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RESOLUTION 02-21

Title: Vision Qualifications for Driver's License

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

Original Author: Patrick J. Droste, MD

Referred To:

House Action:

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

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

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

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

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

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

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

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

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

Whereas, it is well known that a large proportion of mortality involved auto crashes are accompanied by "driver error," and

Whereas, studies have been performed that show that drivers with the visual acuity less than 20/50 can be safe and competent drivers, and

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

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

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

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

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

Relevant MSMS Policy:
None

Relevant AMA Policy:

8.2 Impaired Drivers & Their Physicians

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

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

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

Sources:

1. Keeney, A., (1976). The visually impaired driver and physician responsibilities. (American Journal of Ophthalmology) 83: 799-801.
2. American Medical Association, (2003) Physicians guide to assessing and counseling older drivers. pp. 1-49. a. Essential Quote: "Although many states currently require far visual acuity for 20/40 for an unrestricted license, current research indicates that there is no scientific basis for this cut-off. In fact, studies undertaken in some states have demonