   Memorial Service for Deceased Delegates
   Candidate Forum
   Report from the Chair of the Board – Mark C. Komorowski, MD
   Address of the Interim CEO - Thomas M. George, MD
   Report from the Treasurer – John A. Waters, MD
   Immediate Past President's Citations – Pino D. Colone, MD
   Address of the President – Thomas J. Veverka, MD
   Address of the President-Elect – M. Salim U. Siddiqui, MD, PhD

2:30 – 3:00 pm  Reference Committee on Ways and Means - Delegate

2:30 – 3:30 pm  AMA Town Hall Meeting - Presidential Ballroom

3:00 – 3:30 pm  MDPAC Board of Directors – The Gallery

3:30 – 5:00 pm  Presidents’ Installation and Reception Honoring M. Salim U. Siddiqui, MD, PhD – Plaza Ballroom

5:00 – 6:00 pm  MDPAC Reception – The Gallery
Sunday, April 23, 2023

6:30 – 7:45 am  County and Section Breakfast Meetings
                Ingham/Washtenaw – Salon V
                Saginaw – Salon VI
                Medical Student’s Section – Plaza B
                Wayne/Oakland – The Gallery
                West Michigan Regions 5 & 8 – Salon VII

6:30 – 7:45 am  Michigan Delegation to the AMA Breakfast Meeting – Plaza A

8:00 am  Second Meeting of the House - Presidential Ballroom
          Report of the Committee on Credentials and Tellers
          Nominations and Elections

          Reports of Reference Committees
          Ways and Means
          D – Public Health
          B – Legislation
          A – Medical Care Delivery
          E – Scientific and Educational Affairs
          C – Internal Affairs, Bylaws, and Rules
MSMS Speakers’ Principles of Rules of Order

(Based on Sturgis)

1. Only one main motion

2. A motion may be amended only to second order

3. Motion stated affirmatively

4. Precedence of motion must be honored

5. A motion, once reiterated by Chair, belongs to assembly

6. Member may speak/vote against own motion

7. Any member may move for reconsideration

8. Unless otherwise stated, vote immediately applies only to immediately-pending issue

9. More than majority vote required when rights are limited

10. Requests are rights of member/assembly which may be asked for

11. On appeal, vote always on sustaining speaker or vice speaker

12. Nominations require no second

13. Presiding officer may vote

14. Presiding officer may not adjourn meeting
## Principal Rules Governing Motions

<table>
<thead>
<tr>
<th>Order of precedence</th>
<th>Can interrupt?</th>
<th>Requires second?</th>
<th>Debatable?</th>
<th>Amend-able?</th>
<th>Vote required?</th>
<th>Applies to what other motions?</th>
<th>Can have what other motions applied to it?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Privileged Motions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Adjourn</td>
<td>No</td>
<td>Yes</td>
<td>No(^3)</td>
<td>Yes(^3)</td>
<td>Majority</td>
<td>None</td>
<td>Amend</td>
</tr>
<tr>
<td>2. Recess</td>
<td>No</td>
<td>Yes</td>
<td>Yes(^3)</td>
<td>Yes(^3)</td>
<td>Majority</td>
<td>None</td>
<td>Amend(^3)</td>
</tr>
<tr>
<td><strong>Subsidiary Motions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Postpone temporarily (Table)</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Majority(^2)</td>
<td>Main motion</td>
<td>None</td>
</tr>
<tr>
<td>4. Close debate</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>2/3</td>
<td>Debatable motions</td>
<td>None</td>
</tr>
<tr>
<td>5. Limit debate</td>
<td>No</td>
<td>Yes</td>
<td>Yes(^3)</td>
<td>Yes(^3)</td>
<td>2/3</td>
<td>Debatable motions</td>
<td>Amend(^3)</td>
</tr>
<tr>
<td>6. Postpone to a certain time</td>
<td>No</td>
<td>Yes</td>
<td>Yes(^3)</td>
<td>Yes(^3)</td>
<td>Majority</td>
<td>Main motion</td>
<td>Amend(^3), close debate, limit debate</td>
</tr>
<tr>
<td>7. Refer to committee</td>
<td>No</td>
<td>Yes</td>
<td>Yes(^3)</td>
<td>Yes(^3)</td>
<td>Majority</td>
<td>Main motion</td>
<td>Amend(^3), close debate, limit debate</td>
</tr>
<tr>
<td>8. Amend</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
<td>Rewordable motions</td>
<td>Close debate, limit debate, amend</td>
</tr>
<tr>
<td><strong>Main Motions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. a. The main motion</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
<td>None</td>
<td>Restorative, subsidiary</td>
</tr>
<tr>
<td>9. b. Restorative main motions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amend a previous action</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
<td>Main motion</td>
<td>Subsidiary, restorative</td>
</tr>
<tr>
<td>Ratify</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
<td>Previous action</td>
<td>Subsidiary</td>
</tr>
<tr>
<td>Reconsider</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes(^3)</td>
<td>No</td>
<td>Majority</td>
<td>Main motion</td>
<td>Close debate, limit debate</td>
</tr>
<tr>
<td>Rescind</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Majority</td>
<td>Main motion</td>
<td>Close debate, limit debate</td>
</tr>
<tr>
<td>Resume consideration</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Majority</td>
<td>Main motion</td>
<td>None</td>
</tr>
</tbody>
</table>

## Incidental Motions

<table>
<thead>
<tr>
<th>No order of precedence</th>
<th>Can interrupt?</th>
<th>Requires second?</th>
<th>Debatable?</th>
<th>Amend-able?</th>
<th>Vote required?</th>
<th>Applies to what other motions?</th>
<th>Can have what other motions applied to it?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Motions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appeal</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Majority</td>
<td>Decision of chair</td>
<td>Close debate, limit debate</td>
</tr>
<tr>
<td>Suspend rules</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>2/3</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Consider informally</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Majority</td>
<td>Main</td>
<td>None</td>
</tr>
<tr>
<td><strong>Requests</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question of privilege</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Point of order</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
<td>Any error</td>
<td>None</td>
</tr>
<tr>
<td>Parliamentary inquiry</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
<td>All motions</td>
<td>None</td>
</tr>
<tr>
<td>Withdraw a motion</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
<td>All motions</td>
<td>None</td>
</tr>
<tr>
<td>Division of question</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
<td>Main motion</td>
<td>None</td>
</tr>
<tr>
<td>Division of assembly</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
<td>Indecisive vote</td>
<td>None</td>
</tr>
</tbody>
</table>

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1. Motions are in order only if no motion higher on the list is pending.
2. Requires two-thirds vote when it would suppress a motion without debate.
3. Debatable if no other motion is pending.
4. Withdraw may be applied to all motions.
<table>
<thead>
<tr>
<th>What You Want To Accomplish, in order of precedence</th>
<th>What You Need To Say</th>
</tr>
</thead>
<tbody>
<tr>
<td>Close/adjourn the meeting</td>
<td>“I move that we adjourn”</td>
</tr>
<tr>
<td>Take a break/recess</td>
<td>“I move to recess until…”</td>
</tr>
<tr>
<td>Register a complaint/raise a question of privilege</td>
<td>“I rise to a question of privilege”</td>
</tr>
<tr>
<td>Postpone an item temporarily/Table 2</td>
<td>“I move that we postpone/table the item temporarily”</td>
</tr>
<tr>
<td>Close debate and vote immediately 3</td>
<td>“I move to close debate”</td>
</tr>
<tr>
<td>Limit or extend debate</td>
<td>“I move to limit debate of each speaker to…”</td>
</tr>
<tr>
<td>Postpone to a certain time</td>
<td>“I move to postpone the item until…”</td>
</tr>
<tr>
<td>Refer an item</td>
<td>“I move to refer this item to the Board”</td>
</tr>
<tr>
<td>Amend (by substitution, insertion, deletion)</td>
<td>“I would like to amend the resolution by…”</td>
</tr>
<tr>
<td>Bring business before assembly, i.e. main motion 4</td>
<td>“I move that…”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Restorative Main Motions, no order of precedence. Introduce when nothing else is pending.</th>
<th>What You Need to Say</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amend a previous action</td>
<td>“I move to amend the motion that was…”</td>
</tr>
<tr>
<td>Reconsider an item previously votes upon</td>
<td>“I move to reconsider…”</td>
</tr>
<tr>
<td>Rescind a previously considered item</td>
<td>“I move to rescind…”</td>
</tr>
<tr>
<td>Resume consideration/take from the table</td>
<td>“I move to resume consideration of…”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Incidental Motions, no order of precedence</th>
<th>What You Need to Say</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree with the ruling of the Speaker</td>
<td>“I appeal the ruling of the chair”</td>
</tr>
<tr>
<td>Suspend rules</td>
<td>“I move to suspend the rules requiring…”</td>
</tr>
<tr>
<td>Enforce rules</td>
<td>“Point of order.” State your point when recognized</td>
</tr>
<tr>
<td>Ask about parliamentary procedure</td>
<td>“Point of parliamentary inquiry”</td>
</tr>
<tr>
<td>Request to withdraw a motion</td>
<td>“I wish to withdraw the motion”</td>
</tr>
<tr>
<td>Divide an issue into individual resolved clauses</td>
<td>“I would like to divide the question”</td>
</tr>
<tr>
<td>Ask for a hand count of the assembly</td>
<td>“I call for a division of the assembly”</td>
</tr>
</tbody>
</table>

1 Motions are in order only if no motion higher on the list is pending, e.g. if a motion to close debate is pending, a motion to amend would be out of order, but a motion to recess would be in order, since it outranks the pending motion.
2 Tabling an item effectively results in killing the item and no action being taken unless the item is moved for reconsideration.
3 Unless specifically stated, vote will be taken only on the pending item.
4 Main motions are the resolutions submitted to the HOD.
STURGIS RULES OF ORDER

MOTIONS WITH PRECEDEENCE AND THEIR RANK

Precedented Motions

*Postponing temporarily or tabling a motion means no action is taken & the motion dies.
FLOW CHART FOR BUSINESS ITEMS

1. Did a member of the house request that the item be extracted from the consent calendar?
   - YES
   - NO

2. Did the reference committee recommend "adopt"?
   - NO
   - YES

3. Did the reference committee recommend "do not adopt"?
   - NO
   - YES

4. Did the reference committee recommend "refer"?
   - YES
   - NO

5. Did the reference committee recommend "amend"?
   - YES
   - NO

6. Did the reference committee recommend "substitution" of the original?
   - YES
   - NO

7. The speaker will explain the situation.

Original item is before the house as the Main Motion, discussion is on the proposed substitute.

Did the house adopt the proposed substitute?
   - YES
   - NO

Substitute is enacted.

Original item is before the house as the Main Motion, discussion is on the original item.
OFFICERS, 2022-2023

President: Thomas J. Veverka, MD  
President-Elect: M. Salim U. Siddiqui, MD, PhD  
Immediate Past President: Pino D. Colone, MD  
Secretary: T. Jann Caison-Sorey, MD, MSA, MBA  
Treasurer: John A. Waters, MD  
Speaker: Phillip G. Wise, MD  
Vice Speaker: Bryan W. Huffman, MD  
Chair: Mark C. Komorowski, MD  
Vice Chair: Paul D. Bozyk, MD  
Ex-Officio: Dennis M. Ramus, MD  
Ex-Officio: F. Remington Sprague, MD

REGIONAL DIRECTORS

Talat Danish, MD, MPH, FAAP, Wayne 2023  
Herbert C. Smitherman, Jr., MD, MPH, Wayne 2023  
Paul D. Bozyk, MD, Oakland 2025  
Daniel M. Ryan, MD, Macomb 2023  
Larry Junck, MD, Washtenaw 2025  
Bradley J. Uren, MD, Livingston 2023  
Robert M. Doane, MD, Jackson 2023  
David T. Walsworth, MD, Ingham 2024  
Mark E. Meyer, MD, Kalamazoo 2024

DESIGNATED DIRECTORS

At-Large Physician: Jayne E. Courts, MD, Kent 2023  
Independent Small Practice Physician: Donald P. Condit, MD, MBA, Kent 2023  
Physician Leader From Health System: Christopher J. Milback, MD, MBA, Oakland 2023  
Physician Organization Leader: Paul S. Harkaway, MD, Washtenaw 2023  
Physician Serving as DIO/Representing GME Training: Robert F. Flora, MD, MBA, MPH, Genesee 2023  
Physician Serving In Government/Public Health Role:

SECTION DIRECTORS

Young Physicians Section: Michael J. Redinger, MD, Kalamazoo  
Residents And Fellows Section: Kaitlyn D. Dobesh, MD, JD, Wayne  
Medical Students Section: Anna Kang, Wayne

DELEGATION TO THE AMA

Delegates  
Alternates (in order of seniority)  
Term Expires  
Term Expires

Paul D. Bozyk, MD, Oakland 2024  
T. Jann Caison-Sorey, MD, MSA, MBA, Wayne 2023  
Michael D. Chafty, MD, JD, Kalamazoo 2024  
Betty S. Chu, MD, MBA, Oakland 2023  
Pino D. Colone, MD, Genesee 2023  
Jayne E. Courts, MD, Kent 2024  
Mark C. Komorowski, MD, Bay 2023  
Rose M. Ramirez, MD, Kent 2024  
Venkat K. Rao, MD, Genesee 2024  
Michael A. Sandler, MD Wayne 2023  
Krishna K. Sawhney, MD, Wayne 2023  
Richard E. Smith, MD, Wayne 2024  
David T. Walsworth, MD, Ingham 2023  
Kaitlyn Dobesh, MD, JD, Wayne, Resident  
Christie L. Morgan, MD, Oakland 2024  
Amit Ghose, MD, Ingham 2024  
John A. Waters, MD, Genesee 2024  
Theodore B. Jones, MD, Wayne 2023  
Patricia A. Kolverich, MD, Wayne 2023  
M. Salim U. Siddiqui, MD, PhD, Wayne 2023  
Kenneth Elmassian, DO, Ingham 2023  
Edward C. Bush, MD, Wayne 2023  
Courtland Keteyian, MD, Jackson 2024  
Michael J. Redinger, MD, Kalamazoo 2024  
Ashton Lewandowski, Medical Student
Notification of Slate of Offices – 2023 House of Delegates

REGIONAL DIRECTORS  (Three-year term to 2026 House of Delegates)

Region #1 – Wayne
Talat Danish, MD, MPH, FAAP, Wayne: completed two terms
Herbert C. Smitherman, Jr., MD, MPH, Wayne: completed two terms

Region #2 – Macomb and Oakland
Daniel M. Ryan, MD, Macomb: approved to fill the unexpired term of Doctor Adrian Christie

Region #3 – Lenawee, Livingston, Monroe, and Washtenaw
Bradley J. Uren, MD, Livingston: completed one term

Region #4 – Clinton, Eaton, Hillsdale, Ingham, and Jackson
Robert M. Doane, MD, Jackson: completed one term

Region #5 – Allegan, Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, and Van Buren
OPEN POSITION (Belen Amat, MD, Barry, resigned May 2022)
CANDIDATE: None  (candidate must be from a county other than Kalamazoo)

Region #6 – Genesee, Huron, Lapeer, Sanilac, Shiawassee, St. Clair, and Tuscola
P. Dileep Kumar, MD, MBA, FACP, CPE, St. Clair: completed two terms

Region #7 – Arenac, Bay, Gladwin, Gratiot, Isabella-Clare, Midland, and Saginaw
OPEN POSITION (Mark C. Komorowski, MD, Bay, completed three 3-year terms, ineligible for re-election)
CANDIDATE: Michael Adam Kremer, MD, Bay

Region #9 – See Enclosed Map with Counties
OPEN POSITION  (Candidate must be from a county located in the Upper Peninsula)
CANDIDATE: Ryan J. Brang, MD, Marquette-Alger

DESIGNATED DIRECTORS.  (Three-year term to 2026 House of Delegates)
Following is the official notification of the designated director candidate slate for 2023.

At-Large Physician                          Jayne E. Courts, MD, FACP
Independent Small Practice Physician        Leah Davis, DO
Physician Leader from Health System         Chris Milback, MD, MBA, FAAFP
Physician Organization Leader               Open
Physician Serving as DIO/Representing GME Training Robert Francis Flora, MD, MBA, MPH
Physician Serving in Government/Public Health Role  Jennifer Morse, MD, MPH, FAAFP

**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 2024 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 2025 House of Delegates.

**OFFICERS** *(One-year term to 2024 House of Delegates)*

**Speaker:** Phillip G. Wise, MD, Kent

**Vice Speaker:** Bryan W. Huffman, MD, Ottawa

**President-elect Candidate:** Mark C. Komorowski, MD, Bay

**MICHIGAN DELEGATION TO THE AMA** *(Two-year term to 2025 House of Delegates)*

**Delegates**
- T. Jann Caison-Sorey, MD, MSA, MBA, 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
- Edward C. Bush, MD, Wayne

**CANDIDATES FOR AMA ALTERNATE DELEGATES (TO DATE):**
- Brooke M. Buckley, MD, Wayne

* Four non-incumbent alternate delegate positions are available. Due to an increase in AMA membership, Michigan gained one additional Delegate and Alternate Delegate seat; therefore, Doctor T. Jann Caison-Sorey moved to Delegate pursuant to MSMS Bylaws.

Funding to help cover costs related to attendance at the AMA Annual and Interim meetings is capped at an amount set by the MSMS Board of Directors and based on the current Delegation size of 25 members. To receive reimbursement, each delegate must attend **all** days of the meeting. If the total number of delegates
or alternate delegates increases above the current 25, the per person fixed rate reimbursement will decrease to stay within the budget.

Resident position will take a seat as an AMA Delegate and the Student position will take a seat as an AMA Alternate Delegate for the term 2022-2024.
<table>
<thead>
<tr>
<th>Name</th>
<th>Incumbent</th>
<th>MSMS Member</th>
<th>AMA Member</th>
<th>2022 AMA HOD Engagement</th>
<th>Candidate Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thelma Jann Caison-Sorey, MD, MSA, MBA, FAAP</td>
<td>Yes</td>
<td>Many</td>
<td>Many</td>
<td>Attended the 2022 AMA Annual and Interim HOD Meetings. &lt;br&gt; Participated in Michigan Delegation Caucus Meetings. &lt;br&gt; Participated in Great Lakes States Coalition meetings. &lt;br&gt; Chaired the GLSC interviews for the AMA Council on Science and Public Health. &lt;br&gt; Served on Reference Committee C (Medical Education). &lt;br&gt; Attended Reference Committees. &lt;br&gt; Vice Chair of the AMA Code of Conduct at AMA Meetings and Sponsored Events Committee.</td>
<td>As your Michigan State Medical Society AMA Alternate Delegate, it has been a true honor for me to represent you as part of the Michigan Delegation. I am passionate about the practice of Medicine and most of all, passionate about the livelihoods and well-being of Michigan physicians, our practices and our patients. I will speak up when it is needed. I am diligent and committed. I spoke up and gave voice to making sure we did what was right - as the AMA House of Delegates - as it related to taking a public health stand during our virtual national meeting in 2020. I enjoy interacting with my colleagues and understand what is at stake every time a bill is introduced at a national, state or local level that impacts our ability to practice the centuries old art of medicine which we have been highly trained for. I will always give my best, work hard and stay true to our profession that is unmatched by any other. I ask for your support to continue my roles as your AMA Alternate Delegate and to do the work that will continue to be needed to represent you. Thank you.</td>
</tr>
<tr>
<td>Betty S. Chu, MD, MBA</td>
<td>Yes</td>
<td>25 years</td>
<td>20 years</td>
<td>Attended the 2022 AMA Annual and Interim HOD Meetings. &lt;br&gt; Participated in Michigan Delegation Caucus Meetings. &lt;br&gt; Participated in Great Lakes States Coalition meetings.</td>
<td>Serving on the AMA Delegation has allowed me to use my leadership experiences at the county and state medical society levels to advocate for the voice of Michigan physicians. I hope to continue using the experience in our Michigan practices to influence work at the AMA Council on Medical Service after my recent election to a second term. &lt;br&gt; Our Delegation has a diversity of gender, age, and practice types allowing us to bring multiple perspectives to the AMA. My personal experience in small group private practice,</td>
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<td>Name</td>
<td>Incumbent</td>
<td>MSMS Member</td>
<td>AMA Member</td>
<td>2022 AMA HOD Engagement</td>
<td>Candidate Statement</td>
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<tr>
<td>Pino D. Colone</td>
<td>Yes</td>
<td>34 years</td>
<td>34 years</td>
<td>Attended the 2022 AMA Annual and Interim HOD Meetings.</td>
<td>I am seeking re-election as Delegate on the Michigan Delegation to the American Medical Association (AMA) to continue to represent the physicians of our great state. I also currently serve on the AMA Council on Constitution and Bylaws. I have served as president of MSMS and as Chair of the AMA Council on Constitution and Bylaws. I remain passionate and committed to serving our physicians, our patients, and our profession. I humbly ask for your vote for re-election as Delegate to the Delegate on the Michigan Delegation to the AMA. Thank you.</td>
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<td>Re-elected to the AMA Council on Medical Service (CMS).</td>
<td>hospital physician and medical staff leadership – and now overseeing quality and safety at a large health system makes me uniquely qualified to advocate as a delegate.</td>
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<td>Represented the AMA CMS at assigned Reference Committees.</td>
<td>I look forward to returning to the Michigan Delegation as an active and fully engaged participant.</td>
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<td>Attended Reference Committees.</td>
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<td>Participated in meetings of the following sections/caucuses:</td>
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<td>• Women Physicians Section</td>
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<td>• ACOG</td>
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<td>Name</td>
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<td>AMA Member</td>
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<tr>
<td>Mark C. Komorowski, MD</td>
<td>Yes</td>
<td>30 years</td>
<td>15 years</td>
<td>Attended the 2022 AMA Annual and Interim HOD Meetings.</td>
<td>As Chair of the Delegation I have developed relationships across various demographics to create and promote policies that improve the practice of medicine for all physicians and medical students. Scope of practice issues continue to plague our profession both locally and nationally and I participate in a forum held at the AMA HOD each meeting. Membership in the Integrated Physician Practices Section (IPPS) and Private Practice Physicians Section (PPPS) allows me to acquire and share information with like minded colleagues. The complexion of health is changing with private equity, also known as predatory equity, purchasing private practices. I believe my knowledge and diligence will continue to serve our Delegation and MSMS. I humbly ask for your consideration and vote to remain on our AMA Delegation.</td>
</tr>
<tr>
<td>Michael Sandler, MD</td>
<td>Yes</td>
<td>44 years</td>
<td>44 years</td>
<td>Not able to attend due to schedule conflicts.</td>
<td>As a Delegate, I have attended 32 of the last 34 AMA meetings and have been a full participant with the Michigan Delegation and my specialty caucus. I have been actively involved in</td>
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<tr>
<td>Krishna K. Sawhney, MD</td>
<td>Yes</td>
<td>45 years</td>
<td>45 years</td>
<td>Attended the 2022 AMA Annual and Interim HOD Meetings.</td>
<td>I am an active practicing surgeon at HFHS. Changes in health care management and patient care are constant. I am an active member of IPPS representing general practice. I am knowledgeable about the changes around us. I continue to want to protect and preserve the practice of medicine of tomorrow. I request your support to continue to accomplish that. Thanks.</td>
</tr>
<tr>
<td>David T. Walsworth, MD, FAAP</td>
<td>Yes</td>
<td>32 years</td>
<td>32 years</td>
<td>Attended the 2022 AMA Annual and Interim HOD Meetings.</td>
<td>I am David Walsworth, a family physician from East Lansing. 2023 marks the thirtieth year since my graduation from Wayne State University School of Medicine. My medical career has been dedicated to the service and education of patients, staff, peers, and our profession. For the past fifteen years, it has been my privilege to serve our Michigan State Medical Society House of Delegates at our American Medical Association House of Delegates as an Alternate, and now Delegate. Over the past thirty meetings of our AMA House of Delegates, I have been honored to lead our policy and advocacy issues on nearly every reference committee delegation group, serve on, and chair several reference and house committees. Along with the other Delegates and Alternates, we have helped to bring the resolutions of our MSMS House of Delegates and change the policies of our</td>
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<td>Chaired Reference Committee C (Education) (no extractions)</td>
<td>AMA. I am proud to serve on our delegations and of the contributions that I have made over the years. I ask for your continued support of me as a Delegate to our AMA House of Delegates from our MSMS House of Delegates.</td>
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<td>Attended Reference Committees.</td>
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<td>Participated in meetings of the following sections/caucuses: • Academic Medicine • American Academy of Family Physicians.</td>
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Candidates for Alternate Delegate to the American Medical Association

<table>
<thead>
<tr>
<th>Name</th>
<th>Incumbent</th>
<th>MSMS Member</th>
<th>AMA Member</th>
<th>2022 AMA HOD Engagement</th>
<th>Candidate Statement</th>
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<tbody>
<tr>
<td>Brooke Buckley, MD</td>
<td>No</td>
<td>2 years</td>
<td>24 years</td>
<td>Not applicable; not a member of the Michigan Delegation to the AMA.</td>
<td>I moved from Maryland (where I had been on the Delegation to the AMA for many years). In 2020, I was recruited to Henry Ford by Dr Betty Chu. I am serving on the AMPAC board currently and am the Secretary of AMPAC. I am serving the Wayne County board and the Michigan Medicine Editorial board and would be honored to join the Michigan Delegation. I come off the Maryland delegation in June of 2023. By way of further introduction, I was an Ohio State Medical Association member from 1998-2007 where I was a medical student at OSU and then a resident in general surgery at the Cleveland Clinic System. I served on the MSS and RFS governing councils to the AMA as both a student and a resident. I also was fortunate enough to be on the AMPAC board as a resident.</td>
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<td>E. Chris Bush, MD</td>
<td>Yes</td>
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<td><strong>In Maryland, I was the president of the Maryland State Medical Society from 2015-2016 and served on the MedChi board for many years. Another passion project for me has been the Physician Health Program. I have been on the PHP board for many years in Maryland and continue to give multiple grand rounds yearly around physician burnout and addiction for the PHP program. I am looking for opportunities to continue this work in Michigan.</strong></td>
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<td><strong>Finally, I have always enjoyed being on a geographic delegation versus a specialty delegation. I am board certified in General Surgery and Lifestyle Medicine and have a good relationship with the surgical caucus and the specialty society in the AMA.</strong></td>
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<td><strong>Thank you for considering my application.</strong></td>
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<td><strong>The American Medical Society House of Delegates is the consummate deliberative body that represents all of Medicine and the patients we serve. Any AMA member can present an issue, a concern or a breakthrough concept in the form of a resolution and can see it go through the process toward becoming AMA policy.</strong></td>
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<td><strong>I have had the honor and privilege to serve as one of your Alternate Delegates over the last four years. Our Michigan Delegation is impactful and influential in the House. This dynamic group calls on all of its members to be engaged and involved at every meeting.</strong></td>
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<td><strong>There are a numbers of Sections in the House that represent different constituencies. For years I have served on the Organized Medical Staff Section. We represent hospital and large group medical staffs.</strong></td>
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<td><strong>Over the years I have served on its reference committee, three times as chair. My involvement with the Section has led with many friendships with physicians across the nation.</strong></td>
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| Theodore B. Jones, MD| Yes       | 26 years    | 22 years   | Attended the 2022 AMA Annual Meeting. Unable to attend the 2022 AMA Interim Meeting due to schedule conflict. | Most of these colleagues are also members of the House of Delegates. There is a relatively new section called the Private Practice Physicians Section which I have joined as well.  
As a family physician I also am engaged with my specialty society, the American Academy of Family Physicians. The AAFP is the largest specialty delegation and have developed lifelong friendships with many of its members.  
At the Interim 2021 meeting I chaired the Reference Committee E. That was a challenging experience as it was a virtual meeting due to the Pandemic. The Speakers did a great job working with the physicians and staff to pull it all together.  
Michigan was the host state of the Great Lakes States Chapter in 2022. I was asked to serve as chair for the Reference Committee E work group. That was an enjoyable experience getting to know fellow physicians from the Midwest.  
At the Interim meeting in 2022, Many of the Alternate Delegates were advanced to Delegate status to cover some vacancies in the Delegation. That was a great opportunity to work with our delegates and other House members. The HOD considered many critical issues including human reproductive rights, gun violence, physician burnout and the social determinants of illness.  
In summary, I feel I can contribute in meaningful ways to help support the Delegation represent the physicians of Michigan State Medical Society and the patients we serve.  
There are many ways to serve the patients in our communities as well as the colleagues who serve them. My journey began in our county medical society and then continued with leadership positions there and then in our
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<tbody>
<tr>
<td>Patricia A. Kolowich, MD</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Participated in Michigan Delegation Caucus Meetings.</td>
<td>The opportunity to join our Michigan delegate to the AMA House of Delegates as an alternate delegate has been a privilege that I have embraced with active engagement in all delegate activities and with participation in the work of the House of Delegates, including serving on two Reference Committees and participating with specialty groups focused on academic medicine and equity in medicine. I look forward to continuing the efforts of the delegation to advocate for the health of Michigan communities and their physicians. Thank you for considering my request to serve you for another term in office.</td>
</tr>
<tr>
<td>M. Salim Siddiqui, MD</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Attended the 2022 AMA Annual and Interim HOD Meetings.</td>
<td>The past few years have uncovered many gaps that exist in healthcare, while at the same time putting undue burdens on physicians. As a result, there is no greater time than now to protect the house of medicine and to assure the state medical society as speaker of our House of Delegates. I have enjoyed my time as Alternate Delegate to the AMA. I have again become comfortable with the proceedings and have served on a Reference Committee and been active with the GLSC. There is a ‘learning’ experience with the AMA HOD and I feel that I have progressed in my comfort level and knowledge of the AMA mission and purpose. I feel that I can be an asset to the Delegation. There are not many surgeons on the Delegation, and I believe that I can contribute from a different perspective to the success of the group.</td>
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<td>Participated in Michigan Delegation Caucus Meetings.</td>
<td>collective voice of our physicians is heard. I have been honored and privileged to serve my fellow physicians as their voice not only as an active member of our MSMS, but also as an active Alternate Delegate on our Michigan Delegation to the AMA. I humbly ask to continue to serve as an Alternate Delegate on our Michigan Delegation to the AMA during this critical time.</td>
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<td>Participated in Great Lakes States Coalition meetings.</td>
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<td>Attended Reference Committees.</td>
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<td>Participated in meetings of the following sections/caucuses:</td>
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<td></td>
<td>• Young Physicians</td>
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<td>• Integrated Physician Practices</td>
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<td>• Radiological Society</td>
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<td>• Cancer Caucus</td>
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In Memory

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

Elie Aboulafia, MD
Busharat Ahmad, MD
Syed Akram Ali, MD
Russell Ameter, MD
Leroy C. Barry, MD
Mario Benvenuto, MD
Jeffrey Block, MD
Frederick Brenner, MD
Robert Brown, MD
Harry Burdick, MD
M. Gerard Cloherty, MD
Bhogilal Doshi, MD
Jean-Claude Elie, MD
Donald Elzinga, MD
Carlton Fischer, MD
William Fuqua, MD
Otto Gago, MD
George W. Gibson, DO
Sandra Gladding, MD
Howard S. Goldberg, MD
William Graves, MD
Gerhardt Hein, MD
John Huntington, MD
Charles Inniss, MD
Susan Kennedy, MD
Natalio Kogan, MD
Richard Kreuzer, MD
Zal Kutar, MD
Walter Lee, MD
Susan Lehman, MD
George Lightbourn, MD
Neil Love, MD
Nader Meri, MD
Marilyn Mittenenthal, DO
George Morley, MD
John Morrison, DO
Alan Neiberg, MD
Anna Novak, MD
Donald Paarlberg, MD
Edgardo Paguio, MD
John Pasko, MD
Francis Pauli, MD
Thomas Payne, MD
Sol Pickard, MD
Alex Pickens, MD
Jeffrey Pollet, MD
E. James Potchen, MD
Ananda Prasad, MD
Mohammad Rabbani, MD
Ali Rabbani, MD
J. Eugene Rank, MD
Ralph Raper, MD
Thomas Ringer, MD
Jan Rival, MD
Elmer Robertson, MD
Carla Sander, MD
Paul Schroeder, MD
Garland Scott, Jr., MD
Kirtikant Shah, MD
Joel Silberg, MD
Carleton Smith, MD
John Stageman, MD
Alan Stoddard, MD
Romeo Tabbilos, MD
Ben Tan, MD
Margaret Thompson, MD
Barbara Threatt, MD
Laura Tinning, DO
Paul Vandenbrink, MD
Ronald VanderLugt, MD
Jerry Waldyke, MD
Denis Walsh, MD
James Webb, MD
Jason White, MD
Earl Williams, MD
Ismael Yanga, MD
Charles Zickus, DO
## Roster of Delegates

### OFFICERS:

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>County</th>
<th>Role</th>
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<tbody>
<tr>
<td>Phillip Wise</td>
<td>Speaker</td>
<td>Barry</td>
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<tr>
<td>Bryan Huffman</td>
<td>Vice-Speaker</td>
<td>Berrien</td>
<td>Delegate</td>
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<tr>
<td>T. Jann Caison-Sorey</td>
<td>Secretary</td>
<td>Genesee</td>
<td>Delegate</td>
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<tr>
<td>Belen Amat-Martinez</td>
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<td>Genesee</td>
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<td>Dennis Szymanski</td>
<td>Delegate</td>
<td>Genesee</td>
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<tr>
<td>Khalid Ahmed</td>
<td>Delegate</td>
<td>Grand Traverse - Leelanau - Benzie</td>
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<td>Edward Christy</td>
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<td>Paul Kocheril</td>
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<td>S. Bobby Mukkamala</td>
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<td>Venkat Rao</td>
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<td>Qazi Azher</td>
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<td>John Hebert, III</td>
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<td>Rama Rao</td>
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<td>Brenda Rogers-Gray</td>
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<td>Leah Davis</td>
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<td>Bradley Goodwin</td>
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<td>Frederick Brodeur, Jr.</td>
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<td>Iftiker Ahmad</td>
<td>Delegate</td>
<td>Jackson</td>
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<td>Narasimha Gundamraj</td>
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<td>Wardha Shabbir</td>
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<tr>
<td>Michael Chafty</td>
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## County: Kent

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<th>Name</th>
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<td>Avery</td>
<td>MD</td>
<td>Delegate</td>
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<td>Delegate</td>
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</tr>
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</table>
### Delegate-At-Large: Medical School Dean, Wayne State University

<table>
<thead>
<tr>
<th>Name</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Wael Sakr MD</td>
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</table>

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

<table>
<thead>
<tr>
<th>Name</th>
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</thead>
<tbody>
<tr>
<td>Paula Termuhlen MD</td>
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### Members-At-Large: MDHHS Chief Medical Officer

<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Natasha Bagdasarian MD</td>
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### Medical Student Section

<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Carly Abrahams</td>
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<td></td>
</tr>
<tr>
<td>Viviennne Acuna</td>
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<td></td>
</tr>
<tr>
<td>Nick Bara</td>
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<td></td>
</tr>
<tr>
<td>Khristian Burke</td>
<td>Student Delegate</td>
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</tr>
<tr>
<td>Andrea Dai</td>
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<td></td>
</tr>
<tr>
<td>Danielle DuPuis</td>
<td>Student Delegate</td>
<td></td>
</tr>
<tr>
<td>Joanna Hua</td>
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</tr>
<tr>
<td>Jovan Jande</td>
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<td></td>
</tr>
<tr>
<td>Ashton Lewandowski</td>
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</tr>
<tr>
<td>Nicholas Linville</td>
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<tr>
<td>Madeline Merwin</td>
<td>Student Delegate</td>
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</tr>
<tr>
<td>Emily Ridge</td>
<td>Student Delegate</td>
<td></td>
</tr>
<tr>
<td>Merzia Subhan</td>
<td>Student Delegate</td>
<td></td>
</tr>
<tr>
<td>Kiersten Walsworth</td>
<td>Student Delegate</td>
<td></td>
</tr>
<tr>
<td>Mura Abdul-Nabi</td>
<td>Student Alternate Delegate</td>
<td></td>
</tr>
<tr>
<td>Amanda Cournoyer</td>
<td>Student Alternate Delegate</td>
<td></td>
</tr>
<tr>
<td>Liam Dalton</td>
<td>Student Alternate Delegate</td>
<td></td>
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<tr>
<td>Elizabeth Darga</td>
<td>Student Alternate Delegate</td>
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<tr>
<td>Katelyn de Lara</td>
<td>Student Alternate Delegate</td>
<td></td>
</tr>
<tr>
<td>Vanessa Elliott</td>
<td>Student Alternate Delegate</td>
<td></td>
</tr>
<tr>
<td>Alexander Eskandarian</td>
<td>Student Alternate Delegate</td>
<td></td>
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<tr>
<td>Norah Fanning</td>
<td>Student Alternate Delegate</td>
<td></td>
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<tr>
<td>Marquisha Myles</td>
<td>Student Alternate Delegate</td>
<td></td>
</tr>
<tr>
<td>Sohini Pandit</td>
<td>Student Alternate Delegate</td>
<td></td>
</tr>
<tr>
<td>Aarti Patel</td>
<td>Student Alternate Delegate</td>
<td></td>
</tr>
<tr>
<td>Agnieszka Steiner</td>
<td>Student Alternate Delegate</td>
<td></td>
</tr>
<tr>
<td>Kathryn Tighe</td>
<td>Student Alternate Delegate</td>
<td></td>
</tr>
<tr>
<td>Grace Tremonti</td>
<td>Student Alternate Delegate</td>
<td></td>
</tr>
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</table>

### International Medical Graduate Section

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<tr>
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<tbody>
<tr>
<td>Shilpi Sharma MD</td>
<td>Delegate</td>
<td></td>
</tr>
<tr>
<td>Barouyr Ajemian MD</td>
<td>Alternate Delegate</td>
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### Resident and Fellow Section

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<tr>
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<tbody>
<tr>
<td>Halley Crissman MD, MPH</td>
<td>Delegate</td>
<td></td>
</tr>
<tr>
<td>Gunjan Malhotra MD</td>
<td>Alternate Delegate</td>
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</table>

### Young Physician Section

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
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</thead>
<tbody>
<tr>
<td>John Hopper MD</td>
<td>Specialty Society Delegate</td>
<td></td>
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</tbody>
</table>

### Specialty Society: MI Society of Addiction Medicine

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Delegate/Alternate Delegate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lawrence Hennessey MD</td>
<td>Specialty Society Delegate</td>
<td></td>
</tr>
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</table>

### Specialty Society: MI Allergy & Asthma Society

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Delegate/Alternate Delegate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lawrence Hennessey MD</td>
<td>Specialty Society Delegate</td>
<td></td>
</tr>
</tbody>
</table>
Specialty Society: MI Society of Anesthesiologists
Neeraja Ravikant MD Specialty Society Delegate

Specialty Society: MI Chapter, American College of Cardiology
Sunilkumar Rao DO Specialty Society Delegate

Specialty Society: MI Society of Colon and Rectal Surgeons
Antonia Henry MD Specialty Society Delegate
John Bauman MD Specialty Society Delegate

Specialty Society: MI College of Emergency Physicians
Sara Chakel MD, FACEP Specialty Society Delegate
Luke Saski MD, FACEP Specialty Society Alternate

Specialty Society: MI Society of Eye Physicians and Surgeons
Patrick Droste MD Specialty Society Delegate
Matthew Trese DO Specialty Society Alternate

Specialty Society: MI Academy of Family Physicians
Holli Neiman-Hart MD, FAAFP Specialty Society Delegate
Mary Marshall MD, RN, FAAFP Specialty Society Alternate

Specialty Society: MI Association of Medical Examiners
Carl Hawkins MD Specialty Society Delegate

Specialty Society: MI Neurological Association
Amit Sachdev MD Specialty Society Delegate

Specialty Society: MI Association of Neurological Surgeons
Hazem Eltahawy MD, MHCM, FRCS, FACS Specialty Society Delegate

Specialty Society: MI Section, American College of OB/GYN
Sara Jaber MD Specialty Society Delegate
David Lee MD Specialty Society Alternate

Specialty Society: MI Orthopaedic Society
Christopher Betzle MD Specialty Society Delegate

Specialty Society: MI Otolaryngological Society
Charles Koopmann, Jr., MD Specialty Society Delegate

Specialty Society: American College of Physicians, MI Chapter
Benjamin Diaczok MD Specialty Society Delegate

Specialty Society: MI Academy of Plastic Surgeons
Anthony Zacharek MD Specialty Society Delegate

Specialty Society: MI Psychoanalytic Society
Evangeline Spindler MD Specialty Society Delegate

Specialty Society: MI Association of Public Health & Preventive Medicine
Pamela Hackert MD, JD, MPH Specialty Society Delegate
Avani Sheth MD Specialty Society Alternate
<table>
<thead>
<tr>
<th>Specialty Society</th>
<th>Delegate Name</th>
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</thead>
<tbody>
<tr>
<td>MI Radiological Society</td>
<td>Katharine Scharer MD</td>
<td>Specialty Society Delegate</td>
</tr>
<tr>
<td>MI Rheumatism Society</td>
<td>Amar Majhoo MD</td>
<td>Specialty Society Delegate</td>
</tr>
<tr>
<td>MI Academy of Sleep Medicine</td>
<td>Maria Tovar Torres MD</td>
<td>Specialty Society Delegate</td>
</tr>
<tr>
<td>MI Chapter of the American College of Surgeons</td>
<td>Thomas Thornton MD</td>
<td>Specialty Society Delegate</td>
</tr>
<tr>
<td></td>
<td>Surya Nalamati MD</td>
<td>Specialty Society Alternate</td>
</tr>
</tbody>
</table>
Reference Committee A – Medical Care Delivery
Jon M. Lake, MD, Chair, Jackson
Barry I. Auster, MD, Oakland
Raza Ull Haque, MD, Ingham
Lawrence R. Hennessey, MD, MI Allergy and Asthma Society
Warren F. Lanphear, MD, FACEP, Kent
Wardha Shabbir, MD, Jackson
Emily Ridge, Central Michigan University

Board Advisors:
F. Remington Sprague, MD
Bradley J. Uren, MD

AMA Advisors:
E. Chris Bush, MD
Rose Ramirez, MD
Krishna K. Sawhney, MD
M. Salim U. Siddiqui, MD, PhD

Staff:
Virginia K. Gibson
Stacie J. Saylor

Reference Committee B – Legislation
Courtland Keteyian, MD, MBA, MPH, Chair, Jackson
Christopher J. Allen, MD, Saginaw
Bradley P. Goodwin, MD, Grand Traverse
John M. Pelachyk, MD, St Clair
Donald R. Peven, MD, Oakland
Neeraja T. Ravikant, MD, MI Society of Anesthesiologists
Neelima Thati, MD, Wayne

Board Advisors:
Jayne E. Courts, MD, FACP
Nita M. Kulkarni, MD

AMA Advisors:
Jayne E. Courts, MD, FACP
Amit Ghose, MD
Michael A. Sandler, MD
John A. Waters, MD

Staff:
Kate Dorsey
Josiah Kissling
Reference Committee C – Internal Affairs, Bylaws, and Rules
David W. Whalen, MD, Chair, Kent
Edward A. Christy, MD, Genesee
Betty S. Chu, MD, MBA, Oakland
Pino D. Colone, MD, Genesee
Kenneth Elmassian, DO, Ingham
Theodore B. Jones, MD, FACOG, Wayne

Board Advisors:
Bryan W. Huffman, MD
Phillip G. Wise, MD

AMA Advisors:
Michael D. Chafty, MD, JD
Mark C. Komorowski, MD
Venkat K. Rao, MD

Staff:
Rebecca J. Blake
Jennifer L. Finney

Reference Committee D – Public Health
Anthony M. Zacharek, MD, Chair, MI Academy of Plastic Surgeons
John A. Hopper, MD, MI Society of Addiction Medicine
Sherwin P.T. Imlay, MD, Oakland
James C. Mitchiner, MD, MPH, Washtenaw
Ijeoma N. Opara, MD, Wayne
Rama D. Rao, MD, Genesee
Latonya A. Riddle Jones, MD, Wayne

Board Advisors:
Melanie S. Manary, MD
Mildred J. Willy, MD

AMA Advisors:
Paul D. Bozyk, MD
T. Jann Caison-Sorey, MD, MSA, MBA
Kate Dobesh, MD, JD
Richard E. Smith, MD

Staff:
Dara J. Barrera
Anne’ka B. Marzette
Reference Committee E – Scientific and Educational Affairs
Cheryl D. Gibson Fountain, MD, Chair, Wayne
Nicolas K. Fletcher, MD, MHSA, Wayne
Ved V. Gossain, MD, Ingham
Sara Jaber, MD, MI Section of American College of OB/GYN
Aaron W. Sable, MD, Macomb
John E. VanSchagen, MD, Kent
Kiersten Walsworth, Wayne State University

Board Advisors:
Robert Francis Flora, MD, MBA, MPH
David T. Walsworth, MD

AMA Advisors:
Ashton Lewandowski
Christie L. Morgan, MD
Michael J. Redinger, MD
David T. Walsworth, MD

Staff:
Scott Kempa
Josh C. Richmond

Reference Committee on Ways and Means
Dennis C. Szymanski, MD, Chair, Berrien
Ronald B. Levin, MD, Vice-Chair, Macomb
Anita R. Avery, MD, Kent
E. Chris Bush, MD, Wayne
Venkat K. Rao, MD, Genesee
Edward J. Rutkowski, MD, Grand Traverse

Board Advisors:
Paul D. Bozyk, MD
Mark C. Komorowski, MD
Brian R. Stork, MD
John A. Waters, MD

Staff:
Lauchlin W. S. MacGregor
**Fiscal Note Formula/Narrative**

Resolutions are submitted each year requiring various levels of staff time and outsourced activities to accomplish. Historically, fiscal notes would be assigned only to those resolutions requiring unbudgeted outsourced expenses. The 2018 Ways and Means Committee requested that both staff time and outsourced costs be reported for each resolution to better measure the costs associated with accomplishing each resolution. The estimated costs include outsourced costs, staff time and related overhead costs. These amounts represent the estimated costs to accomplish the resolution.

The process to develop estimated fiscal note costs includes all staff expected to be involved in each type of resolution and the estimated amount of time it will take to accomplish the resolution from beginning to end. The time required to accomplish a resolution includes direct activities, various levels of prep/review/approvals/follow up, committee structures, department meetings, staff meetings, CEO meetings, board reference committees, board meetings, website updates, database updates, etc.

The staff costs are projected based on salaries, benefits, taxes and overhead allocated and the number of estimated hours needed to accomplish the resolution. Overhead is applied based on the same IRS approved methodology as used on the MSMS annual tax return. Overhead includes a portion of all costs associated with an employee performing their duties including but not limited to: desks, chairs, office supplies, office space, computers, printers, IT infrastructure, phone system, heating, cooling, electric, HR, accounting, office maintenance/repairs, cleaning, etc. The final component is any outsourced costs, if needed.

Below is a table of resolution activity types and the related estimated fiscal note costs:

<table>
<thead>
<tr>
<th>Activity Type</th>
<th>Activity Name</th>
<th>Estimated Staff Cost Range</th>
<th>Estimated Outsourced Cost Range</th>
<th>Total Estimated Cost Range</th>
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<tbody>
<tr>
<td>Advocacy</td>
<td>Messaging Campaign</td>
<td>4,500 - 9,000</td>
<td>-</td>
<td>4,500 - 9,000</td>
</tr>
<tr>
<td>Advocacy</td>
<td>Legislative</td>
<td>16,000 - 32,000</td>
<td>-</td>
<td>16,000 - 32,000</td>
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<tr>
<td>Advocacy</td>
<td>Ask AMA to Advocate</td>
<td>1,000 - 2,000</td>
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<td>1,000 - 2,000</td>
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<tr>
<td>Advocacy</td>
<td>Regulatory/Industry</td>
<td>12,000 - 24,000</td>
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<td>12,000 - 24,000</td>
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<tr>
<td>Education/Outreach</td>
<td>Collaborative Outreach Efforts</td>
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<td>-</td>
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<tr>
<td>Education/Outreach</td>
<td>Physician Outreach Efforts</td>
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<td>Public Education Campaign</td>
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<td>Basic Reporting/Communication</td>
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<tr>
<td>Education/Outreach</td>
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<td>Governance</td>
<td>Board Study</td>
<td>2,500 - 5,000</td>
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<tr>
<td>Governance</td>
<td>Bylaws Amendments</td>
<td>2,000 - 4,000</td>
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<td>2,000 - 4,000</td>
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<td>Governance</td>
<td>Bylaws Changes With Study</td>
<td>4,000 - 8,000</td>
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<td>4,000 - 8,000</td>
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<tr>
<td>Governance</td>
<td>New/Revised MSMS/AMA Policy</td>
<td>1,000 - 2,000</td>
<td>-</td>
<td>1,000 - 2,000</td>
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<tr>
<td>Other</td>
<td>External Consultants to Study Issue</td>
<td>2,000 - 4,000</td>
<td>25,000 - 50,000</td>
<td>27,000 - 54,000</td>
</tr>
<tr>
<td>Other</td>
<td>Request Cost Increase to Budget</td>
<td>1,000 - 2,000</td>
<td>-</td>
<td>specific amount</td>
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</tbody>
</table>
House of Delegates Conflict of Interest Policy

All members of the Michigan State Medical Society House of Delegates should declare any conflict of interest, including regulatory capture*, to the House of Delegates and its Reference Committees prior to testimony. The MSMS House of Delegates considers a potential conflict of interest to exist when a Delegate, Alternate Delegate, other physician member or a non-member testifying on the floor of the House of Delegates or in Reference Committee has a relationship, or engages in any activity, or has any personal financial or commercial interest that might impair his or her independence or judgment or inappropriately influence his or her decisions or actions concerning MSMS matters.


*Regulatory capture refers to the corruption of the regulatory process such that public good is sacrificed in favor of the commercial interests of the regulated entity.
At the 2022 House of Delegates, Resolution 45-22 – MSMS Committee on Membership Recruitment and Retention was introduced. The original resolved read that MSMS re-establish the Membership Committee with the following criteria:

- Committee meetings to occur no less than six times a year;
- Committee membership to be composed of MSMS leadership and staff, as well as not more than one leader and one staff member from each of the component societies for which MSMS is responsible for collecting dues;
- The Committee is to have a significant role in developing and adjusting the annual membership recruitment and retention plan; and
- The Committee is to develop a membership report for the 2023 MSMS House of Delegates that includes dues rates from other state and county medical societies for all membership categories to determine if a new dues rate structure is needed; state and component society membership benefits to determine if changes or enhancements are needed; the short- and long-term impact of COVID-19 on membership; and any other significant membership information that the Committee requests.

Reference Committee C and the House of Delegates were supportive of a new Membership Committee. The resolution was amended by the Reference Committee to allow the Membership Committee, once established, to develop their own criteria for membership and meeting regularity.

MSMS leadership began the formation of the Committee immediately following the House of Delegates. Paul Bozyk, MD, MSMS Board Vice-Chair, agreed to take on the responsibility to chair the Membership Committee. Counties were asked to submit recommendations for appointment. According to MSMS bylaws, physicians would be voting member of the official Committee, while county and MSMS staff would be welcome as ex-officio members. After several solicitations throughout the summer, the Committee had its founding members and scheduled its first meeting on September 27, 2022. Please find a complete committee roster at http://MSMS.org/Committees. Additional meetings followed on November 3, 2022, January 19, 2023, and March 22, 2023. Each meeting was scheduled several months in advance for 90 minutes in length. Several exceeded the scheduled timelines.
At the 2022 meeting, the House of Delegates had assigned several resolutions to the Membership Committee to address prior to moving on to new business.

Resolution 04-21 was referred to the MSMS Board of Directors for study in 2021 and again in 2022. In 2022, the Board referred the resolution to the MSMS Membership Committee for review and recommendations. Resolution 04-21 asked “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 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.”

Resolution 04-21 was introduced to ensure that the County Medical Societies gain access to all member or non-member information regardless of county of origin. The key issue was providing information that allowed county medical societies to determine if physicians were assigned to the correct county without compromising some of the personal data that is in the member record. Each county has access, through the MSMS member database portal, to the entire member record, but due to the confidentiality provisions of MSMS, that record cannot be shared with other counties. Basic identifying information is available on the MSMS website through the physician directory, but it is cumbersome for county staff to use since they have to search county by county to determine if a member has moved or been reassigned to a different county.

According to MSMS legal counsel, membership information that MSMS obtains comes in via the MSMS Website or other electronic sources that are subject to the MSMS Website Privacy Policy. That policy describes the types of information that is collected and subject to the policy. This includes information given by members “on applications or other forms” on the MSMS website (i.e. all information members provide on applications for membership or renewals of membership). The policy provides that none of this information will be shared with “third parties” without the consent of the member. “Third parties” meaning in this context would be anyone other than the person or entity the information is provided to (i.e. MSMS). The information cannot be inferred that a county medical society was not intended to be a third party since they are all separate entities with no common ownership with MSMS. Therefore, the MSMS Website Privacy Policy prevents MSMS from disclosing the information it has obtained to county medical societies absent member approval.

Since member data and transparency are such an important part of the partnership between MSMS and the counties, MSMS has worked with their IT vendor to continue to create additional reporting as requested by the counties. For every dues-charging county, the following reports have been made available:

(continued)
The Membership Committee spent time reviewing background information and receiving input from County Executives and MSMS staff. After thorough research and thoughtful dialogue, committee members supported a compromise that met the needs of the county while still abiding by the privacy policy. An Excel document will be emailed quarterly to all county medical societies with information from the public Member Directory from Connect.MSMS.org. Information will include: First Name, Middle Name, Last Name, Credentials, Price List, Group Billing Parent Account, Employer, Address 2: Name, Address 2: Street 1, Address 2: Street 2, Address 2: Street 3, Address 2: City, Address 2: State/Province, Address 2: ZIP/Postal Code, Primary Work Phone, Address 2: County, Address 3: City, Address 3: County Membership, Email, Join Date. Additionally, a second Excel document with the same fields will be emailed monthly to all county medical society chapter officers of the information that is specific to the new and reinstated report to make it easier for the counties to review. As this resolution was referred to the Board, this report will be submitted to the 2023 House as Board Action Report #3-23 for action.

- The quarterly membership directory report has been sent on the following dates: April 4, 2022; October 3, 2022; January 2, 2023; and April 5, 2023.
- The added monthly new/reinstated member report has been sent on the following dates: February 6, 2023; March 6, 2023; and April 3, 2023.

The second resolution assigned to the Membership Committee by the House of Delegates was Resolution 48-22, Group Membership Recruitment. This resolution asks that MSMS report any group membership solicitation plans to the impacted component societies; include the impacted component societies in the group solicitation and negotiations; require a written contract for any group membership over 50 members and shares the roster and contract with component societies in advance of finalizing contracts; and obtain the home and/or primary work address of each individual member under the group bill. The Reference Committee strongly supported this resolution and strongly encouraged the MSMS Board to take into consideration all of the aspects for membership recruitment; including the value of the individuals that obtain membership through other groups; promoting value to members; and to the organizations supporting group membership.

The Membership Committee reviewed the current process regarding group memberships. Discussion included a sympathetic balance of assuring the process is administratively easy for
large groups willing to invest thousands of dollars in dues while also assuring contact information and county assignments are correct. The Committee also discussed that forcing groups into a contract or agreement would not be beneficial as the respective organizations would not enter into any litigation; therefore, it was on advice of the Committee to dissolve the requirement of a formal contract or agreement for any group member. The Membership Committee was supportive of the final compromise as it relates to future large groups. Since this resolution was approved by the House of Delegates, it does not need to be reconsidered at this year’s meeting.

Doctor Bozyk led the Committee on several other agenda items in the last seven months. This included extensive information on state and county membership processes, information sharing and best practices with recruitment and retention, initial ideas around regionalization, dues investment rates, and membership benefits. Further conversation and action on all of these issues will continue at future meetings. Doctor Bozyk has been deliberate in his intention to allow the physician members and staff to speak freely and provide commentary on the prescribed work by the House but also any other topic or concern brought to his attention. While the Committee has not completed all tasks yet, a meaningful attempt has been made to provide open dialogue and transparency to all parties involved.

One item that came up during a Committee meeting was understanding corporation/unincorporate associations and tax exempt information for 501c6 organizations. Doctor Bozyk asked MSMS staff to provide an additional benefit to the county medical societies to help them understand these differences. Plante Moran, MSMS’s certified public accounting and business advisory firm, produced a document with frequently asked questions regarding tax exempt information for 501c6 organizations. Kerr Russell, MSMS’s Legal Counsel firm, has created a document regarding corporations vs. unincorporated associations for support. Both documents are at the end of this report.

The last item within Resolution 45-22, is for the development of a membership report that includes dues rates from other state and county medical societies, an analysis of the dues structure and a look-back to the impact of COVID. That information is available at [http://MSMS.org/2023DuesRates](http://MSMS.org/2023DuesRates). The report indicates Oklahoma has the lowest active dues rates at $300 per year while Delaware has the highest at $757. The average investment is $480. MSMS active dues rates is currently set at $495. For active county medical societies, Berrien County has lowest dues rate at $25; while Genesee has the highest dues rate at $385. The average investment for an active county medical society is $200. There are currently 24 county medical societies who charge dues with 33 county medical societies who are inactive, charging no dues. The intent of this data is to identify if the state and county benefits outweigh the dues investment or vice versa.

Membership to MSMS and active county medical societies provide enormous benefits. The list of benefits, which are still being collected, are available by visiting [http://MSMS.org/2023MemberBenefits](http://MSMS.org/2023MemberBenefits).

(continued)
The COVID pandemic has had both a positive and negative impact on membership. While membership prior to 2022 was on an upward trend, it was the Henry Ford Medical Group who withdrew its longtime membership to MSMS and the respective county medical societies that caused that positive trend to turn. Losing roughly 1,100 members has had a negative influence on overall membership. However, had HFMG chosen to renew, MSMS’s membership trend would have continued to increase for 2022 and 2023. The pandemic has shown a lot of benefits to physicians and their practices, particularly among physician organizations.

In conclusion, this report represents a lot of hard work by a lot of committed individuals, open minds willing to repair broken relationships, and a shared mission to improve organized medicine in Michigan. While the work is not complete, the Committee will continue to tackle these issues one at a time with the collective wisdom to do what is best for patients and physicians.

The Committee members include:

Paul Bozyk, MD, Oakland County Medical Society, Chair
Belen Amat Martinez, MD, Barry County, Member
Janak Bhavsar, MD, Jackson County Medical Society, Member
Edward Christy, MD, Genesee County Medical Society, Member
Jennifer Dehlin, MD, Marquette-Alger County Medical Society, Member
Evelyn Eccles, MD, Washtenaw County Medical Society, Member
Edward Fody, MD, Ottawa County Medical Society, Member
Aliya Hines, MD, PhD, Wayne County Medical Society of Southeast Michigan, Member
John Hopper, MD, Washtenaw County Medical Society, Member
Bryan Huffman, MD, Ottawa County Medical Society, Member
Melanie Manary, MD, Northern Michigan Medical Society, Member
Latonya Riddle-Jones, MD, Wayne County Medical Society of Southeast Michigan, Member
Manveen Saluja, MD, Oakland County Medical Society, Member
M Salim Siddiqui MD, PhD Wayne County Medical Society of Southeast Michigan Member
Thomas Veverka MD, FACS Saginaw County Medical Society Member
David Walsworth, MD, Ingham County Medical Society, Member
Phillip Wise, MD, Kent County Medical Society, Member
Claudia Zacharek, MD, Saginaw County Medical Society, Member
Ashok Gupta, MD, Oakland County Medical Society, Member
Daniel Ryan, MD, Macomb County Medical Society, Member
Amit Ghose, MD, Ingham County Medical Society, Member
Allison Blodgett, CPMSM, Midland County Medical Society, County Staff
Karen Carter, Wayne County Medical Society of Southeast Michigan, County Staff
Joan Cramer, Saginaw County Medical Society, County Staff
Patricia Dalton, MPA, MA, Kent County Medical Society, County Staff
Joyce DeLong, Berrien County Medical Society, County Staff

(continued)
Valerie, Doane, Jackson County Medical Society, County Staff
Shirley Green, Muskegon County Medical Society, County Staff
David Hoff, Genesee County Medical Society, County Staff
Angela Kempainen, CAE, Ingham County Medical Society, County Staff
Annamarie Kindsvater, LPTA, St. Clair County Medical Society, County Staff
Heidi Leach, Macomb County Medical Society, County Staff
Romy Shubitowski, Oakland County Medical Society, County Staff
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As a not-for-profit, MSMS is a business advocate and practice resource for Michigan physicians.
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<td>Revisions to the MSMS Policy Manual and the 2023 Sunset Policy</td>
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# REAFFIRMATION CALENDAR

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<td>Patients’ Right to Choose Non-Participating Physician Practices</td>
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Title:  Equitable Interpreter Services and Fair Reimbursement

Introduced by:  Alice Hou, MA and David Lee, MD, for the Medical Student Section

Original Author:  Alice Hou

Referred To:  Re-affirmation Calendar

House Action:

Whereas, all patients deserve equitable, fair, and high-level care in a language in which they can comprehend, and

Whereas, more than 25 million Americans speak English “less than very well,” according to the U.S. Census Bureau, and the National Center for Health Statistics reports about 37.6 million adults have difficulty with their hearing, and

Whereas, this population is less able to access health care and is at higher risk of adverse outcomes such as medication complications, noncompliance, and decreased patient satisfaction, and

Whereas, Title VI of the Civil Rights Act and Executive Order 13166 mandate that interpreter services be provided for patients with limited English proficiency (LEP) who need this service, and Section 1557 of the Affordable Care Act has also created protections for medical interpreter services as part of its protections from discrimination on the basis of race, color, or country of origin, and

Whereas, unfortunately, there are currently only 14 states and 1 district that offer reimbursements for this service, including Connecticut, District of Columbia, Iowa, Idaho, Kansas, Maine, Minnesota, Montana, New Hampshire, New York, Texas (only sign language interpreters), Utah, Vermont, Washington, and Wyoming, and

Whereas, in the aforementioned states, providers can claim an administrative match for 50-75 percent of translation and interpretation claimed as an administrative expense if they are not already reimbursed as part of the direct service rates, and

Whereas, as of 2009, oral interpreter services can be claimed using billing code T-1013 along with the CPT Code appropriate for the clinical encounter, and

Whereas, in the 36 other states in which reimbursement for interpreter services is not codified, physicians sometimes have to bear the burden of the cost, which can cost up to $150.00/hour, and

Whereas, studies have shown enforcement of hospital regulations to provide interpreters is inconsistent, and lack of reimbursement decreases hospital incentive to comply and many hospitals are not providing language services in a manner consistent with related CLAS standards, and

Whereas, although coding methods are available, their use is limited because payers expect physicians to absorb the cost of interpretation services as part of their business expenses, and

Whereas, in 2000, the CPT Editorial Panel responded to a request of the House of Delegates to review the development of a CPT Code for use of medical interpreters by using the modifier “32,” and
Whereas, in addition to accrued cost, physicians often spend more time per visit with patients requiring medical interpreters due to initial set-up, dialogue in multiple languages, as well as additional clarifications; therefore be it

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to support the standardization of physician reimbursement in regards to interpreter services, whether it be the usage of a CPT code or more widespread direct reimbursement by the state; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to reaffirm Policy D-385.957, which advocates for legislative and/or regulatory changes to require that payers including Medicaid programs and Medicaid managed care plans cover interpreter services and directly pay interpreters for such services, and relieve the burden of the costs associated with translation services.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000

Relevant MSMS Policy: None

Relevant AMA Policy:

Certified Translation and Interpreter Services D-385.957
Our AMA will: (1) work to relieve the burden of the costs associated with translation services implemented under Section 1557 of the Affordable Care Act; and (2) advocate for legislative and/or regulatory changes to require that payers including Medicaid programs and Medicaid managed care plans cover interpreter services and directly pay interpreters for such services, with a progress report at the 2017.

Interpreter Services and Payment Responsibilities H-385.917
Our AMA supports efforts that encourage hospitals to provide and pay for interpreter services for the follow-up care of patients that physicians are required to accept as a result of that patient's emergency room visit and Emergency Medical Treatment and Active Labor Act (EMTALA)-related services. Interpreters For Physician Visits D-90.999 Our AMA continues to monitor enforcement of those provisions of the ADA to assure that physician offices are not subjected to undue burdens in their efforts to assure effective communication with hearing disabled patients.

Language Interpreters D-385.978
Our AMA will: (1) continue to work to obtain federal funding for medical interpretive services; (2) redouble its efforts to remove the financial burden of medical interpretive services from physicians; (3) urge the Administration to reconsider its interpretation of Title VI of the Civil Rights Act of 1964 as requiring medical interpretive services without reimbursement; (4) consider the feasibility of a legal solution to the problem of funding medical interpretive services; and (5) work with governmental officials and other organizations to make language interpretive services a covered benefit for all health plans inasmuch as health plans are in a superior position to pass on the cost of these federally mandated services as a business expense.

Appropriate Reimbursement for Language Interpretive Services D-160.992
1. Our AMA will seek legislation to eliminate the financial burden to physicians, hospitals and health care providers for the cost of interpretive services for patients who are hearing impaired or do not speak English.
2. Our AMA will seek legislation and/or regulation to require health insurers to fully reimburse physicians and other health care providers for the cost of providing sign language interpreters for hearing impaired patients in their care.

Sources:


6. Diamond LC, Wilson-Stronks A, Jacobs EA. Do hospitals measure up to the national culturally and linguistically appropriate services standards?. Medical care. 2010 Dec 1;1080-7
Title: Advancing Efforts to Decrease Maternal Mortality

Introduced by: David Lee, MD, MS, for the MI Section, American College of OB/GYN

Original Authors: Halley Crissman, MD, MPH, Sara Jaber, MD, David Lee, MD, MS, Madeline Merwin, MD, and Suha Syed, MD

Referred To: Re-affirmation Calendar

Whereas, the maternal mortality in Michigan has increased from 16.7 deaths per 100,000 live births for 2015-2019 to 18.7 per 100,000 live births for 2016-2020, and

Whereas, there is a huge disparity in maternal mortality rates between White and Black women in Michigan with rates estimated at 20.3 deaths per 100,000 live births for Whites compared with 36 deaths per 100,000 live births for Blacks for the period 2016-2020, and

Whereas, the most common causes of maternal mortality are cardiovascular disease, infection, and obstetrical complications such as postpartum hemorrhage, elevated blood pressure, complications from delivery, and unsafe abortion procedures, and

Whereas, data from 2017-2019 revealed that greater than 80 percent of maternal deaths corresponding to 4 out of 5 of these deaths were “preventable,” and

Whereas, there has been tremendous efforts at the national and state level to help with reducing maternal mortality, particularly those that could be avoided, and

Whereas, the Maternal Mortality Review Committees (MMRC) are multidisciplinary committees that assemble at the local and state level to evaluate the conditions surrounding pregnancy-related deaths and provide future recommendations to prevent such cases from occurring, and

Whereas, the American College of Obstetricians and Gynecologists (ACOG) published the “maternal levels of care,” which would assist in the reduction of maternal morbidity and mortality by risk-appropriate maternal care stratification, and

Whereas, the maternal levels of care are defined as regionalized maternal care programs that aim to enhance access to care by better defining and reinforcing relationships between health care systems in a region, including well-defined capabilities and criteria for patients to remain at their local hospital versus transferring to a higher level of care, and

Whereas, the maternal levels of care set the standard for “consultation and transfer of care as deemed appropriate based on the clinical condition” such that low to moderate risk patients may remain at their local hospital, while high risk patients who require escalation of care or subspecialty care be transferred to the suitable health system, and
Whereas, a four-tier maternal level of care system was devised which includes: Level I (Basic Care), Level II (Specialty Care), Level III (Subspecialty Care), and Level IV (Regional Perinatal Health Care Centers) and enables a risk-based stratification and ensures that appropriate medical, surgical, emergent and comprehensive care are provided to patients which enable optimizing the care received, and ultimately reducing maternal morbidity and mortality, and

Whereas, levels of care designations are established by “regional and state health care entities, national accreditation and professional organization guidelines, identified regional perinatal health care service needs, and regional resources,” and

Whereas, the Alliance for Innovation on Maternal Health (AIM) is a “national data-driven maternal safety and quality improvement initiative,” whose goal is to enhance maternal safety and health-related outcomes through “evidence-based patient safety bundles,” and

Whereas, AIM achieves its goals by utilizing health care systems and state level collaboration to line up “national, state and hospital level engagement efforts,” and

Whereas, local efforts have included the Michigan Maternal Mortality Surveillance (MMMS) program which involves an organized procedure for the identification and review of the cases of maternal deaths at the state level to issue policy recommendations that assist in preventing future occurrences, and

Whereas, initiatives such as the establishment of levels-of-care designations and the AIM program have been integral in advancing healthcare, continued work is required to ensure elimination of healthcare disparities within our communities and around the world; therefore be it

RESOLVED: That MSMS participate with stakeholders to advance statewide initiatives, including Michigan AIM, and support the adoption of “maternal levels of care” in an effort to decrease maternal morbidity and mortality in Michigan.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $2,000-$4,000

Relevant MSMS Policy:

**Michigan Maternal Health, Safety, and Quality Care Initiatives**
MSMS shall participate with other stakeholders involved in the care of pregnant women to advance statewide initiatives to improve maternal health outcomes including, but not limited to, Maternal Levels of care at birthing centers.

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, implement, and sustain a maternal mortality surveillance system that centers around health equity; 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.

**State Maternal Mortality Review Committees H-60.909**
Our AMA supports: (1) the important work of maternal mortality review committees; (2) work with state and specialty medical societies to advocate for state and federal legislation establishing Maternal Mortality Review Committees; and (3) work with state and specialty medical societies to secure funding from state and federal governments that fully supports the start-up and ongoing work of state Maternal Mortality Review Committees.

**Reducing Inequities and Improving Access to Insurance for Maternal Health Care H-185.917**
1. Our AMA acknowledges that structural racism and bias negatively impact the ability to provide optimal health care, including maternity care, for people of color. 2. Our AMA encourages physicians to raise awareness among colleagues, residents and fellows, staff, and hospital administrators about the prevalence of racial and ethnic inequities and the effect on health outcomes, work to eliminate these inequities, and promote an environment of trust. 3. Our AMA encourages physicians to pursue educational opportunities focused on embedding equitable, patient-centered care for patients who are pregnant and/or within 12 months postpartum into their clinical practices and encourages physician leaders of health care teams to support similar appropriate professional education for all members of their teams. 4. Our AMA will continue to monitor and promote ongoing research regarding the impacts of societal (e.g., racism or unaffordable health insurance), geographical, facility-level (e.g., hospital quality), clinician-level (e.g., implicit bias), and patient-level (e.g., comorbidities, chronic stress or lack of transportation) barriers to optimal care that contribute to adverse and disparate maternal health outcomes, as well as research testing the effectiveness of interventions to address each of these barriers. 5. Our AMA will promote the adoption of federal standards for clinician collection of patient-identified race and ethnicity information in clinical and administrative data to better identify inequities. The federal data collection standards should be: (a) informed by research (including real-world testing of technical standards and standardized definitions of race and ethnicity terms to ensure that the data collected accurately reflect diverse populations and highlight, rather than obscure, critical distinctions that may exist within broad racial or ethnic categories), (b) carefully crafted in conjunction with clinician and patient input to protect patient privacy and provide non-discrimination protections, and (c) lead to the dissemination of best practices to guide respectful and non-coercive collection of accurate, standardized data relevant to maternal health outcomes. 6. Our AMA supports the development of a standardized definition of maternal mortality and the allocation of resources to states and Tribes to collect and analyze maternal mortality data (i.e., Maternal Mortality Review Committees and vital statistics) to enable stakeholders to better understand the underlying causes of maternal deaths and to inform evidence-based policies to improve maternal health outcomes and promote health equity. 7. Our AMA encourages hospitals, health systems, and state medical associations and national medical specialty societies to collaborate with non-clinical community organizations with close ties to minoritized and other at-risk populations to identify opportunities to best support pregnant persons and new families. 8. Our AMA encourages the development and funding of resources and outreach initiatives to help pregnant individuals, their families, their communities, and their workplaces to recognize the value of comprehensive prepregnancy, prenatal, peripartum, and postpartum care. These resources and initiatives should encourage patients to pursue both physical and behavioral health care, strive to reduce barriers to pursuing care, and highlight care that is available at little or no cost to the patient. 9. Our AMA supports adequate payment from all payers for the full spectrum of evidence-based prepregnancy, prenatal, peripartum, and postpartum care. 10. Our AMA encourages hospitals, health systems, and states to participate in maternal safety and quality improvement initiatives such as the Alliance for Innovation on Maternal Health program and state perinatal quality collaboratives. 11. Our AMA will advocate for increased access to risk-appropriate care by encouraging hospitals, health systems, and states to adopt verified, evidence-based levels of maternal care.

**Classification and Surveillance of Maternal Mortality H-420.948**
Our AMA will: (1) encourage research efforts to characterize the health needs for pregnant inmates, including efforts that utilize data acquisition directly from pregnant inmates while ensuring appropriate
nondiscrimination and privacy safeguards; (2) support legislation requiring all correctional facilities, including those that are privately-owned, to collect and publicly report pregnancy-related healthcare statistics with transparency in the data collection process while ensuring appropriate nondiscrimination and privacy safeguards; (3) encourages data collection on pregnancy and other reproductive health outcomes of incarcerated people and research efforts to characterize the health needs for pregnant inmates, including efforts that utilize data acquisition directly from pregnant inmates; (4) supports legislation requiring all correctional facilities, including those that are privately-owned, to collect and report pregnancy-related healthcare statistics with transparency in the data collection process; (5) opposes the separation of infants from incarcerated pregnant individuals post-partum; and (6) supports solutions, such as community-based programs, which allow infants and incarcerated postpartum individuals to remain together.

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:
5. American College of Obstetricians and Gynecologists. The Maternal Levels of Care Verification Program
6. American College of Obstetricians and Gynecologists. State Implementation
10. American College of Obstetricians and Gynecologists. Alliance for Innovation on Maternal Health (AIM)
Whereas, the rising cost of medical care has affected our lives, and
Whereas, preauthorization requirements and unnecessary temporizing protocols raises costs of the above, and
Whereas, appropriate decisions for the customized care to patients are invariably not taken into consideration; therefore be it

RESOLVED: That medical decisions be made by licensed medical practitioners.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000

Relevant MSMS Policy:

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

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

Accountability of Utilization Review Firms
Utilization review firms employed by insurance companies should be held accountable for medical decisions based on their review.

Relevant AMA Policy:

Physician and Non physician Licensure and Scope D-160.995
1. Our AMA will: (a) continue to support the activities of the Advocacy Resource Center in providing advice and assistance to specialty and state medical societies concerning scope of practice issues to include the collection, summarization and wide dissemination of data on the training and the scope of practice of physicians (MDs and DOs) and nonphysician groups and that our AMA make these issues a
legislative/advocacy priority; (b) endorse current and future funding of research to identify the most cost effective, high-quality methods to deliver care to patients, including methods of multidisciplinary care; and (c) review and report to the House of Delegates on a periodic basis on such data that may become available in the future on the quality of care provided by physician and nonphysician groups.

2. Our AMA will: (a) continue to work with relevant stakeholders to recognize physician training and education and patient safety concerns, and produce advocacy tools and materials for state level advocates to use in scope of practice discussions with legislatures, including but not limited to infographics, interactive maps, scientific overviews, geographic comparisons, and educational experience; (b) advocate for the inclusion of non-physician scope of practice characteristics in various analyses of practice location attributes and desirability; (c) advocate for the inclusion of scope of practice expansion into measurements of physician well-being; and (d) study the impact of scope of practice expansion on medical student choice of specialty.

3. Our AMA will consider all available legal, regulatory, and legislative options to oppose state board decisions that increase non-physician health care provider scope of practice beyond legislative statute or regulation.
Whereas, medicine belongs to individuals who have the required qualifications and training for diseases, and

Whereas, medicine continues to undergo new technology, research and development, and

Whereas, the care of patients has become unclear to many, and

Whereas, insurance companies are now involved in the decision-making process related to where, how, and when patients are treated through mechanisms such as preauthorization; therefore be it

RESOLVED: That MSMS create a committee or department to study and make recommendations regarding insurance company decision making processes related to where, how, and when patients are being treated through mechanisms such as preauthorization; and be it further

RESOLVED: That MSMS apprise membership of any recommendations or other relevant information pertaining to insurance company decision making processes related to where, how, and when patients are being treated through mechanisms such as preauthorization.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000

Relevant MSMS Policy:

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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.

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3. Our AMA will consider all available legal, regulatory, and legislative options to oppose state board decisions that increase non-physician health care provider scope of practice beyond legislative statute or regulation.
Title: Patients' Right to Choose Non-Participating Physician Practices

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

Original Author: Belen Amat, MD

Referred To: Re-affirmation Calendar

House Action:

Whereas, Michigan Compiled Law 500.129 recognizes Direct Primary Care (DPC) or other similar practices by clarifying that a medical retainer agreement is not insurance and not subject to the Michigan Insurance Code if certain criteria is met, and

Whereas, DPC and other practices may 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 option 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 or other practices which provide 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 the majority of the cost of outpatient testing, medications, and consults, and

Whereas, DPC physicians and other physician office teams have to become 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 patient pays 100 percent of the cost of the medical treatment 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 has passed legislation prohibiting denial of referrals by DPC physicians; therefore be it
RESOLVED: That MSMS work with Michigan health insurers to educate them on the role of Direct Primary Care physicians and other practices which may not be associated with hospital system offices, 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 medication, order tests, and referrals on patients who have with health insurance plans.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $12,000-$24,000

Relevant MSMS Policy:

Promotion of Direct Primary Care Services (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.

Increasing Insurance and Access Options for Patients (Resolution 50-14)
RESOLVED: That MSMS explore and monitor new programs and initiatives in health care such as those involving direct patient primary care and high deductible health care plans with health savings accounts; and be it further
RESOLVED: That MSMS educate physicians regarding new programs and initiatives in health care such as those involving direct patient primary care and high deductible health care plans with health savings accounts.

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.
## RESOLUTIONS BY COMMITTEE

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### BOARD ACTION REPORT

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Title: Requiring Translated Procedural Consent Forms

Introduced by: Ashton Lewandowski, for the Medical Student Section

Original Author: Charlotte Jackson

Referred To: Reference Committee A

Whereas, procedural informed consent is an ethical and legal responsibility of clinicians providing care for patients to ensure, at a minimum, their understanding of the details and risks surrounding the indicated procedure, and

Whereas, the Joint Commission defines health literacy as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions," which includes in the language the patient predominantly speaks, and

Whereas, Title VI of the federal Civil Rights Act requires that hospitals provide interpretation services to Limited English Proficiency (LEP) patients and those with disabilities that affect their ability to communicate, underscoring the importance of relaying comprehensible materials to patients, and

Whereas, the U.S. Food and Drug Administration (FDA) requires informed consent documents for research to be provided in a language understandable by the study subject, or in the same language in which the consent is conducted, and consent for medical procedures should be held to the same or higher standard as for research purposes, and

Whereas, there is evidence to suggest that patients with limited English proficiency, especially when professional medical interpreter services are not used consistently, are at risk for increased length of stay, more complications, and worse clinical outcomes, and

Whereas, in the state of Michigan, there are 942,897 citizens comprising 10 percent of the population, who do not speak English at home, and

Whereas, in the state of Michigan, the most prevalent languages spoken, following English, are Arabic, Spanish, and Chinese (Mandarin and Cantonese), and

Whereas, of those most common languages, a significant percentage (38.6 percent of Arabic speakers, 34.7 percent of Spanish speakers, 39.1 percent of Chinese speakers) of those Michiganders speak English less than "very well" and would need an interpreter for any consent process; therefore be it

RESOLVED: That MSMS advocate the state legislature to require procedural consent forms to be offered in at least the three most common languages in the state aside from English; and be it further

RESOLVED: That MSMS encourage its members to use translated procedural consent forms in their practice.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $16,000-$32,000

Relevant MSMS Policy:
**MSMS Guide on Legal Issues for Physicians Treating Hearing Impaired or Limited English Proficiency Patients**

**Relevant AMA Policy:** None

**Sources:**


2. Joint Commission "What Did the Doctor Say?": Improving Health Literacy to Protect Patient Safety, Executive Summary [http://www.jointcommission.org/assets/1/18/improving_health_literacy.pdf](http://www.jointcommission.org/assets/1/18/improving_health_literacy.pdf) (Accessed on February 17, 2023)


Title: Transparency Requirement For Hospital Requested Exemption Filing from ACA Categorical Discrimination

Introduced by: Ashton Lewandowski, for the Medical Student Section

Original Authors: Danielle DuPuis and Joanna Hua

Referred To: Reference Committee A

House Action:

Whereas, categorical discrimination in healthcare is illegal under Title 1 of the Affordable Care Act (ACA), and

Whereas, the Nondiscrimination in Health Programs and Activities 92.302 provides a route for hospital institutions to apply for religious exemptions to act in compliance with the law, and

Whereas, patients have a right to dictate their own methods of care, and

Whereas, hospital and healthcare institutions are not currently required to report the statuses of their religious exemption requests or policies, and

Whereas, patients are not aware of which healthcare institutions have requested religious exemptions or have enacted policies under said filing, and

Whereas, records of religious exemption requests go to the Health and Human Services office of Civil Rights are only accessible via a Freedom of Information request, and

Whereas, the Freedom of Information request is not an accessible or timely mechanism for the public to ascertain such necessary information for their care, and

Whereas, patients could face adverse health consequences if information about exemptions is not available to the public and they require care that the healthcare facility will not provide; therefore be it

RESOLVED: That MSMS advocates all health care facilities be required to make their filings for religious or other exemptions accessible to the public; and be it further

RESOLVED: That MSMS will encourage and contribute to the formation of a national public database that all exemption filings will be compiled and available to the public; and be it further

RESOLVED: That MSMS will support that a Freedom of Information Act request is not required for the public to access exemption filing data.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $16,000-$32,000
Relevant MSMS Policy: None

Relevant AMA Policy: None

Sources:
7. Ibid
Whereas, public resolutions supporting Medicare for All have been passed in Detroit (March 2019), Ann Arbor (May 2020), Pittsfield Township (June 2020), Kalamazoo County (June 2020), Ypsilanti (March 2021), and Kalamazoo (July 2022), which combined are home to more than one million Michigan residents, and

Whereas, other physician groups such as the American College of Physicians, the Vermont Medical Society, the Hawaii Medical Association, the New Hampshire Medical Society, and the Washington State Medical Association endorse single-payer health care reform, and

Whereas, 27.2 million Americans lacked health insurance in 2021, and 5 percent of Michigan residents were uninsured, and

Whereas, compared to ten other high-income countries, the U.S. ranks last in health care affordability and has the highest rate of infant mortality and mortality amenable to health care, and

Whereas, in 2020 the U.S. spent $4.1 trillion on health care, or 19.7 percent of gross domestic product, twice as much per capita on health care as the average of wealthy nations providing universal health coverage, and

Whereas, illness and medical bills contribute to 66.5 percent of all bankruptcies, a figure that is virtually unchanged since before the passage of the Affordable Care Act, and

Whereas, there is single-payer legislation in both houses of Congress, H.R. 1976 and S. 4204, proposing an alternative financing mechanism for national health insurance that does not supplant the private practice of medicine, and

Whereas, Federal insurance programs operate with substantially greater efficiency compared to private insurance operations, with the administrative overhead of Medicare representing 1.16 percent of total spending as of 2021, as compared to the approximately 20-25 percent of total spending on administration within the private sector, and

Whereas, providers lose billions of dollars’ worth of labor hours each year to addressing prior authorizations and dealing with insurers billing and documentation requirements, and

Whereas, total administrative costs in the U.S. account for 34.2 percent of health care spending and the U.S. has been projected to save more than $500 billion annually on administrative costs with a single-payer system, and

Whereas, billing-driven documentation that contributes to physician burnout would be greatly reduced under a single-payer system, and
Whereas, a single-payer system could control costs through proven-effective mechanisms such as global budgets for hospitals and negotiated drug prices, thereby making health care financing sustainable, and

Whereas, single-payer reform will reduce the financial burden on physicians of malpractice lawsuits as suits for injured patients need not include coverage of future medical expenses, and

Whereas, many racial and ethnic minorities remain far more likely than non-Hispanic white people to be uninsured, single-payer reform will dramatically reduce health disparities, in line with previous triumphs in health care reform such as the passage of Medicare in 1965 leading to the desegregation of 99.6 percent of U.S. hospitals, and

Whereas, a single-payer system will allow patients to freely choose their doctors, give physicians a choice of practice setting, and protect the doctor-patient relationship, while continuing to provide avenues for physicians to ensure fair compensation; therefore be it

RESOLVED: That MSMS continues to express its support for access to comprehensive, affordable, high-quality health care, as pursuant to Resolution 81-06 in support of universal health coverage, by replacing language in current policies that oppose single-payer systems with neutral or supportive language, and it be further;

RESOLVED: That MSMS amend existing policy, “National Health Care,” to read as follows:

National Health Care
MSMS supports free-choice methods of medical and health care and the establishment of a physician-designed national health insurance program, providing universal health coverage for all as an evidence-based policy informed by the latest in economic and healthcare policy research that continues to fairly fund all physician practices; and be it further

RESOLVED: That MSMS recognize and endorse that advocacy for a national health insurance program from the standpoint of local and state medical societies is a necessity for national change, and, moreover, that advocating for this change on a national level addresses health disparities specific to Michigan, and, as such, represents an important issue in the purview of MSMS and other state and local medical societies.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000

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.

Automatic and Affordable Health Insurance Coverage for All
MSMS supports affordable health insurance coverage for Americans.

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.

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. 

**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. Distributed 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.

Sources:

8. Wagner, Orliza, and Cox, "How does health spending in the U.S. compare to other countries?". Health System Tracker. Peterson-KFF. Published 2022 Jan 21
9. Himmelstein et al., ÆoeMedical bankruptcy: Still common despite the Affordable Care Act,ÆÊ American Journal of Public Health, March 1, 2019
11. Disorders, et al., “Physician burnout in the electronic health record era: Are we ignoring the real cause?” Annals of Internal Medicine, July 3, 2018
Title: Reimbursement for Postpartum Depression Prevention

Introduced by: Ashton Lewandowski, for the Medical Student Section

Original Authors: Adefolarin Alade, Patrick Ancheta, Heba Basha, Dayaan Ghani, Madison Polay, and Laura Carravallah, MD

Referred To: Reference Committee A

House Action:

Whereas, the Centers for Disease Control and Prevention (CDC) reports that more than one in eight women with a recent live birth experience postpartum depression, and

Whereas, untreated mood and anxiety disorders amongst pregnant women and new mothers cost approximately $14.2 billion over five years, with more than half the costs occurring within the first year due to pregnancy and birth complications, and

Whereas, the United States Preventive Services Task Force (USPSTF) recommends prevention of depression in pregnant and postpartum women by a wide range of providers in standard prenatal care settings and provides a grade of B, and

Whereas, Section 2713 of the Affordable Care Act requires private insurers to cover preventive services recommended by the USPSTF with a grade of A or B, along with those recommended by ACIP, Bright Futures, and HRSA's guidelines for women's health, and

Whereas, the Affordable Care Act requires insurers to cover these services with no cost-sharing (i.e., no deductible and no co-pay), and

Whereas, given this USPSTF recommendation to provide postpartum depression prevention, these services should be reimbursable under the Affordable Care Act, and

Whereas, the USPSTF recommends two postpartum depression prevention programs, including the Reach Out, Stay Strong, Essentials for Mothers of Newborns (ROSE) Program and the Mothers & Babies (MB) Program, and

Whereas, research has shown that receiving either the MB or ROSE intervention during pregnancy reduces the odds of developing postpartum depression by 53 percent and 50 percent respectively, and

Whereas, prenatal health care providers currently must provide a mental health diagnosis code to bill for postpartum depression prevention, and thus primary prevention does not qualify, and

Whereas, useful Current Procedural Terminology Codes (CPT) for postpartum depression prevention include but are not limited to 98960-98962 regarding a “non-physician health care professional uses a standard curriculum to educate a patient about his or her disease or disorder to enable the patients and caregivers to effectively manage disease,” and

Whereas, California reimburses for these services, but is currently the only state that has done so, and
Whereas, administration of postpartum prevention interventions by nurses, health educators, community health workers, and other paraprofessionals has been shown to be non-inferior to licensed mental health providers in reducing rates of postpartum depression; therefore be it

RESOLVED: That MSMS advocates for state Medicaid programs to reimburse CPT codes such as 98960-98962 that can be used for postpartum depression prevention by a broad range of health workers, with services currently covered under the Affordable Care Act; and be it further

RESOLVED: That MSMS advocates for an initiative to allow mental health professionals to bill under a “pregnancy” diagnosis code, so that they can deliver perinatal and postnatal mental health preventive interventions; and be it further

RESOLVED: That MSMS advocates for state Medicaid programs to provide avenues for nurses, doulas, community health workers, and health educators trained in these programs as part of physician-led health care teams to deliver these primary prevention interventions and be reimbursed; and be it further

RESOLVED: That MSMS advocates for states, payers, and health systems to make evidence-based postpartum depression prevention services, such as Reach Out, Stay Strong, Essentials for New Mothers (ROSE) and Mothers & Babies (MB), the official standard of care and increase bundle payments accordingly statewide; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to advocate for evidence-based postpartum depression prevention services, such as Reach Out, Stay Strong, Essentials for New Mothers (ROSE) and Mothers & Babies (MB), to become the official standard of care for all federally-funded health care programs for pregnant women federally

WAYS AND MEANS COMMITTEE FISCAL NOTE: $12,000-$24,000

Relevant MSMS Policy: None

Relevant AMA Policy:

Improving Mental Health Services for Pregnant and Postpartum Mothers H-420.95

Our AMA: (1) supports improvements in current mental health services for women during pregnancy and postpartum; (2) supports advocacy for inclusive insurance coverage of mental health services during gestation, and extension of postpartum mental health services coverage to one year postpartum; (3) supports appropriate organizations working to improve awareness and education among patients, families, and providers of the risks of mental illness during gestation and postpartum; and (4) will continue to advocate for funding programs that address perinatal and postpartum depression, anxiety and psychosis, and substance use disorder through research, public awareness, and support programs.

Sources:


RESOLUTION 23-23

Title: Create ICD-10 Codes for Drug and Medical Supply Shortages

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

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

Referred To: Reference Committee A

Whereas, one purpose of the vast ICD-10 coding system is to track patient data for research and resource allocation, and

Whereas, the ICD-10 system identifies a variety of Social Determinants of Health (SDOH) that track inability to access medical care facilities, there are no unique codes that identify inability to access pharmaceuticals and medical supplies, and

Whereas, drug shortages and medical supply shortages are impacting countless patients nationwide, often on a regional basis with certain communities disproportionately affected, and

Whereas, physicians are spending excess time locating medications and supplies for patients facing these shortages without an appropriate code to reflect this additional complexity of care and risk to the patient; therefore be it

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to work with other stakeholders to create ICD-10 codes to reflect medication shortages and health care supply shortages that are impacting patient health and well-being.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000

Relevant MSMS Policy: None

Relevant AMA Policy:

National Drug Shortages H-100.956
1. Our AMA considers drug shortages to be an urgent public health crisis, and recent shortages have had a dramatic and negative impact on the delivery and safety of appropriate health care to patients.
2. Our AMA supports recommendations that have been developed by multiple stakeholders to improve manufacturing quality systems, identify efficiencies in regulatory review that can mitigate drug shortages, and explore measures designed to drive greater investment in production capacity for products that are in short supply, and will work in a collaborative fashion with these and other stakeholders to implement these recommendations in an urgent fashion.
3. Our AMA supports authorizing the Secretary of the U.S. Department of Health and Human Services (DHHS) to expedite facility inspections and the review of manufacturing changes, drug applications and supplements that would help mitigate or prevent a drug shortage.
4. Our AMA will advocate that the US Food and Drug Administration (FDA) and/or Congress require drug manufacturers to establish a plan for continuity of supply of vital and life-sustaining medications and vaccines to avoid production shortages whenever possible. This plan should include establishing the necessary resiliency and redundancy in manufacturing capability to minimize disruptions of supplies in foreseeable circumstances including the possibility of a disaster affecting a plant.

5. The Council on Science and Public Health shall continue to evaluate the drug shortage issue, including the impact of group purchasing organizations and pharmacy benefit managers on drug shortages, and report back at least annually to the House of Delegates on progress made in addressing drug shortages.

6. Our AMA urges continued analysis of the root causes of drug shortages that includes consideration of federal actions, evaluation of manufacturer, Group Purchasing Organization (GPO), pharmacy benefit managers, and distributor practices, contracting practices by market participants on competition, access to drugs, pricing, and analysis of economic drivers, and supports efforts by the Federal Trade Commission to oversee and regulate such forces.

7. Our AMA urges regulatory relief designed to improve the availability of prescription drugs by ensuring that such products are not removed from the market or caused to stop production due to compliance issues unless such removal is clearly required for significant and obvious safety reasons.

8. Our AMA supports the view that wholesalers should routinely institute an allocation system that attempts to fairly distribute drugs in short supply based on remaining inventory and considering the customer's purchase history.

9. Our AMA will collaborate with medical specialty society partners and other stakeholders in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs.

10. Our AMA urges that during the evaluation of potential mergers and acquisitions involving pharmaceutical manufacturers, the Federal Trade Commission consult with the FDA to determine whether such an activity has the potential to worsen drug shortages.

11. Our AMA urges the FDA to require manufacturers to provide greater transparency regarding the pharmaceutical product supply chain, including production locations of drugs, and provide more detailed information regarding the causes and anticipated duration of drug shortages.

12. Our AMA supports the collection and standardization of pharmaceutical supply chain data in order to determine the data indicators to identify potential supply chain issues, such as drug shortages.

13. Our AMA encourages global implementation of guidelines related to pharmaceutical product supply chains, quality systems, and management of product lifecycles, as well as expansion of global reporting requirements for indicators of drug shortages.

14. Our AMA urges drug manufacturers to accelerate the adoption of advanced manufacturing technologies such as continuous pharmaceutical manufacturing.

15. Our AMA supports the concept of creating a rating system to provide information about the quality management maturity, resiliency and redundancy, and shortage mitigation plans, of pharmaceutical manufacturing facilities to increase visibility and transparency and provide incentive to manufacturers. Additionally, our AMA encourages GPOs and purchasers to contractually require manufacturers to disclose their quality rating, when available, on product labeling.

16. Our AMA encourages electronic health records (EHR) vendors to make changes to their systems to ease the burden of making drug product changes.

17. Our AMA urges the FDA to evaluate and provide current information regarding the quality of outsourcer compounding facilities.

18. Our AMA urges DHHS and the U.S. Department of Homeland Security (DHS) to examine and consider drug shortages as a national security initiative and include vital drug production sites in the critical infrastructure plan.
RESOLUTION 24-23

Title: Reducing Stigma for Treatment of Substance Use Disorder

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

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

Referred To: Reference Committee A

Whereas, mental health care and health care for substance use disorders are health care, not a “carve out” or an exception to health care, and

Whereas, current Medicaid benefits in the state of Michigan provide coverage for transportation costs for patients traveling to/from an office visit for general health care or mental health care visits, and

Whereas, treatment of substance use disorder (SUD) may also require transportation to office visits for treatment with medication for opioid use disorder (MOUD) and/or for counseling, and

Whereas, the cost of transportation may be a barrier to ongoing participation in the treatment and recovery process for patients with SUD, and

Whereas, the cost of transportation (and lack of access) may be an added barrier to accessing MOUD for the uninsured, underinsured, or patients insured through Medicaid, and

Whereas, this lack of coverage for transportation costs for patients seeking treatment for SUD potentially adds to the stigma for SUD and may discourage accessing treatment; therefore, be it

RESOLVED: That MSMS advocate to require Medicaid coverage for transportation costs for all Medicaid health care services without a “carve out” for patients diagnosed with a substance use disorder who are being treated with medication for opioid use disorder; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to advocate coverage for transportation costs for all Medicaid or Medicare health care services without a “carve out” for patients diagnosed with a substance use disorder who are being treated with medication for opioid use disorder.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $12,000-$24,000

Relevant MSMS Policy: None

Relevant AMA Policy: None
Whereas, many health insurance plans require an annual deductible amount that must be paid before any insurance coverage “kicks in” at the beginning of each calendar year, and

Whereas, the cost of a single dose of some medications, a single treatment, and/or a single procedure may lead to a bill that exceeds the full deductible amount in a single payment, and

Whereas, the need to pay the full amount of the deductible for a single billing episode may create undue financial hardship for some patients to pay at the beginning of the calendar year, and

Whereas, the lack of an option to pay the deductible in a quarterly or monthly manner may lead some patients to stop taking or delay a potentially lifesaving medication/treatment/procedure, thus placing the patient’s health at risk, and

Whereas, the patient’s awareness of this concern leads some patients to avoid refilling a medication or incurring the health care cost without seeking financial assistance of the medical care facility providing the care (or the pharmacy filling the medication), and

Whereas, once the payment of the deductible has occurred (i.e., often near the end of the calendar year), many patients try to schedule treatments and procedures, leading to an imbalance in the clinical schedules of health care facilities with possible scheduling/access strain; therefore, be it

RESOLVED: That MSMS work with the Michigan Department of Insurance and Financial Services and third-party payers to explore options for the provision of quarterly and/or monthly payments for the annual deductible amount for all patients; and be it further

RESOLVED: That MSMS work with the Michigan Department of Insurance and Financial Services to provide public education regarding all available payment options for health care insurance that will benefit the people of the state of Michigan.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $12,000-$24,000

Relevant MSMS Policy: None

Relevant AMA Policy: None
Title: Unnecessary Charges for Ophthalmic Medications

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

Original Authors: Patrick J. Droste, MD, and Lauren Fletcher-Morehouse, DO

Referred To: Reference Committee A

House Action:

Whereas, studies have shown that ophthalmic diagnostic medication can be used from patient to patient without evidence of secondary infection, and

Whereas, there is a current shortage of ophthalmic diagnostic and therapeutic medications to diagnose and treat ophthalmic conditions and disease, and

Whereas, currently, many hospital systems and their pharmacies are requiring unit doses for inpatient and operating room dispensing BUT they do not require unit dosage for patient evaluation in the outpatient setting, clinics, and

Whereas, hospital systems charge maximally for unit dose ophthalmic medications and charge up to $275,000 per year for these medications and make a significant profit from unit dose /patient dispensing, and

Whereas, plastic bottles, used for unit dose medication, possess a larger than necessary volume than is needed for the patient which contributes to excess cost, waste of medication and shortage of product, and

Whereas, ophthalmic medication, used in an inpatient or operating room setting, cannot be given to the patient to take home, even though they have been charged for the medication, and

Whereas, these practices by Health Institution Pharmacies (HIP) have been in place for many years without review; therefore it be

RESOLVED: That MSMS encourage Health Institution Pharmacies (HIP) to review their current practices and modify their inpatient recommendations for eye medication to be consistent with HIP outpatient practices for ophthalmic medication; and be it further

RESOLVED: That MSMS support that a patient who receives therapeutic ophthalmic medicine, to be used after discharge or operation, be able to take this medication with them when leaving the hospital.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000 - $2,000
Relevant MSMS Policy:

Remove Inpatient Pharmacy Requirements of Labeling/Dispensing Sparsely Used Meds to Patients at Discharge
MSMS supports working with the Michigan Pharmacists Association and Michigan Health and Hospital Association to investigate which labeling and dispensing requirements need to be revised to make it possible for patients to safely take home their partially used medications at time of discharge.

Relevant AMA Policy: None
Whereas, social determinants of health (SDoH) remain ongoing issues in community and public health, and

Whereas, unmet social needs are associated with worse treatment adherence, increased likelihood of hospitalization, higher morbidity, and as a result, greater costs of care, and

Whereas, clinical care contributes to 10-20 percent of modifiable contributors of individual health, with the remaining 80-90 percent stemming from individual, social, and environmental factors, and

Whereas, screening practices are inconsistent across the country, and are more likely to happen in practices serving low-income patient populations, and

Whereas, in a 2019 study, 24 percent of hospitals and 16 percent of physician practices reported performing social needs screening, and patients also noted they often had few alternative means of addressing their social needs outside of their healthcare-related encounters, and

Whereas, a study noted 27 percent of screened patients screened positive for social need, the most commonly reported needs were financial strain (56 percent) and social isolation (37 percent), and only 23 percent requested support, and

Whereas, addressing SDoH as part of healthcare professionals’ visits remains an unfunded mandate as screening patients and initiating referrals do not generate reimbursement, and

Whereas, diagnoses related to SDoH are generally contained in the “Z-codes” portion of the International Classification of Diseases 10th revision (ICD-10) are not reimbursable, and as a result, disincentivizes proactively screening for and addressing these problems, and

Whereas, in 2017, only 1.4 percent of claims contained SDoH Z-code data (Z55-Z-65), with the Z-code for “homelessness” (Z-59.0) being the most commonly utilized, and

Whereas, to adequately address SDoH in the current state of affairs, a healthcare professional may have to intrude upon their personal time and thus may increase their risk of burnout, and

Whereas, the lack of reimbursement for SDoH also means not being able to acquire and maintain resources such as social workers and benefits navigators who are competent and efficient in helping patients tackle these problems, and
Whereas, health care and health insurance restructuring are increasingly shifting toward capitated care models and are generating interest in cost-savings measures including addressing social needs, and

Whereas, provision of navigation services significantly reduced risk of child hospitalization during first year of life, and noted benefits on outcomes including asthma severity scores and avoidable utilization of healthcare resources, and

Whereas, implementing universal SDoH screening has been demonstrated to be feasible and, with the proper intervention guidelines in place, opens the door to sustainable cost-savings in the long-run, and

Whereas, policy 51-22 (Medicaid Funding to Address Social Determinants of Health) does not sufficiently empower MSMS to pursue insurance coverage of SDoH-related categories as identified in validated surveys; therefore be it

RESOLVED: That MSMS partner with medical, insurance, public health, social services, and government organizations to collectively identify and advocate for adequate reimbursement to screen for, and intervene on, identified social determinants of health.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $12,000-$24,000

Relevant MSMS Policy:

ACTION REPORT #03-23 OF THE BOARD OF DIRECTORS (Resolution 51-22)
Resolution 51-22 asked, “that MSMS support the use of Michigan Medicaid waivers to allocate federal Medicaid funding towards non-medical services that address social determinants of health, including services towards transportation costs, access to nutritious produce, housing expenditures, and the ability to purchase preventative care products; and that MSMS advocate for the adoption of Michigan Medicaid Managed Care protocols that support the creation of stipends exclusively for Medicaid individuals who express a need for funding to improve their social determinants of health.” At its meeting on January 25, 2023, the MSMS Board of Directors approved the recommendation of the Health Care Delivery Department to disapprove Resolution 51-22.

Availability of Medical Respite Centers
MSMS supports policies that increase the availability of medical respite centers and programs for use by individuals experiencing homelessness. Additionally, MSMS recognizes that local stakeholders must be able to secure adequate funding for medical respite programs, including, but not limited to, the expansion of current facilities in urban areas with large populations of individuals who are homeless.

Reduce Harm in Encampment Removals or Relocations
MSMS encourages the collaborative efforts of local governments, public health departments, social service organizations, and other stakeholders to develop a comprehensive plan to address the health care and social needs of individuals experiencing homelessness who would be impacted by the removal or relocation of an encampment in which they have been living. In the event of a public health recommendation of encampment clearance, the plan should establish procedures to safely and humanely remove or relocate encampments.

Expand Medicaid Transportation to Include Healthy Grocery Destinations
MSMS supports the inclusion of supermarkets, food banks and pantries, and local farmers markets as destinations covered by Medicaid transportation policy.

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.

Sources:
19. Robeznieks A. Social determinants of health and medical coding: What to know
Title: Access to Telemedicine Health Care Delivery System

Introduced by: David Lee, MD, MS, for the MI Section, American College of OB/GYN

Original Author: Halley Crissman, MD, MPH, Sara Jaber, MD, David Lee, MD, MS, Madeline Merwin, and Suha Syed, MD

Referred To: Reference Committee A

House Action:

Whereas, telemedicine is defined as the delivery of medical services by utilizing telecommunication technology with the basic aim of improving access to care, and

Whereas, barriers to health care access remain a major challenge with data from the Centers for Disease Control and Prevention showing that close to 19 percent of adults ages 18-64 years either did not receive or experienced delay in receiving the appropriate medical services with estimates tripling for individuals below the national poverty line, and

Whereas, barriers to health care access may include transportation challenges related to “lack of availability of a vehicle in the household or do not drive, geographic distance, or cost,” and

Whereas, other barriers to health care access include “the expanding shortage of practicing physicians,” and

Whereas, telemedicine enhances “access to and efficiency of” health care services as well as improves quality of care and patient health-related outcomes, and

Whereas, in December 2022, the United States Congress adopted language in the Consolidated Appropriations Act of 2023 recognizing the important role of telehealth and extending telehealth payment and regulatory flexibility for two years, and

Whereas, state laws must be established to regulate telemedicine access to care and to ensure adequate reimbursement of telemedicine; therefore be it

RESOLVED: That MSMS adopt AMA policy, Coverage of and Payment for Telemedicine H-480.946, to ensure patients’ access to care and improved health outcomes.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000

Relevant MSMS Policy:

Telemedicine for Access to Early Medical Abortion Care
MSMS supports access for medical abortions via telemedicine for first trimester pregnancies consistent with American College of Obstetricians and Gynecologists clinical management guidelines.
Relevant AMA Policy:

Coverage of and Payment for Telemedicine H-480.946

1. Our AMA believes that telemedicine services should be covered and paid for if they abide by the following principles: a) A valid patient-physician relationship must be established before the provision of telemedicine services, through: - A face-to-face examination, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine; or - A consultation with another physician who has an ongoing patient-physician relationship with the patient. The physician who has established a valid physician-patient relationship must agree to supervise the patient’s care; or - Meeting standards of establishing a patient-physician relationship included as part of evidence-based clinical practice guidelines on telemedicine developed by major medical specialty societies, such as those of radiology and pathology. Exceptions to the foregoing include on-call, cross coverage situations; emergency medical treatment; and other exceptions that become recognized as meeting or improving the standard of care. If a medical home does not exist, telemedicine providers should facilitate the identification of medical homes and treating physicians where in-person services can be delivered in coordination with the telemedicine services. b) Physicians and other health practitioners delivering telemedicine services must abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services. c) Physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services or be providing these services as otherwise authorized by that state’s medical board. d) Patients seeking care delivered via telemedicine must have a choice of provider, as required for all medical services. e) The delivery of telemedicine services must be consistent with state scope of practice laws. f) Patients receiving telemedicine services must have access to the licensure and board certification qualifications of the health care practitioners who are providing the care in advance of their visit. g) The standards and scope of telemedicine services should be consistent with related in-person services. h) The delivery of telemedicine services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes. i) The telemedicine service must be delivered in a transparent manner, to include but not be limited to, the identification of the patient and physician in advance of the delivery of the service, as well as patient cost-sharing responsibilities and any limitations in drugs that can be prescribed via telemedicine. j) The patient’s medical history must be collected as part of the provision of any telemedicine service. k) The provision of telemedicine services must be properly documented and should include providing a visit summary to the patient. l) The provision of telemedicine services must include care coordination with the patient’s medical home and/or existing treating physicians, which includes at a minimum identifying the patient’s existing medical home and treating physicians and providing to the latter a copy of the medical record. m) Physicians, health professionals and entities that deliver telemedicine services must establish protocols for referrals for emergency services. 2. Our AMA believes that delivery of telemedicine services must abide by laws addressing the privacy and security of patients’ medical information. 3. Our AMA encourages additional research to develop a stronger evidence base for telemedicine. 4. Our AMA supports additional pilot programs in the Medicare program to enable coverage of telemedicine services, including, but not limited to store-and-forward telemedicine. 5. Our AMA supports demonstration projects under the auspices of the Center for Medicare and Medicaid Innovation to address how telemedicine can be integrated into new payment and delivery models. 6. Our AMA encourages physicians to verify that their medical liability insurance policy covers telemedicine services, including telemedicine services provided across state lines if applicable, prior to the delivery of any telemedicine service. 7. Our AMA encourages national medical specialty societies to leverage and potentially collaborate in the work of national telemedicine organizations, such as the American Telemedicine Association, in the area of telemedicine technical standards, to the extent practicable, and to take the lead in the development of telemedicine clinical practice guidelines.

1.2.12 Ethical Practice in Telemedicine

Innovation in technology, including information technology, is redefining how people perceive time and distance. It is reshaping how individuals interact with and relate to others, including when, where, and how patients and physicians engage with one another. Telehealth and telemedicine span a continuum of technologies that offer new ways to deliver care. Yet as in any mode of care, patients need to be able to trust that physicians will place patient welfare above other interests, provide competent care, provide the
information patients need to make well-considered decisions about care, respect patient privacy and confidentiality, and take steps to ensure continuity of care. Although physicians’ fundamental ethical responsibilities do not change, the continuum of possible patient-physician interactions in telehealth/telemedicine give rise to differing levels of accountability for physicians. All physicians who participate in telehealth/telemedicine have an ethical responsibility to uphold fundamental fiduciary obligations by disclosing any financial or other interests the physician has in the telehealth/telemedicine application or service and taking steps to manage or eliminate conflicts of interests. Whenever they provide health information, including health content for websites or mobile health applications, physicians must ensure that the information they provide or that is attributed to them is objective and accurate. Similarly, all physicians who participate in telehealth/telemedicine must assure themselves that telemedicine services have appropriate protocols to prevent unauthorized access and to protect the security and integrity of patient information at the patient end of the electronic encounter, during transmission, and among all health care professionals and other personnel who participate in the telehealth/telemedicine service consistent with their individual roles. Physicians who respond to individual health queries or provide personalized health advice electronically through a telehealth service in addition should: (a) Inform users about the limitations of the relationship and services provided. (b) Advise site users about how to arrange for needed care when follow-up care is indicated. (c) Encourage users who have primary care physicians to inform their primary physicians about the online health consultation, even if in-person care is not immediately needed. Physicians who provide clinical services through telehealth/telemedicine must uphold the standards of professionalism expected in in-person interactions, follow appropriate ethical guidelines of relevant specialty societies and adhere to applicable law governing the practice of telemedicine. In the context of telehealth/telemedicine they further should: (d) Be proficient in the use of the relevant technologies and comfortable interacting with patients and/or surrogates electronically. (e) Recognize the limitations of the relevant technologies and take appropriate steps to overcome those limitations. Physicians must ensure that they have the information they need to make well-grounded clinical recommendations when they cannot personally conduct a physical examination, such as by having another health care professional at the patient’s site conduct the exam or obtaining vital information through remote technologies. (f) Be prudent in carrying out a diagnostic evaluation or prescribing medication by: (i) establishing the patient’s identity; (ii) confirming that telehealth/telemedicine services are appropriate for that patient’s individual situation and medical needs; (iii) evaluating the indication, appropriateness and safety of any prescription in keeping with best practice guidelines and any formulary limitations that apply to the electronic interaction; and (iv) documenting the clinical evaluation and prescription. (g) When the physician would otherwise be expected to obtain informed consent, tailor the informed consent process to provide information patients (or their surrogates) need about the distinctive features of telehealth/telemedicine, in addition to information about medical issues and treatment options. Patients and surrogates should have a basic understanding of how telemedicine technologies will be used in care, the limitations of those technologies, the credentials of health care professionals involved, and what will be expected of patients for using these technologies. (h) As in any patient-physician interaction, take steps to promote continuity of care, giving consideration to how information can be preserved and accessible for future episodes of care in keeping with patients’ preferences (or the decisions of their surrogates) and how follow-up care can be provided when needed. Physicians should assure themselves how information will be conveyed to the patient’s primary care physician when the patient has a primary care physician and to other physicians currently caring for the patient. Collectively, through their professional organizations and health care institutions, physicians should: (i) Support ongoing refinement of telehealth/telemedicine technologies, and the development and implementation of clinical and technical standards to ensure the safety and quality of care. (j) Advocate for policies and initiatives to promote access to telehealth/telemedicine services for all patients who could benefit from receiving care electronically. (k) Routinely monitor the telehealth/telemedicine landscape to: (i) identify and address adverse consequences as technologies and activities evolve; and (ii) identify and encourage dissemination of both positive and negative outcomes.

The Promotion of Quality Telemedicine H-160.937
1. The AMA adopts the following principles for the supervision of nonphysician providers and technicians when telemedicine is used: A. The physician is responsible for, and retains the authority for, the safety and quality of services provided to patients by nonphysician providers through telemedicine. B. Physician
supervision (e.g. regarding protocols, conferencing, and medical record review) is required when nonphysician providers or technicians deliver services via telemedicine in all settings and circumstances. C. Physicians should visit the sites where patients receive services from nonphysician providers or technicians through telemedicine, and must be knowledgeable regarding the competence and qualifications of the nonphysician providers utilized. D. The supervising physician should have the capability to immediately contact nonphysician providers or technicians delivering, as well as patients receiving, services via telemedicine in any setting. E. Nonphysician providers who deliver services via telemedicine should do so according to the applicable nonphysician practice acts in the state where the patient receives such services. F. The extent of supervision provided by the physician should conform to the applicable medical practice act in the state where the patient receives services. G. Mechanisms for the regular reporting, recording, and supervision of patient care delivered through telemedicine must be arranged and maintained between the supervising physician, nonphysician providers, and technicians. H. The physician is responsible for providing and updating patient care protocols for all levels of telemedicine involving nonphysician providers or technicians. 2. The AMA urges those who design or utilize telemedicine systems to make prudent and reasonable use of those technologies necessary to apply current or future confidentiality and privacy principles and requirements to telemedicine interactions. 3. The AMA emphasizes to physicians their responsibility to ensure that their legal and ethical requirements with respect to patient confidentiality and data integrity are not compromised by the use of any particular telemedicine modality. 4. The AMA advocates that continuing medical education conducted using telemedicine adhere to the standards of the AMA’s Physician Recognition Award and the Accreditation Criteria of the Accreditation Council for Continuing Medical Education. 5. Our AMA supports the appropriate use of telemedicine in the education of medical students, residents, fellows and practicing physicians.

Insurance Coverage Parity for Telemedicine Service D-480.969
1. Our AMA will advocate for telemedicine parity laws that require private insurers to cover telemedicine-provided services comparable to that of in-person services, and not limit coverage only to services provided by select corporate telemedicine providers. 2. Our AMA will develop model legislation to support states’ efforts to achieve parity in telemedicine coverage policies. 3. Our AMA will work with the Federation of State Medical Boards to draft model state legislation to ensure telemedicine is appropriately defined in each state’s medical practice statutes and its regulation falls under the jurisdiction of the state medical board.

Professionalism in Telemedicine and Telehealth D-480.974
The Council on Ethical and Judicial Affairs will review Opinions relating to telemedicine/telehealth and update the Code of Medical Ethics as appropriate.

Established Patient Relationships and Telemedicine D-480.964
Our AMA will: 1) work with state medical associations to encourage states that are not part of the Interstate Medical Licensure Compact to consider joining the Compact as a means of enhancing patient access to and proper regulation of telemedicine services; (2) advocate to the Interstate Medical Licensure Compact Commission and Federation of State Medical Boards for reduced application fees and secondary state licensure(s) fees processed through the Interstate Medical Licensure Compact; (3) work with interested state medical associations to encourage states to pass legislation enhancing patient access to and proper regulation of telemedicine services, in accordance with AMA Policy H-480.946, “Coverage of and Payment for Telemedicine”; and (4) continue to support state efforts to expand physician licensure recognition across state lines in accordance with the standards and safeguards outlined in Policy H-480.946.

Telemedicine in Medical Education D-295.313
1. Our AMA encourages appropriate stakeholders to study the most effective methods for the instruction of medical students, residents, fellows and practicing physicians in the use of telemedicine and its capabilities and limitations. 2. Our AMA will collaborate with appropriate stakeholders to reduce barriers to the incorporation of telemedicine into the education of physicians and other health care professionals. 3. Our AMA encourages the Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education to include core competencies in telemedicine in undergraduate medical education and graduate medical education training.
Telemedicine Models and Access to Care in Post-Acute and Long-Term Care D-480.966
Our AMA will: (1) advocate for removal of arbitrary limits on telemedicine visits by medical practitioners in nursing facilities and instead base them purely on medical necessity, and collaborate with relevant national medical specialty societies to effect a change in Medicare’s policy regarding this matter under the provisions of Physician Fee Schedule (PFS) and Quality Payment Program (QPP); and (2) work with relevant national medical specialty societies and other stakeholders to influence Congress to broaden the scope of telemedicine care models in post-acute and long-term care and authorize payment mechanisms for models that are evidence based, relevant to post-acute and long-term care and continue to engage primary care physicians and practitioners in the care of their patients.

Access and Equity in Telemedicine Payments D-480.970
Our AMA will advocate that the Centers for Medicare & Medicaid Services pay for telemedicine services for patients who have problems accessing physician specialties that are in short supply in areas that are not federally determined shortage areas, if that area can show a shortage of those physician specialists.

Technology and the Practice of Medicine G-615.035
Our AMA encourages the collaboration of existing AMA Councils and working groups on matters of new and developing technology, particularly electronic medical records (EMR) and telemedicine.

Telemedicine H-480.968
The AMA: (1) encourages all national specialty societies to work with their state societies to develop comprehensive practice standards and guidelines to address both the clinical and technological aspects of telemedicine; (2) will assist the national specialty societies in their efforts to develop these guidelines and standards; and urges national private accreditation organizations (e.g., URAC and JCAHO) to require that medical care organizations which establish ongoing arrangements for medical care delivery from remote sites require practitioners at those sites to meet no less stringent credentialing standards and participate in quality review procedures that are at least equivalent to those at the site of care delivery.

Ensuring Continued Enhanced Access to Healthcare via Telemedicine and Telephonic Communication D-480.961
Our AMA will advocate that the HIPAA enforcement moratorium for telehealth services be extended by at least 365 days after the end of the COVID-19 public health emergency, during which time physicians and other affected parties shall not be subject to HIPAA audits and other HIPAA enforcement activity relative to telehealth.

COVID-19 Emergency and Expanded Telemedicine Regulations D-480.963
Our AMA: (1) will continue to advocate for the widespread adoption of telehealth services in the practice of medicine for physicians and physician-led teams post SARS-COV-2; (2) will advocate that the Federal government, including the Centers for Medicare & Medicaid Services (CMS) and other agencies, state governments and state agencies, and the health insurance industry, adopt clear and uniform laws, rules, regulations, and policies relating to telehealth services that: (a) provide equitable coverage that allows patients to access telehealth services wherever they are located, and (b) provide for the use of accessible devices and technologies, with appropriate privacy and security protections, for connecting physicians and patients; (3) will advocate for equitable access to telehealth services, especially for at-risk and under-resourced patient populations and communities, including but not limited to supporting increased funding and planning for telehealth infrastructure such as broadband and internet-connected devices for both physician practices and patients; and (4) supports the use of telehealth to reduce health disparities and promote access to health care.

Electronic Prescribing D-120.972
1. Our AMA will (a) ask the Drug Enforcement Administration to accelerate the promulgation of digital certificate standards for direct electronic transmission of controlled substance prescriptions to support the patient safety goals and other governmental initiatives; and (b) urge Congress to work towards unifying state prescription standards and standard vocabularies to facilitate adoption of electronic prescribing. 2. Our AMA
will support national efforts to amend federal law and federal Drug Enforcement Administration regulations to allow for the e-prescribing of a medication, including a controlled substance, needed by a patient with a mental health or behavioral health diagnosis when a valid patient-physician relationship has been established through telemedicine and in accordance with state law and accepted standards of care.

**Face-to-Face Encounter Rule D-330.914**

1. Our AMA will: (A) work with the Centers for Medicare & Medicaid Services (CMS) and appropriate national medical specialty societies to ensure that physicians understand the alternative means of compliance with and payment policies associated with Medicare’s face-to-face encounter policies, including those required for home health, hospice and durable medical equipment; (B) work with CMS to continue to educate home health agencies on the face-to-face documentation required as part of the certification of eligibility for Medicare home health services to ensure that the certification process is streamlined and minimizes paperwork burdens for practicing physicians; and (C) continue to monitor legislative and regulatory proposals to modify Medicare’s face-to-face encounter policies and work to prevent any new unfunded mandatory administrative paperwork burdens for practicing physicians. 2. Our AMA will work with CMS to enable the use of HIPAA-compliant telemedicine and video monitoring services to satisfy the face-to-face requirement in certifying eligibility for Medicare home health services.

Sources:

Title: Evidence-Based Anti-Obesity Medication as a Covered Benefit

Introduced by: Stephanie Clemens, MD, for the Oakland County Delegation

Original Author: Stephanie Clemens, MD

Referred To: Reference Committee A

House Action:

Whereas, obesity is a complex, multifactorial, common, serious, relapsing, and costly chronic disease that serves as a major risk factor for developing conditions such as heart disease, stroke, type 2 diabetes, renal disease, non-alcoholic steatohepatitis, and certain types of cancer, and

Whereas, health care costs are 34 percent higher for people with obesity, with the total cost of obesity in the U.S. being $1.7 trillion, and

Whereas, weight bias negatively impacts those affected financially, mentally, socially, and physically, and

Whereas, Michigan currently ranks 21st in states impacted by obesity, with 68.5 percent of adult Michiganders being classified as overweight or obese, and

Whereas, health care coverage for obesity and weight management is inadequate and insufficient, and varies significantly by each health plan, with millions of Americans being denied access to evidence-based treatments to help them address this disease and the numerous comorbidities that accompany obesity; for example, a majority of state employee health plans fail to cover FDA-approved obesity drugs and 27 state health exchanges exclude coverage for metabolic and bariatric surgery, and

Whereas, people who are affected by obesity deserve access to affordable, individualized medical coverage for science-based treatments in the same way as other chronic diseases are managed; therefore be it

RESOLVED: That MSMS support and advocate that health care plans cover evidence-based, medically necessary treatments for obesity, and that access to care should not be hindered by undue prerequisites on the part of the patient; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to advocate for adequate coverage of FDA approved anti-obesity medications and to not exclude anti-obesity medications from coverage based on a benefit exclusion or a carve-out.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $16,000-$32,000
Relevant MSMS Policy:

Childhood Obesity as a Covered Benefit
MSMS supports the treatment of childhood obesity a benefit covered by health insurance plans.

Relevant AMA Policy:

Obesity as a Major Public Health Problem H-150.953
Our AMA will: (1) urge physicians as well as managed care organizations and other third party payers to recognize obesity as a complex disorder involving appetite regulation and energy metabolism that is associated with a variety of comorbid conditions; (2) work with appropriate federal agencies, medical specialty societies, and public health organizations to educate physicians about the prevention and management of overweight and obesity in children and adults, including education in basic principles and practices of physical activity and nutrition counseling; such training should be included in undergraduate and graduate medical education and through accredited continuing medical education programs; (3) urge federal support of research to determine: (a) the causes and mechanisms of overweight and obesity, including biological, social, and epidemiological influences on weight gain, weight loss, and weight maintenance; (b) the long-term safety and efficacy of voluntary weight maintenance and weight loss practices and therapies, including surgery; (c) effective interventions to prevent obesity in children and adults; and (d) the effectiveness of weight loss counseling by physicians; (4) encourage national efforts to educate the public about the health risks of being overweight and obese and provide information about how to achieve and maintain a preferred healthy weight; (5) urge physicians to assess their patients for overweight and obesity during routine medical examinations and discuss with at-risk patients the health consequences of further weight gain; if treatment is indicated, physicians should encourage and facilitate weight maintenance or reduction efforts in their patients or refer them to a physician with special interest and expertise in the clinical management of obesity; (6) urge all physicians and patients to maintain a desired weight and prevent inappropriate weight gain; (7) encourage physicians to become knowledgeable of community resources and referral services that can assist with the management of overweight and obese patients; and (8) urge the appropriate federal agencies to work with organized medicine and the health insurance industry to develop coding and payment mechanisms for the evaluation and management of obesity.
RESOLUTION 53-23

Title: ICD-10 Coding, Site Laterality, and Denial of Claims

Introduced by: David Whalen, MD, for Kent County Medical Society

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

Referred To: Reference Committee A

Whereas, ICD-10 coding allows for significant specificity with an alphanumeric coding system, and

Whereas, the ICD-10 coding specificity addresses acuity, initial/subsequent encounters, site laterality, and complications, and

Whereas, ICD-10 specificity is relevant and has guidance and rules for assigning Diagnostic Related Group (DRG) for inpatient facility coding, this specificity, guidance, and rules are not intended for professional claim coding, and

Whereas, designating site laterality (i.e., right-sided, left-sided, bilateral, or unspecified) on the professional claim often does not change the treated condition, acuity, medical decision making, or planned treatment, and

Whereas, appropriate health care has usually been provided and documented in the electronic medical record even if site laterality has not been specified in the ICD-10 condition code submitted on the professional claim (i.e., the work has been done and should be reimbursed), and

Whereas, ICD-10 coding guidance allows unspecified laterality as a valid diagnosis code under certain conditions, and

Whereas, third party professional claim forms require a Current Procedural Terminology code to determine payment amount, and an ICD-10 code to support the medical need for the professional service does not impact payment for the service, and

Whereas, third party payor denials of payable professional claims add unnecessary administrative cost to the health care system, and

Whereas, third party payors are often denying insurance claims and payment for professional services if an unspecified code is used rather than specifying laterality, even though this level of specificity plays no role in the complexity of medical decision making and even though site laterality is usually documented within the electronic medical record; therefore, be it

RESOLVED: That MSMS advocate with third party payors in the State of Michigan to reimburse insurance claims with reasonable documentation, even if site laterality is unspecified; and, be it further
RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) advocate with the AMA to ban third party payors from denial of insurance claims for professional services based solely on lack of site laterality specification in the ICD-10 code used for billing.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000

Relevant MSMS Policy: None

Relevant AMA Policy:

**Opposing Coverage Decisions Based Solely on ICD-10 Code Specificity H-70.914**
Our AMA opposes limitations in coverage for medical services based solely on diagnostic code specificity.
ACTION REPORT #02-23 OF THE BOARD OF DIRECTORS

SUBJECT: Resolution 38-22
NBPAS as Equivalent Certification for Health Insurers and Hospitals

REFERRED TO: Reference Committee A

HOUSE ACTION:

RECOMMENDATION: That the 2023 House of Delegates disapprove Resolution 38-22, “NBPAS as Equivalent Certification for Health Insurers and Hospitals.”

Resolution 38-22 was referred to the MSMS Board of Directors for study. The Board referred the resolution to the Health Care Delivery Department for review and recommendation.

Resolution 38-22 asked “that MSMS work expediently with Michigan insurance companies to update their board certification language to be in compliance with current National Committee for Quality Assurance and Utilization Review Accreditation Commission standards, recognizing board certification with National Board of Physicians and Surgeons as equivalent to American Board of Medical Specialties and American Osteopathic Association certification for physician participation; and that MSMS support the efforts of physician members working to change their hospital bylaws to recognize National Board of Physicians and Surgeons as equivalent to American Board of Medical Specialties and American Osteopathic Association certification for hospital privileges; and that the Michigan Delegation to the American Medical Association (AMA) ask the AMA to bring the recent recognition of National Board of Physicians and Surgeons as equivalent to American Board of Medical Specialties and American Osteopathic Association certification for National Committee for Quality Assurance, The Joint Commission, and Utilization Review Accreditation Commission credentialing for the consideration of our AMA as an option for physicians nationwide to consider in their continuing certification needs.”

Reference Committee B (Legislation) considered Resolution 38-22 during the 2022 MSMS House of Delegates. The Committee heard testimony in support and opposition to the Resolution. The main point of disagreement related to whether the certification processes of National Board of Physicians and Surgeons are equivalent to those of the American Board of Medical Specialties and American Osteopathic Association. There

(continued)
were passionate opinions on both sides. Therefore, the Committee believed it was prudent for the Board to investigate this topic further and develop recommendations considering current MSMS policy.

According to the website for the National Board of Physicians and Surgeons (NBPAS) it was founded in 2015 to “provide physicians a choice in continuous board certification that is clinically rigorous, evidence-based, less burdensome and nationally accepted.” It certifies physicians in all fifty states. The website also states that it meets all national accreditation standards for hospitals and health plans which includes The Joint Commission (TJC), The National Committee on Quality Assurance (NCQA), and the Utilization Review Accreditation Commission (URAC).

The Joint Commission added NBPAS as a Designated Equivalent Source Agency in 2022. The Joint Commission defines a designated equivalent source as “agencies that have been determined to maintain a specific item(s) of credential(s) information that is identical to the information at the primary source.” The National Committee on Quality Assurance (NCQA) list NBPAS as another acceptable verification source for physicians by stating “boards in the United States that are not members of the ABMS or AOA (e.g., NBPAS), if the organization documents within its policies and procedures which specialty board it accepts and obtains annual written confirmation from the board that the board performs primary source verification of completion of education and training.” The Utilization Review Accreditation Commission (URAC) has stated that it will accept a physician board certification, including NBPAS, as long as it meets one or more of the following criteria:

- The physician board certification is accepted by a state or federal entity of the U.S. or one if its territories, which include, but are not limited to: a state or federal legislature, regulatory agency, department, division, or program, or a state medical board.
- The physician clinical leadership for an organization providing health services has determined that a physician board certification is acceptable.

MSMS staff researched the requirement for NBPAS and for each specialty board for American Board of Medical Specialties (ABMS). The attached grid shows the requirements for each organization.

The second Resolved asks that MSMS support efforts of members who are working to change hospital bylaws to recognize NBPAS as an equivalent organization. This is outside of the purview of MSMS; therefore, it is not something that MSMS could do.

The third Resolved asks that the Michigan Delegation to the American Medical Association (AMA) ask the AMA to consider NPBAS as an option for physicians to
consider in their continuing education needs. At the November meeting of the AMA House of Delegates, the AMA considered Resolution 316, “Recognizing Specialty Certifications for Physicians.” The AMA passed this amended resolution that amended AMA Policy H-275.926, “Medical Specialty Board 15 Certification Standards,” to include language stating:

“It is AMA policy that when the equivalency of board certification must be determined, the certification program must first meet accepted standards for certification that include both 1) a process for defining specialty-specific standards for knowledge and skills and 2) offer an independent, external assessment of knowledge and skills for both initial certification and recertification in the medical specialty. In addition, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, will be utilized for that determination.”

A side-by-side comparison of the requirements of NBPAS and ABMS shows that the organizations do not have equivalent standards. NBPAS is a primary source verification agency for licensure, hospital privileges, and continuing medical education credits. The various specialty boards for ABMS include additional training such as cognitive assessment and quality improvement. It is outside of the purview of MSMS to change hospital bylaws. Finally, it does not appear that NBPAS will meet the recently passed amendments to AMA Policy H-275.926, defining the standards needed for a specialty-specific certification program.

At its meeting on January 25, 2023, the MSMS Board of Directors approved the recommendation of the Health Care Delivery Department to disapprove Resolution 38-22.

Attachments
Resolution 38-22
NBPAS VS ABMS Requirements Comparison
Resolution 316 (I-22) – Final Action
RESOLUTION 38-22

Title: NBPAS as Equivalent Certification For Health Insurers and Hospitals

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

Original Author: Megan Edison, MD

Referred To: Reference Committee B

House Action:

Whereas, MSMS and the AMA have longstanding policy opposing continuing board certification as a requirement for hospital privileges or insurance plan participation, and

Whereas, insurers and hospital systems continue to ignore this, citing their own corporate credentialing concerns, as “board certified physician” are a marker of quality as measured by the National Committee for Quality Assurance (NCQA), The Joint Commission (TJC), and Utilization Review Accreditation Commission (URAC), and

Whereas, previously, the credentialing language of NCQA, TJC, and URAC only allowed American Board of Medical Specialties (ABMS) and American Osteopathic Association (AOA) certification, leaving physicians no other option than to participate in ABMS or AOA recertification for hospital or insurance participation, and

Whereas, ABMS and AOA are no longer the only options for physicians, other organizations such as National Board of Physicians and Surgeons (NBPAS) provide board certification, and unlike ABMS and AOA, adhere firmly to the AMA Principles on Continuing Board Certification, and

Whereas, NCQA now recognizes board certification with NBPAS as equivalent to ABMS and AOA certification for insurance company credentialing, and

Whereas, TJC now recognizes board certification with NBPAS as equivalent to ABMS and AOA certification in the Joint Commission’s glossary for the Ambulatory Care, Behavioral Health and Human Services, Critical Access Hospital, Hospital, and Office-Based Surgery accreditation manuals effective July 2022, and

Whereas, URAC now recognizes board certification with NBPAS as equivalent to ABMS and AOA certification in their accreditation standards for health care organizations, and

Whereas, MSMS policy on board recertification champions these options, stating “MOC should not be the monopoly of any single entity. Physicians should be able to access a range of alternatives from different entities,” and

Whereas, official acceptance of NBPAS as equivalent to ABMS and AOA certification for NCQA, TJC, and URAC credentialing should leave no reason why insurers and hospitals should continue to require recertification by only ABMS and AOA; therefore be it
RESOLVED: That MSMS work expediently with Michigan insurance companies to update their board certification language to be in compliance with current National Committee for Quality Assurance and Utilization Review Accreditation Commission standards, recognizing board certification with National Board of Physicians and Surgeons as equivalent to American Board of Medical Specialties and American Osteopathic Association certification for physician participation; and be it further

RESOLVED: That MSMS support the efforts of physician members working to change their hospital bylaws to recognize National Board of Physicians and Surgeons as equivalent to American Board of Medical Specialties and American Osteopathic Association certification for hospital privileges; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask the AMA to bring the recent recognition of National Board of Physicians and Surgeons as equivalent to American Board of Medical Specialties and American Osteopathic Association certification for National Committee for Quality Assurance, The Joint Commission, and Utilization Review Accreditation Commission credentialing for the consideration of our AMA as an option for physicians nationwide to consider in their continuing certification needs.

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

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, through its Council on Medical Education, will 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.
38. Our AMA, through its Council on Medical Education, will continue to work with the ABMS and ABMS member boards to implement key recommendations outlined by the Continuing Board Certification: Vision for the Future Commission in its final report, including the development of new, integrated standards for continuing certification programs by 2020 that will address the Commission’s recommendations for flexibility in knowledge assessment and advancing practice, feedback to diplomates, and consistency.
39. Our AMA will work with the ABMS and its member boards to reduce financial burdens for physicians holding multiple certificates who are actively participating in continuing certification through an ABMS member board, by developing opportunities for reciprocity for certification requirements as well as consideration of reduced or waived fee structures.

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 diplomat 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.
<table>
<thead>
<tr>
<th>Requirement</th>
<th>NBPAS</th>
<th>ABMS</th>
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<tbody>
<tr>
<td>Initial Board Certification</td>
<td>Must receive it through ABMS/AOA</td>
<td>N/A</td>
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<tr>
<td><strong>Part 1: Professional Standing</strong></td>
<td></td>
<td></td>
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<tr>
<td>Medical Licensure</td>
<td>Current, valid unrestricted license</td>
<td>Current, valid unrestricted license</td>
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<tr>
<td>Active Hospital Privileges</td>
<td>Must have active privileges to practice specialty in at least one US hospital or outpatient facility</td>
<td>Require verification of hospital privileges</td>
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<tr>
<td>Other Items</td>
<td>Candidates who have had their medical staff appointment/membership or clinical privileges involuntarily revoked must have subsequently maintained medical staff appointment/membership or clinical privileges for at least 24 months in another U.S. hospital or outpatient facility. If medical staff appointment/privileges were lost solely due to not participating in MOC, this will be verified with the medical staff office and candidates may still qualify for NBPAS recertification.</td>
<td>Some specialties require self-attestation, peer references and/or signing of professional conduct statement</td>
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<tr>
<td><strong>Part II. Lifelong Learning &amp; Self-Assessment</strong></td>
<td></td>
<td></td>
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<tr>
<td>New applicant</td>
<td>New applicant: 50 hours of CME w/in past 24 months; lapsed</td>
<td>Total required CME hours varies depending on</td>
</tr>
<tr>
<td>Part III. Cognitive Expertise/Assessment of Knowledge, Judgement and Skills</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Not Applicable</td>
<td></td>
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<tr>
<td>The specialties had varying requirements ranging from answering a specific number of questions electronically to completing a MOC exam.</td>
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<table>
<thead>
<tr>
<th>Part IV. Practice Assessment/Quality Improvement/Improvement in Medical Practice</th>
</tr>
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<tbody>
<tr>
<td>Not Applicable</td>
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<tr>
<td>The majority of specialties required some type of activity, but the type of activity varied.</td>
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<tr>
<th>Cost</th>
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<tr>
<td>$189 every two years</td>
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<tr>
<td>$125-$1,500 per year</td>
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</table>
Whereas, Specialty certification is a critical component of our system of physician self-regulation and is essential to serve the public and the medical profession by improving the quality of health care through setting professional standards for lifelong certification; and

Whereas, The Institute for Credentialing Excellence defines a professional certification program as one that provides an independent assessment of the knowledge, skills, and/or competencies required for competent performance of a professional role or specific work-related tasks and responsibilities; and

Whereas, The Institute for Credentialing Excellence further states that certification is also intended to measure continued competence through recertification or renewal requirements; and

Whereas, Only the entity that initially certifies an individual should recertify the individual’s certificate thereafter; and

Whereas, According to policy H-275.926, “Medical Specialty Board Certification Standards,” our AMA opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of the American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board-certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety; and

Whereas, There are many legitimate certifying boards beyond the ABMS and AOA-BOS (e.g., American Board of Oral and Maxillofacial Surgery, American Board of Obesity Medicine, and American Board of Physician Specialties) that curate knowledge and set standards for required knowledge in a medical specialty and grant physicians certification who successfully meet their independent assessments of knowledge and skills; and

Whereas, According to policy H-275.926, “Medical Specialty Board Certification Standards,” our AMA advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not; and

Whereas, Efforts by organizations that do not meet the basic standards for initial and continuing certification to gain recognition by state legislatures and national organizations are ongoing and will be confusing to the public and other health care stakeholders; therefore be it
RESOLVED, That our American Medical Association amend Policy H-275.926, “Medical Specialty Board Certification Standards,” by addition to read as follows:

Our AMA:
1. (1) Opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.
2. (2) Opposes any action, regardless of intent, by organizations providing board certification for non-physicians that appears likely to confuse the public about the unique credentials of medical specialty board certification or take advantage of the prestige of medical specialty board certification for purposes contrary to the public good and safety.
3. (3) Continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, the certification program must first meet industry standards for certification that include both 1) a process for defining specialty-specific standards for knowledge and skills and 2) offer an independent, external assessment of knowledge and skills for both initial certification and recertification in the medical specialty. In addition, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, will be utilized for that determination.
4. (4) Opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.
5. (5) Advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.
6. (6) Encourages member boards of the ABMS to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms.

RESOLVED, That our AMA advocate for federal and state legislatures, federal and state regulators, physician credentialing organizations, hospitals, other health care stakeholders and the public to define physician board certification as establishing specialty-specific standards for knowledge and skills, using an independent assessment process to determine the acquisition of knowledge and skills for initial certification and recertification. (Directive to Take Action)

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

Received: 10/19/22

REFERENCES:
1. Institute for Credentialing Excellence. Definition of Certification, at https://www.credentialingexcellence.org/About, accessed 19 October 2022
RELEVANT AMA POLICY

Medical Specialty Board Certification Standards H-275.926

Our AMA:
(1) Opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.
(2) Opposes any action, regardless of intent, by organizations providing board certification for non-physicians that appears likely to confuse the public about the unique credentials of medical specialty board certification or take advantage of the prestige of medical specialty board certification for purposes contrary to the public good and safety.
(3) Continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, be utilized for that determination.
(4) Opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.
(5) Advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.
(6) Encourages member boards of the ABMS to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms.

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 report regarding the CBC process at the request of the House of Delegates or when deemed necessary by the Council on Medical Education.
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 Coalition for Physician Accountability, formerly known as 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, through its Council on Medical Education, will 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.

38. Our AMA, through its Council on Medical Education, will continue to work with the American Board of Medical Specialties (ABMS) and ABMS member boards to implement key recommendations outlined by the Continuing Board Certification: Vision for the Future Commission in its final report, including the development and release of new, integrated standards for continuing certification programs that will address the Commission's recommendations for flexibility in knowledge assessment and advancing practice, feedback to diplomates, and consistency.

39. Our AMA will work with the ABMS and its member boards to reduce financial burdens for physicians holding multiple certificates who are actively participating in continuing certification through an ABMS member board, by developing opportunities for reciprocity for certification requirements as well as consideration of reduced or waived fee structures.

ACTION REPORT #03-23 OF THE BOARD OF DIRECTORS

SUBJECT: Resolution 51-22
Medicaid Funding to Address Social Determinants of Health

REFERRED TO: Reference Committee A

HOUSE ACTION:

RECOMMENDATION: That the 2023 House of Delegates disapprove Resolution 51-22, “Medicaid Funding to Address Social Determinants of Health.”

Resolution 51-22 was referred to the MSMS Board of Directors for study. The Board referred the resolution to the Health Care Delivery Department for review and recommendation.

Resolution 51-22 asked, “that MSMS support the use of Michigan Medicaid waivers to allocate federal Medicaid funding towards non-medical services that address social determinants of health, including services towards transportation costs, access to nutritious produce, housing expenditures, and the ability to purchase preventative care products; and that MSMS advocate for the adoption of Michigan Medicaid Managed Care protocols that support the creation of stipends exclusively for Medicaid individuals who express a need for funding to improve their social determinants of health.”

Reference Committee A (Medical Care Delivery) considered Resolution 51-22 during the 2022 MSMS House of Delegates. Most of the testimony heard was in opposition to this resolution due to concern that Medicaid funding for medical care is already inadequate and taking funds from Medicaid to fund social determinants of health could further lower Medicaid reimbursement. However, the Committee also discussed North Carolina’s 1115 Medicaid waiver program which created the state’s Healthy Opportunities Pilot Program and authorized the use of Medicaid funds to pay for enhanced case management and other support services. The Committee decided to refer to the Board for further study to include evaluation of 1115 Medicaid waiver programs like North Carolina’s.

Section 1115 Medicaid Demonstration Waivers. Section 1115 of the Social Security Act (Section 1115) gives the Secretary of Health and Human Services authority to approve pilot or demonstration projects that are found to be likely to assist promoting the objectives of the Medicaid program. These demonstration waivers usually test

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board changes in eligibility, benefits and cost-sharing and payment and delivery systems. The purpose of the Section 1115 waivers is to give states flexibility to design and improve their programs.

During the review, CMS ensures the stated objectives align with those of Medicaid. CMS also reviews the proposal to ensure it is consistent with federal policies, including the degree to which it may replace state-only costs for existing programs or services. They also want to ensure the proposal is not better supported through other federal and non-federal funding sources.

Demonstrations must be budget neutral to the Federal government, which means that Federal Medicaid expenditures will not be more than Federal spending without the demonstration. The Section 1115 waivers are usually approved for an initial five-year period and can be extended for up to an additional three to five years.

Currently, the state of Michigan has three Section 1115 demonstration waivers. The Flint Michigan Section 1115 Demonstration enables Michigan to expand coverage to all pregnant women and children up to age 21, who are currently served by the Flint water system or were served by the Flint water system between April 2014 and the date when the water system was deemed safe. The Healthy Michigan Section 1115 demonstration waiver enables Michigan to test innovative cost sharing and financial responsibility for care. The Michigan 1115 Behavioral Health Demonstration (formerly Pathways to Integration) will give beneficiaries access to high quality, evidence-based opioid use disorder (OUD) and other substance use disorder (SUD) services.

Examples of three states with Social Determinants of Health pilots include North Carolina, Washington State, and California.

**North Carolina- Healthy Opportunities Pilot.** CMS authorized $650 million in Medicaid funding to North Carolina for their Health Opportunities pilot. In this pilot program, managed care plans must implement standardized screening questions to assess enrollees’ non-medical needs and connect beneficiaries with unmet needs with community resources. In certain regions, the Healthy Opportunities Pilot will authorize the use of Medicaid funds to pay for enhanced case management and other support services for high-risk beneficiaries that meet physical or behavioral health and social risk factors. The program will address housing instability, transportation insecurity, food insecurity, interpersonal violence, and toxic stress.

**Washington – Accountable Communities of Health.** CMS authorized $994 million to Washington State. The state launched a regional Accountable Communities of Health
(ACH) model which sought to improve clinical care outcomes and preventive services using collaboration across clinical and community organizations to account for SDOH. ACHs had to build up their organizational infrastructure so they could develop project plans and distribute funds to regional partners. They focused on improving transitional care, improving the integration of physical and behavioral health care, and increasing access to oral health services.

California – Whole Person Care. CMS authorized $1.5 billion over five years to California for the Whole Person Care (WPC) pilot program. This program aims to coordinate care (physical and behavioral health and social needs) for high-risk, high utilizing beneficiaries. They want to increase integration and data sharing among county agencies, health plans, and other community-based organizations. The state picked 25 WPCs across the state and asked them to identify target populations and interventions. They receive care coordination and other services not covered by Medi-Cal. Common services offered include housing-related services, employment assistance, medical respite, and sobering centers.

**MDHHS Social Determinants of Health Strategy – Michigan’s Roadmap to Healthy Communities.** In April 2022, the Michigan Department of Health and Human Services (MDHHS) published a Social Determinants of Health Strategy called *Michigan’s Roadmap to Healthy Communities*. It is a focused approach to align efforts at the state and local level to “improve the health and social outcomes of all Michigan residents while working to achieve health equity by eliminating disparities and barriers to social and economic opportunities.” The overarching strategy will have three focus areas: housing stability, food security, and health equity.

The housing stability focus area includes three priorities: supporting populations made vulnerable to housing instability, holistic approaches to healthy housing, and addressing housing access for all people experiencing homelessness. The priority focusing on populations made vulnerable to housing instability will tailor interventions specific to people and communities disadvantaged by policies, practices, and systems. The priority focusing on holistic approaches to healthy housing will include strategies incorporating lead mitigation, weatherization, and potable water access. The priority focusing on addressing housing access for people experiencing homelessness will expand eviction diversion programs and increase resources for accessing housing.

The food security focus area includes three priorities: supporting people made vulnerable to food insecurity, streamlining processes to improve access to food benefits, and alignment on key food security reforms. The priority focusing on supporting populations made vulnerable to food insecurity will include strategies to eliminate

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barriers to a person’s ability to be food secure and supporting community assets with systems to help short-term and long-term food security. For the priority focusing on streamlining processes to improve access to food benefits, MDHHS will take an inward look at their programs and policies that support food security. For the priority focusing on alignment on key food security reforms, MDHHS will look for additional partners to ensure programs are connected for greater impact.

The health equity focus area includes three priorities: supporting people made vulnerable to adverse health outcomes, improving MDHHS-driven equity programs and policies, and strengthening community engagement to support community-driven solutions. The priority focusing on supporting people made vulnerable to adverse health outcomes will include tailored interventions to people and communities that have been historically disadvantaged by polices, practices and systems. The priority focusing on improving MDHHS-driven equity programs and policies will include integrating existing efforts to advance health equity within the SDOH strategy, align efforts with statewide agencies, and integrate equity recommendations into all MDHHS programs. The priority focusing on strengthening community engagement will include an emphasis on engaging with residents to develop policies and funding that supports community-driven solutions.

MDHHS Social Determinants of Health Strategy plan had not been published at the time of the writing of the resolution. After reviewing MDHHS’s plan, it is believed that the state’s plan includes tactics that will help individuals find affordable, safe housing. Furthermore, the plan includes tactics to remove barriers to being food secure and will improve access to food benefits. The plan also includes tactics for advancing health equity by aligning efforts with statewide agencies and integrating recommendations into all MDHHS programs. It is believed that MDHHS needs time to implement and report on their strategy before asking them to apply for a waiver of federal funds that could reallocate money away for reimbursement. MSMS should monitor MDHHS’s plan and provide input where appropriate.

At its meeting on January 25, 2023, the MSMS Board of Directors approved the recommendation of the Health Care Delivery Department to disapprove Resolution 51-22.

Attachment
Resolution 51-22

(continued)
RESOLUTION 51-22

Title: Medicaid Funding to Address Social Determinants of Health

Introduced by: Mara Darian, for the Medical Student Section

Original Authors: Victor Agbafe, Kumaran Arivoli, Jesper Ke, and Neil Vaishampayan

Referred To: Reference Committee A

House Action:

Whereas, more than 80 percent of the factors that affect an individual’s health are related to non-clinical socioeconomic, environmental, and behavioral factors called the social determinants of health, and

Whereas, socioeconomic income level is the strongest contributing factor to health disparities in America with those below the five percent percentile income level experiencing a 0.21 year decrease in life expectancy between 2001 and present day while those in the top five percent experienced a 2.5 year increase in life expectancy, and

Whereas, the lack of nutritious food options is correlated to a doubling risk of increased cardiovascular disease, obesity, renal disease, and chronic conditions, and

Whereas, individuals eligible for Medicaid, those below the 130 percent federal poverty line, are 2.5 times more likely to have fast food restaurants, six times less likely to have fresh produce, and seven times more likely to shop for food at convenience stores than those with income greater than 350 percent of the federal poverty line, and

Whereas, the ability to purchase important preventative health and hygiene products, such as condoms, face masks, tampons, and antibacterial hand soap is further decreased for patients that fall under the Medicaid eligible 130 percent federal poverty line contributing to a higher spread of COVID-19, sexually transmitted, and infectious disease within this population, and

Whereas, access to affordable housing options is associated with greater physical health, greater psychological health, decreased substance use, better effectiveness of health care, more children reaching their developmental milestones, better management of chronic conditions, and a reduction in emergency department visits, and

Whereas, the federal funding of Medicaid does not allow for expenditures on many non-medical services, states can utilize state plans and waiver authorities to add non-medical services to their benefits packages, and

Whereas, states can utilize the Medicaid Managed Care stipends to allocate funds for individuals who express a need for transportation services, access to nutritional foods, funds to purchase preventative care products, and/or assistance with rent or housing costs; therefore be it
RESOLVED: That MSMS support the use of Michigan Medicaid waivers to allocate federal Medicaid funding towards non-medical services that address social determinants of health, including services towards transportation costs, access to nutritious produce, housing expenditures, and the ability to purchase preventative care products; and be it further

RESOLVED: That MSMS advocate for the adoption of Michigan Medicaid Managed Care protocols that support the creation of stipends exclusively for Medicaid individuals who express a need for funding to improve their social determinants of health.

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

Relevant MSMS Policy:

Expand Medicaid Transportation to Include Healthy Grocery Destinations
MSMS supports the inclusion of supermarkets, food banks and pantries, and local farmers markets as destinations covered by Medicaid transportation policy. (Res29-19)

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.
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RESOLUTION 04-23

Title: Protect Working Families With Medical Debt Burden

Introduced by: Nicolas K. Fletcher, MD, MHSA, for the Wayne County Delegation

Original Author: Nicolas K. Fletcher, MD, MHSA

Referred To: Reference Committee B

House Action:

Whereas, 14 percent of Michigan residents live with medical debt (approximately 1.6 million individuals), and

Whereas, Michigan residents’ medical debt balance is more than $1.5 billion, with Michigan residents owing on average $1,200, and

Whereas, debt collection cases dominate Michigan’s District Court, second in filing rate only to traffic cases, and

Whereas, 78 percent of default judgment cases in Michigan result in garnishment of wages and assets, and

Whereas, people with medical debt are far less likely to fill a prescription, see a specialist when needed, visit a doctor or clinic for a medical problem and more likely to skip a needed test, treatment, or follow-up visit, and

Whereas, out of every 100 people in the U.S., between 18 and 35 people have medical debt in collections, with Black, Indigenous, and people of color and people with lower incomes having higher rates of medical debt than the general population, and

Whereas, the COVID-19 pandemic brought renewed attention to medical debt, health inequities, and public health; therefore be it

RESOLVED: That MSMS lobby state and county officials to modernize and update garnishment protections to protect assets Michigan residents need to pay down debt (i.e., wages or property); and be it further

RESOLVED: That MSMS work with the appropriate state regulatory agency to cap the maximum interest rate on medical debt at 5 percent; and be it further

RESOLVED: The Michigan Delegation to the American Medical Association (AMA) encourage our AMA to work with the appropriate national organizations to address the medical debt crisis by adopting robust policies at the federal and state level that prevent medical debt, help consumers avoid court involvement, and ensure that court-involved cases do not result in devastating consequences on patients’ employment, physical health, mental wellbeing, housing, and economic stability.
WAYS AND MEANS COMMITTEE FISCAL NOTE: $12,000 – $24,000

Relevant MSMS Policy: None

Relevant AMA Policy:

Exclusion of Medical Debt That Has Been Fully Paid or Settled H-373.996
Our AMA supports the principles contained in The Medical Debt Relief Act as drafted and passed by the US House of Representatives to provide relief to the American consumer from a complicated collections process and supports medical debt resolution being portrayed in a positive and productive manner.

Health Plan Payment of Patient Cost-Sharing D-180.979
Our AMA will: (1) support the development of sophisticated information technology systems to help enable physicians and patients to better understand financial obligations; (2) encourage states and other stakeholders to monitor the growth of high deductible health plans and other forms of cost-sharing in health plans to assess the impact of such plans on access to care, health outcomes, medical debt, and provider practice sustainability; (3) advocate for the inclusion of health insurance contract provisions that permit network physicians to collect patient cost-sharing financial obligations (e.g., deductibles, co-payments, and co-insurance) at the time of service; and (4) monitor programs wherein health plans and insurers bear the responsibility of collecting patient co-payments and deductibles.

Sources:
3. Health care has become the largest source of debt in collections in the U.S. https://medicaldebtpolicyscorecard.org/
Whereas, the term “physician” refers specifically to a health care practitioner who has successfully matriculated and graduated from an allopathic or an osteopathic school of medicine, and

Whereas, the term health care practitioner refers to anyone who provides health care services, and

Whereas, some health care practitioners are misleading patients when they introduce themselves, implying they are physicians, and

Whereas, some health care practitioners are performing procedures and delivering treatments while allowing patients to believe they are physicians, and

Whereas, some non-physician health care practitioners are performing treatments and procedures unsupervised by physicians, and

Whereas, insurance companies are paying less for procedures and treatments that are delivered by non-physician health care practitioners, and

Whereas, patient care is potentially compromised by medical procedures and treatments delivered by unsupervised non-physician health care practitioners, and

Whereas, physicians are more likely to be sued for incorrect treatments and procedures performed by non-physician health care practitioners than the practitioners themselves, and

Whereas, health center and hospital Chief Executive Officers are directing their facilities to hire non-physician health care practitioners to deliver treatment and procedures instead of physicians because this practice saves their facilities money; therefore be it

RESOLVED: That MSMS believes all health care practitioners must clearly identify themselves as a physician or as a non-physician practitioner, including their credentials and field of specialty; and be it further

RESOLVED: That MSMS believes that a physician must directly supervise all non-physician practitioners. In cases where a non-physician practitioner is practicing unsupervised in a health
care facility, the health care facility must acknowledge in writing that the facility is directly responsible for patient care provided by the non-physician practitioners; and be it further RESOLVED: That MSMS supports all insurance companies annually reporting outcomes for all health care practitioners against whom they have taken corrective action to the health care facilities where they have privileges and their respective licensing Boards. Additionally, health care practitioners shall self-report any corrective actions to the health care facilities where they have privileges and their respective licensing Boards; and be it further RESOLVED: That MSMS supports all hospitals and health care facilities reporting any outcomes of health care practitioners that have led to a corrective action to the health practitioner’s respective licensing Boards.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000

Relevant MSMS Policy:

Clear Identification of Health Worker Position/Title with ID Tags
MSMS supports that physicians, nurses and other health providers wear a clearly visible photo identification badge that states their credentials in large block letters with descriptions such as “physician,” “nurse,” “physician assistant,” “nurse practitioner,” and that the badges be worn at all times when in contact with patients.

Non-Physician Practitioner Use Rules
MSMS supports daily physician supervision of all non-physician practitioners who provide care to hospitalized patients as documented by a signature.

Relevant AMA Policy:

Clarification of Healthcare Physician Identification: Consumer Truth & Transparency D-405.974
Our AMA will advocate for: (1) legislation that would establish clear legal definitions for use of words or terms “physician,” “surgeon,” “medical doctor,” “doctor of osteopathy,” “M.D.,” “D.O.,” or any other allopathic or osteopathic medical specialist; and (2) “Truth & Transparency” legislation that would combat medical title misappropriation; that such legislation would require non-physician healthcare practitioners to clearly and accurately state their level of training, credentials, and board licensure in all professional interactions with patients including hospital and other health care facility identifications, as well as in advertising and marketing materials; and that such legislation would prohibit non-physician healthcare practitioners from using any identifying terms (i.e. -ologist) that can mislead the public.

Supervision of Non-Physician Practitioners by Physicians D-35.978
Our AMA will advocate: (1) to ensure physicians on staff receive written notification when their license is being used to document supervision of non-physician practitioners; (2) that physician supervision should be explicitly defined and mutually agreed upon; (3) for advanced notice and disclosure to the physician before they are hired or as soon as practicably known by provider organizations and institutions that anticipate physician supervision of non-physician practitioners as a condition for physician employment; (4) that organizations, institutions, and medical staffs that have physicians who participate in supervisory duties for non-physician practitioners have processes and procedures in place that have been developed with appropriate clinical physician input; and (5) that physicians be able to report professional concerns about care provided by the non-physician practitioners to the appropriate leadership with protections against retaliation.
Supervision and Proctoring by Facility Medical Staff H-375.967

Our AMA advocates that the conduct of medical staff supervision be included in medical staff bylaws and be guided by the following principles:

(1) Physicians serving as medical staff supervisors should be indemnified at the facility's expense from malpractice claims and other litigation arising out of the supervision function.

(2) Physicians being supervised should be indemnified at the facility's expense for any damages that might occur as a result of implementing interventions recommended by medical staff supervisors.

(3) AMA principles of peer review as found in Policies H-320.968 [2,d], H-285.998 [5], and H-320.982 [2c,d] should be adhered to in the conduct of medical staff supervision.

(4) The medical staff member serving as supervisor should be determined through a formal process by the department chair or medical staff executive committee.

(5) The scope of the medical staff supervision should be limited to the provision of services that have been restricted, are clearly questionable, or are under question, as determined by the department chair or medical staff executive committee.

(6) The duration of the medical staff supervision should be limited to the amount of time necessary to adequately assess the degree of clinical competence in the area of skill being assessed.

(7) Medical staff supervision should include a sufficient volume of procedures or admissions for meaningful assessment.

(8) Medical staff supervisors should provide periodic performance reports on each patient to the appropriate designated medical staff committee. The reports should be transcribed or transcripted by the medical staff office to assure confidentiality. The confidentiality of medical staff supervision reports must be strictly maintained.

(9) Physicians whose performance is supervised should have access to the performance reports submitted by medical staff supervisors and should be given the opportunity to comment on the contents of the reports.

Scopes of Practice of Physician Extenders H-35.973

Our AMA supports the formulation of clearer definitions of the scope of practice of physician extenders to include direct appropriate physician supervision and recommended guidelines for physician supervision to ensure quality patient care.

Principles for Revision of the Medical Staff Section of The Joint Commission "Accreditation Manual for Hospitals" H-220.990

The AMA supports adherence to the following principles as the basis for any revision of the Medical Staff Section of the "Accreditation Manual for Hospitals": (1) continued use of the term "Medical Staff" in the title of the chapter and throughout the Manual; (2) deletion of any specific reference to limited licensed practitioners without precluding such practitioners from having hospital privileges consonant with their training, experience and current competence, if approved by the normal credentialing process; (3) consideration of qualified limited licensed practitioners in accordance with state law, and when approved by the executive committee of the medical staff, by the governing board, and when their services are appropriate to the goals and missions of that hospital, taking into account the training, experience and current clinical competence of the practitioners; (4) provision that the executive committee of the medical staff is composed of members selected by the medical staff, or appointed in accordance with the hospital bylaws. All members of the active medical staff, as defined in the Medical Staff Bylaws, are eligible for membership on the executive committee, and a majority of the executive committee members must be fully licensed physician members (Doctors of Medicine or Doctors of Osteopathy) of the active medical staff in the hospital; (5) assurance that the medical care of all patients remains under the supervision and direction of qualified, fully licensed physicians (Doctors of Medicine or Doctors of Osteopathy); and (6) assurance that the continued high quality of care, credentialing of physicians and other licensed practitioners, and effective quality assurance programs remain under the supervision and direction of fully licensed physicians.

Sources:
Title: Persons Charged with or Convicted of Violent Offense Subject to Firearm Regulation

Introduced by: Ashton Lewandowski, for the Medical Student Section

Original Authors: Adefolarin Alade, Patrick Ancheta, Heba Basha, Dayaan Ghani, Madison Polay, and Laura Carravallah, MD

Referred To: Reference Committee B

House Action:

Whereas, Title 18 U.S. Code Section 3553 “Imposition of a Sentence” defines “violent offense” as “a crime of violence, as defined in [Title18, Part I, Chapter 1,] Section 16 [Crime of Violence Defined], that is punishable by imprisonment,” and

Whereas, a “crime of violence” under the U.S. Code of Public Law of the 98th Congress under Title 18, Part I, Chapter 1, Section 16, Subsection (a) is defined as “an offense that has as an element the use, attempted use, or threatened use of physical force against the person or property of another,” and

Whereas, the Gun Control Act of 1988 only prohibits the sale to, and possession of firearms by, a person indicted or convicted of misdemeanors punishable by more than two years of imprisonment, and

Whereas, per Section 28.422 of the Michigan Legislature, Michigan does not state or enforce the limitations of firearm sales to persons charged with or convicted of a violent offense misdemeanor with any length of imprisonment, and

Whereas, “Handgun possession is prohibited for people who have committed a violent misdemeanor punishable by less than 1 year of imprisonment” in five states including California, Hawaii, New York, Connecticut, and Maryland since 2016, and

Whereas, aggravated assaults accounted for 68.2 percent of violent crimes reported to law enforcement in 2019, and

Whereas, California saw a “37% lower gun death rate than the national average” as of June 2022 since enacting firearm safety laws, and

Whereas, Hawaii had the lowest gun death rate at 2.5 deaths per capita in 2019 following its history of strict firearm legislation, and

Whereas, 15 states have adopted a similar policy which bans the purchase of firearms for those that have been convicted of a violent misdemeanor, and
Whereas, states like California and Hawaii have subsequently rescinded firearm possession for periods of 10 years up to indefinite suspension of possession, respectively, and

Whereas, adoption of this and similar policies by other states have correlated in an 18 percent reduction in total homicide rates, and

Whereas, the American Medical Association (AMA) has set precedent for supporting firearm restrictions in purchasing and possession in the cases of domestic violence; therefore be it

RESOLVED: That MSMS lobby for a restriction on the purchase of new firearms in Michigan by people with assault, violent assault and battery, or other violent misdemeanor convictions for 10 years; and be it further

RESOLVED: That MSMS lobby for a rescindment of any and all firearm possession by people with assault, violent assault and battery, or other violent misdemeanor convictions for 10 years; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to study the effect of including a rescindment period of 10 years in accordance with other established rescindment periods presented by other states.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $16,000-$32,000

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.

Reduction of Gun Violence
MSMS supports federal and state legislation ensuring that physicians can fulfill their role in preventing firearm injuries by health screening, patient counseling on gun safety, and referral to mental health services for those with behavioral/emotional medical conditions and supports federal and state evidence based research on firearm injury and the use of state/national firearms injury databases to inform state/federal health policy.

Evidence-based Research on Firearm Adverse Incidents
MSMS supports evidence-based research on gun-related injuries and deaths, including funding for such research, and the collection of health care, medical examiner, and criminal justice data at the local, state, and federal level.

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 Safety and Research H-145.975

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

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

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

4. Our AMA and other organizations will develop and disseminate a formal educational program to enable clinicians to effectively and efficiently address suicides with an emphasis on seniors and other high-risk populations.

5. Our AMA will develop with other interested organizations a toolkit for clinicians to use addressing Extreme Risk Protection Orders in their individual states.

6. Our AMA will partner with other groups interested in firearm safety to raise public awareness of the magnitude of suicide in seniors and other high-risk populations, and interventions available for suicide prevention.

7. Our AMA and all interested medical societies will: (a) educate physicians about firearm epidemiology, anticipatory guidance, and lethal means screening for and exploring potential restrictions to access to high-lethality means of suicide such as firearms. Health care clinicians, including trainees, should be provided training on the importance of anticipatory guidance and lethal means counseling to decrease firearm injuries and deaths and be provided training introducing evidence-based techniques, skills and strategies for having these discussions with patients and families; (b) educate physicians about lethal means counseling in health care settings and intervention options to remove lethal means, either permanently or temporarily from the home.

Sources:
4. Michigan Legislature. (n.d.). Section 28.422 License to purchase, carry, possess, or transport pistol; issuance; qualifications; applications; sale of pistol; exemptions; transfer of ownership to heir or devisee; nonresident; active duty status; forging application as felony; implementation during business hours [Policy]. http://www.legislature.mi.gov/(S(njf3xehjr4lpb35oxpotebz3))/mileg.aspx?page=GetObject&objectname=mcl-28-422


Title: Physician Antiretaliation, Due Process, and Indemnification Rights

Introduced by: David Whalen, MD, for the Grand Traverse-Leelanau-Benzie County Delegation

Original Author: Leah Davis, DO

Referred To: Reference Committee B

Whereas, Michigan law regarding the corporate practice of medicine prohibits “a for-profit entity, either a corporation or a limited liability company, from practicing medicine or employing a physician to provide professional medical services” but excludes non-profit organizations, and

Whereas, a decreasing percentage of physicians maintain ownership in their medical practices, and

Whereas, an increasing percentage of physicians in Michigan are now employed directly or indirectly by hospitals, health systems, medical service organizations affiliated with health systems which may allow merely notional physician leadership, or contracted through large contract management groups, and

Whereas, consolidation of healthcare corporations with restrictive non-compete clauses in physician employment contracts combined with high average educational debt of medical school graduates/new physicians has brought about conditions of oligopsony (and even monopsony in some regions) in the Michigan physician labor market, in which physicians may feel compelled to remain in employment or contractual obligation with an entity which may be attempting to direct or control their medical autonomy, and

Whereas, in some geographic locations, third party contractors are taking advantage of these factors and eliminating the “due process” provisions from employment contracts, and

Whereas, current legislation prohibiting workplace retaliation might be circumvented by hospitals, health systems, and medical service organizations which may wish to unfairly remove a physician with whom they do not agree by simply requesting that the contract management group, for which the physician is directly employed, no longer use the physician to staff their facility, and

Whereas, nonphysician practitioners (NPPs) (e.g., nurse practitioners, physician assistants, certified registered nurse assistants, etc.), pharmacists, and other health professionals may be delegated through legislation to perform certain duties and functions which may overlap with the duties and functions of an independent licensed physician, and

Whereas, corporate entities which employ or contract with physicians may require acceptance of collaborative agreements with NPPs as a duty of employment, without the physician’s input regarding quality assessment, hiring or firing, staffing ratios, or the provision of time or compensation to adequately collaborate regarding the medical care delegated to NPPs, and

Whereas, there have been some cases of termination of physicians based on accusations that were not clearly substantiated and for which the physician was not afforded the opportunity of a fair hearing or peer review through the appropriate medical staff processes; therefore be it
RESOLVED: That MSMS (1) continue to assess the needs of employed physicians, ensuring autonomy in clinical decision-making and self-governance; (2) promote physician collaboration, teamwork, partnership, and leadership in emerging health care organizational structures, including but not limited to hospitals, health care systems, medical groups, insurance company networks and accountable care organizations, in order to assure and be accountable for the delivery of quality health care; (3) advocate for the rights of physicians against employer retaliation, including unfair or discriminatory termination of employment or contractual obligation for conscious objection and/or conscious refusal to participate in any activity that the physician judges to be unethical or unsafe for patients; and (4) advocate for the physician’s authority to practice medicine based on medical judgment, conscience, ethics, morals, or good faith obligation toward patients to a non-physician or corporate entity; and be it further

RESOLVED: That MSMS adopt policy and advocate (1) to ensure physicians on staff receive written notification when their license is being used to document supervision of non-physician practitioners; (2) that physician supervision should be explicitly defined and mutually agreed upon; (3) that advanced notice and disclosure be provided to physicians before they are hired or as soon as practicably known by provider organizations and institutions that anticipate physician supervision of non-physician practitioners as a condition for physician employment; (4) that organizations, institutions, and medical staffs that have physicians who participate in supervisory duties for non-physician practitioners have processes and procedures in place that have been developed with appropriate clinical physician input; (5) that physicians have the right to object to or refuse to allow their license to be used to document supervision of non-physician practitioners without fear of retaliation; (6) that physicians be able to report professional concerns about care provided by the non-physician practitioners to the appropriate leadership with protections against retaliation; and (7) should be indemnified at the organizations’ and institutions’ expense from malpractice claims and other litigation arising out of the supervision function.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $12,000-$24,000

Relevant MSMS Policy:

Non-Physician Practitioner Use Rules
MSMS supports daily physician supervision of all non-physician practitioners who provide care to hospitalized patients as documented by a signature.

Relevant AMA Policy:

Supervision of Non-Physician Practitioners by Physicians D-35.978
Our AMA will advocate: (1) to ensure physicians on staff receive written notification when their license is being used to document supervision of non-physician practitioners; (2) that physician supervision should be explicitly defined and mutually agreed upon; (3) for advanced notice and disclosure to the physician before they are hired or as soon as practicably known by provider organizations and institutions that anticipate physician supervision of non-physician practitioners as a condition for physician employment; (4) that organizations, institutions, and medical staffs that have physicians who participate in supervisory duties for non-physician practitioners have processes and procedures in place that have been developed with appropriate clinical physician input; and (5) that physicians be able to report professional concerns about care provided by the non-physician practitioners to the appropriate leadership with protections against retaliation.

Supervision and Proctoring by Facility Medical Staff H-375.967
Our AMA advocates that the conduct of medical staff supervision be included in medical staff bylaws and be guided by the following principles:
(1) Physicians serving as medical staff supervisors should be indemnified at the facility’s expense from malpractice claims and other litigation arising out of the supervision function.
(2) Physicians being supervised should be indemnified at the facility’s expense for any damages that might occur as a result of implementing interventions recommended by medical staff supervisors.
AMA principles of peer review as found in Policies H-320.968 [2,d], H-285.998 [5], and H-320.982 [2c,d] should be adhered to in the conduct of medical staff supervision.

The medical staff member serving as supervisor should be determined through a formal process by the department chair or medical staff executive committee.

The scope of the medical staff supervision should be limited to the provision of services that have been restricted, are clearly questionable, or are under question, as determined by the department chair or medical staff executive committee.

The duration of the medical staff supervision should be limited to the amount of time necessary to adequately assess the degree of clinical competence in the area of skill being assessed.

Medical staff supervision should include a sufficient volume of procedures or admissions for meaningful assessment.

Medical staff supervisors should provide periodic performance reports on each patient to the appropriate designated medical staff committee. The reports should be transcribed or transcripted by the medical staff office to assure confidentiality. The confidentiality of medical staff supervision reports must be strictly maintained.

Physicians whose performance is supervised should have access to the performance reports submitted by medical staff supervisors and should be given the opportunity to comment on the contents of the reports.

**Scopes of Practice of Physician Extenders H-35.973**

Our AMA supports the formulation of clearer definitions of the scope of practice of physician extenders to include direct appropriate physician supervision and recommended guidelines for physician supervision to ensure quality patient care.

**Principles for Revision of the Medical Staff Section of The Joint Commission "Accreditation Manual for Hospitals" H-220.990**

The AMA supports adherence to the following principles as the basis for any revision of the Medical Staff Section of the "Accreditation Manual for Hospitals": (1) continued use of the term "Medical Staff" in the title of the chapter and throughout the Manual; (2) deletion of any specific reference to limited licensed practitioners without precluding such practitioners from having hospital privileges consonant with their training, experience and current competence, if approved by the normal credentialing process; (3) consideration of qualified limited licensed practitioners in accordance with state law, and when approved by the executive committee of the medical staff, by the governing board, and when their services are appropriate to the goals and missions of that hospital, taking into account the training, experience and current clinical competence of the practitioners; (4) provision that the executive committee of the medical staff is composed of members selected by the medical staff, or appointed in accordance with the hospital bylaws. All members of the active medical staff, as defined in the Medical Staff Bylaws, are eligible for membership on the executive committee, and a majority of the executive committee members must be fully licensed physician members (Doctors of Medicine or Doctors of Osteopathy) of the active medical staff in the hospital; (5) assurance that the medical care of all patients remains under the supervision and direction of qualified, fully licensed physicians (Doctors of Medicine or Doctors of Osteopathy); and (6) assurance that the continued high quality of care, credentialing of physicians and other licensed practitioners, and effective quality assurance programs remain under the supervision and direction of fully licensed physicians.

**Physician Independence and Self-Governance D-225.977**

Our AMA will: (1) continue to assess the needs of employed physicians, ensuring autonomy in clinical decision-making and self-governance; and (2) promote physician collaboration, teamwork, partnership, and leadership in emerging health care organizational structures, including but not limited to hospitals, health care systems, medical groups, insurance company networks and accountable care organizations, in order to assure and be accountable for the delivery of quality health care.

**Fair Process for Employed Physicians H-435.942**

1. Our AMA supports whistleblower protections for health care professionals and parties who raise questions that include, but are not limited to, issues of quality, safety, and efficacy of health care and are adversely treated by any health care organization or entity.

2. Our AMA will advocate for protection in medical staff bylaws to minimize negative repercussions for physicians who report problems within their workplace.
Whereas, advance practice registered nurse practitioners (APRNs) and physician assistants (PAs) may engage or assist in activities that may include the evaluation and medical diagnosis of human illness or injury; the medical, procedural or surgical treatment of human illness or injury; or any other activity pursuant to their defined scope of practice, delegation and supervision by a physician, or a written practice or collaborative agreement with a participating or collaborating physician, and

Whereas, the requirements regarding collaborative or practice agreements with APRNs and PAs differ in Michigan, and

Whereas, as defined in Michigan law, PAs are health professionals who provide medical or osteopathic medical and surgical services under the terms of a practice agreement with a licensed participating physician, and

Whereas, Michigan's law stipulates that PAs may not practice medicine unless the PA has entered into a practice agreement with a participating physician which sets forth the process between the PA and participating physician for communication, availability, decision making, as well as protocols for designating alternative physicians for consultations when the participating physician is unavailable for consultation, and

Whereas, under Michigan law, an APRN is a registered professional nurse who has been granted a specialty certification in the area of (1) nurse midwifery, (2) nurse practitioner, or (3) clinical nurse specialist, and

Whereas, unless otherwise permitted by Michigan law, nurses may only perform certain duties that fall under the purview of medicine (e.g., prescribing controlled substances) if done so at the delegation and under the supervision of a physician, and

Whereas, an APRN is not required perform a task under delegation or supervision which falls within the scope of practice of the APRN, and

Whereas, Michigan's law pertaining to delegation and supervision includes conditions which the supervising physician must meet including, but not limited, to the continuous availability of direct communication in person or by radio, telephone, or telecommunication between the supervised individual and the licensed health professional; the availability of the licensed health
professional on a regularly scheduled basis to (1) review the practice of the supervised individual, (2) provide consultation to the supervised individual, (3) to review records, and (4) further educate the supervised individual in the performance of the individual’s functions; and the provision of predetermined procedures and drug protocol, and

Whereas, a collaborating/participating physician must have an active license to practice in the state of Michigan, he/she is not required to be physically in the state of Michigan, resulting in instances of physicians located at a distant geographic location (e.g., another state) and remotely overseeing the activities of APRNs and PAs in Michigan, and

Whereas, there are requirements that a physician “may delegate to a licensed or unlicensed individual who is otherwise qualified by education, training, or experience the performance of selected acts, tasks, or functions where the acts, tasks, or functions fall within the scope of practice of the licensee's profession and will be performed under the licensee's supervision,” there are still many instances in which a physician is collaborating with APRNs and/or PAs engaging in medical practices for which the collaborating/participating physician is neither Board Certified nor residency or fellowship trained, and

Whereas, these situations are not considered to be conducive to safe medical care of patients, contribute to the lack of truth and transparency in the quality of care which may be offered by non-physician practitioners, and may lead to loss of confidence in and respect for the medical profession by the public over time, and

Whereas, such legislation has not yet been forthcoming from the Michigan Legislature; therefore, be it

RESOLVED: That MSMS affirms the urgency of defining standards for “collaborative agreements” with advanced practice registered nurses (APRNs) and that MSMS seek and support legislation that would require APRNs to work in a setting and perform tasks and procedures that are within the collaborating physician’s particular field of medicine, as qualified by residency training and/or board certification to perform; and be it further

RESOLVED: That MSMS believes physicians who enter into collaborative or practice agreements with advanced practice registered nurses (APRNs) or physician assistants (PAs) from a location outside of Michigan must be available to answer questions and directly collaborate with the non-physician practitioners, or to examine the patient, during a majority of the hours of activity of the APRN and/or PA via video conferencing; and be it further

RESOLVED: That MSMS supports the appropriate licensing Boards and agency investigating physicians who deliberately violate the spirit of safe collaborative medical practice with non-physicians by (1) engaging in a pattern of negligent delegation to, supervision of, or collaboration with NPPs, (2) supervising activities for which the physician is not formally trained and/or board certified, or (3) not being promptly available to communicate with the NPP and/or patient; and censure physicians who disregard collaborative requirements by aiding and abetting the unlicensed practice of medicine.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000
Relevant MSMS Policy:

**Nursing: Scope of Practice**
MSMS opposes the practice of medicine by independent nurse practitioners.

MSMS supports the establishment of written protocols between the physician and nurse practitioner.

**Physician’s Relationship with License Limited Practitioners**
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 license 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.”

Relevant AMA Policy:

**Models / Guidelines for Medical Health Care Teams H-160.906**
1. Our AMA defines ‘physician-led’ in the context of team-based health care as the consistent use by a physician of the leadership knowledge, skills and expertise necessary to identify, engage and elicit from each team member the unique set of training, experience, and qualifications needed to help patients achieve their care goals, and to supervise the application of these skills.

2. Our AMA supports the following elements that should be considered when planning a team-based care model according to the needs of each physician practice:

**Patient-Centered:**
a. The patient is an integral member of the team.
b. A relationship is established between the patient and the team at the onset of care, and the role of each team member is explained to the patient.
c. Patient and family-centered care is prioritized by the team and approved by the physician team leader.
d. Team members are expected to adhere to agreed-upon practice protocols.
e. Improving health outcomes is emphasized by focusing on health as well as medical care.
f. Patients’ access to the team, or coverage as designated by the physician-led team, is available twenty-four hours a day, seven days a week.
g. Safety protocols are developed and followed by all team members.

**Teamwork:**
h. Medical teams are led by physicians who have ultimate responsibility and authority to carry out final decisions about the composition of the team.
i. All practitioners commit to working in a team-based care model.
j. The number and variety of practitioners reflects the needs of the practice.
k. Practitioners are trained according to their unique function in the team.
l. Interdependence among team members is expected and relied upon.
m. Communication about patient care between team members is a routine practice.
n. Team members complete tasks according to agreed-upon protocols as directed by the physician leader.
Clinical Roles and Responsibilities:
o. Physician leaders are focused on individualized patient care and the development of treatment plans.
p. Non-physician practitioners are focused on providing treatment within their scope of practice consistent with their education and training as outlined in the agreed upon treatment plan or as delegated under the supervision of the physician team leader.
q. Care coordination and case management are integral to the team's practice.
r. Population management monitors the cost and use of care, and includes registry development for most medical conditions.

Practice Management:
s. Electronic medical records are used to the fullest capacity.
t. Quality improvement processes are used and continuously evolve according to physician-led team-based practice assessments.
u. Data analytics include statistical and qualitative analysis on cost and utilization, and provide explanatory and predictive modeling.
v. Prior authorization and precertification processes are streamlined through the adoption of electronic transactions.

Guidelines for Integrated Practice of Physician and Nurse Practitioner H-160.950

Our AMA endorses the following guidelines and recommends that these guidelines be considered and quoted only in their entirety when referenced in any discussion of the roles and responsibilities of nurse practitioners:

1. The physician is responsible for the supervision of nurse practitioners and other advanced practice nurses in all settings.
2. The physician is responsible for managing the health care of patients in all practice settings.
3. Health care services delivered in an integrated practice must be within the scope of each practitioner's professional license, as defined by state law.
4. In an integrated practice with a nurse practitioner, the physician is responsible for supervising and coordinating care and, with the appropriate input of the nurse practitioner, ensuring the quality of health care provided to patients.
5. The extent of involvement by the nurse practitioner in initial assessment, and implementation of treatment will depend on the complexity and acuity of the patients' condition, as determined by the supervising/collaborating physician.
6. The role of the nurse practitioner in the delivery of care in an integrated practice should be defined through mutually agreed upon written practice protocols, job descriptions, and written contracts.
7. These practice protocols should delineate the appropriate involvement of the two professionals in the care of patients, based on the complexity and acuity of the patients' condition.
8. At least one physician in the integrated practice must be immediately available at all times for supervision and consultation when needed by the nurse practitioner.
9. Patients are to be made clearly aware at all times whether they are being cared for by a physician or a nurse practitioner.
10. In an integrated practice, there should be a professional and courteous relationship between physician and nurse practitioner, with mutual acknowledgment of, and respect for each other's contributions to patient care.
Physicians and nurse practitioners should review and document, on a regular basis, the care of all patients with whom the nurse practitioner is involved. Physicians and nurse practitioners must work closely enough together to become fully conversant with each other's practice patterns.

**Sources:**
1. [https://www.michiganpa.org/page/practiceagreement](https://www.michiganpa.org/page/practiceagreement)
2. [https://cdn.ymaws.com/micnp.org/resource/resmgr/resources_&_links/micnp_collaborative_agreement.pdf](https://cdn.ymaws.com/micnp.org/resource/resmgr/resources_&_links/micnp_collaborative_agreement.pdf)
Title: Dedicated On-Site Physician Requirement for Emergency Departments

Introduced by: David Whalen, MD, for the Grand Traverse-Leelanau-Benzie County Delegation

Original Author: Leah Davis, DO

Referred To: Reference Committee B

House Action:

 Whereas, patients seeking emergency medical care should seek care at facilities prepared to offer evaluation and medical diagnosis of undifferentiated acute symptoms, recognition and stabilization of emergency conditions, appropriate emergency treatment when available and/or transfer to a higher level of care for emergency conditions when appropriate, and

 Whereas, facility designations using the term “emergency” within their title may be assumed by laypersons or medical professionals to imply the ability to offer all of the above emergency duties and services, and

 Whereas, in the state of Michigan physicians are the only health professionals authorized to practice medicine without limitation, and

 Whereas, the shift from “supervision” to “collaboration” of non-physician practitioners (e.g., APRNs, PAs, and CRNAs) in Michigan, may imply a lower degree of physician involvement in the care of the patient inasmuch as, collaboration may imply mere consultation of the physician only when deemed necessary by the NPP which is inadequate in the setting of acute medical care because NPPs have not been trained in the great breadth of medicine, as have physicians, and cannot consistently recognize all acute emergency situations in which immediate physician care is required, and

 Whereas, every patient presenting to a facility in Michigan which represents itself as a place where patients can seek emergency medical care should be under the direct and real-time care of a licensed physician including the on-site and real-time supervision of NPPs, and

 Whereas, despite an overall physician deficit, there is not a lack of emergency medicine (EM) physician workforce as there is a predicted surplus of EM physicians by the year 2030; therefore be it

 RESOLVED: That MSMS pursue the enactment of legislation or regulation requiring all facilities in the state of Michigan that imply the provision of emergency medical care have the real-time, on-site presence of a physician, and real-time, on-site supervision of non-physician practitioners (e.g., APRNs, PAs, and CRNAs, as defined by CMS) by a licensed physician with training and experience in emergency medical care whose primary duty is dedicated to patients seeking emergency medical care in that emergency department, and be it further
RESOLVED: That the MSMS Delegation to the American Medical Association (AMA) ask our AMA to pursue the enactment of legislation or regulation requiring all facilities that imply the provision of emergency medical care have the real-time, on-site presence of a physician, and real-time, on-site supervision of non-physician practitioners (e.g., APRNs, PAs, and CRNAs, as defined by CMS) by a licensed physician with training and experience in emergency medical care whose primary duty is dedicated to patients seeking emergency medical care in that emergency department.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $16,000-$32,000

Relevant MSMS Policy:

Non-Physician Practitioner Use Rules
MSMS supports daily physician supervision of all non-physician practitioners who provide care to hospitalized patients as documented by a signature.

Nursing: Scope of Practice
MSMS opposes the practice of medicine by independent nurse practitioners. MSMS supports the establishment of written protocols between the physician and nurse practitioner.

Relevant AMA Policy:

Physician and NonPhysician Licensure and Scope of Practice D-160.995
1. Our AMA will: (a) continue to support the activities of the Advocacy Resource Center in providing advice and assistance to specialty and state medical societies concerning scope of practice issues to include the collection, summarization and wide dissemination of data on the training and the scope of practice of physicians (MDs and DOs) and nonphysician groups and that our AMA make these issues a legislative/advocacy priority; (b) endorse current and future funding of research to identify the most cost effective, high-quality methods to deliver care to patients, including methods of multidisciplinary care; and (c) review and report to the House of Delegates on a periodic basis on such data that may become available in the future on the quality of care provided by physician and nonphysician groups.
2. Our AMA will: (a) continue to work with relevant stakeholders to recognize physician training and education and patient safety concerns, and produce advocacy tools and materials for state level advocates to use in scope of practice discussions with legislatures, including but not limited to infographics, interactive maps, scientific overviews, geographic comparisons, and educational experience; (b) advocate for the inclusion of non-physician scope of practice characteristics in various analyses of practice location attributes and desirability; (c) advocate for the inclusion of scope of practice expansion into measurements of physician well-being; and (d) study the impact of scope of practice expansion on medical student choice of specialty.
3. Our AMA will consider all available legal, regulatory, and legislative options to oppose state board decisions that increase non-physician health care provider scope of practice beyond legislative statute or regulation.
WHEREAS, nurse practitioners (NPs) continue to pursue legislation aimed at granting “full practice authority” (FPA), which the American Association of Nurse Practitioners (AANP) defines as “the authorization of nurse practitioners (NPs) to evaluate patients; diagnose, order and interpret diagnostic tests; and initiate and manage treatments - including prescribe medications - under the exclusive licensure authority of the state board of nursing,” with the goal that “NP licensure is not contingent on unnecessary contracts or relationships with a physician or oversight by the state medical board,” and

WHEREAS, physician assistants (PAs) continue to pursue legislation aimed at granting “optimal team practice” (OTP), which the American Academy of Physician Assistants (AAPA) defines as “eliminate the legal requirement for a specific relationship between a PA, physician or any other healthcare provider in order for a PA to practice to the full extent of their education, training and experience,” and

WHEREAS, the legislative goals of FPA and OTP aim to the obtain independence by removing physician supervision, collaboration and oversight, and

WHEREAS, the Centers for Medicare and Medicaid Services define the term non-physician practitioners (NPPs) as “health care providers who practice either in collaboration with or under the supervision of a physician, including physician assistants, nurse practitioners, and clinical nurse specialists, are referred to as non-physician practitioners (NPPs),” and

WHEREAS, the terms “residency,” “resident,” “fellowship,” and “fellow” refer to physician training programs and are clearly defined by the ACGME, these terms are increasingly being used by NPP training programs to describe training of much shorter intervals and much less vigor than that of physicians, leading to confusion regarding the degree of training of individual healthcare practitioners; therefore be it

RESOLVED: That MSMS use the terms “unsupervised practice of medicine” in place of “independent practice of medicine” when referring to the activities of nurse practitioners, certified registered nurse anesthetists, and physician assistants; “non-physician practitioner” (NPP) to describe physician assistants, nurse practitioners, and clinical nurse specialists; and “residency,” “resident,” “fellowship,” and “fellow” in discussions regarding physicians only.
Relevant MSMS Policy: None

Relevant AMA Policy: None

Sources:
Title: Enable Over-the-Counter Hormonal Contraception

Introduced by: David Lee, MD, MS, for the MI Section, American College of OB/GYN

Original Authors: Halley Crissman, MD, MPH, Sara Jaber, MD, David Lee, MD, MS, Madeline Merwin, and Suha Syed, MD

Referred To: Reference Committee B

House Action:

Whereas, approximately 87 percent of women in the United States utilize contraception at some point, and

Whereas, contraceptives also have applications beyond birth control including menstrual symptom regulation and reduction in severity of symptoms including acne and endometriosis-related pain, and

Whereas, oral contraceptive pills remain the most common mode of contraception, comprising roughly 21 percent of contraceptive use in the United States, and

Whereas, while access to hormonal contraceptives was historically limited by need for a prescription from a healthcare professional, there is increasing interest in being able to access oral contraceptives without a prescription, and

Whereas, data suggests people can accurately self-identify contraindications to oral contraceptives from a checklist and therefore mitigate concerns about patients accessing these medications without a prescription, and

Whereas, access to over the counter contraception could help mitigate disparities for people of lower socioeconomic status who often face multiple barriers in receiving prescriptions for contraceptives, and

Whereas, approving combined hormonal contraceptive pills as an over-the-counter medication would enable the United States to join the ranks of countries whom have already approved over-the-counter hormonal contraception, and

Whereas, the Supreme Court’s 2022 decision of Dobbs v Jackson sparked intense concerns that contraception would be more difficult to obtain, and

Whereas, the rate of unintended pregnancies in the United States of America is estimated to be as high as 45 percent, and

Whereas, the cost for a publicly funded unintended pregnancy is $8,798, and in Michigan 61.5 percent of publicly funded births are unintended, resulting in $282 million in annual public expenditure, and

Whereas, people of lower socioeconomic status are disproportionately impacted by the consequences of unintended pregnancy and abortion, and
Whereas, making oral hormonal contraception an over-the-counter medication is projected to yield cost-savings in the greater healthcare ecosystem in the form of reduced number of unintended pregnancies and reduced expenditures in care related to increased effective contraceptive use, and

Whereas, the American College of Obstetricians & Gynecologists now advocates for oral contraceptive pills, vaginal rings, the contraceptive patch, and depot medroxyprogesterone acetate to be accessible as over-the-counter medications, and

Whereas, ensuring evidence-based education about, access to, and use of contraceptive methods are integral components to individuals across all ages exercising their reproductive rights and to advancing healthcare equity; therefore be it

RESOLVED: That MSMS replace existing policy, “Oral Contraceptives Available Over-the-Counter” to read as follows:

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

MSMS supports the American College of Obstetricians and Gynecologists’ Committee Opinion 788 which supports access to over-the-counter contraception including oral pills, vaginal rings, contraceptive patches, and depot medroxyprogesterone acetate; and be it further;

RESOLVED: That MSMS support inclusion of over-the-counter contraception as a qualified medical expense under tax-advantaged accounts including but not limited to health savings accounts and flexible spending accounts.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000

Relevant MSMS Policy:

**Tax Exemption Status for Over-The-Counter Medications**

MSMS supports removing the sales tax on all over-the-counter medications.

**Behind the Counter Hormonal Contraception Devices**

MSMS supports the American College of Obstetricians and Gynecologists Committee policy to allow contraceptive vaginal rings and contraceptive patches to be available behind the counter.

**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.

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

MSMS supports the concept of making the “morning after” contraceptive pill an over-the-counter medication.

Relevant AMA Policy:

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

Our AMA: (1) encourages the US Food and Drug Administration to approve a switch in status from prescription to over-the-counter for oral contraceptives, without age restriction; (2) encourages the continued study of issues relevant to over-the-counter access for oral contraceptives; and (3) will work with expert stakeholders to advocate for the availability of hormonal contraception as an over-the-counter medication.

**Coverage of Contraceptives by Insurance H-180.958**

1. Our AMA supports federal and state efforts to require that every prescription drug benefit plan include coverage of prescription contraceptives. 2. Our AMA supports full coverage, without patient cost-sharing, of all contraception without regard to prescription or over-the-counter utilization because all contraception is essential preventive health care.
**Contraceptive Advertising H-75.995**
Our AMA supports the concept of providing accurate and balanced information on the effectiveness, safety and risks/benefits of contraception in all public media and urges that such advertisements include appropriate information on the effectiveness, safety and risk/benefits of various methods.

**Reducing Unintended Pregnancy H-75.987**
Our AMA: (1) urges health care professionals to provide care for women of reproductive age, to assist them in planning for pregnancy and support age-appropriate education in esteem building, decision-making and family life in an effort to introduce the concept of planning for childbearing in the educational process; (2) supports reducing unintended pregnancies as a national goal; and (3) supports the training of all primary care physicians and relevant allied health professionals in the area of preconception counseling, including the recognition of long-acting reversible contraceptives as efficacious and economical forms of contraception.

**Opposition to HHS Regulations on Contraceptive Services for Minors H-75.998**
(1) Our AMA continues to oppose regulations that require parental notification when prescription contraceptives are provided to minors through federally funded programs, since they create a breach of confidentiality in the physician-patient relationship. (2) The Association encourages physicians to provide comparable services on a confidential basis where legally permissible.

**Sources:**
Title: Address Disproportionate Sentencing for Drug Offenses

Introduced by: Nicolas K. Fletcher MD, MHSA, for the Wayne County Delegation

Original Author: Nicolas K. Fletcher, MD, MHSA

Referred To: Reference Committee B

House Action:

Whereas, crack cocaine is no more dangerous than powdered cocaine, it presents different dangers because it is smoked or injected while powder cocaine is snorted, and

Whereas, current sentencing disparities would land a powder-cocaine offender in prison for one day and put a crack-cocaine offender behind bars for 18 days (1:18) for possession of the same amount, and

Whereas, five grams of crack cocaine is punished like 90 grams of powder cocaine, and

Whereas, the crack and powder cocaine sentencing disparity has disproportionately impacted people of color for the past three decades, a vestige of the War on Drugs, and

Whereas, eighty-five percent of offenders convicted under the crack cocaine sentencing law (Anti-Drug Abuse Act of 1986) are Black Americans, and

Whereas, the War on Drugs continues to disproportionately consume human potential and inflict trauma and suffering on communities of color despite wide-ranging evidence of its misguided origins and devastating impacts, and

Whereas, incarceration is linked to adverse health effects extending far beyond prison walls, and

Whereas, people who have been incarcerated face higher rates of mental illness, substance use disorder, communicable diseases, and chronic diseases, and

Whereas, individuals incarcerated have lower life expectancies, with each year in prison taking two years of life, and

Whereas, the majority of an estimated five hundred thousand people incarcerated for drug offenses are arrested for simple possession, a nonviolent crime, and

Whereas, 74 percent of the public (majorities across the political spectrum) support ending the sentencing disparity between crack and powder cocaine offenses; therefore be it

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to actively lobby for federal and state legislation aimed at eliminating the national crack
and powder cocaine sentencing disparity (from 18:1 to 1:1) and apply it retroactively to those
already convicted or sentenced; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask
our AMA to collaborate with appropriate stakeholders, including, but not limited to, courts,
government agencies, professional organizations, and criminal/social justice organizations to
advocate for addressing excessive legal punishments for low-level, nonviolent drug crimes at state
and federal levels.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000

Relevant MSMS Policy:

Resentencing for Individuals Convicted of Marijuana-Based Offenses
MSMS supports the expungement, destruction, or sealing of criminal records for marijuana
offenses committed prior to Michigan’s adult-use marijuana law adopted by ballot initiative in 2018
and now considered legal. Additionally, MSMS supports the elimination of violations or other
penalties for persons under parole, probation, pre-trial, or criminal supervision for marijuana
offenses committed prior to Michigan’s adult use marijuana law adopted by ballot initiative in 2018
and now considered legal.

Relevant AMA Policy:

Expungement, Destruction, and Sealing of Criminal Records for Legal Offenses Related to
Cannabis Use or Possession H-95.910
1. Our AMA supports automatic expungement, sealing, and similar efforts regarding an arrest or
conviction for a cannabis-related offense for use or possession that would be legal or
decriminalized under subsequent state legalization or decriminalization of adult use or medicinal

cannabis.
2. Our AMA supports automatic expungement, sealing, and similar efforts regarding an arrest or
conviction of a cannabis-related offense for use or possession for a minor upon the minor reaching
the age of majority.
3. Our AMA will inquire to the Association of American Medical Colleges, Accreditation Council for
Graduate Medical Education, Federation of State Medical Boards, and other relevant medical
education and licensing authorities, as to the effects of disclosure of a cannabis related offense on
a medical school, residency, or licensing application.
4. Our AMA supports ending conditions such as parole, probation, or other court-required
supervision because of a cannabis-related offense for use or possession that would be legal or
decriminalized under subsequent state legalization or decriminalization of adult use or medicinal

cannabis.

Sources:
1. Data Show Racial Disparity in Crack Sentencing
3. Booker and Durbin Announce Legislation to Eliminate Federal Crack and Powder Cocaine Sentencing
eliminate-federal-crack-and-powder-cocaine-sentencing-disparity
4. A bill that would have impacted racial disparity in cocaine crimes died in the Senate
https://www.michiganradio.org/2023-01-09/a-bill-that-would-have-impacted-racial-disparity-in-cocaine-crimes-died-in-the-senate

5. The Racist Roots of the War on Drugs and the Myth of Equal Protection for People of Color
https://lawrepository.ualr.edu/cgi/viewcontent.cgi?article=2106&context=lawreview
Title: Removing Legal Impediments to Women’s Reproductive Rights

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

Original Author: Richard Burney, MD

Referred To: Reference Committee B

Whereas, in 2022 the people of Michigan passed an amendment to the Michigan Constitution that made abortion legal, and

Whereas, many Michigan laws have been passed and still exist regulating women’s reproductive rights, including the 1931 abortion ban, and

Whereas, this new amendment did not remove or invalidate many existing Michigan laws intended to regulate many aspects of reproductive health, including but not limited to: 1) the 24-hour waiting period, 2) unnecessarily onerous abortion clinic health standards, 3) the ban on public funding for abortions, and 4) the so-called “partial birth abortion” ban, and

Whereas, this leaves uncertainty as to women’s reproductive rights, which may take years to resolve in the courts, and

Whereas, the women of Michigan after passage of this constitutional amendment should not have to wait years to achieve effective reproductive freedom; therefore be it

RESOLVED: That MSMS encourage the Michigan Legislature to repeal the 1931 law banning abortion; and be it further

RESOLVED: That MSMS encourage the Michigan Legislature to invalidate any and all laws that currently restrict women’s reproductive rights and are impediments to comprehensive women’s health care.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $16,000-$32,000

Relevant MSMS Policy:

No Constitutional Prohibition
There should be no amendment to the Constitution of the United States that would prohibit abortion.

Opposition to Government Regulations Limiting Scope of Women’s Health Coverage
MSMS supports maintaining the privacy and confidentiality of anyone who purchases additional coverage riders for any benefits including abortion and opposes any limitations on the scope of health care coverage that private insurance companies can offer in a comprehensive health plan.
Relevant AMA Policy:

**Preserving Access to Reproductive Health Services D-5.999**

Our AMA: (1) recognizes that healthcare, including reproductive health services like contraception and abortion, is a human right; (2) opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion; (3) will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, fertility preservation, contraception, and abortion; (4) supports shared decision-making between patients and their physicians regarding reproductive healthcare; (5) opposes any effort to undermine the basic medical principle that clinical assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations to be made only by healthcare professionals with their patients; (6) opposes the imposition of criminal and civil penalties or other retaliatory efforts against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services; (7) will advocate for legal protections for patients who cross state lines to receive reproductive health services, including contraception and abortion, or who receive medications for contraception and abortion from across state lines, and legal protections for those that provide, support, or refer patients to these services; and (8) will advocate for legal protections for medical students and physicians who cross state lines to receive education in or deliver reproductive health services, including contraception and abortion.

**Support for Access to Preventive and Reproductive Health Services H-425.969**

Our AMA supports access to preventive and reproductive health services for all patients and opposes legislative and regulatory actions that utilize federal or state health care funding mechanisms to deny established and accepted medical care to any segment of the population.

**Abortion H-5.995**

Our AMA reaffirms that: (1) abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in conformance with standards of good medical practice and the Medical Practice Act of his state; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment. Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally held moral principles. In these circumstances, good medical practice requires only that the physician or other professional withdraw from the case, so long as the withdrawal is consistent with good medical practice.

**Sources:**
2. MCL 750.14 (PA 328 of 1931): Michigan Legislature - Section 750.14
**RESOLUTIONS BY COMMITTEE**

**REFERENCE COMMITTEE C – INTERNAL AFFAIRS, BYLAWS, AND RULES**

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<td>MSMS Bylaws Revision to Codify Standard Practice for Members Joining or Transferring Membership</td>
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Title: Free Digital CME for MSMS Members to Promote Membership Growth

Introduced by: Venkat Rao, MD

Original Author: Venkat Rao, MD

Referred To: Reference Committee C

RESOLVED: That the MSMS Board of Directors study the possibility of offering free online CME for state mandated content to MSMS members to promote retention and recruitment of membership for the purposes of growing membership revenue.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $2,500-$5,000

Relevant MSMS Policy:

Mission Statement of MSMS CME Program
Purpose: The purpose of the Michigan State Medical Society (MSMS) Continuing Medical Education (CME) Program is to help Michigan physicians meet their continuing medical education needs through the sponsorship of quality Category I CME activities.

Content Areas: The Committee will address educational activities which serve to maintain, develop, or increase the knowledge, skills, and professional performance and relationships that a physician uses to provide services for patients, the public, or the profession. The content of CME is that body of knowledge and skills generally recognized and accepted by the profession as within the basic medical sciences, the discipline of clinical medicine, and the provision of health care to the public. All continuing educational activities which assist physicians in carrying out their professional responsibilities more effectively and efficiently are CME.

Target Audience: The CME activities will address the needs of Michigan Physicians.

Types of Activities Provided: The MSMS Committee on CME Programming serves the CME needs of MSMS and of noncommercial, health related organizations that are not accredited to offer Category I credit. Jointly sponsored programs must comply with the MSMS CME Programming Committee’s policies and meet its programming criteria.
in order to receive approval for Category I credit. The Committee on CME Programming shall assure proper needs assessment, development, conduct and supervision of MSMS sponsored CME activities.

Expected Results of Program: The Committee expects that the programs will contribute to cost effective care for the well-being of patients and the public; stimulate clinical competency; and provide quality Category I CME activities that give practicing physicians educational opportunities which contribute significantly to the continuum of professional learning.

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.

Relevant AMA Policy:

Reduced Continuing Medical Education (CME) Fees for Retired Physicians D-300.994
Our AMA supports reduced registration fees for retired physicians at all continuing medical education (CME) programs and encourages CME providers to consider a reduced fee policy for retired physicians.
Whereas, as a result of the most recent reorganization of the MSMS Board of Directors there are only two geographic board positions for a vast, diverse portion of the state of Michigan where only one position has been routinely filled, and

Whereas, it is currently stated in the MSMS Constitution that “one Regional Director must hold membership in a county located in the upper peninsula” (Article IX, Section 1), and

Whereas, for a variety of reasons it is not always possible to recruit active participation of MSMS member physicians from the upper peninsula willing to serve as a Regional Director, and

Whereas, no other Region has such specific exclusionary geographic requirements stated in the Bylaws regarding the selection of Regional Director; therefore be it

RESOLVED: That the MSMS Constitution Article IX, Section 1(a) be amended by addition to read as follows:

a) Two Directors (the “Regional Directors”) from each of the nine regions depicted on Exhibit A to the Bylaws (each a “Region” and collectively the “Regions”). The Regional Directors shall be elected by those members holding membership in a county located in that Region. No more than one Regional Director may hold membership in a single county unless a region consists of a single county. One Regional Director must hold membership in a county located in the upper peninsula unless no such member is available in which case, the two Regional Directors from Region 9 may come from the northern lower peninsula of the state.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $2,000-$4,000

Relevant MSMS Bylaws:

ARTICLE IX—THE BOARD OF DIRECTORS
Section 1. - COMPOSITION—The Board of Directors shall be the executive body of the Society. Effective at the first meeting of the Board of Directors immediately following the final meeting of the House of Delegates held at its 2020 Annual Session, the Board of Directors shall consist of:

a) Two Directors (the “Regional Directors”) from each of the nine regions depicted on Exhibit A to the Bylaws (each a “Region” and collectively the “Regions”). The Regional Directors shall be elected by those members holding membership in a county located in that Region. No more than one Regional Director may hold membership in a single county unless a region consists of a single county. One Regional Director must hold membership in a county located in the upper peninsula unless no such member is available in which case, the two Regional Directors from Region 9 may come from the northern lower peninsula of the state.

b) The President, President-Elect, Immediate Past President, Secretary, Treasurer, Speaker and Vice Speaker of the House of Delegates.

c) One Director elected by those members in each of the membership classifications defined in Sections 2.50 and 2.60 of the Bylaws, and one Director elected by those members in the Young Physicians Section as defined in
Section 20.60 of the Bylaws. These seats will be for one-year renewable terms, and the directors elected must remain in the category elected for the entire term.

d) The following ex officio Directors: (i) the Chair of the delegates to the AMA or another member of the delegation, designated as a substitute; and (ii) the two members serving as the physician representatives on the Blue Cross Blue Shield of Michigan Board of Directors.

e) Up to six Directors elected by the House of Delegates representing those constituencies deemed from time to time the most relevant to the current health care marketplace to be designated by the nominating committee of the House of Delegates with input from the Board of Directors and the House of Delegates (the “Designated Directors”). The Designated Directors shall serve three-year terms. Designated Directors may not serve more than three consecutive terms; the same individual may serve additional terms after an absence of at least one year.

MSMS Bylaws - 13.20 ELECTION OF REGIONAL DIRECTORS—
Regional Directors shall be elected as provided in Article IX, Section 1(a) of the Constitution. Each component society in a Region shall be notified in writing by the Secretary of the Society at least sixty days in advance of the Annual Session when a Regional Director is to be elected from that Region. If, by reason of death or resignation, a vacancy in the office of Regional Director occurs at any time other than during an Annual Session, each component society in that Region shall be promptly notified in writing by the Secretary of the Society. Thereupon the seated delegates of such Region may caucus, and if a majority of the seated delegates from such Region shall submit a nomination to the Board of Directors to fill such vacancy, the Board of Directors shall appoint such nominee to serve as interim Regional Director of such Region until a successor is elected in accordance with Article IX, Section 1(e) of the Constitution.

If a vacancy in the office of Regional Director occurs during an Annual Session of the Society, the delegates of the component societies in the Region affected shall be given notice thereof and afforded time to caucus and consider nominations to fill such vacancy.
RESOLUTION 43-23

Title: Establish a Senior Section for MSMS Members

Introduced by: Ved Gossain, MD, for the Ingham County Delegation

Original Authors: Ved Gossain, MD, Jaime Aragones, MD, Theodore Roumell, MD

Referred To: Reference Committee C

House Action:

Whereas, the U.S. population of individuals aged 65 years and older represents 16 percent of the population today, but is expected to grow to be 21.6 percent by 2040, and

Whereas, the progressive growth in the over 65 and above cohort will continue to require lifelong learning and “careering” for many people, including physicians, and

Whereas, the American Medical Association’s (AMA) Senior Physicians Section (SPS) was established in 2012 with the mission of engaging physicians 65 years of age and above, both active and retired, to introduce and promote ideas, policies, products, and services that are of relevance to senior physicians- including helping to foster healthy aging and lifelong learning, and

Whereas, the SPS provides leadership in addressing the issues germane to the seniors and, by presenting these ideas in the form of resolutions to the AMA House of Delegates, has ignited a change in the policies for the senior constituency in the AMA, and

Whereas, the AMA SPS was recently reviewed by the AMA Council on Long Range Planning and Development and was recommended for continuation through 2027, and

Whereas, the current members of the AMA Governing Council of the AMA SPS strongly encourage that every state medical society should have a senior physician section to advocate on behalf of senior physicians, senior patients, and their needs, and

Whereas, MSMS currently recognizes the need for medical students, resident physicians, and young physicians to have a designated section to address the specific needs of those physicians at that point in their lives and careers, but does not have a designated section for those physician members at the opposite end of their careers; therefore be it

RESOLVED: That the MSMS Constitution and Bylaws be amended by addition to establish a Senior Physicians Section as follows:

ARTICLE VII—HOUSE OF DELEGATES

Section 1. - COMPOSITION—The House of Delegates shall be the legislative body of the Society and shall consist of delegates elected by component societies, recognized specialty societies, delegates from the Residents and Fellows, Students, Young Physicians, Organized Medical Staff, Senior Physicians, and International Medical Graduates Sections, and other
sections as shall from time to time be approved by the House of Delegates, delegates-at-large and ex officio members, as prescribed by the Bylaws.

12.10 COMPOSITION—The House of Delegates shall be composed of members elected by the component societies, a delegate from each recognized specialty society, a delegate from the Resident and Fellow Section, one delegate from the Organized Medical Staff Section, a delegate from the Senior Physicians Section, a delegate from the Young Physicians Section, a delegate from the International Medical Graduates Section and one voting at-large delegate for every 50 MSMS student members to be selected by the MSMS Medical Student Section. These student delegates and alternate delegates must be members of the MSMS Medical Student Section. All other delegates and alternate delegates must be voting members of MSMS.

Each component society shall be entitled to send to the House of Delegates each year one delegate for each fifty voting members (active, life, and active emeritus) and one delegate for each additional major fraction thereof. Any component society having less than fifty members shall be entitled to send one delegate.

The president of a component medical society that all or part of which is located more than 400 miles by road from the site of the House of Delegates may designate a Regional Director of its region to serve as a delegate to the House of Delegates, provided that no member of the component medical society will otherwise be present in person serving as a delegate in any capacity. In the case of such designation of a single Regional Director by two or more component societies, said Regional Director shall have only one vote on all matters before the House of Delegates.

12.30 ELECTION - CERTIFICATION—Each component society shall elect the number of delegates to which it is entitled. The number of delegates shall be determined by the State Society as of December 1, preceding the House of Delegates meeting. The component society shall also elect an equal number of alternate delegates and shall designate the order or seniority thereof. Promptly after election the secretary of the component society, recognized specialty society, Resident and Fellow Section, Medical Student Section, Young Physicians Section, International Medical Graduates Section, Senior Physicians Section, or Organized Medical Staff Section shall certify the names of its delegates and alternate delegates to the Secretary of this Society.

12.40 SEATING - TENURE—A delegate becomes a member of the House of Delegates when the Speaker is notified in writing of the delegates election by the secretary of the component society, specialty society, Resident and Fellow Section, Medical Student Section, Young Physicians Section, International Medical Graduates Section or Organized Medical Staff Section. Such certification shall be submitted by February 1 of each year. The delegate shall remain a member of the House of Delegates until the Speaker is notified, in writing, by the secretary of the component society, specialty society, Resident and Fellow Section, Medical Student Section, Young Physicians Section, International Medical Graduates Section, Senior Physicians Section, or Organized Medical Staff Section that the delegate has been replaced. The delegate shall remain a member of the House of Delegates regardless of whether or not an alternate substitutes for him/her at any meeting of the House.
12.50 SEATING OF ALTERNATE DELEGATES—An alternate delegate may substitute for a duly
certified delegate at any regular or special meeting of the House of Delegates provided that
such substitution is authorized in writing by the secretary of the component society,
specialty society, Resident and Fellow Section, Medical Student Section, Young Physicians
Section, International Medical Graduates Section, Senior Physicians Section, or Organized
Medical Staff Section.

20.80 SENIOR PHYSICIANS SECTION - “To provide representation for the interests of
senior physicians within the structure of the Michigan State Medical Society, there
shall be a section on senior physicians, composed of physicians over 65 years of age
and who are active or active emeritus members of MSMS.

The purpose of the Section will be to provide a forum within the organizational
structure of the Society for the study and consideration of matters of special interest
or significance to senior physicians in Michigan.
At its annual meeting, the Section shall elect a chair, a vice-chair, a secretary and at
least two at-large members. It shall also elect one delegate and one alternate delegate
to the MSMS House of Delegates, each of whom shall serve for a term of two years.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $4,000-$8,000

Relevant MSMS Policy: See Above

Relevant AMA Bylaws:

Senior Physicians Section B-7.9
The Senior Physicians Section is a delineated Section.

7.9.1 Membership. All active physician members of the AMA age 65 and above shall be members of
the Senior Physicians Section.

7.9.2 Elections. Membership on the Governing Council shall be determined through election by
members of the Senior Physicians Section. All members of the Senior Physicians Section shall be
entitled to vote in elections of Governing Council members. Ballot distribution and the voting
process shall be conducted pursuant to election procedures adopted by the Governing Council and
approved by the Board of Trustees.

7.9.2.1 Election of Officers. The Governing Council shall elect the Section Chair-Elect from among
the Governing Council members.

7.9.3 Cessation of Membership. If an officer or Governing Council member ceases to be an active
member of the AMA prior to the expiration of the term for which elected, the term of such officer
or member shall terminate and the position shall be declared vacant.

Source:
Title: Repeal of HOD Resolution 65-14

Introduced by: Donald Peven, MD

Original Author: Donald Peven, MD

Referred To: Reference Committee C

Whereas, once a resolution is introduced into the MSMS House of Delegates, it is no longer the property of the submitter but is considered to be property of the House, and, therefore, at that point the AMA membership status (or, for that matter, any other attribute) of the original submitter is immaterial to consideration of said resolution, and

Whereas, since any resolution that is passed by the MSMS House of Delegates is considered passed by the House of Delegates as a whole, the AMA membership status (or, for that matter, any other attribute) of the original submitter is immaterial to said resolution, and

Whereas, no resolution that is passed by the MSMS House of Delegates is capable of “requiring action by the AMA;” it can only require action by the MSMS Delegation to the AMA, a body that represents MSMS as a whole, not merely those members who choose to belong to the AMA, and

Whereas, as actions and positions taken by the AMA reflect on all physicians whether or not they are AMA members, it is unfair to require that a delegate maintain AMA membership in order to introduce a resolution to the MSMS House of Delegates; therefore be it

RESOLVED: That Resolution 65-14, requiring that resolutions submitted to the MSMS House of Delegates that require action by the AMA may only be submitted by MSMS members that are also members of the AMA be repealed.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000

Relevant MSMS Policy:

AMA Advocacy for AMA Members (65-14)

RESOLVED: That resolutions submitted to the MSMS House of Delegates that require action by the AMA may only be submitted by MSMS members that are also members of the AMA.

Relevant AMA Bylaws:

Procedure. B-2.11
2.11.1 Order of Business. The Order of Business will be proposed by the Speaker and approved by the House of Delegates.

At any meeting, the House of Delegates, by majority vote, may change the order of business.

2.11.2 Privilege of the Floor. The House of Delegates, by a two-thirds vote of delegates present and voting, may extend to any person an invitation to address the House.

2.11.3 Introduction of Business.
2.11.3.1 Resolutions. To be considered as regular business, each resolution must be introduced by a delegate or organization represented in the House of Delegates and must have been submitted to the AMA not later than 30 days prior to the commencement of the meeting at which it is to be considered, with the following exceptions.

2.11.3.1.1 Exempted Resolutions. If any member organization’s house of delegates or primary policy making body, as defined by the organization, adjourns during the 5-week period preceding commencement of an AMA House of Delegates meeting, the organization is allowed 7 days after the close of its meeting to submit resolutions to the AMA. All such resolutions must be received by noon of the day before the commencement of the AMA House of Delegates meeting. The presiding officer of the organization shall certify that the resolution was adopted at its just concluded meeting and that the body directed that the resolution be submitted to the AMA House of Delegates.

2.11.3.1.2 AMA Sections. Resolutions presented from the business meetings of the AMA Sections may be presented for consideration by the House of Delegates no later than the recess of the House of Delegates opening session to be accepted as regular business. Resolutions presented after the recess of the opening session of the House of Delegates will be accepted in accordance with Bylaw 2.11.3.1.4.

2.11.3.1.3 Late Resolutions. Late resolutions may be presented by a delegate prior to the recess of the opening session of the House of Delegates, and will be accepted as business of the House of Delegates only upon two-thirds vote of delegates present and voting.

2.11.3.1.4 Emergency Resolutions. Resolutions of an emergency nature may be presented by a delegate any time after the opening session of the House of Delegates is recessed. Emergency resolutions will be accepted as business only upon a three-fourths vote of delegates present and voting, and if accepted shall be presented to the House of Delegates without consideration by a reference committee. A simple majority vote of the delegates present and voting shall be required for adoption.

2.11.3.1.5 Withdrawal of Resolutions. A resolution may be withdrawn by its sponsor at any time prior to its acceptance as business by the House of Delegates.

2.11.3.1.6 Resolutions not Accepted. Late resolutions and emergency resolutions not accepted as business by the House of Delegates may be submitted for consideration at a future meeting in accordance with the procedure in Bylaw 2.11.3.

2.11.3.2 Business from the Board of Trustees. Reports, recommendations, resolutions or other new business, may be presented by the Board of Trustees at any time during a meeting. Items of business presented before the recess of the opening session of the House of Delegates will be accepted as regular business. Items of business presented after the recess of the opening session of the House of Delegates will be accepted as emergency business and shall be presented to the House of Delegates without consideration by a reference committee. A two-thirds vote of the delegates present and voting shall be required for adoption.

2.11.3.3 Business from the Councils. Reports, opinions or recommendations from a council of the AMA or a special committee of the House of Delegates may be presented at any time during a meeting. Items of business presented before the recess of the opening session of the House of Delegates will be accepted as regular business. Items of business presented after the recess of the opening session of the House of Delegates will be accepted as emergency business and shall be presented to the House of Delegates without consideration by a reference committee. A two-thirds vote of the delegates present and voting shall be required for adoption.

2.11.3.4 Informational Reports of Sections. Informational reports may be presented by the AMA Sections on an annual basis.

2.11.4 Referral to Reference Committee. Reports, recommendations, resolutions or other new business presented prior to the recess of the opening session of the House of Delegates shall be referred to an appropriate reference committee for hearings and report, subject to acceptance as business of the House of Delegates. Items of business presented after the recess of the opening session are not referred to reference committee, but rather heard by the House of Delegates as a whole, subject to acceptance as business of the House of Delegates. Informational items are not referred to a reference committee.

2.11.6 Quorum. A majority of the voting members of the House of Delegates Official Call shall constitute a quorum.
2.11.4 Referral to Reference Committee. Reports, recommendations, resolutions or other new business presented prior to the recess of the opening session of the House of Delegates shall be referred to an appropriate reference committee for hearings and report, subject to acceptance as business of the House of Delegates. Items of business presented after the recess of the opening session are not referred to reference committee, but rather heard by the House of Delegates as a whole, subject to acceptance as business of the House of Delegates. Informational items are not referred to a reference committee.

2.11.6 Quorum. A majority of the voting members of the House of Delegates Official Call shall constitute a quorum.
ACTION REPORT #04-23 OF THE BOARD OF DIRECTORS

SUBJECT: Resolution 04-21
Dissemination of Information to the County Medical Societies

REFERRED TO: Reference Committee C

HOUSE ACTION:

RECOMMENDATION: That the 2023 House of Delegates approve Resolution 04-21, “Dissemination of Information to County Medical Societies,” as amended to read:

RESOLVED: An Excel document will be emailed regularly to all county medical society chapters with information from the public Member Directory at Connect.MSMS.org. Information will include: First Name, Middle Name, Last Name, Credentials, Price List, Group Billing Parent Account, Employer, Address 2: Name, Address 2: Street 1, Address 2: Street 2, Address 2: Street 3, Address 2: City, Address 2: State/Province, Address 2: ZIP/Postal Code, Primary Work Phone, Address 2: County, Address 3: City, Address 3: County, County Membership, Email, Join Date; and be it further

RESOLVED: A second Excel document will be emailed monthly to all county medical society chapter officers of the information that is specific to the new and reinstated report to make it easier for the counties to review. Information will include: First Name, Middle Name, Last Name, Credentials, Price List, Group Billing Parent Account, Employer, Address 2: Name, Address 2: Street 1, Address 2: Street 2, Address 2: Street 3, Address 2: City, Address 2: State/Province, Address 2: ZIP/Postal Code, Primary Work Phone, Address 2: County, Address 3: City, Address 3: County, County Membership, Email, Join Date.

Resolution 04-21 was referred to the MSMS Board of Directors for study in 2021 and again in 2022. In 2022, the Board referred the resolution to the MSMS Committee on Membership Recruitment and Retention for review and recommendation.

Resolution 04-21 asked “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

(continued)
duly chartered County Medical Societies as requested without regard to the members’ or nonmembers’ county of origin; and 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."

Resolution 04-21 was introduced to ensure that the County Medical Societies gain access to all member or non-member information regardless of county of origin. The key issue was providing information that allowed county medical societies to determine if physicians were assigned to the correct county without compromising some of the personal data that is in the member record. Each county has access, through the MSMS member database portal, to the entire member record, but due to the confidentiality provisions of MSMS, that record cannot be shared with other counties. Basic identifying information is available on the MSMS website through the physician directory, but it is cumbersome for county staff to use since they have to search county by county to determine if a member has moved or been reassigned to a different county.

According to MSMS legal counsel, membership information that MSMS obtains comes in via the MSMS Website or other electronic sources that are subject to the MSMS Website Privacy Policy. That policy describes the types of information that is collected and subject to the policy. This includes information given by members “on applications or other forms” on the MSMS website (i.e. all information members provide on applications for membership or renewals of membership). The policy provides that none of this information will be shared with “third parties” without the consent of the member. “Third parties” meaning in this context would be anyone other than the person or entity the information is provided to (i.e. MSMS). The information cannot be inferred that a county medical society was not intended to be a third party since they are all separate entities with no common ownership with MSMS. Therefore, the MSMS Website Privacy Policy prevents MSMS from disclosing the information it has obtained to county medical societies absent member approval.

Since member data and transparency are such an important part of the partnership between MSMS and the counties, MSMS has worked with their IT vendor to continue to create additional reporting as requested by the counties. For every dues-charging county, the following reports have been made available:

1. Chapter Society Members – created June 2019
2. Member Directory – created June 2019
3. Chapter Reimbursement Information – created October 2020
4. Contact Summary Report – created March 2021
5. County Change Report – created July 2021
6. Deceased Report – created July 2021

(continued)
7. County New/Reinstated Report – created April 2021
8. Non-Paid Dues Report – created February 2022
9. Quarterly Report of Member Data – created April 2022

The Committee spent several meetings reviewing background information and receiving input from County Executives and MSMS staff. After thorough research and thoughtful dialogue, Committee members supported a compromise that met the needs of the county while still abiding by the privacy policy.

An Excel document will be emailed quarterly to all county medical societies with information from the public Member Directory from Connect.MSMS.org. Information will include: First Name, Middle Name, Last Name, Credentials, Price List, Group Billing Parent Account, Employer, Address 2: Name, Address 2: Street 1, Address 2: Street 2, Address 2: Street 3, Address 2: City, Address 2: State/Province, Address 2: ZIP/Postal Code, Primary Work Phone, Address 2: County, Address 3: City, Address 3: County, County Membership, Email, Join Date.

Additionally, a second Excel document with the same fields will be emailed monthly to all county medical society chapter officers of the information that is specific to the new and reinstated report to make it easier for the counties to review.

At its meeting on March 15, 2023, the MSMS Board of Directors approved the recommendation of the Committee on Membership Recruitment and Retention to approve Resolution 04-21, as amended.

Attachment
Resolution 04-21
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
ACTION REPORT #05-23 OF THE BOARD OF DIRECTORS

SUBJECT: Revisions to the MSMS Policy Manual and the 2023 Sunset Policy

REFERRED TO: Reference Committee C

HOUSE ACTION:

RECOMMENDATION: That the 2023 MSMS House of Delegates approve the attached additions to the MSMS Policy Manual and the 2023 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 16, 2023, to review existing policy slated for review pursuant to the MSMS sunset policy; reviewed the 2022 House of Delegates Resolutions and Board Action Reports, as well as the MSMS Board Actions from January through October 2022. Following its review, the Committee voted to recommend that the MSMS Board of Directors recommend approval of the updates to the MSMS Policy and 2023 Sunset Report.

At its meeting on March 15, 2023, the MSMS Board of Directors approved the updates to the MSMS Policy Manual and the 2023 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
   2023 Sunset Report
CHILDREN AND YOUTH
(See also: Domestic Violence; Health Care Insurance; Immunizations; Mental Health; Public Health; Safety and Accident Prevention; Sports)

Education
Ending Early School Start Times in Michigan
MSMS encourages the Michigan Department of Education to educate school districts, caregivers, and students on the harms of insufficient sleep and the benefits of later school starts. MSMS supports legislative efforts to adopt middle school and high school start times that have been proven to provide students with the best opportunity to obtain the physiologically required amount of sleep; thereby, resulting in scholastic, psychological, and health benefits. (Res20-22)

Prevention, Safety, and Screening
Limit the Pornography Viewing by Minors Over the Internet
MSMS supports legislation that would strengthen child-centric content protection by internet service providers and/or search engines in order to limit the access of pornography to minors on the Internet and mobile applications. MSMS supports the education of parents and health care professionals about the public health impact of pornography exposure during childhood. (Res36-22)

Universal K-12 Mental Health Screenings in Michigan Public Schools
MSMS supports annual, voluntary K-12 mental health screening that is evidence-based and age appropriate within all Michigan Public Schools that possess adequate referral resources that will serve to effectively identify and refer youth to needed mental health services. (Res56-22)

COMMUNICATIONS
Non-Stigmatizing Verbiage
MSMS encourages the use of clinically accurate, non-stigmatizing, person-first terminology when referring to the disease of addiction. MSMS 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. (Res04-22)

Physician Not Labeled as Provider
MSMS opposes the current custom by government and insurance companies of labeling physicians as providers 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 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.
– Amended 1993
– Edited 1998
– Reaffirmed (Sunset Report 2020)
– Amended (Res18-22)

CONTINUING MEDICAL EDUCATION
(See also: Elder Care; End of Life Care; Medical Education and Training; Pain Management; Public Health)

ELDER CARE
(See also: Long-Term Care)

Educational Activities Addressing Needs of the Elderly Seniors
MSMS supports, through existing MSMS committees and programs, educational activities addressing the special medical, social and economic needs of the elderly seniors, including those in senior living communities. (Prior to 1990)
– Reaffirmed (Sunset Report 2021)
– Reaffirmed (Res15-22)
– Amended 2022

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

Practice of Medicine and Workplace
Informed Consent for Pelvic Examinations on Patients Who Are Unconscious or Under Anesthesia
MSMS adopts American Medical Association Policy H–140.828 - Ensuring Consent for Educational Physical Exams on Anesthetized and Unconscious Patients. (Res57-22)

GOVERNMENT PROGRAMS AND REGULATORY OVERSIGHT
(See also: Health Care Delivery; Managed Care; Medicaid; Medicare; Pharmacy and Pharmaceuticals; Workers’ Compensation)

Convicted Sex Buyers
MSMS supports rehabilitation and education of convicted sex buyers. (Res37-22)

Curb Human Trafficking
MSMS supports human trafficking legislation which toughens criminal and financial penalties for persons soliciting sexual activity for payment rather than the victims of trafficking. (Res14-20)
– Reaffirmed (Res35-22)

Excessive Medical Administrative Costs
MSMS opposes additional regulatory requirements that place a financial burden on the physicians or hospitals without compensation. (Res81-90A)
– Edited 1998
– Reaffirmed (Sunset Report 2021)
– Reaffirmed (Res02-22)

Oppose Mandated Use of Gonad Shields
MSMS supports the removal of state and national laws and regulations that mandate the routine use of gonad shields in medical imaging. (Res19-22)

HEALTH CARE DELIVERY
**Access**

**Eliminate Medical Co-Payments in Prisons and Jails**
MSMS supports the elimination of medical copayments in prisons and jails across the state of Michigan. (Res60-22)

**Services for Survivors of Human Trafficking**
MSMS supports providing access to, and payment for, health care services to survivors of human trafficking regardless of their citizenship status. Such service shall include comprehensive trauma-informed social services that is available to survivors of human trafficking and sex workers. (Res37-22)

**Continuity of Care**

**Continuity of Care Upon Release from Correctional Systems**
MSMS adopts AMA policy H-430.986 - Health Care While Incarcerated. (Res55-22)

**Medical Necessity**

**Clinical Laboratory Improvement Amendment Requirements**
Any confirmatory laboratory testing for urine drug screens should be considered at the discretion of the ordering physician with the best interests of the patient in mind. (Res22-22)

**Off-Label Policy**
MSMS supports AMA Policy, “Patient Access to Treatments Prescribed by Their Physicians H-120.988” as a basic medical right and responsibility of a physician to provide the best care available to our patients. (Res23-22)

**HEALTH CLINICIANS OTHER THAN PHYSICIANS**
(See also: Hospital-Physician Relations; Licensure; Scope of Practice)

**Medical Professional Identification Transparency**
MSMS supports only the use of titles and descriptors that align with a physician or non-physician provider’s state-issued licenses or credentials. MSMS encourages the adoption of legislation which requires professionals in clinical health care settings to clearly and accurately identify to patients their name, credentials, and professional title(s). (Res18-22)

**Retain Physician Assistant Professional Title**
MSMS opposes the title change of Physician Assistant to Physician Associate. (Res28-22)

**Transparency of Practice Agreements Between Physicians and Non-Physicians**
MSMS supports public transparency of practice agreements, or lack of such agreements, between physicians and non-physician providers (such as nurse practitioners and physician assistants), as a reflection of our professionalism and commitment to patient safety in a physician-led care model. (Res29-22)

**HEALTH PLANNING**

**Bedside Nursing and Health Care Staff Shortages**
MSMS encourages collaboration amongst appropriate stakeholders on short and long-term strategies and solutions, for addressing the nursing and health care staff shortages, which promote a stable work force and career longevity. (Res21-22)

**IMMUNIZATIONS**
Vaccination to Mitigate the COVID-19 Pandemic
MSMS favors requiring COVID-19 vaccinations for health care workers (with legitimate exceptions). (Res41-22)

LICENSURE

CME Credit for Continuing Board Certification
MSMS believes that active participation in specialty continuing certification, which is aligned with the American Board of Medical Specialties’ Standards for Continuing Certification, constitutes evidence of substantial compliance with continuing medical education (CME) requirements and an acceptable means of meeting CME requirements for license renewal. (Res31-22)

MATERNAL AND INFANT HEALTH

Cannabis Use During Pregnancy
MSMS believes there is a need for the following:
1. Research during pregnancy on the impacts of recreational cannabis use on the fetus;
2. Professional education for prenatal care providers to be able to provide consistent recommendations on cannabis use in pregnancy; and,
3. A review of Child Protective Services (CPS) policies concerning the mandated referral of pregnant patients to CPS solely for cannabis use.
(Res05-22)

MEDICAL EDUCATION AND TRAINING

Advocacy Training in Medical Schools
MSMS encourages all Michigan and U.S. medical schools and residency programs to incorporate significant, more formalized training in health care policy and patient care advocacy into their curricula to aid in the development of our next generation of physician leaders. (Res55-13) – Reaffirmed (Res49-22)

Improving and Standardizing Pregnancy and Lactation Accommodations for Medical Board Examinations
MSMS supports and will advocate for: (1) the implementation of a minimum of 60 minutes of additional, scheduled break time for all test takers who are pregnant and/or lactating during all medical licensure and certification examinations; (2) the addition of pregnancy comfort aids, including but not limited to ginger teas, saltines, wastebaskets, and antiemetics, to any medical licensure or certification examination’s pre-approved list of Personal Item Exemptions (PIEs) permitted in the secure testing area for all test takers who are pregnant and/or lactating; (3) the availability of cold space to store expressed milk during testing and private spaces for partners and babies to wait for testers to breastfeed on breaks; and, (4) fee-waivers for pregnant students with documented medical complications of pregnancy that would impact their ability to complete and who need to reschedule their United States Medical Licensing Examination exam. (Res59-22)

Mental Health First Aid Training
MSMS supports physician acquisition of emergency mental health response skills and shall promote education courses for physicians, fellows, residents, and medical students. (Res14-22)

Standards in Cultural Humility Training within Medical Education
MSMS supports initiatives by Michigan medical schools to include cultural humility training for medical students as part of their cultural competency curricula; including but not limited to integrating cultural humility within didactic and experiential learning across medical school curricula. (Res53-22)

**MEDICARE**

**Medicare Prescription Drug Pricing**
MSMS supports lowering Medicare prescription drug prices to make prescription drugs more affordable for Medicare beneficiaries. (Res24-22)

**MEMBERSHIP**

**Group Membership Recruitment**
It is expected that MSMS will work with impacted component societies on group membership recruitment activities by doing the following:
- Report any group membership solicitation plans to the impacted component societies;
- Include the impacted component societies in the group solicitation and negotiations;
- Require a written contract for any group membership over 50 members and share the roster and contract with the impacted component societies in advance of the finalizing contract; and,
- Obtain the home and/or primary work address of each individual member under the group bill, whether from the group contact or through research by MSMS. (Res48-22)

**Inclusion of Northern Michigan in the Rotation for the HOD Meeting**
MSMS shall rotate the annual House of Delegates meeting between the east and west side of the state, but at least once every 12 years, the western meeting shall take place in a northern county. (Res03-22)

**MSMS Committee on Membership Recruitment and Retention**
MSMS shall convene a Membership Committee composed of MSMS leadership and staff, as well as diverse representation of component societies for which MSMS is responsible for collecting dues. The Committee is charged with helping to develop and adjust the annual membership recruitment and retention plan. The Membership Committee shall meet at a frequency as determined necessary by the Committee, but not less than once per year. (Res45-22)

**MENTAL HEALTH**

**Improve Access to Pediatric Mental Health Services**
MSMS supports efforts to expand pediatric mental health capacity in Michigan. Additionally, MSMS shall communicate about the availability of and ability to utilize Michigan Child Care Collaborative services. (Res01-22)

**Support of Michigan Mental Health Court System**
MSMS supports continued expansion of Michigan’s mental health court system. (Res16-22)

**PUBLIC HEALTH**
(See also: Children and Youth; Immunizations; Informed Consent; Nutrition; Tobacco and Smoking)

**Education**

**Human Trafficking Education and Awareness**
MSMS encourages the State Board of Education, Michigan secondary schools and colleges, as well as other influential organizations to increase health care professionals’ and others’
awareness of the prevalence, symptoms, and signs of human trafficking and increase awareness of signs of human trafficking. MSMS also supports an extensive education campaign to raise awareness about the lifelong physical harm and trauma experienced by survivors of human trafficking and sex workers. (Res17-17) – Amended (Re37-22)

General

Strengthen Support for Local Health Department Medical Directors and the Medical Health Officer Role
MSMS shall advocate for (a) strong physician-led teams within governmental public health as to support and enhance the voice of physicians for the benefit of population health; (b) consistent, sustainable funding to support our public health infrastructure; (c) incentives, including loan forgiveness and debt reduction, to help strengthen the governmental public health workforce in recruiting and retaining staff; (d) public health data modernization and data governance efforts as well as efforts to promote interoperability between health care and public health; and (e) efforts to ensure equitable access to public health funding and programs. (Res27-22)

SAFETY AND ACCIDENT PREVENTION

Automobile and Bicycle Safety

Vision Qualifications for Driver’s License
MSMS supports the creation of and will participate in a multi-stakeholder effort led by the American Medical Association to address standardized vision requirements 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. (Board Action Report #2, 2022 HOD, re Res02-21)

Firearm Safety

Prohibit Persons from Carrying Firearms and Explosive Devices in Local and State Government Buildings
MSMS believes that firearms and explosive devices of all kinds, with a carry exception for law enforcement officials, should be prohibited from local and state government buildings. (Res34-22)

Waiting Period for Gun Purchase
MSMS supports the establishment of a waiting period for all firearm purchases in Michigan. (Res12-22)

SCOPE OF PRACTICE
(See also: Health Clinicians Other Than Physicians)

Practice Agreement Availability and Transparency
MSMS supports the adoption of state legislation to achieve transparency of practice agreements between physicians and non-physician providers, or lack of such agreements, in a manner easily accessible to patients, in the form of website and/or marketing material disclosures, so that patients may be informed of the credentials of their entire care team. (Res29-22)

Radiology Interpretation by Physicians
MSMS believes that radiological image interpretation is to be performed only by physicians and may not be delegated to non-physician practitioners as defined by the Centers for Medicare and Medicaid Services. (Res46-22)

**SUBSTANCE USE AND ADDICTION**
(See also: Pharmacy and Pharmaceuticals; Health Care Delivery; Public Health)

**Substance Abuse Use During Pregnancy**
MSMS encourages routine drug screening of pregnant women.

MSMS opposes 1) making the use of controlled substances during pregnancy a felony; and 2) the removal of a child from its mother during the hospital stay solely due to evidence from a single positive drug test without an evaluation from a social worker. (Board-July96)
– Amended (Res31-19)
– Amended 2023

**TAXES**

**Expanded Child Tax Credit**
MSMS supports a permanent annual, refundable child tax credit for each child under the age of 19. (Res07-22)
Sunset Report to 2023 MSMS House of Delegates

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>Index</th>
<th>Policy</th>
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<tbody>
<tr>
<td>AUTOPSIES</td>
<td>Autopsy Procedures</td>
<td>Res66-12</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td>ETHICS (Practice of Medicine and Workplace)</td>
<td>Physician Participation in Patient Mutilation</td>
<td>Board-Oct08 Reaffirmed (Res51-12)</td>
<td>Retain, policy is still relevant. Suggested technical edit – change “participating” to “participation”</td>
</tr>
<tr>
<td>HEALTH INFORMATION TECHNOLOGY</td>
<td>Mandating e-Prescribing</td>
<td>Board Action Report #1, 2013 HOD, re Res8-12</td>
<td>Sunset. This directive has been achieved. Electronic prescribing of controlled and non-controlled substances is common practice.</td>
</tr>
<tr>
<td>Index</td>
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<tr>
<td>HOSPITAL-PHYSICIAN RELATIONS</td>
<td>Required Physical Exams of Physicians by Hospitals</td>
<td></td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td></td>
<td>MSMS opposes hospital medical staff policy that mandates all physicians of a particular age undergo physical and neuropsychological exams in order to remain on staff.</td>
<td>Res16-12</td>
<td></td>
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<tr>
<td>MEDICAID</td>
<td>Coverage of Approved Medications</td>
<td></td>
<td>Retain, policy is still relevant.</td>
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<td></td>
<td>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.</td>
<td>Res2-12</td>
<td></td>
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<tr>
<td>MEDICAL EDUCATION &amp; TRAINING</td>
<td>Adopting Alternative Sources of Graduate Medical Education Funding</td>
<td></td>
<td>Retain, policy is still relevant.</td>
</tr>
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<td></td>
<td>MSMS supports the principle or concept of an all-payer fund that would distribute the cost of training physicians across Medicare, Medicaid, and private health insurance plans.</td>
<td>Res22-12</td>
<td></td>
</tr>
<tr>
<td>MEDICAL EDUCATION &amp; TRAINING</td>
<td>Ethical Duties in Teaching Medicine</td>
<td></td>
<td>Retain, policy is still relevant.</td>
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<td></td>
<td>MSMS supports that undergraduate and postgraduate medical trainees be taught by the example of their teachers that the ultimate welfare of each patient is primary and takes precedence over educational needs where there is a conflict between these two goals.</td>
<td>Res15-12</td>
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<tr>
<td>NUTRITION</td>
<td>Nutrition Labels and Nutrition Education in Elementary School</td>
<td></td>
<td>Retain, policy is still relevant.</td>
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<td>MSMS supports nutrition education, including how to read and interpret nutrition labels on food packaging, be implemented in elementary school curricula in Michigan as a prevention measure for obesity and resulting morbidity.</td>
<td>Res18-12</td>
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<td>Index</td>
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| PUBLIC HEALTH (Communicable Disease) | **Expedited Partner Therapy for Gonorrhea and Chlamydia**<br>MSMS supports amending the public health code to make expedited partner therapy legal in Michigan and supports immunity from professional and civil liability if expedited partner therapy is provided according to the regulations.<br>MSMS supports immunity from professional and civil liability if expedited partner therapy is provided according to the regulations. | Res1-12 | Amend, policy is still relevant.<br>**In 2014, the Michigan Public Health Code was amended to permit the use of EPT (MCL 333.5110). Therefore, language referencing legislation should be removed, as well as the specific reference to gonorrhea and chlamydia since the statute is broader. The revised policy would read as follows:**

**Expedited Partner Therapy**<br>MSMS supports Michigan law that makes expedited partner therapy (as defined by the CDC) legal in Michigan and supports immunity from professional and civil liability if expedited partner therapy is provided in accordance with the law. |
| PUBLIC HEALTH (Environmental Health Issues) | **Lead Free Wheel Weights**<br>MSMS opposes the use of lead wheel weights in Michigan. | Res10-12 | Retain, policy is still relevant. |
| PUBLIC HEALTH (Environmental Health Issues) | **Storing of Nuclear Waste Near the Great Lakes Shore**<br>MSMS objects to storing nuclear waste by states and provinces within the Great Lakes Basin area in a manner which threatens to contaminate the Great Lakes. | Res27-09A | Retain, policy is still relevant. |
| PUBLIC HEALTH (Healthy Choices) | **Ban Tanning Booth Use by Minors in Michigan**<br>MSMS opposes access to the use of indoor tanning equipment by anyone under the age of 18. | Res38-12 | Retain, policy is still relevant. |
| SCOPE OF PRACTICE | **Health Profession Boards Need to Protect Patients**<br>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 | Retain, policy is still relevant. |
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, it is the practice of our county medical societies and our MSMS that new members to MSMS join the component medical society of the county where they either live or primarily work, and

Whereas, 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 reside or primary location of practice** or direct members through the Resident and Fellow Section or the Medical Student Section.

4.10 MEMBERSHIP AS PRIVILEGE - NOT RIGHT--- Anyone eligible may apply for component membership within the county where they reside or primary location of practice. Any exception would require written, mutual agreement between the physician and/or physician group, 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.

5.10 CHANGE OF LOCATION - PROCEDURE---When a member of a component society, by reason of change of **residence or primary location of 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: $1,000-$2,000 for new MSMS policy.

**Background:** This resolution is the same as Board Action Report 3-22 with the addition of “primary” to place of work.

**Relevant MSMS Policy:** None

**Relevant AMA Policy:** None

**Sources:**
1. [https://connect.msms.org/Membership/Join](https://connect.msms.org/Membership/Join)
2. Source: January 14, 2021, MSMS Board of Directors Meeting Packet The Saginaw County Medical Society has approved also submitting this resolution on their behalf.
### RESOLUTION

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### BOARD ACTION REPORT

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<td>#01-23</td>
<td>Resolution 33-22 - “Repeal of Michigan’s Abortion Law”</td>
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Title: Protecting Access to Gender-Affirming Care

Introduced by: Ashton Lewandowski, for the Medical Student Section

Original Author: Vivienne Acuna, Mary Finedore, Jessyca Judge, Darian Mills, Lucy Nguyen, and Susanna Wang

Referred To: Reference Committee D

House Action:

Whereas, the World Health Organization (WHO) defines gender-affirming care as, “any single or combination of a number of social, psychological, behavioral or medical (including hormonal treatment or surgery) interventions designed to support and affirm an individual’s gender identity,” and

Whereas, according to a JAMA published analysis of a survey of 27,715 transgender and gender-diverse patients, gender-affirming surgery is associated with decreased odds of psychological distress, tobacco smoking, and suicidal ideation compared to transgender and gender-diverse patients with no history of gender-affirming surgery, and

Whereas, according to a prospective cohort study of adolescent patients published by JAMA, gender-affirming care, including puberty blockers and gender-affirming hormones, is associated with 60 percent lower odds of experiencing moderate or severe depression and 73 percent lower odds of suicidal ideations, and

Whereas, a large survey of 35,000 LGBTQ+ youth found that 94 percent of LGBTQ+ youth reported recent politics surrounding threats to care negatively impacted their mental health, and

Whereas, a large number of medical associations, including the American Psychiatric Association, the American Academy of Family Physicians, the American Academy of Pediatricians, and the Pediatric Endocrine Society, support comprehensive access to gender-affirming care for transgender and gender-diverse patients, including children and adolescents, and

Whereas, a large number of medical associations, including the American Medical Association, American Psychiatric Association, the American College of Gynecologists and Obstetricians, and the American Association of Clinical Endocrinology, oppose legislation that seek to restrict patient access to gender-affirming care for transgender and gender-diverse patients, or that seek to punish, imprison, or fine healthcare providers who provide gender-affirming care, and

Whereas, since 2021, four states (Arkansas, Tennessee, Arizona, and Alabama) have implemented bans restricting or banning access to gender-affirming care, and

Whereas, in 2022, the governor of Texas ordered the state’s child welfare agency to investigate gender-affirming care as child abuse cases, and
Whereas, nine states’ Medicaid policies explicitly exclude trans health care from their services covered, and

Whereas, over the past two years, there were more than 20 bills in 25 states filed in state legislatures that would target transgender medical care, and there are at least 20 bills in 9 states filed in state legislatures that could be passed in 2023, and

Whereas, pending bills in multiple states, such as House Bill No. 6454 in Michigan, would charge parents who help their children receive gender-affirming care, as well as health care providers providing gender-affirming care, with first-degree child abuse, punishable by life imprisonment, and

Whereas, legislation punishing health care providers for providing gender-affirming care has created undue emotional stress on providers, with many citing anxiety from the uncertainty of needing to close their practice, radically transform their clinical practice and research, or move to a different state, and

Whereas, in response to the many bans over the past year, eight states and Washington, D.C. introduced legislation to protect access to gender-affirming care, and

Whereas, the American Medical Society and Michigan State Medical Society have already demonstrated a commitment to oppose any efforts that deny an individual’s right to determine their gender identity, to speak against policies that are discriminatory and create greater health disparities in medicine, and to support increased access for gender affirming treatments; therefore be it

RESOLVED: That MSMS support legislation that seeks to protect patient access to gender-affirming care; and be it further

RESOLVED: That MSMS oppose legislation that seeks to ban or restrict patient access to gender-affirming care; and be it further

RESOLVED: That MSMS oppose legislation that seeks to punish, imprison, or fine health care providers for providing gender-affirming care as recommended by established medical guidelines.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $16,000-$32,000

Relevant MSMS Policy:

Support of *LGBTQIA Anti-Discrimination Legislation
MSMS opposes discrimination based on gender identity and sexual orientation.
*LGBTQIA: Lesbian; gay; bisexual; transgender; queer; intersex; asexual/ally (ally—a person who does not identify as LGBTQIA but supports the rights and safety of those who do)

Promotion of LGBTQ-Friendly and Gender-Neutral Intake Forms
MSMS encourages the use of intake forms in health care settings including private medical practices and hospitals that allow patients to share their biological sex, current gender identity, sexual orientation, and preferred gender pronoun(s) in a culturally-sensitive and voluntary manner.
Sex and Gender-Based Medicine in Clinical Medical Education
MSMS encourages the inclusion of sex and gender-based medicine in clinical medical education in Michigan, including but not limited to, medical schools, residency programs and Continuing Medical Education programs.

Oppose Criminalization of Physicians and Patients for Evidence Based Standard of Medical Care (41-20)
RESOLVED: That MSMS oppose the criminalization of physicians for delivering evidence-based standard of medical care, as well as for refusing to engage in care that is neither safe nor evidence based.

RELEVANT AMA POLICY:

Affirming the Medical Spectrum of Gender H-65.962
Our AMA opposes any efforts to deny an individual’s right to determine their stated sex marker or gender identity.

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991
1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.

2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.

4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.

Discriminatory Policies that Create Inequities in Health Care H-65.963
Our AMA will: (1) speak against policies that are discriminatory and create even greater health disparities in medicine; and (2) be a voice for our most vulnerable populations, including sexual, gender, racial and ethnic minorities, who will suffer the most under such policies, further widening the gaps that exist in health and wellness in our nation.
Healthcare Equity Through Informed Consent and a Collaborative Healthcare Model for the Gender Diverse Population H-140.824

Our AMA supports: (1) shared decision making between gender diverse individuals, their health care team, and, where applicable, their families and caregivers; and (2) treatment models for gender diverse people that promotes informed consent, personal autonomy, increased access for gender affirming treatments and eliminates unnecessary third party involvement outside of the physician-patient relationship in the decision making process.

Right for Gamete Preservation Therapies H-65.956

1. Fertility preservation services are recognized by our AMA as an option for the members of the transgender and non-binary community who wish to preserve future fertility through gamete preservation prior to undergoing gender affirming medical or surgical therapies.

2. Our AMA supports the right of transgender or non-binary individuals to seek gamete preservation therapies.

Nondiscriminatory Policy for the Health Care Needs of LGBTQ Populations D-65.996

Our AMA will encourage and work with state medical societies to provide a sample printed nondiscrimination policy suitable for framing, and encourage individual physicians to display for patient and staff awareness as one example: “This office appreciates the diversity of human beings and does not discriminate based on race, age, religion, ability, marital status, sexual orientation, sex, or gender identity.”

Reaffirm the MSMS and AMA’s Commitment to Diversity and Tolerance

RESOLVED: That MSMS reaffirms its commitment to diversity and inclusion and condemns all attempts by agencies, be they government or private, to discriminate based on race, religion, sexual orientation, creed, sex, gender identity, disability, ethnic origin, national origin, or age as stated in “MSMS Position on Discrimination;” and supports current AMA Policies H-65.965, H-65.978; and D 160.988.

Sources:
RESOLUTION 03-23

Title: Newborn Screening for Urea Cycle Disorder

Introduced by: Ashton Lewandowski, for the Medical Student Section

Original Authors: Hashim Aslam, Riya Chhabra, Raywa Masti, Inderjeet Sahota, Merzia Subhan, and Deepali Tailor

Referred To: Reference Committee D

House Action:

Whereas, urea cycle disorders are inherited metabolic errors that affect urea synthesis, and

Whereas, urea cycle disorders can cause high ammonia levels that are toxic to the brain (hyperammonemic encephalopathy), and

Whereas, these deficiencies have been identified in all urea cycle enzymes, and

Whereas, deficiencies of OTC and CPS1 enzymatic activities are the most common types of urea cycle disorders and can be debilitating and ultimately fatal if not detected within hours to days, and

Whereas, the incidence of urea cycle disorders is 1 in 8,200 births/year and the average birth prevalence is 1 in 35,000 per year, and

Whereas, the complications of urea cycle disorders can be lethal in 11 percent of patients in the first year of life and 31 percent of patients have a developmental delay, and

Whereas, relatively inexpensive blood ammonia tests ($59) can be used to diagnose urea cycle disorders within minutes, and

Whereas, 10 states require CPS1 deficiency screenings and 8 states require OTC deficiency screenings, and

Whereas, including urea cycle disorders in the newborn screening could theoretically diagnose up to two-thirds of all patients, and

Whereas, early and ongoing treatments such as diets low in protein, arginine and citrulline supplements, dialysis, and liver transplants can lead to better growth and development; therefore be it

RESOLVED: That MSMS support newborn screenings for newborns born in the state of Michigan; and be it further

RESOLVED: That MSMS encourages the inclusion of urea cycle disorders specifically OTC and CPS1 deficiency in the newborn screening through blood nitrogen level or other similar tests.
WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000

Relevant MSMS Policy:

Michigan Newborn Screening Program: Addition of Spinal Muscular Atrophy
MSMS supports the inclusion of spinal muscular atrophy in the Michigan Newborn Screening Program.

Relevant AMA Policy:

Standardization of Newborn Screening Programs H-245.973
Our AMA: (1) recognizes the need for uniform minimum newborn screening (NBS) recommendations; (2) encourages continued research and discussions on the potential benefits and harms of NBS for certain diseases; and (3) supports screening for critical congenital heart defects for newborns following delivery prior to hospital discharge.

Sources:
RESOLUTION 05-23

Title: Inclusive Language Policy

Introduced by: Steven Daveluy, MD, FAAD, for the Wayne County Delegation

Original Authors: Carly Abrahams, Steven Daveluy, MD, FAAD, Ijeoma Nnodim Opara, MD, Sohini Pandit, and LaTonya Riddle-Jones, MD

Referred To: Reference Committee D

House Action:

Whereas, the impact of language has received increased attention nationally, including the American Medical Association’s publishing the resource, “Advancing Health Equity: a Guide to Language, Narrative, and Concepts,” which provides a framework for inclusive language, and

Whereas, utilization of inclusive language by leaders is capable of increasing team engagement across a hierarchy to achieve team goals more effectively, and

Whereas, health inequities are extensively documented in the United States, with disproportionate impacts on life expectancy, maternal and infant mortality, and various aspects of population health, and

Whereas, health service research demonstrates inequities in the health care system through health care provider bias, prejudice, and stereotyping; racial bias in clinical decision tools; and, policies that limit access to quality care, and

Whereas, inclusive language is capable of reducing stigma and bias in health care delivery and research, positively impacting professional and patient satisfaction, patient experience, clinical outcomes, and reducing healthcare disparities, and

Whereas, inclusive language fosters a sense of belonging which is critical to the wellness and wellbeing of a diverse physician workforce and central to achieving health equity in alignment with the quintuple aims of the Institute for Healthcare Improvement; therefore be it

RESOLVED: That MSMS, under the guidance of its Task Force to Advance Health Equity and Policy Manual Review Committee, develop an inclusive language policy consistent with the framework published in the American Medical Association’s “Advancing Health Equity: a Guide to Language, Narrative, and Concepts;” and be it further

RESOLVED: That MSMS notify its members and the county medical societies of the inclusive language policy once developed and include a call to action to follow the policy for all resolutions submitted to the 2024 and future House of Delegates meetings.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000
Relevant MSMS Policy:

**MSMS Position on Discrimination**

MSMS is committed to diversity and inclusion. MSMS condemns all attempts by agencies, be they government or private, to discriminate in licensure, licensure by endorsement, jobs, promotions, hospital privileges, reimbursement, residency medical staff and academic appointments, professional society memberships, financial aid and board certification, based on race, religion, sexual orientation, creed, sex, gender identity, disability, ethnic origin, national origin, or age. Additionally, MSMS supports current AMA Policies H-65.965, H-65.978; and D-160.988.

Relevant AMA Policy:

**Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment H-65.950**

Our AMA recognizes broad and evolving protected personal characteristics spanning identity, origin, and status that include those outlined by regulatory authorities overlapping with those prioritized by AMA. To prevent misunderstandings and facilitate collaboration to move medicine forward, AMA acknowledges preferred terminology for protected personal characteristics outlined in the actual sources used in the 2021 AMA Strategic Plan to Embed Racial Justice and Advance Health Equity and the AMA-AAMC Advancing Health Equity such as the CDC's Health Equity Guiding Principles for Inclusive Communication that may be used in AMA policies and position statements.

Sources:
Title: Well-Trained County Health Officers

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

Original Author: Beth Peter, MD

Referred To: Reference Committee D

Whereas, Michigan’s county health departments are an integrated part of health care delivery, expertise, and population health within the state, particularly in crisis situations like infectious disease outbreaks or toxin exposure events, and

Whereas, county health officers make decisions that affect patient care and patient health for their respective counties, and

Whereas, MSMS has a long history of advocating for quality standards to ensure medical decisions are made by properly trained individuals that meet the training criteria for their role in the health care system, and

Whereas, the state of Michigan has requirements in place to ensure County Health Officers are qualified, delineated in the Michigan Administrative Code R 325.13003, which requires that county health officers meet both educational and experience standards to ensure that they are qualified to fill their position, and

Whereas, the recently elected Ottawa County Board of Commissioners has removed their newly appointed county health officer without cause, and recommended replacing them with an individual who does not meet the state mandated qualifications for a county health officer, and

Whereas, the 2023 Ottawa County Board of Commissioners has chosen to appoint public health officials outside of the usual processes, without the usual formal national search and open interview process, and without meeting the normal qualifications for the position; therefore be it

RESOLVED: That MSMS support staffing county public health departments with highly qualified individuals through the processes outlined by the Department of Human Services with formal job searches and open interviews to hire qualified candidates for permanent positions; and be it further

RESOLVED: That MSMS advocate for the appointment of qualified individuals to county health roles in cases where normal protocols to ensure the selection of qualified candidates are not followed. This advocacy may include, but should not be limited to, letters or phone calls to the relevant county or state agencies charged with oversight.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000
**Relevant MSMS Policy:**

**Organized Medicine’s Liaison with Public Health**
MSMS encourages its component medical societies to develop liaison committees with their local public health departments and participate in local community assessment and improvement programs.

**Data Tampering in Public Health Reporting**
MSMS strongly opposes any intentional tampering, distortion, or manipulation of data used in preparation for an official report by public employees as they represent dangers to public health and unethical acts. MSMS supports the criminalization of acts of intentional distortion, manipulation, or omission of data used in preparation for an official report by public employees, in an effort to dissuade such unethical actions and the danger they pose to public health.

**Establish and Maintain Stand-Alone Michigan Department of Public Health**
MSMS supports the establishment and maintenance of a standalone Michigan Department of Public Health that is organized in a way to ensure that an effective structure is in place to prioritize, meet, and respond to the public health needs of Michigan residents.

**Require MDHHS Director to be a Physician**
MSMS supports a requirement that the director of the Michigan Department of Health and Human Services be a physician licensed in the state of Michigan.

**Relevant AMA Policy:**

**Public Health Service H-440.998**
In matters pertaining to the traditional responsibilities of the United States Public Health Service, the medical and related scientific decisions should remain within the purview and jurisdiction of those who are trained medical officers.
Whereas, the rate of unintended pregnancies in the United States of America is estimated to be as high as 45 percent, and

Whereas, unintended pregnancies increase the use of healthcare dollars, the risk of adverse patient outcomes including risks to physical and mental health, for social discord, and for socioeconomic challenges, and

Whereas, emergency contraception is utilized to decrease pregnancy risk after unprotected intercourse or contraceptive failures, and

Whereas, options for emergency contraception include oral medications and intrauterine devices, and

Whereas, levonorgestrel (Plan B) which is approved for use up to 72 hours after sexual intercourse, and ulipristal acetate (Ella) which is approved for use up to 120 hours after sexual intercourse, are oral medications for emergency contraception, and

Whereas, Plan B is already available over the counter, and

Whereas, Ella, which currently requires a prescription, is the recommended oral emergency contraceptive for people with a body mass index >25 kg/m2, is more effective in preventing unintended pregnancy, and has similar risk profile compared to levonorgestrel, and

Whereas, the copper intrauterine device (Cu-IUD) is the most effective form of emergency contraception and a Cu-IUD device is approved for use up to 10 years, and

Whereas, investigations on the role of levonorgestrel intrauterine device have found it to be non-inferior to the Cu-IUD, and

Whereas, there are no established contraindications to emergency contraceptive use beyond hypersensitivities to medication ingredients, pre-existing pregnancy, or contraindications that would otherwise be considered during routine provision of reproductive healthcare, and
Whereas, emergency contraception does not terminate an established pregnancy but rather prevents pregnancy through delaying ovulation or impairing sperm function and motility, thus ultimately inhibiting fertilization, and

Whereas, access to emergency contraception continues to be limited by insufficient patient awareness of over-the-counter options and by misconceptions that emergency contraception functions as an abortifacient, and

Whereas, ensuring evidence-based education about, access to, and use of emergency contraception are integral components to individuals exercising their reproductive rights and to advancing healthcare equity, and

Whereas, in 2022, Michigan Ballot Proposal 3 of 2022 (Right to Reproductive Freedom Initiative) amended the Michigan constitution to specifically establish individual rights to reproductive freedom and to invalidate state laws in conflict with the amendment; therefore be it

RESOLVED: That MSMS partner with other medical organizations to issue a statement encouraging physicians to provide patients with evidence-based information about emergency contraception as part of the counseling and informed consent process provided to any patient requesting emergency contraception; and be it further

RESOLVED: That MSMS support efforts to increase access to emergency contraception in various medical settings including ambulatory offices, pharmacies, emergency departments, and hospitals.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $4,500-$9,000

Relevant MSMS Policy:

Oral Contraceptives Available Over-the-Counter
MSMS supports the American College of Obstetricians and Gynecologists’ committee opinion which supports making oral contraceptives available as over the counter medication.

Over the Counter Contraception (The Morning After Pill)
MSMS supports the concept of making the “morning after” contraceptive pill an over the counter medication.

Relevant AMA Policy:

Access to Emergency Contraception H-75.985
It is the policy of our AMA: (1) that physicians and other health care professionals should be encouraged to play a more active role in providing education about emergency contraception, including access and informed consent issues, by discussing it as part of routine family planning and contraceptive counseling; (2) to enhance efforts to expand access to emergency contraception, including making emergency contraception pills more readily available through pharmacies, hospitals, clinics, emergency rooms, acute care centers, and physicians’ offices; (3) to recognize that information about emergency contraception is part of the comprehensive information to be provided as part of the emergency treatment of sexual assault victims; (4) to support educational programs for physicians and patients regarding treatment options for the emergency treatment of sexual assault victims, including information about emergency contraception; and (5) to encourage writing advance prescriptions for these pills as requested by their patients until the pills are available over-the-counter.
Access to Emergency Contraception D-75.997
1. Our AMA will: (a) intensify efforts to improve awareness and understanding about the availability of emergency contraception in the general public; and (b) support and monitor the application process of manufacturers filing for over-the-counter approval of emergency contraception pills with the Food and Drug Administration (FDA). 2. Our AMA: (a) will work in collaboration with other stakeholders (such as American College of Obstetricians and Gynecologists, American Academy of Pediatrics, and American College of Preventive Medicine) to communicate with the National Association of Chain Drug Stores and the National Community Pharmacists Association, and request that pharmacies utilize their website or other means to signify whether they stock and dispense emergency contraception, and if not, where it can be obtained in their region, either with or without a prescription; and (b) urges that established emergency contraception regimens be approved for over-the-counter access to women of reproductive age, as recommended by the relevant medical specialty societies and the US Food and Drug Administration's own expert panel.

Preserving Patients’ Ability to Have Legally Valid Prescriptions Filled H-120.947
1. Our AMA reaffirms our policies supporting responsibility to the patient as paramount in all situations and the principle of access to medical care for all people; and supports legislation that requires individual pharmacists or pharmacy chains to fill legally valid prescriptions or to provide immediate referral to an appropriate alternative dispensing pharmacy without interference. In the event that an individual pharmacist or pharmacy chain refers a patient to an alternative dispensing source, the individual pharmacist or the pharmacy chain should return the prescription to the patient and notify the prescribing physician of the referral. 2. Our AMA supports the concept of advance prescription for emergency contraception for all women in order to ensure availability of emergency contraception in a timely manner.

Sexual Assault Survivors H-80.999
1. Our AMA supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing physicians involved in providing care to sexual assault survivors. 2. Our AMA advocates for the legal protection of sexual assault survivors’ rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (a) receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing, treatment of injuries, and collection of forensic evidence; (b) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (c) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (d) be informed of these rights and the policies governing the sexual assault evidence kit; and (e) access to emergency contraception information and treatment for pregnancy prevention. 3. Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016. 4. Our AMA will advocate for increased post-pubertal patient access to Sexual Assault Nurse Examiners, and other trained and qualified clinicians, in the emergency department for medical forensic examinations. 5. Our AMA will advocate at the state and federal level for (a) the timely processing of all sexual examination kits upon patient consent; (b) timely processing of “backlogged” sexual assault examination kits with patient consent; and (c) additional funding to facilitate the timely testing of sexual assault evidence kits.

Sources:
Title: Avoid Use of ICD COVID Vaccination Status Codes and Prevent Discrimination Based on Vaccine Status

Introduced by: Sherwin Imlay, MD, for the Oakland County Delegation

Original Author: Joann Smith, MD

Referred To: Reference Committee D

House Action:

Whereas, ICD code system is developed by the World Health Organization (WHO) and widely used for billing and governmental statistics analysis by the Centers for Disease Control and Prevention (CDC) and the National Center for Health Statistics (NCHS), and

Whereas, brilliant and well-meaning physicians differ in professional opinion regarding safety and efficacy of the new COVID 19 immunizations and possible harms and sequelae, and

Whereas, the American public has an expectation of medical privacy, and

Whereas, being nonvaccinated is a natural human state and acceptance of vaccination is a personal choice., and

Whereas, new ICD 10 codes for under immunization for COVID 19 were proposed at a meeting September 14-15, 2021, because “there is interest in being able to track people who are not immunized or partially immunized” and a new category of Z28 - immunization not carried out and under immunization status; Z28.3 - under immunization status; Z28.31 - under immunization for COVID 19 status; Z28.310 - unvaccinated for COVID 19; Z28.311 - partially vaccinated for COVID 19; Z28.39 - other unvaccinated status. These codes were put into use in January 2023, and

Whereas, discrimination on the basis of vaccination status has already occurred in the provision of medical care, in forcible vaccination in order to continue employment, to continue military service, to cross borders, to use airlines for travel or to attend educational institutions, and

Whereas, governmental tracking of unvaccinated or sub vaccinated status may lead to further coercion or discrimination in the future; therefore be it

RESOLVED: That MSMS advise physicians, and those coding and billing for physician services, not to use the new Z28 set of ICD codes, due to their potential for abuse and violation of privacy and advise physicians not to discriminate in the provision of medical care, or allow others to do so, based on COVID 19 immunization status.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $2,000-$4,000

Relevant MSMS Policy: None

Relevant AMA Policy: None
Sources:
1. ICD Coordination and Maintenance Committee Courtesy Joseph Mercola, Epoch Times, February 14, 2023: https://twitter.com/mercola/status/1625520073698947073/photo/1
Whereas, an estimated 1.6 million people living in the United States identify as transgender,
and
Whereas, gender dysphoria, or gender incongruence, refers to psychological distress that
results from an incongruence between one's sex assigned at birth and one's gender identity, and
Whereas, for transgender individuals, standards of care recognize medically necessary
services that affirm gender or treat gender dysphoria may include mental health counseling, non-
medical social transition, gender-affirming hormone therapy, and/or gender-affirming surgeries, and
Whereas, according to the World Health Organization (WHO), gender-affirming care
includes the range of social, psychological, behavioral, and medical interventions to "support and
affirm" one's gender identity when it is not in parallel with the gender given at birth, and
Whereas, major medical associations, in the United States, including the American Medical
Association (AMA), American Academy of Pediatrics (AAP), American Academy of Family Physicians
(AAFP), American Psychological Association (APA), Endocrine Society, and the American College of
Obstetricians and Gynecologists (ACOG), recognize the medical necessity of gender transition-
related care for improving the physical and mental health of transgender people, and
Whereas, such interventions assist transgender individuals in aligning the emotional,
interpersonal and biological portions of their lives with their gender identity to help function in
society, and
Whereas, the AMA specifically supports public and private health insurance coverage for
treatment of gender dysphoria, and
Whereas, evidence reveals that transgender patients experience exclusionary behaviors,
misgendering, and intimidation from health care providers as well as other patients, and
Whereas, transgender individuals in Michigan often face social and economic
marginalization, and experience a variety of barriers to healthcare, including overt discrimination,
inadequate health insurance coverage, and poor physician knowledge of appropriate treatment,
Whereas, the increased prevalence of mental health conditions among transgender individuals is widely thought to be a consequence of minority stress, the chronic stress from coping with societal stigma, and discrimination because of one’s gender identity and expression, and

Whereas, harm, including risk of depression and worsened dysphoria with potential for serious life-threatening mental health implications, is risked when medically necessary and appropriate gender-affirming care is withheld, and

Whereas, transgender children, like all children, have the best chance to thrive when they are supported and can obtain the health care they need; studies suggest that improved body satisfaction and self-esteem following the receipt of gender-affirming care is protective against poorer mental health and supports healthy relationships with parents and peers, dramatic reductions in suicide attempts, as well as decreased rates of depression and anxiety, and

Whereas, medically supervised care can reduce rates of potentially harmful self-sourced hormones, use of construction-grade silicone injections, and other interventions that have the potential to cause adverse events, and

Whereas, gender-affirming care is associated with improved well-being, mental health and self-image; therefore be it

RESOLVED: That MSMS affirms that an individual’s genotypic sex, phenotypic sex, sexual orientation, gender, and gender identity are not always aligned or indicative of the other, and that gender for many individuals may differ from the sex assigned at birth; and be it further

RESOLVED: That MSMS support access to gender-affirming care including the spectrum of behavioral, psychological, medical, and surgical interventions for the treatment of gender dysphoria or gender incongruence and shall support public and private health insurance coverage for treatment of gender dysphoria or gender incongruence; and be it further

RESOLVED: That MSMS opposes criminalization and legislative interference in the provision of gender-affirming care as outlined by generally-accepted standards of medical and surgical practice; and be it further

RESOLVED: That MSMS supports education on gender diversity and gender-affirming care at all levels of medical education, including medical school, residency, and continuing professional development; and be it further

RESOLVED: That MSMS partner with other medical organizations to issue a statement encouraging physician education regarding gender-affirming care and affirming that physicians should assist in transferring and referring transgender patients to the appropriate health care when they are unable to provide the gender-affirming services the patient needs.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $4,500-$9,000

Relevant MSMS Policy:

Ban Conversion Therapy
MSMS supports legislative efforts to ban "reparative" or "conversion" therapy for sexual orientation or gender identity.

**Oppose Criminalization of Physicians and Patients for Evidence Based Standard of Medical Care (41-20)**

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

**Relevant AMA Policy:**

**Access to Basic Human Services for Transgender Individuals H-65.964**

Our AMA: (1) opposes policies preventing transgender individuals from accessing basic human services and public facilities in line with one’s gender identity, including, but not limited to, the use of restrooms; and (2) will advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender individuals according to one’s gender identity.

**Medical Spectrum of Gender D-295.312**

Given the medical spectrum of gender identity and sex, our AMA: (1) will work with appropriate medical organizations and community based organizations to inform and educate the medical community and the public on the medical spectrum of gender identity; (2) will educate state and federal policymakers and legislators on and advocate for policies addressing the medical spectrum of gender identity to ensure access to quality health care; and (3) affirms that an individual’s genotypic sex, phenotypic sex, sexual orientation, gender and gender identity are not always aligned or indicative of the other, and that gender for many individuals may differ from the sex assigned at birth.

**Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation H-315.967**

Our AMA: (1) supports the voluntary inclusion of a patient’s biological sex, current gender identity, sexual orientation, preferred gender pronoun(s), preferred name, and clinically relevant, sex specific anatomy in medical documentation, and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner; (2) will advocate for collection of patient data in medical documentation and in medical research studies, according to current best practices, that is inclusive of sexual orientation, gender identity, and other sexual and gender minority traits for the purposes of research into patient and population health; (3) will research the problems related to the handling of sex and gender within health information technology (HIT) products and how to best work with vendors so their HIT products treat patients equally and appropriately, regardless of sexual or gender identity; (4) will investigate the use of personal health records to reduce physician burden in maintaining accurate patient information instead of having to query each patient regarding sexual orientation and gender identity at each encounter; and (5) will advocate for the incorporation of recommended best practices into electronic health records and other HIT products at no additional cost to physicians.

**Healthcare Equity Through Informed Consent and a Collaborative Healthcare Model for the Gender Diverse Population H-140.824**

Our AMA supports: (1) shared decision making between gender diverse individuals, their health care team, and, where applicable, their families and caregivers; and (2) treatment models for gender diverse people that promotes informed consent, personal autonomy, increased access for gender affirming treatments and eliminates unnecessary third party involvement outside of the physician-patient relationship in the decision making process.

**Patient-Reported Outcomes in Gender Confirmation Surgery H-460.893**

Our AMA supports: (1) initiatives and research developed by specialty societies and other relevant stakeholders to establish standardized protocols for patient selection, surgical management, and preoperative and postoperative care for transgender patients undergoing gender confirmation surgeries; and (2) implementation of standardized tools, such as questionnaires, developed by specialty societies and other relevant stakeholders to evaluate outcomes of gender confirmation surgeries.
Affirming the Medical Spectrum of Gender H-65.962
Our AMA opposes any efforts to deny an individual’s right to determine their stated sex marker or gender identity.

Access to Basic Human Services for Transgender Individuals H-65.964
Our AMA: (1) opposes policies preventing transgender individuals from accessing basic human services and public facilities in line with one’s gender identity, including, but not limited to, the use of restrooms; and (2) will advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender individuals according to one’s gender identity.

Encouraging Research Into the Impact of Long-Term Administration of Hormone Replacement Therapy in Transgender Patients H-460.907
Our AMA encourages research into the impact of long-term administration of hormone replacement therapy in transgender patients.

Reducing Suicide Risk Among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Through Collaboration with Allied Organizations H-60.927
Our AMA will partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth suicide and improve health among LGBTQ youth.

Removing Financial Barriers to Care for Transgender Patients H-185.950
Our AMA supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician.

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991
1. Our AMA: (a) believes that the physician’s nonjudgmental recognition of patients’ sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity. 2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors. 3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues. 4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-
Support of Human Rights and Freedom H-65.965

Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual’s sex, sexual orientation, gender, gender identity or transgender status, race, religion, disability, ethnic origin, national origin or age; (3) opposes any discrimination based on an individual’s sex, sexual orientation, gender identity, race, appearance, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the health and social welfare of the citizens of the United States, urges expedient passage for appropriate hate crimes prevention legislation in accordance with our AMA’s policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.

Sources:


Title: Personal Choices, Sexuality, and Reproductive Health Education

Introduced by: Federico Mariona, MD, for the Wayne County Delegation

Original Author: Federico Mariona, MD

Referred To: Reference Committee D

WHEREAS, the phrase “my body, my choice” has been used by persons advocating for women’s right to access the interruption of pregnancy as an essential part of health care, and

WHEREAS, the strongest vehicle for enabling choice is a solid education on all matters related to the selected choice, including the understanding that these choices have consequences with potential harms to self or others and that may have a negative undesirable outcome, and

WHEREAS, requiring the induced interruption of a pregnancy may frequently indicate that the pregnancy is untimely, unplanned or the result of a criminal act, and

WHEREAS, untimely conception or a sexually transmitted infection may be the result of the choice to practice unprotected sexual intercourse, and

WHEREAS, faced with an unplanned pregnancy the gestating person has three distinct choices: parenting, adoption, or induced abortion, each with known short- and long-term consequences, and

WHEREAS, preventing all affected persons from exercising choice may represent an undue coercion, and

WHEREAS, in contemporary medical practice there is a plethora of available and accessible technologies that effectively prevent or avoid the occurrence of a sexually transmitted infection or an unplanned pregnancy when appropriately and consistently utilized; therefore be it

RESOLVED: That MSMS seek collaboration with the Michigan Department of Health and Human Services, the Michigan Department of Education, all major medical professional societies, reproductive rights advocacy groups, and parental organizations to implement and maintain a statewide age-appropriate, culturally respectful comprehensive sexuality and reproductive health education and reproductive rights program to be completed by age 12, prior to the initiation of sexual activity (sexual debut) for all persons; and be it further

RESOLVED: That MSMS Delegation to the American Medical Association (AMA) ask the AMA to expand a statewide age-appropriate, culturally respectful comprehensive sexuality and reproductive health education and reproductive rights curriculum nationwide.
Relevant MSMS Policy:

Continuous Waiver for School Sex Education Opt-Out
MSMS supports requiring parents or guardians who choose to have their children opt out of school sex education to submit an opt-out notice each year that their child is to be excused from school sex education instead of allowing an automatic continuous waiver renewal.

Define ‘Medically Accurate’ in Sex Education Program Requirements
MSMS supports “medically accurate” information in sex education programs to be defined as information that satisfies all of the following:
1. Relevant to informed decision-making based on the weight of scientific evidence.
2. Consistent with generally recognized scientific theory, conducted under accepted scientific methods.
3. Published in peer-reviewed journals with findings replicated by subsequent studies.
4. Recognized as accurate and objective information by mainstream professional organizations such as AMA, American College of Obstetricians and Gynecologists, American Public Health Association, and American Academy of Pediatrics; government agencies such as Center for Disease Control, Food and Drug Administration, and National Institutes of Health; and, scientific advisory groups such as the Institute of Medicine and the Advisory Committee on Immunization Practices.

Public Funding of Sex Education Programs
MSMS supports public funding of state and federal level comprehensive sex and reproductive education programs that meet the components of comprehensive sexuality education as outlined by the American College of Obstetricians and Gynecologists, recognizing that these programs are the most effective in creating positive health outcomes for students and should be made available to all students in the state of Michigan in an age appropriate manner.

Statement on Sex Education
Public schools should be required to teach medically accurate, age appropriate, comprehensive sex education at all school levels with the option for parental opt out. Sex education programs should 1) be part of an overall health education program; 2) be presented in a manner commensurate with the maturation level of the students; 3) include age-appropriate training on how to give and withhold consent (based on the definition of consent as the unambiguous and voluntary agreement between all participants in each physical act within the course of interpersonal relationships, including respect for personal boundaries); 4) have professionally developed curricula; 5) include ample opportunities to involve parents and other concerned members of the community; and 6) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training.

Relevant AMA Policy:

Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools H-170.968
(1) Supports the concept of sexuality education in the home, when possible, as well as developmentally appropriate sexuality education programming in the schools at all levels, at local option and direction; (2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms and other effective barrier protection methods available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and
sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of LGBTQ+ youth; (f) appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities; (g) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; (h) are part of an overall health education program; and (i) include culturally competent materials that are language-appropriate for Limited English Proficiency (LEP) pupils;

(3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate;

(4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program;

(5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems;

(6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes;

(7) Supports federal funding of comprehensive sex education programs that stress the importance of preventing unwanted teenage pregnancy and sexually transmitted infections via comprehensive education, including contraceptive choices, abstinence, and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and

(8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy;

(9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, and conversations about consent; and

(10) Encourages physicians and all interested parties to develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate.

**Health Information and Education H-170.986**

(1) Individuals should seek out and act upon information that promotes appropriate use of the health care system and that promotes a healthy lifestyle for themselves, their families and others for whom they are responsible. Individuals should seek informed opinions from health care professionals regarding health information delivered by the mass media self-help and mutual aid groups are important components of health promotion/disease and injury prevention, and their development and maintenance should be promoted.

(2) Employers should provide and employees should participate in programs on health awareness, safety and the use of health care benefit packages.

(3) Employers should provide a safe workplace and should contribute to a safe community environment. Further, they should promptly inform employees and the community when they know that hazardous substances are being used or produced at the worksite.

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

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

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

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

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

(9) Educational programs for health professionals at all levels should incorporate an appropriate emphasis on health promotion/disease and injury prevention and patient education in their curricula.
Third party payers should provide options in benefit plans that enable employers and individuals to select plans that encourage healthy lifestyles and are most appropriate for their particular needs. They should also continue to develop and disseminate information on the appropriate utilization of health care services for the plans they market.

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

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

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

Sources:
Title: Climate Change Designation, Goals, and Implementation of Measures

Introduced by: Terrence Joiner, MD, for the Washtenaw County Delegation

Original Author: Terrence Joiner, MD

Referred To: Reference Committee D

Whereas, the health care industry is among the most carbon-intensive service sectors in the industrialized world, and

Whereas, substantial increases in morbidity and mortality are expected in association with a range of health outcomes including heat-related illness, illness caused by poor air quality, undernutrition from reducing food quality and security, and related vector-borne diseases, and

Whereas, vulnerable populations (e.g., inner city, low income, homeless, etc.) and regions (e.g., inner city and rural), especially in Michigan, will be differentially affected with expected increases in poverty and inequities as a consequence of climate change, and

Whereas, the combustion of fossil fuels is the major source of both air pollution and the greenhouse gas emissions during climate change, and

Whereas, fetuses, infants, and children are especially vulnerable to air pollution and climate change; therefore be it

RESOLVED: That MSMS support efforts to educate physicians and other health care workers that climate change is creating a health care emergency and that these climate change effects are disproportionately causing health consequences among these vulnerable populations; and be it further

RESOLVED: That MSMS support and advocate to educate our communities, medical and non-medical, about the impact of climate change on health outcomes for the residents of Michigan; and be it further

RESOLVED: That MSMS, in conjunction with the Michigan Department of Health and Human Services, advocate for education of the public as to ways to mitigate the impact the effects of climate change and reduce the use of fossil fuels; and be it further

RESOLVED: That MSMS will support the membership in efforts to address climate change by advocating for members to use available resources for climate change education and mitigation through its support and membership in groups such as the Medical Society for Climate Change and Health, My Green Doctor, and Practice Green Health.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $2,000-$4,000
Relevant MSMS Policy:

Air and Water Pollution
Reasonable and scientific study should be directed toward the sensible control of the major problems of air and water pollution, whether it is the dusts and wastes of industry, the products of combustion of gasoline or oil (automobiles), the combustion products of home heating and burning equipment, or of smoking tobacco.

Air Pollution and EPA Clean Power Plan Policies
MSMS supports:
- The Environmental Protection Agency’s authority to promulgate rules to regulate and control greenhouse gas emissions in the United States;
- Increased physician participation in regional and state decision-making regarding air pollution across the United States;
- State legislation and regulations that meaningfully reduce power plant emissions of carbon dioxide and nitrogen oxide;
- Efforts to limit carbon dioxide emissions through the reduction of the burning of coal in the state’s power generating plants, efforts to improve the efficiency of power plants, and continued development of alternative renewable energy sources; and,
- National enactment of the U.S. Environmental Protection Agency’s Clean Power Plan and the implementation of the Plan’s policies in Michigan.

Climate Change
MSMS supports the American Medical Association policy, Global Climate Change and Human Health (H-135.938).

Endorse Environmental Protection Agency (EPA) Air Quality Standards
MSMS supports the current Environmental Protection Agency (EPA) air quality standards for ozone, nitrogen oxides, and particulates.

Medical Society Consortium on Climate and Health
MSMS endorses the Consensus Statement of the Medical Society Consortium on Climate and Health. (See Addendum R in website version)

Policy Statement of Environmental Pollution
MSMS supports:
1. Efforts to improve environmental health.
2. All agencies charged with the control of environmental pollution.
3. Increasing the Michigan landfill tipping fee to discourage the use of Michigan landfills by neighboring states and countries in order to preserve the quality of Michigan’s environment for years to come.

Support of the Clean Air Act
MSMS supports the Clean Air Act.

Relevant AMA Policy:

Global Climate Change and Human Health H-135.938
Our AMA: 1. Supports scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes have adversely affected the physical and mental health of people. We recognize that minoritized and marginalized populations, children, pregnant people, the elderly, rural communities, and those who are economically disadvantaged will suffer disproportionate harm from climate change.
2. Supports educating the medical community on the adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.
3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.

4. Encourages physicians to assist in educating patients and the public on the physical and mental health effects of climate change and on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.

5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that adaptation interventions are equitable and prioritize the needs of the populations most at risk.


7. Encourages physicians to assess for environmental determinants of health in patient history-taking and encourages the incorporation of assessment for environmental determinants of health in patient history-taking into physician training.

**Climate Change Education Across the Medical Education Continuum H-135.919**

Our AMA: (1) supports teaching on climate change in undergraduate, graduate, and continuing medical education such that trainees and practicing physicians acquire a basic knowledge of the science of climate change, can describe the risks that climate change poses to human health, and counsel patients on how to protect themselves from the health risks posed by climate change; (2) will make available a prototype presentation and lecture notes on the intersection of climate change and health for use in undergraduate, graduate, and continuing medical education; and (3) will communicate this policy to the appropriate accrediting organizations such as the Commission on Osteopathic College Accreditation and the Liaison Committee on Medical Education.

**Declaring Climate Change a Public Health Crisis D-135.966**

1. Our AMA declares climate change a public health crisis that threatens the health and well-being of all individuals.

2. Our AMA will protect patients by advocating for policies that: (a) limit global warming to no more than 1.5 degrees Celsius, (b) reduce US greenhouse gas emissions aimed at carbon neutrality by 2050, and (c) support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens.

3. Our AMA will develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting.

**Climate Change and Human Health D-135.963**

1. Our AMA declares climate change a public health crisis that threatens the health and well-being of all individuals. 2. Our AMA will protect patients by advocating for policies that: (a) limit global warming to no more than 1.5 degrees Celsius, (b) reduce US greenhouse gas emissions aimed at a 50 percent reduction in emissions by 2030 and carbon neutrality by 2050, and (c) support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens. 3. Our AMA will consider signing on to the Department of Health and Human Services Health Care Pledge or making a similar commitment to lower its own greenhouse gas emissions. 4. Our AMA encourages the health sector to lead by example in committing to carbon neutrality by 2050. 5. Our AMA will develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting.

**AMA Advocacy for Environmental Sustainability and Climate H-135.923**

Our AMA (1) supports initiatives to promote environmental sustainability and other efforts to halt global climate change; (2) will incorporate principles of environmental sustainability within its business operations; and (3) supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities.
Stewardship of the Environment H-135.973
The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation; (12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues; (15) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded funding for environmental research by the federal government; and (17) encourages family planning through national and international support.

Sources:
RESOLUTION 45-23

Title: Decarbonization of Health Care Facilities

Introduced by: Jerry Walden, MD, for the Washtenaw County Delegation

Original Author: Jerry Walden, MD

Referred To: Reference Committee D

House Action:

Whereas, the climate crisis may be the greatest challenge facing humans, with important present and future health consequences for adults and children, caused in large part by the mining and drilling of fossil fuels and their subsequent combustion, releasing climate warming greenhouse gases, and

Whereas, particulate air pollution caused by the burning of fossil fuels and heavy industry are the cause of common and important health consequences including large numbers of deaths and significant incidence of disability in adults and children, and

Whereas, health care is responsible for approximately 8.5 percent of U.S. greenhouse gas emissions, and

Whereas, approaches exist to reduce and eliminate greenhouse gas emissions by the health care sector, and

Whereas, some anesthetic gases have substantial greenhouse effect, which can be reduced by eliminating some anesthetic gases and reducing the use of others; therefore be it

RESOLVED: That MSMS support the reduction of the greenhouse gas profile of health care facilities and the involvement of physicians in this effort including the following:

A. Reduction in the release of CO2 and methane related to building electricity, building heating and cooling, water heating, vehicle use, components of buildings, and other sources.

B. Reduction in release of anesthetic gases which have greenhouse effect, including desflurane which should be eliminated, nitrous oxide which should be reduced to the extent possible, and others.

C. Reduction in greenhouse gas release related to products used in health care, employee and patient travel, and other sources.

D. Electrification of appliances to enable future powering by electricity from sustainable sources, replacing use of fossil fuels.

E. Reactivation by the U.S. Department of Health and Human Services (HHS) or other government agencies of the opportunity for health care systems to sign the HHS pledge form.

F. Signing of the HHS pledge form by health care systems in Michigan.

G. Development and participation in climate resilience plans by health care systems.
Relevant MSMS Policy:

**Air Pollution and EPA Clean Power Plan Policies**
MSMS supports:
- The Environmental Protection Agency’s authority to promulgate rules to regulate and control greenhouse gas emissions in the United States;
- Increased physician participation in regional and state decision-making regarding air pollution across the United States;
- State legislation and regulations that meaningfully reduce power plant emissions of carbon dioxide and nitrogen oxide;
- Efforts to limit carbon dioxide emissions through the reduction of the burning of coal in the state’s power generating plants, efforts to improve the efficiency of power plants, and continued development of alternative renewable energy sources; and,
- National enactment of the U.S. Environmental Protection Agency’s Clean Power Plan and the implementation of the Plan’s policies in Michigan.

**Climate Change**
MSMS supports the American Medical Association policy, Global Climate Change and Human Health (H-135.938).

**Endorse Environmental Protection Agency (EPA) Air Quality Standards**
MSMS supports the current Environmental Protection Agency (EPA) air quality standards for ozone, nitrogen oxides, and particulates.

**Medical Society Consortium on Climate and Health**
MSMS endorses the Consensus Statement of the Medical Society Consortium on Climate and Health. (See Addendum R in website version)

**Policy Statement of Environmental Pollution**
MSMS supports:
1. Efforts to improve environmental health.
2. All agencies charged with the control of environmental pollution.
3. Increasing the Michigan landfill tipping fee to discourage the use of Michigan landfills by neighboring states and countries in order to preserve the quality of Michigan’s environment for years to come.

**Support of the Clean Air Act**
MSMS supports the Clean Air Act.

**Relevant AMA Policy:**

**Declaring Climate Change a Public Health Crisis D-135.966**
1. Our AMA declares climate change a public health crisis that threatens the health and well-being of all individuals.
2. Our AMA will protect patients by advocating for policies that: (a) limit global warming to no more than 1.5 degrees Celsius, (b) reduce US greenhouse gas emissions aimed at carbon neutrality by 2050, and (c) support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens.
3. Our AMA will develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting.
Climate Change and Human Health D-135.963
1. Our AMA declares climate change a public health crisis that threatens the health and well-being of all individuals. 2. Our AMA will protect patients by advocating for policies that: (a) limit global warming to no more than 1.5 degrees Celsius, (b) reduce US greenhouse gas emissions aimed at a 50 percent reduction in emissions by 2030 and carbon neutrality by 2050, and (c) support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens. 3. Our AMA will consider signing on to the Department of Health and Human Services Health Care Pledge or making a similar commitment to lower its own greenhouse gas emissions. 4. Our AMA encourages the health sector to lead by example in committing to carbon neutrality by 2050. 5. Our AMA will develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting.

AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies H-135.921
1. Our AMA will: (a) choose for its commercial relationships, when fiscally responsible, vendors, suppliers, and corporations that have demonstrated environmental sustainability practices that seek to minimize their fossil fuels consumption; and (b) support efforts of physicians and other health professional associations to proceed with divestment, including to create policy analyses, support continuing medical education, and to inform our patients, the public, legislators, and government policy makers. 2. Our AMA: (a) declares that climate change is an urgent public health emergency, and calls upon all governments, organizations, and individuals to work to avert catastrophe; (b) urges all health and life insurance companies, including those that provide insurance for medical, dental, and long-term care, to work in a timely, incremental, and fiscally responsible manner to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels; and (c) will send letters to the nineteen largest health or life insurance companies in the United States to inform them of AMA policies concerned with climate change and with fossil fuel divestments, and urging these companies to divest.

AMA Advocacy for Environmental Sustainability and Climate H-135.923
Our AMA (1) supports initiatives to promote environmental sustainability and other efforts to halt global climate change; (2) will incorporate principles of environmental sustainability within its business operations; and (3) supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities.

Sources:
RESOLUTION 46-23

Title: Climate Change Education

Introduced by: Rebecca Daniel, MD, for the Washtenaw County Delegation

Original Author: Rebecca Daniel, MD

Referred To: Reference Committee D

House Action:

Whereas, the climate crisis may be the greatest challenge facing humans, with important present and future health consequences for adults and children, and

Whereas, particulate air pollution and greenhouse gases caused by the burning of fossil fuels and heavy industry are the causes of common and important health consequences including large numbers of deaths and significant incidence of disability in adults and children, and

Whereas, physicians and other health care workers, by virtue of their scientific training as a basis for understanding climate change, medical training as a basis for understanding health consequences, respect in the community, and tradition of caring about the health and welfare of their communities, have good qualifications to be a positive force in educating each other and our patients about these dangers of climate change and air pollution, and

Whereas, physicians and other health care workers benefit from education on these matters, enabling them to be a more effective force in dealing with climate change and air pollution; therefore be it

RESOLVED: That MSMS support efforts to educate physicians and other health care workers about climate change including its health consequences; air pollution and its health consequences; approaches to mitigating climate changes, air pollution, and their health consequences; and approaches to resilience from the effects of climate change and air pollution. Such support may include, but is not limited to:

1. Live or virtual presentations at the MSMS Annual Scientific Meeting, at the MSMS House of Delegates Meeting, and within health care settings and other venues as appropriate.
2. Periodic new items and suggestions to members via Michigan Medicine, Medigram, and other channels of communication.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $2,000-$4,000

Relevant MSMS Policy:

Climate Change
MSMS supports the American Medical Association policy, Global Climate Change and Human Health (H-135.938).
Medical Society Consortium on Climate and Health
MSMS endorses the Consensus Statement of the Medical Society Consortium on Climate and Health. (See Addendum R in website version)

Relevant AMA Policy:

Climate Change Education Across the Medical Education Continuum H-135.919
Our AMA: (1) supports teaching on climate change in undergraduate, graduate, and continuing medical education such that trainees and practicing physicians acquire a basic knowledge of the science of climate change, can describe the risks that climate change poses to human health, and counsel patients on how to protect themselves from the health risks posed by climate change; (2) will make available a prototype presentation and lecture notes on the intersection of climate change and health for use in undergraduate, graduate, and continuing medical education; and (3) will communicate this policy to the appropriate accrediting organizations such as the Commission on Osteopathic College Accreditation and the Liaison Committee on Medical Education.
Title: Support for Climate Plans for the State of Michigan, Counties, Townships and Municipalities, School Districts and Other Governmental Entities in Michigan

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

Original Author: James Mitchiner, MD, MPH

Referred To: Reference Committee D

House Action:

RESOLVED: That MSMS supports Michigan’s Healthy Climate Plan, including measures to fund and implement this plan; and be it further

RESOLVED: That MSMS supports development and implementation of climate plans for counties, townships, cities and other municipalities, school districts, and other governmental entities in Michigan; and be it further

RESOLVED: That MSMS urges physician involvement in developing, building support for, funding, and implementing climate plans for counties, townships, cities and other municipalities, school districts, and other governmental entities in Michigan.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000
Relevant MSMS Policy:

Climate Change
MSMS supports the American Medical Association policy, Global Climate Change and Human Health (H-135.938).

Medical Society Consortium on Climate and Health
MSMS endorses the Consensus Statement of the Medical Society Consortium on Climate and Health. (See Addendum R in website version)

Relevant AMA Policy:

Stewardship of the Environment H-135.973
The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation; (12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues; (15) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded funding for environmental research by the federal government; and (17) encourages family planning through national and international support.

Global Climate Change and Human Health H-135.938
Our AMA: 1. Supports scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes have adversely affected the physical and mental health of people. We recognize that minoritized and marginalized populations, children, pregnant people, the elderly, rural communities, and those who are economically disadvantaged will suffer disproportionate harm from climate change.
2. Supports educating the medical community on the adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.
3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.
4. Encourages physicians to assist in educating patients and the public on the physical and mental health effects of climate change and on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.
5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that adaptation interventions are equitable and prioritize the needs of the populations most at risk.


7. Encourages physicians to assess for environmental determinants of health in patient history-taking and encourages the incorporation of assessment for environmental determinants of health in patient history-taking into physician training.

**Climate Change Education Across the Medical Education Continuum H-135.919**

Our AMA: (1) supports teaching on climate change in undergraduate, graduate, and continuing medical education such that trainees and practicing physicians acquire a basic knowledge of the science of climate change, can describe the risks that climate change poses to human health, and counsel patients on how to protect themselves from the health risks posed by climate change; (2) will make available a prototype presentation and lecture notes on the intersection of climate change and health for use in undergraduate, graduate, and continuing medical education; and (3) will communicate this policy to the appropriate accrediting organizations such as the Commission on Osteopathic College Accreditation and the Liaison Committee on Medical Education.

**Declaring Climate Change a Public Health Crisis D-135.966**

1. Our AMA declares climate change a public health crisis that threatens the health and well-being of all individuals.

2. Our AMA will protect patients by advocating for policies that: (a) limit global warming to no more than 1.5 degrees Celsius, (b) reduce US greenhouse gas emissions aimed at carbon neutrality by 2050, and (c) support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens.

3. Our AMA will develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting.

**Climate Change and Human Health D-135.963**

1. Our AMA declares climate change a public health crisis that threatens the health and well-being of all individuals.

2. Our AMA will protect patients by advocating for policies that: (a) limit global warming to no more than 1.5 degrees Celsius, (b) reduce US greenhouse gas emissions aimed at a 50 percent reduction in emissions by 2030 and carbon neutrality by 2050, and (c) support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens.

3. Our AMA will consider signing on to the Department of Health and Human Services Health Care Pledge or making a similar commitment to lower its own greenhouse gas emissions.

4. Our AMA encourages the health sector to lead by example in committing to carbon neutrality by 2050.

5. Our AMA will develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting.

**AMA Advocacy for Environmental Sustainability and Climate H-135.923**

Our AMA (1) supports initiatives to promote environmental sustainability and other efforts to halt global climate change; (2) will incorporate principles of environmental sustainability within its business operations; and (3) supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities.

**Source:**

ACTION REPORT #01-23 OF THE BOARD OF DIRECTORS

SUBJECT: Resolution 33-22
Repeal of Michigan’s Abortion Law

REFERRED TO: Reference Committee D

HOUSE ACTION:

RECOMMENDATION: That the 2023 House of Delegates approve Resolution 33-22, “Repeal of Michigan’s Abortion Law,” as amended to read:

RESOLVED: That MSMS believes: 1) the physician-patient relationship is deeply personal and must be respected and protected at all costs; 2) physicians and their patients should be free to consider, discuss, and pursue medical procedures guided by a physician’s best medical judgment and a patient’s physical health and safety; and 3) as a Society, MSMS has always been and continues to be opposed to the potential criminalization of physicians and their patients in making health care decisions; and be it further

RESOLVED: That MSMS advocate to repeal Michigan Compiled Laws 750.14 and 750.15, due to the criminalization of physicians.

As originally introduced, Resolution 33-22 asked that “MSMS advocate to repeal Act 328 of 1931, regardless of the outcome of the current case before the Supreme Court.” Although the Reference Committee recommended to approve Resolution 33-22, it was extracted and ultimately referred to the MSMS Board of Directors for study and decision in 2022.

The Board addressed the resolution at its meeting in July of 2022. Background on the law was provided as follows:

Per MSMS Legal Counsel, Public Act 328 of 1931 created Michigan’s Penal Code. It consolidated all the various criminal statutes in Michigan in one place. It is about 300 pages long and has to do with a great many things in addition to abortion. Below are Sections 14 and 15 which criminalize abortion (with an exception applicable when necessary to save the life of the mother).

(continued)
750.14 Miscarriage; administering with intent to procure; felony, penalty.  
Sec. 14. Administering drugs, etc., with intent to procure miscarriage—Any person who shall willfully administer to any pregnant woman any medicine, drug, substance or thing whatever, or shall employ any instrument or other means whatever, with intent thereby to procure the miscarriage of any such woman, unless the same shall have been necessary to preserve the life of such woman, shall be guilty of a felony, and in case the death of such pregnant woman be thereby produced, the offense shall be deemed manslaughter. In any prosecution under this section, it shall not be necessary for the prosecution to prove that no such necessity existed.


Constitutionality: Section held unconstitutional as relating to abortions in the first trimester of a pregnancy as authorized by the pregnant woman's attending physician in the exercise of his medical judgment. People v Bricker, 389 Mich 524; 208 NW2d 172 (1973).

Former law: See section 34 of Ch. 153 of R.S. 1846, being CL 1857, § 5744; CL 1871, § 7543; How., § 9108; CL 1897, § 11503; CL 1915, § 15225; CL 1929, § 16741; sec. 35 of Ch. 153 of R.S. 1846; Act 61 of 1867; CL 1871, § 7544; How., § 9109; CL 1897, §11504; CL 1915, § 15226; and CL 1929, § 16742.

750.15 Abortion, drugs or medicine; advertising or sale to procure; misdemeanor.  
Sec. 15. Selling drugs, etc., to produce abortion—Any person who shall in any manner, except as hereinafter provided, advertise, publish, sell or publicly expose for sale any pills, powder, drugs or combination of drugs, designed expressly for the use of females for the purpose of procuring an abortion, shall be guilty of a misdemeanor. Any drug or medicine known to be designed and expressly prepared for producing an abortion, shall only be sold upon the written prescription of an established practicing physician of the city, village, or township in which the sale is made; and the druggist or dealer selling the same shall, in a book provided for that purpose, register the name of the purchaser, the date of the sale, the kind and quantity of the medicine sold, and the name and residence of the physician prescribing the same.

History: 1931, Act 328, Eff. Sept. 18, 1931;MCL 1948, 750.15.
The Board also reviewed existing MSMS policy supporting the following:

- Insurance coverage for abortion, including Medicaid funding
- Standardization of abortion training opportunities in OB-GYN residencies
- No amendment to the Constitution of the United States that would prohibit abortion
- That an abortion is a medical procedure and should be performed only by a licensed physician
- The right of patients to be free from coercion in determining when and if they will submit to medical procedures such as sterilization and abortion
- Access to health care facilities and civil action suits against those interfering with such access
- Advocacy against prohibitions on the performance of abortions based on the gender of the fetus because such restrictions infringe upon the physician-patient relationship
- Access for medical abortions via telemedicine for first trimester pregnancies consistent with ACOG clinical management guidelines
- That all fetal remains resulting from abortions be handled as required under MI law
- Maintaining the privacy and confidentiality of anyone who purchases additional coverage riders for any benefits including abortion and opposes any limitations on the scope of health care coverage that private insurance companies can offer in a comprehensive health plan
- Advocacy opposing the criminalization of physicians for delivering evidence-based standard of medical care, as well as for refusing to engage in care that is neither safe nor evidence based
- An amendment to Michigan’s Parental Consent Law MCL 722.903 to offer exemptions in cases of abuse, assault, incest, or neglect

The Board engaged in a robust discussion of the US Supreme Court ruling, current status related to abortion in Michigan, MSMS and AMA policies, and the resolution’s “ask.” It was determined that sections 14 and 15 of the 1931 law were in opposition to MSMS’s position regarding criminalization. The Board added a Resolved statement outlining basic principles and modified the original Resolved statement to narrow the

(continued)
scope to the applicable sections of law and include the statement regarding the criminalization of physicians.

At its meeting in July of 2022, the MSMS Board of Directors approved the recommendation to approve Resolution 33-22, as amended.

Attachment
   Resolution 33-22
RESOLUTION 33-22

Title: Repeal of Michigan’s Abortion Law

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

Original Author: Richard Burney, MD

Referred To: Reference Committee D

House Action: REFERRED TO MSMS BOARD OF DIRECTORS

Whereas, the Michigan Penal Code, Act 328 of 1931, Sections 750.14 and 7650.15 make it illegal to provide abortion services of any kind, including medically induced abortions, and

Whereas, it is possible that the U. S. Supreme Court will reverse the Roe v. Wade decision making abortion legal, overruling state laws, and

Whereas, should this happen, Michigan’s 1931 law would become effective, preventing abortion services except in the first trimester, and

Whereas, this would significantly impair women’s freedom, health, and well-being; therefore be it

RESOLVED: That MSMS advocate to repeal Act 328 of 1931, regardless of the outcome of the current case before the Supreme Court.

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

Relevant MSMS Policy:

No Constitutional Prohibition
There should be no amendment to the Constitution of the United States that would prohibit abortion. (Prior to 1990)

Abortion as Medical Procedure
Abortion is a medical procedure and should be performed only by a licensed physician in conformance with standards of good medical practice and the Public Health Code of the state of Michigan. (Prior to 1990)

Relevant AMA Policy:

Policy on Abortion H-5.990
The issue of support of or opposition to abortion is a matter for members of the AMA to decide individually, based on personal values or beliefs. The AMA will take no action which may be construed as an attempt to alter or influence the personal views of individual physicians regarding abortion procedures.

Abortion H-5.995
Our AMA reaffirms that: (1) abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in conformance with standards of good medical practice and the Medical Practice Act of his state; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment. Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally held moral principles. In these circumstances, good medical practice requires only that the physician or other professional withdraw from the case, so long as the withdrawal is consistent with good medical practice.

Right to Privacy in Termination of Pregnancy H-5.993
The AMA reaffirms existing policy that (1) abortion is a medical procedure and should be performed only by a duly licensed physician in conformance with standards of good medical practice and the laws of the state; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment or personally held moral principles. In these circumstances good medical practice requires only that the physician or other professional withdraw from the case so long as the withdrawal is consistent with good medical practice. The AMA further supports the position that the early termination of pregnancy is a medical matter between the patient and the physician, subject to the physician's clinical judgment, the patient's informed consent, and the availability of appropriate facilities.

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

Source:
1. Section 750.14 (of the law) held unconstitutional as relating to abortions in the first trimester of a pregnancy as authorized by the pregnant woman's attending physician in the exercise of his medical judgment. People v Bricker, 389 Mich 524; 208 NW2d 172 (1973). Whether this ruling would be affected by reversing Roe is not known.
## RESOLUTIONS BY COMMITTEE

**REFERENCE COMMITTEE E – SCIENTIFIC AND EDUCATIONAL AFFAIRS**

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Whereas, access to and use of paid parental leave is associated with decreased infant mortality, decreased child behavior problems, increased likelihood of immunization completion, and decreased infant rehospitalization, and

Whereas, maternity leave is associated with a maternal benefit of improved postpartum mental health, decreased maternal rehospitalization, and improved breastfeeding, and

Whereas, paternity leave is associated with increased paternal involvement in neonatal care, while paternal involvement is also associated with fewer symptoms of postpartum depression in mothers, higher maternal and paternal relationship quality, and positive birth outcomes and development in infants and toddlers, and

Whereas, in 2021, the U.S. Department of Labor estimated that both parents were employed in 62.3 percent of married couple families with children, and

Whereas, compared to other high-income countries, the United States is the only country without paid parental leave, while the average paid maternity leave entitlement in 10 Organisation for Economic Co-operation and Development (OECD) countries is 44 weeks, and

Whereas, the health benefits of parental leave continues to increase as parental leave is extended, with the greatest mortality reduction occurring with 40 weeks of job-protected time off, and

Whereas, the Accreditation Council for Graduate Medical Education (ACGME) guarantees six weeks of paid parental leave for residents of ACGME accredited supporting institutions, the American Academy of Pediatrics (AAP) supports a minimum of 12 weeks paid leave, with an option for more, based on the strong evidence it benefits maternal physical and mental health outcomes, as well as the growth and development of infants, and

Whereas, following the 2022 AMA Interim Meeting, the AMA modified existing AMA policy to recommend that medical practices, departments, and training programs strive to provide 12 weeks of paid parental, family, and medical necessity leave in a 12-month period for their attending and trainee physicians as needed, and
Whereas, the American Medical Association H-405.960 policy endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity, and

Whereas, MSMS Resolution 07-15 addresses the importance of paid parental leave for the general population, it fails to address its necessity and areas for improvement amongst physician, resident, and medical student health care providers; therefore be it

RESOLVED: That MSMS encourage policy development regarding provision of a minimum of 12-week maternal and paternal leave for medical students, physicians, and residents in accordance with recommendations from the American Academy of Pediatrics.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000

Relevant MSMS Policy:

Parental Paid Leave
MSMS supports parental paid leave.

Relevant AMA Policy:

Policies for Parental, Family and Medical Necessity Leave H-405.960
Our AMA urges residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement. Our AMA recommends that medical practices, departments and training programs strive to provide 12 weeks of paid parental, family and medical necessity leave in a 12-month period for their attending and trainee physicians as needed.

Sources:
3. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4934583/
8. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5415087/
Whereas, medical aid in dying (MAID) is a medical practice that allows competent and terminally ill patients, who are expected to expire within six months, to request lethal medications that they plan to self-administer, and

Whereas, MAID differs from the practices of physician assisted suicide (PAS) or medical euthanasia, as the patient is the actor who precipitates their own death, instead of the physician, and

Whereas, the need to give patients with severe suffering and terminal disease the option to choose when, and by what means, their life ends is in line with medical practice in eleven states and jurisdictions, and

Whereas, approximately 74 million Americans live in states where MAID is currently practiced, and

Whereas, the current non-standard language of processes related to, but not identical to MAID, has created confusion in the minds of patients, creating the potential for situations where a patient may not know what is legal or what might happen to them should they ask their physician about MAID, as well as confusion for physicians about what their patients may be trying to discuss with them, and

Whereas, 72 percent of Americans agreed that doctors should be legally allowed to help a terminally ill patient die, and

Whereas, only 28 percent of U.S. physicians did not agree that physician-assisted dying should be made legal for terminally ill patients, and

Whereas, interstate medical tourism to Oregon for MAID was recently found to be permissible, meaning all U.S. physicians will now need a basic understanding of these practices in order to provide guidance to their patients, and

Whereas, Michigan House Bill 4461, was recently submitted in support of regulating the practice of MAID by defining the practice, protecting physicians who choose to practice, including language to require MAID regulated in regard to health care insurance, and creation of a reporting registry; therefore be it
RESOLVED: That MSMS define and adopt medical aid in dying (MAID) as allowing competent and terminally ill patients months to request a physician’s prescription for lethal medications they plan to self-administer, and that this term be distinct from physician assisted suicide and medical euthanasia; and be it further

RESOLVED: That MSMS sunset its existing policies “Position on Physician Assisted Suicide” and “Oppose Legislative Interference in Patient/Physician Relationship;” and be it further

RESOLVED: That MSMS should bring to public attention to the options physicians have to treat terminally ill patients so that assisted suicide is not considered a necessary alternative to continued medical care and that medical aid in dying is a part of end of life discussions; and be it further

RESOLVED: That due to the ruling allowing a Michigan patient to visit Oregon to undergo MAID for the purposes of medical tourism, MSMS advocate for state legislative action that would protect and serve Michigan patients wishing to pursue MAID; and be it further

RESOLVED: That MSMS adopt a position of studied neutrality on MAID, allowing for physicians of diverse backgrounds and lived experiences to share their perspectives in a way that protects their freedoms to participate in MAID prescribing or opting out.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $16,000-$32,000

Relevant MSMS Policy:

Oppose Legislative Interference in Patient/Physician Relationship
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.

Physician Assisted Suicide Legislation
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.

Position on Physician Assisted Suicide
MSMS adopts the following position of the American Medical Association on physician assisted suicide:

"Physician assisted suicide occurs when a physician facilitates a patient’s death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).

"It is understandable, though tragic, that some patients in extreme duress----such as those suffering from a terminal, painful, debilitating illness, may come to decide that death is preferable to life. However, allowing physicians to participate in assisted suicide would cause more harm than good. Physician assisted suicide is fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks.

"Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible."
Multidisciplinary interventions should be sought including special consultation, hospice care, pastoral support, family counseling, and other modalities. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication.”

**Relevant AMA Policy:**

**Physician Assisted Suicide H-140.952**

It is the policy of the AMA that: (1) Physician assisted suicide is fundamentally inconsistent with the physician’s professional role. (2) It is critical that the medical profession redouble its efforts to ensure that dying patients are provided optimal treatment for their pain and other discomfort. The use of more aggressive comfort care measures, including greater reliance on hospice care, can alleviate the physical and emotional suffering that dying patients experience. Evaluation and treatment by a health professional with expertise in the psychiatric aspects of terminal illness can often alleviate the suffering that leads a patient to desire assisted suicide. (3) Physicians must resist the natural tendency to withdraw physically and emotionally from their terminally ill patients. When the treatment goals for a patient in the end stages of a terminal illness shift from curative efforts to comfort care, the level of physician involvement in the patient’s care should in no way decrease. (4) Requests for physician assisted suicide should be a signal to the physician that the patient’s needs are unmet and further evaluation to identify the elements contributing to the patient’s suffering is necessary. Multidisciplinary intervention, including specialty consultation, pastoral care, family counseling and other modalities, should be sought as clinically indicated. (5) Further efforts to educate physicians about advanced pain management techniques, both at the undergraduate and graduate levels, are necessary to overcome any shortcomings in this area. Physicians should recognize that courts and regulatory bodies readily distinguish between use of narcotic drugs to relieve pain in dying patients and use in other situations.

**Decisions Near the End of Life H-140.966**

Our AMA believes that: (1) The principle of patient autonomy requires that physicians must respect the decision to forgo life-sustaining treatment of a patient who possesses decision-making capacity. Life-sustaining treatment is any medical treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment includes, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration. (2) There is no ethical distinction between withdrawing and withholding life-sustaining treatment. (3) Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death. More research must be pursued, examining the degree to which palliative care reduces the requests for euthanasia or assisted suicide. (4) Physicians must not perform euthanasia or participate in assisted suicide. A more careful examination of the issue is necessary. Support, comfort, respect for patient autonomy, good communication, and adequate pain control may decrease dramatically the public demand for euthanasia and assisted suicide. In certain carefully defined circumstances, it would be humane to recognize that death is certain and suffering is great. However, the societal risks of involving physicians in medical interventions to cause patients’ deaths is too great to condone euthanasia or physician-assisted suicide at this time. (5) Our AMA supports continued research into and education concerning pain management.

**Sources:**

8. Our Care, Our Choice Act, (2019)
13. Choices C. Medical Aid in Dying Online 2023
14. Data from: United States Census. 2020
Title: Importance of Palliative Care Provision and Physician Training

Introduced by: Ashton Lewandowski, for the Medical Student Section

Original Authors: Aubrey Haughn and Marisa Stratelak

Referred To: Reference Committee E

House Action:

Whereas, the World Health Organization (WHO) defines palliative care as “an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual,” and

Whereas, early utilization of palliative care increases patient quality of life, survival, symptom relief, and satisfaction of care, while also reducing depressive symptoms and low mood, and

Whereas, palliative care involvement is associated with lower costs of healthcare in the form of decreased ICU length of stays, emergency room visits, and hospital readmissions, with the most savings occurring with early palliative care involvement and patients with high comorbidities, and

Whereas, palliative care promotes patient autonomy in tailoring their end-of-life care to maximize their quality of life in the location of their choosing without compromising significant symptom relief, and

Whereas, patient barriers to palliative care utilization include racial minorities, low socioeconomic status, and rural location; provider barriers to palliative care referral include difficulty initiating palliative care discussions with patients, misunderstandings of the goal of palliative care and ability to continue medical treatment, and believing a palliative care treatment is considered “giving up,” and

Whereas, more than 40 million people in the United States are above the age of 65 and by 2050 there are expected to be 89 million. Current hospice and palliative medicine training capacity is insufficient to keep up with population growth and demand for services, and so we must also rely on provision and connection to palliative care services through primary care physicians, and

Whereas, primary care physicians are frequently the first medical provider contacted by patients and thus can identify patients in need of palliative care services early and incorporate elements of palliative care into their practice, and

Whereas, when primary care providers are involved in delivery and planning of end of life care, there is better coordination of care and fewer acute care services used, and
Whereas, family medicine residents reported increased comfort in all areas of measured end-of-life care following a required four-week palliative care medicine rotation, and

Whereas, AMA policy H-70.915, encourages all physicians to become skilled in palliative medicine and MSMS Resolution 32-16 asked to encourage appropriate hospice and palliative care utilization for eligible patients, and

Whereas, WHO Resolution WHA67.19, urges physicians to develop, strengthen, and implement appropriate palliative care policies for comprehensive, cost-effective continuum of care as well as including ongoing palliative care education to providers; therefore be it

RESOLVED: That MSMS encourage the usage of palliative care and the provision of palliative care education in the training of physicians with an emphasis on those in primary care.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000

Relevant MSMS Policy:

Pain Management and Hospice Education
MSMS recommends and promotes effective education in pain management, opioid tapering, referral best practices, and/or hospice care for physicians and medical students.

Relevant AMA Policy:

Good Palliative Care H-70.915
Our AMA encourages all physicians to become skilled in palliative medicine; recognizes the importance of providing interdisciplinary palliative care for patients with disabling chronic or life-limiting illness to prevent and relieve suffering and to support the best possible quality of life for these patients and their families; encourages education programs for all appropriate health care professionals, and the public as well, in care of the dying patient; and the care of patients with disabling chronic or life-limiting illness. Relevant WHO policy: Strengthening of palliative care as a component of comprehensive care throughout the life course WHA67.19 That WHO supports the inclusion of palliative care actions and indicators in the WHO comprehensive global monitoring framework; noting with appreciation the inclusion of medicines needed for pain and symptom control in palliative care settings; noting with appreciation the efforts of nongovernmental organizations and civil society in continuing to highlight the importance of palliative care, including adequate availability and appropriate use of internationally controlled substances for medical and scientific purposes, as set out in the United Nations international drug control conventions

Sources:
1. https://who.int/news-room/fact-sheets/detail/palliative-care
RESOLUTION 14-23

Title: Moving Beyond the BMI

Introduced by: Ashton Lewandowski, for the Medical Student Section

Original Author: Vanessa Elliott and Charlotte Kreger

Referred To: Reference Committee E

House Action:

Whereas, Body Mass Index (BMI) has been a widely adopted clinical approximation to
categorize patients by body size, and

Whereas, BMI is a limited metric for adiposity; it is a non-specific height-to-weight ratio that
is not differentiated for gender or body shape, and through original standardization for white male
bodies, BMI is even less accurate for minoritized groups, and

Whereas, BMI is a poor predictor of a patient’s actual health; using BMI as a proxy for
metabolic health inaccurately categorizes 36 million Americans, and BMI is not reliably tied to
differences in mortality, and

Whereas, physician focus on patients’ BMI reinforces weight stigma, which is a
psychological stressor that has several well-established physiological and psychological health
effects including heart disease, stroke, depression, and anxiety disorder, and

Whereas, physician focus on BMI damages the patient-physician relationship, diverts
attention away from other concerns, results in missed diagnoses, and is tied to reduced care
utilization, and

Whereas, while traditional weight-focused counseling does not result in meaningful health
improvement, may lead to weight cycling, or may contribute to weight stigma within health care
encounters, weight inclusive counseling provides an avenue for physicians to counsel patients on
health-enhancing behaviors without discussing BMI or prescribing weight loss, and

Whereas, current structural factors force physicians to provide weight-focused care with
requirements to collect patients’ BMI where it is not medically necessary, retraumatizing and
re-stigmatizing patients, and requirements to provide weight-focused counseling and follow-up
that detract physician time from other conditions that should take precedence, and

Whereas, Michigan is uniquely situated to lead the nation in reducing weight stigma in
health care, as it is the first and only state to explicitly protect freedom from weight discrimination
in employment as a civil right; therefore be it

RESOLVED: That MSMS opposes the use of BMI as a proxy for health; and be it further
RESOLVED: That MSMS oppose measures mandating weight-focused physician care, committing to the reconfiguration of electronic medical records, removal of BMI as a requirement for reimbursements, and elimination of performance measures requiring BMI-based care; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to acknowledge weight stigma as a social determinant of health, recognizing the instrumental role of physicians in perpetrating and exacerbating the negative effects of weight stigma on patients' health.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000

Relevant MSMS Policy: None

Relevant AMA Policy:

Clinical Utility of Measuring BMI and Waist Circumference H-440.866
Our AMA supports:
(1) greater emphasis in physician educational programs on the risk differences among ethnic and age groups at varying levels of BMI and the importance of monitoring waist circumference in individuals with BMIs below 35 kg/m2;
(2) additional research on the efficacy of screening for overweight and obesity, using different indicators, in improving various clinical outcomes across populations, including morbidity, mortality, mental health, and prevention of further weight gain; and
(3) more research on the efficacy of screening and interventions by physicians to promote healthy lifestyle behaviors, including healthy diets and regular physical activity, in all of their patients to improve health and minimize disease risks.

Sources:


Title: Designation of Descendants of Enslaved Africans in America

Introduced by: Rev. Don J.H. Tynes, MD, for the Wayne County Delegation

Original Authors: Holly Gilmer, MD, Anita V. Moncrease, MD, MPH, and Rev. Don J.H. Tynes, MD, for the Wayne County Delegation

Referred To: Reference Committee E

House Action:

Whereas, the designation of African American and Black has been expanded to include any person who immigrated from Africa or Caribbean countries and obtained American citizenship at any point in recent history, and

Whereas, since 2003 the United States Supreme Court, ruled the definition of "Black" included every person who identifies as Black on a census form including people who check the box for Black and any other racial or ethnic category such as white, Asian, and Hispanic or Latino, which the federal government considers to be an ethnicity that can be of any race, and

Whereas, anyone Black or White who was born in Africa, immigrated to the United States, and legally becomes an American citizen is considered an African American, i.e., Elon Musk, business magnate, and

Whereas, the number of immigrants entering the United States legally rose from 3.3 million in the 1960s to a record 7.3 million in the 1980s; and during the 1990s, some 900,000 Black immigrants came from the Caribbean; another 400,000 came from Africa; still many others came from Europe, Pacific Rim, Arab and Asian countries, and

Whereas, today, nearly one in ten Black Americans is an immigrant or the child of an immigrant in the United States, and

Whereas, the “Intelligent” survey found 34 percent of white students who applied to colleges and universities falsely claimed they were a racial minority on their application; 81 percent of students who faked minority status did so to improve their chances of getting accepted and 50 percent did it to get minority-focused financial aid, and

Whereas, the “Intelligent” survey found that 3 in 4, or 77 percent, of white applicants who faked minority status on their applications were accepted to those colleges, and

Whereas, Descendants of Enslaved Africans in America are the only people in U.S. history classified as nonhuman and property, to undergo chattel slavery, and to be deemed by the U.S. constitution 3/5 of a human, according to the 13th, 14th, and 15th amendments, and

Whereas, the Descendants of Enslaved Africans in America are the only people for whom it was illegal to attend school or learn how to read and write in the United States; therefore be it
RESOLVED: That MSMS supports the term Descendants of Enslaved Africans in America should be defined and added to the glossary of the Association of American Medical Colleges; and be it further

RESOLVED: That MSMS supports the term Descendants of Enslaved Africans in America should be defined and added to medical school applications; and be it further

RESOLVED: That MSMS work with organized medicine and medical schools to accurately separate Descendants of Enslaved Africans in America from the generic terms African American and Black.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000

Relevant MSMS Policy: None

Relevant AMA Policy: None

Sources:
Bibliography: Evidence of Non-African Americans Claiming to be African Americans for personal gain:
3. Leah Asmelash. A White professor says she has been pretending to be Black for her entire professional career. CNN. Updated 11:59 AM EDT, Fri September 4, 2020
5. Colleen Flaherty. Feeling the Need to Defend Your Credentials Why did Elizabeth Warren divulge her genetic test results, which show she is in fact part Native American, while simultaneously insisting that she’s always been evaluated professionally as a white person? Inside Higher Ed. October 16, 2018
9. Cambridge Advanced Learner’s Dictionary & Thesaurus Â© Cambridge University Press. Cultural Appropriation: the act of taking or using things from a culture that is not your own, especially without showing that you understand or respect this culture.
10. Maha Ikram Cherid. “Ain’t Got Enough Money to Pay Me Respect”: Blackfishing, Cultural Appropriation, and the Commodification of Blackness. Maha Ikram Cherid https://orcid.org/0000-0002-2768-4698 maha.cherid@mail.mcgill.caView all authors and affiliations Volume 21, Issue 5 https://doi.org/10.1177/15327086211029357 Internet February 6, 2023

Evidence of the invention of Race as a Matter of Politics and Not Science

Definition of African American(s)
1. African Americans are an ethnic group consisting of Americans with partial or total ancestry from sub-Saharan Africa. The term “African American” generally denotes descendants of enslaved Africans who are from the United States (Ref)
2. The glossary that is available on the AAMC FACTS website, as well as the FACTS tables that display the full race/ethnicity response options does not include DOESAA: FACTS Glossary: https://www.aamc.org/data-reports/students-residents/interactive-data/facts-glossary Example FACTS Table with response options: https://www.aamc.org/media/6046/download?attachment
3. AAMC DATA FACTS TABLE 12-A of the freshman class acceptees for medical schools in the United States in 2021: 456 African Americans, who are not distinguished as immigrant or non-immigrant; 203 individuals indicating more than 1 Black or African American response, which implies an immigrant status or admixture; 33 “other Black or African American” which implies immigrant status.
Whereas, Congress passed the Consolidated Appropriations Act (CAA) that was signed into law at the federal level on December 27, 2022, and

Whereas, Congress recently passed the Consolidated Appropriations Act of 2023 (CAA) on December 29, 2022, which eliminated the “DATA-waiver Program” (Drug Addiction Treatment Act of 2000, or DATA 2000), and

Whereas, the CAA has eliminated the “X-waiver” registration requirement for licensure to prescribe buprenorphine for any prescribers who have a DEA license with coverage for Schedule III, IV, and V narcotic medications (Schedule III for buprenorphine), and

Whereas, the Drug Enforcement Administration (DEA) and Substance Abuse and Mental Health Services Administration (SAMHSA) provided input into the CAA with the intent of improving access to the prescribing of buprenorphine for the treatment of Opioid Use Disorder (OUD), and

Whereas, the CAA also introduced new training requirements for all prescribers who have a DEA license which will become effective on June 21, 2023, with the requirements yet to be determined by the DEA and SAMHSA, and

Whereas, the federal CAA does not impact any applicable state laws or regulations, and

Whereas, the state of Michigan has extensive Continuing Medical Education (CME) physician licensure requirements that include CME hours for a one-time requirement for “Opioids and Controlled Substances Awareness Training Standards for Prescribers and Dispensers of Controlled Substances” (effective January 4, 2019) and an every three-year licensing/relicensing cycle requirement for three hours in the area of pain and symptom management, with at least one hour specifically focused on controlled substance prescribing, and

Whereas, the Michigan Department of Licensing and Regulatory Affairs (LARA) has not yet determined how to implement the new CAA training requirements, and

Whereas, MSMS has existing policy that no additional CME requirements should be added to the current state of Michigan physician licensure requirements; therefore be it

RESOLVED: That MSMS work with Michigan Department of Licensing and Regulatory Affairs to include the Consolidated Appropriations Act training requirements (once determined by
the DEA and SAMHSA) in the current Michigan CME requirements for physician licensure; and be it further

RESOLVED: That MSMS work with Michigan Department of Licensing and Regulatory Affairs in the state of Michigan to allow prescribers who already completed the education required in the recent past to obtain the “X-waiver” to be given specific CME credits and/or a waiver for completion of this specified CME (eight hours for physicians and twenty-four hours for Advanced Practice Professionals); and be it further

RESOLVED: That MSMS advocate that the Consolidated Appropriations Act training requirements replace the current Michigan CME requirements for the one-time opioids training standards requirement and the ongoing three-year licensure/re-licensure cycle requirement for pain and symptom management/controlled substance prescribing.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $12,000-$24,000

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.

Eliminate the X Waiver
MSMS supports eliminating the requirement for obtaining a waiver to prescribe buprenorphine for the treatment of opioid use disorder.

Expand Access to Medication for the Treatment of Opioid Use Disorder
MSMS recommends the removal of legislative, regulatory, and other barriers to the use of medications for 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.
Title: Use of Artificial Intelligence in Medicine

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

Original Author: Megan Edison, MD

Referred To: Reference Committee E

Whereas, Artificial Intelligence (AI) is poised to revolutionize many industries, including the field of medicine, and

Whereas, AI has the potential to improve patient safety and quality of care, and

Whereas, AI can enable more accurate and efficient patient care and reduce the workload of medical practitioners, and

Whereas, the use of AI in medicine is likely to be disruptive and requires careful consideration, and

Whereas, MSMS is committed to providing its members with the latest advances in medical technology; therefore be it

RESOLVED: That MSMS explore the potential uses of Artificial Intelligence (AI) in medicine, including but not limited to, the development of sophisticated medical diagnostics, the use of AI in telehealth services, the application of AI to medical research, and the potential for AI to improve patient outcomes; and be it further

RESOLVED: That MSMS create a task force to investigate the potential applications of Artificial Intelligence (AI) in medicine, develop recommendations for how MSMS members can best utilize AI in their practices; and report its findings.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $2,500-$5,000

Relevant MSMS Policy: None

Relevant AMA Policy: None

Source:
This resolution was written entirely by AI using the ChatGPT prompt “write a resolution to the Michigan State Medical Society regarding use of AI in medicine.”
RESOLUTION 28-23

Title: Physician Right to Prescribe Approved Devices and Drugs

Introduced by: Venkat Rao, MD, for the Genesee County Delegation

Original Author: Venkat Rao, MD

Referred To: Reference Committee E

Whereas, the Food and Drug Administration (FDA), the Centers for Disease Control and Prevention (CDC), and other state and federal agencies have attempted to restrict a physician’s best medical judgement in the prescribing of medicines and devices off-label, and

Whereas, the U.S. government passed Medicare by assuring physicians that it would never interfere with the practice of medicine but has done so extensively, and

Whereas, the Consolidated Appropriations Act, 2023, included language allowing the FDA to prevent physician and patient access to drugs or devices which are already approved, and

Whereas, the FDA wishes to interfere in the practice of medicine, and

Whereas, off-label use of approved medicines and devices is often the standard of care, and

Whereas, more than 20 percent of all practice related prescriptions are written for off-label use; therefore be it

RESOLVED: That MSMS advocate against any state of Michigan attempts to restrict off-label prescribing; and be it further

RESOLVED: That the MSMS Delegation to the American Medical Association (AMA) ask the AMA to advocate against any attempts to restrict off-label prescribing; and be it further

RESOLVED: That MSMS Delegation to the American Medical Association (AMA) ask the AMA to seek repeal of the FDA authority contained in the Consolidated Appropriations Act, 2023 to restrict a physician’s right to prescribe off-label use of drugs and devices.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000

Relevant MSMS Policy:

Off Label Policy (23-22)
RESOLVED: That MSMS support AMA Policy, “Patient Access to Treatments Prescribed by Their Physicians H-120.988” as a basic medical right and responsibility of a physician to provide the best care available to our patients; and be it further
RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to amend AMA Policy, “Patient Access to Treatments Prescribed by Their Physicians H-120.988.” by addition as follows:

Patient Access to Treatments Prescribed by Their Physicians H-120.988 1. Our AMA confirms its strong support for the autonomous clinical decision-making authority of a physician and that a physician may lawfully use an FDA approved drug product or medical device for an off-label indication when such use is based upon sound scientific evidence or sound medical opinion; and affirms the position that, when the prescription of a drug or use of a device represents safe and effective therapy, third party payers, including Medicare, should consider the intervention as clinically appropriate medical care, irrespective of labeling, should fulfill their obligation to their beneficiaries by covering such therapy, and be required to cover appropriate 'off-label' uses of drugs on their formulary. 2. Our AMA strongly supports the important need for physicians to have access to accurate and unbiased information about off-label uses of drugs and devices, while ensuring that manufacturer-sponsored promotions remain under FDA regulation. 3. Our AMA supports the dissemination of generally available information about off-label uses by manufacturers to physicians. Such information should be independently derived, peer reviewed, scientifically sound, and truthful and not misleading. The information should be provided in its entirety, not be edited or altered by the manufacturer, and be clearly distinguished and not appended to manufacturer-sponsored materials. Such information may comprise journal articles, books, book chapters, or clinical practice guidelines. Books or book chapters should not focus on any particular drug. Dissemination of information by manufacturers to physicians about off-label uses should be accompanied by the approved product labeling and disclosures regarding the lack of FDA approval for such uses, and disclosure of the source of any financial support or author financial conflicts. 4. Physicians have the responsibility to interpret and put into context information received from any source, including pharmaceutical manufacturers, before making clinical decisions (e.g., prescribing a drug for an off-label use). 5. Our AMA strongly supports the addition to FDA-approved labeling those uses of drugs for which safety and efficacy have been demonstrated. 6. Our AMA supports the continued authorization, implementation, and coordination of the Best Pharmaceuticals for Children Act and the Pediatric Research Equity Act. 7. OURAMA SUPPORTS PHYSICIAN AUTONOMY WITH REGARD TO DECIDING APPROPRIATE DOSING.

Oncology Advisory Panel
MSMS supports the establishment of an oncology advisory panel to advise all health insurance carriers about the efficacy, appropriateness and routes of administration for off-label indications of U.S. Food and Drug Administration-approved drugs used in anti-neoplastic therapy.

Relevant AMA Policy:

Patient Access to Treatments Prescribed by Their Physicians H-120.988
1. Our AMA confirms its strong support for the autonomous clinical decision-making authority of a physician and that a physician may lawfully use an FDA approved drug product or medical device for an off-label indication when such use is based upon sound scientific evidence or sound medical opinion; and affirms the position that, when the prescription of a drug or use of a device represents safe and effective therapy, third party payers, including Medicare, should consider the intervention as clinically appropriate medical care, irrespective of labeling, should fulfill their obligation to their beneficiaries by covering such therapy, and be required to cover appropriate 'off-label' uses of drugs on their formulary. 2. Our AMA strongly supports the important need for physicians to have access to accurate and unbiased information about off-label uses of drugs and devices, while ensuring that manufacturer-sponsored promotions remain under FDA regulation. 3. Our AMA supports the dissemination of generally available information about off-label uses by manufacturers to physicians. Such information should be independently derived, peer reviewed, scientifically sound, and truthful and not misleading. The information should be provided in its entirety, not be edited or altered by the manufacturer, and be clearly distinguished and not appended to manufacturer-sponsored materials. Such information may comprise journal articles, books, book chapters, or clinical practice guidelines. Books or book chapters should not focus on any particular drug. Dissemination of information by manufacturers to physicians about off-label uses should be accompanied by the approved product labeling
and disclosures regarding the lack of FDA approval for such uses, and disclosure of the source of any financial support or author financial conflicts.

4. Physicians have the responsibility to interpret and put into context information received from any source, including pharmaceutical manufacturers, before making clinical decisions (e.g., prescribing a drug for an off-label use).

5. Our AMA strongly supports the addition to FDA-approved labeling those uses of drugs for which safety and efficacy have been demonstrated.

6. Our AMA supports the continued authorization, implementation, and coordination of the Best Pharmaceuticals for Children Act and the Pediatric Research Equity Act.

Sources:
4. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4743297/
5. https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/410250
Title: Medical Education for Medication Reconciliation

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

Original Author: Cynthia Ochs, MD

Referred To: Reference Committee E

Whereas, medical documentation has moved to electronic health records (EHR) and is now a required documentation modality through Centers for Medicare and Medicaid Services (CMS), and

Whereas, medical documentation in the EHR is protected through the Health Insurance Portability and Accountability Act (HIPAA), and

Whereas, use of the EHR and HIPAA have resulted in limited access and lack of interface between dissimilar EHRs, and

Whereas, skilled nursing facilities (SNF) and other patient care settings and primary providers in these facilities often do not have access to the same EHR as acute care facilities, primary care physicians, and specialty physicians within their geographic domain, and

Whereas, many older patients have complex care needs that may result in transitions for care with documentation for their health care in multiple care settings with dissimilar EHRs, and

Whereas, the medication list within one EHR may not be accurate in any care setting due to these transitions and dissimilar EHRs, and

Whereas, the “source of truth” for the medication list may be fragmented, and no longer resides with the patient, especially if the patient has a degree of cognitive impairment, and

Whereas, medication errors have been shown to result in severe illness, hospitalization, and death for 1.5 million patients annually in the United States with an estimated cost of $77 billion (with the majority of health care dollars spent on patients over the age of 65), and

Whereas, careful medication reconciliation utilizing all relevant EHR resources and patient input by a physician in each care setting at each visit is imperative to ascertain and maintain accuracy of the medication list, and

Whereas, many physicians rely on other health care professionals, such as licensed pharmacists, to perform medication reconciliation, although thorough reconciliation including diagnostic indications for each medication and consideration of overlapping side effects may exceed their scope of practice; therefore be it
RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to work with Centers for Medicare and Medicaid Services and other relevant organizations to study current medication-reconciliation practices across transitions of care with dissimilar electronic health records to evaluate the impact on patient safety and quality of care, and to determine the potential need for additional medical education to ensure patient safety and quality of care related to medication errors; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask the AMA to work with the Accreditation Council for Graduate Medical Education to determine potential changes in graduate medical education requirements to improve medication reconciliation and to ensure improved patient safety and quality of care related to medication errors.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000

Relevant MSMS Policy:

Pharmacy: Cooperation to Insure Patient Medication Safety
MSMS works with the Michigan Pharmacists Association to assure patient safety, confidentiality, and continuity of care.

Pharmacy: Medication Information
MSMS supports the efforts of pharmacies to educate patients and prevent medication-induced problems.

Relevant AMA Policy:

Pharmacy Review of First Dose Medication D-120.965
1. Our AMA supports medication reconciliation as a means to improve patient safety.
2. It is AMA policy that (a) systems be established to support physicians in medication reconciliation, and (b) medication reconciliation requirements should be at a level appropriate for a particular episode of care and setting.

Hospital Discharge Communications H-160.902
1. Our AMA encourages the initiation of the discharge planning process, whenever possible, at the time patients are admitted for inpatient or observation services and, for surgical patients, prior to hospitalization.
2. Our AMA encourages the development of discharge summaries that are presented to physicians in a meaningful format that prominently highlight salient patient information, such as the discharging physician's narrative and recommendations for ongoing care.
3. Our AMA encourages hospital engagement of patients and their families/caregivers in the discharge process, using the following guidelines:
   a. Information from patients and families/caregivers is solicited during discharge planning, so that discharge plans are tailored to each patient's needs, goals of care and treatment preferences.
   b. Patient language proficiency, literacy levels, cognitive abilities and communication impairments (e.g., hearing loss) are assessed during discharge planning. Particular attention is paid to the abilities and limitations of patients and their families/caregivers.
   c. Specific discharge instructions are provided to patients and families or others responsible for providing continuing care both verbally and in writing. Instructions are provided to patients in layman's terms, and whenever possible, using the patient's preferred language.
   d. Key discharge instructions are highlighted for patients to maximize compliance with the most critical orders.
e. Understanding of discharge instructions and post-discharge care, including warning signs and symptoms to look for and when to seek follow-up care, is confirmed with patients and their families/caregiver(s) prior to discharge from the hospital.

4. Our AMA supports making hospital discharge instructions available to patients in both printed and electronic form, and specifically via online portals accessible to patients and their designated caregivers.

5. Our AMA supports implementation of medication reconciliation as part of the hospital discharge process. The following strategies are suggested to optimize medication reconciliation and help ensure that patients take medications correctly after they are discharged:
   a. All discharge medications, including prescribed and over-the-counter medications, should be reconciled with medications taken pre-hospitalization.
   b. An accurate list of medications, including those to be discontinued as well as medications to be taken after hospital discharge, and the dosage and duration of each drug, should be communicated to patients.
   c. Medication instructions should be communicated to patients and their families/caregivers verbally and in writing.
   d. For patients with complex medication schedules, the involvement of physician-led multidisciplinary teams in medication reconciliation including, where feasible, pharmacists should be encouraged.

6. Our AMA encourages patient follow-up in the early time period after discharge as part of the hospital discharge process, particularly for medically complex patients who are at high-risk of re-hospitalization.

7. Our AMA encourages hospitals to review early readmissions and modify their discharge processes accordingly.

Reducing Polypharmacy as a Significant Contributor to Senior Morbidity D-120.928

1. Our AMA will work with other organizations e.g., AARP, other medical specialty societies, PhRMA, and pharmacists to educate patients about the significant effects of all medications and most supplements, and to encourage physicians to teach patients to bring all medications and supplements or accurate, updated lists including current dosage to each encounter.

2. Our AMA along with other appropriate organizations encourages physicians and ancillary staff if available to initiate discussions with patients on improving their medical care through the use of only the minimal number of medications (including prescribed or over-the-counter, including vitamins and supplements) needed to optimize their health.

3. Our AMA will work with other stakeholders and EHR vendors to address the continuing problem of inaccuracies in medication reconciliation and propagation of such inaccuracies in electronic health records.

4. Our AMA will work with other stakeholders and EHR vendors to include non-prescription medicines and supplements in medication lists and compatibility screens.

Continuity of Care for Patients Discharged from Hospital Settings H-125.974

Our AMA:

(1) will advocate for protections of continuity of care for medical services and medications that are prescribed during patient hospitalizations, including when there are formulary or treatment coverage changes that have the potential to disrupt therapy following discharge;

(2) supports medication reconciliation processes that include confirmation that prescribed discharge medications will be covered by a patient’s health plan and resolution of potential coverage and/or prior authorization (PA) issues prior to hospital discharge;

(3) supports strategies that address coverage barriers and facilitate patient access to prescribed discharge medications, such as hospital bedside medication delivery services and the provision of transitional supplies of discharge medications to patients;

(4) will advocate to the Office of the National Coordinator for Health Information Technology (ONC) and the Centers for Medicare & Medicaid Services (CMS) to work with physician and hospital organizations, and health information technology developers, in identifying real-time pharmacy benefit implementations and published standards that provide real-time or near-time formulary information across all prescription drug plans, patient portals and other viewing applications, and electronic health record (EHR) vendors;

(5) will advocate to the ONC to include proven and established real-time pharmacy benefit criteria within its certification program;
(6) will advocate to the ONC and the CMS that any policies requiring health information technology developers to integrate real-time pharmacy benefit systems (RTPB) within their products do so without disruption to EHR usability and minimal to no cost to physicians and hospitals, providing financial support if necessary; and

(7) supports alignment and real-time accuracy between the prescription drug data offered in physician-facing and consumer-facing RTPB tools.

Sources:
Title: Prohibit Discriminatory ERAS® Filters In NRMP Match

Introduced by: Venkat Rao, MD, and Amit Ghose, MD

Original Author: Venkat Rao, MD, and Amit Ghose, MD

Referred To: Reference Committee E

House Action:

Whereas, programs require applicants to go through the Electronic Residency Application Service® (ERAS®) for residency selection in the National Residency Match Program (NRMP), and

Whereas, the ERAS® requires mandatory information be filled out in the application including gender, medical school name, etc., and

Whereas, there are pre-programmed filters available in the ERAS® system such as Foreign Medical Graduates, and

Whereas, program directors apply these filters regularly, according to the survey by the NRMP post-match data, and

Whereas, program directors admit to applying the medical school accreditation filter - Liaison Committee on Medical Education (LCME) vs non-LCME - frequently in downloading applications, and

Whereas, applying this filter completely eliminates the downloading of all international medical graduates’ applications; thereby, leaving them no chance of being considered by the program directors regardless of how competitive their application may be, and

Whereas AMA policy is not to discriminate candidates in residency selection based on their education in foreign countries,

Whereas, according to Accreditation Council for Graduate Medical Education criteria, program directors are required not to discriminate in the selection process of any group as a block; therefore be it

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to oppose the use of discriminatory filters in the Electronic Residency Application Service® (ERAS®) system and work to eliminate discriminatory filters that prevent international medical graduates and other groups from consideration by the program directors.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000

Relevant MSMS Policy:
**MSMS Position on Discrimination**
MSMS is committed to diversity and inclusion. MSMS condemns all attempts by agencies, be they
government or private, to discriminate in in licensure, licensure by endorsement, jobs, promotions, hospital
privileges, reimbursement, residency medical staff and academic appointments, professional society
memberships, financial aid and board certification, based on race, religion, sexual orientation, creed, sex,
gender identity, disability, ethnic origin, national origin, or age. Additionally, MSMS supports current AMA

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

**Relevant AMA Policy:**

**Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection**
Our AMA will: 1. encourage medical schools, medical honor societies, and residency/fellowship programs to
work toward ethical, equitable, and transparent recruiting processes, which are made available to all
applicants.
2. advocate for residency and fellowship programs to avoid using objective criteria available in the Electronic
Residency Application Service (ERAS) application process as the sole determinant for deciding which
applicants to offer interviews.
3. advocate to remove membership in medical honor societies as a mandated field of entry on the Electronic
Residency Application Service (ERAS)—thereby limiting its use as an automated screening mechanism—and
encourage applicants to share this information within other aspects of the ERAS application.
4. advocate for and support innovation in the undergraduate medical education to graduate medical
education transition, especially focusing on the efforts of the Accelerating Change in Medical Education
initiative, to include pilot efforts to optimize the residency/fellowship application and matching process and
encourage the study of the impact of using filters in the Electronic Residency Application Service (ERAS) by
program directors on the diversity of entrants into residency.
5. encourage caution among medical schools and residency/fellowship programs when utilizing novel online
assessments for sampling personal characteristics for the purpose of admissions or selection and monitor use
and validity of these tools.

**Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual**
Our AMA:
1. opposes questioning residency or fellowship applicants regarding marital status, dependents, plans for
marriage or children, sexual orientation, gender identity, age, race, national origin, and religion;
2. will work with the Accreditation Council for Graduate Medical Education, the National Residency Matching
Program, and other interested parties to eliminate questioning about or discrimination based on marital and
dependent status, future plans for marriage or children, sexual orientation, age, race, national origin, and
religion during the residency and fellowship application process;
3. will continue to support efforts to enhance racial and ethnic diversity in medicine. Information regarding
race and ethnicity may be voluntarily provided by residency and fellowship applicants;
4. encourages the Association of American Medical Colleges (AAMC) and its Electronic Residency Application
Service (ERAS) Advisory Committee to develop steps to minimize bias in the ERAS and the residency training
selection process; and
5. will advocate that modifications in the ERAS Residency Application to minimize bias consider the effects
these changes may have on efforts to increase diversity in residency programs.
Instructions for Accessing the Annual Financial Report

The Annual Financial Report is an attachment to the PDF of the handbook. Click on the Ways and Means instruction page on a computer or laptop, click on the paper clip on the left side of the screen. The report is password protected. The password for delegates and alternates is included in the delegate email from April 3, 2023. If you need assistance, please email Rebecca Blake at rblake@msms.org or 517-336-5729.

Message from Ways and Means Committee Chair, Dennis Szymanski, MD

The Ways and Means Committee discusses financial “policy” of MSMS at the annual House of Delegates meeting. If anyone has “bookkeeping” type questions on the MSMS Annual Financial Report, please email your questions prior to the meeting to Lauchlin MacGregor, Chief Financial Officer at lmacgregor@msms.org. Responses to these questions will be given prior to the meeting. This will allow the Ways and Means Committee meeting to be more efficient and effective with its time Saturday morning by focusing its discussion on the financial policy of MSMS. Thank you.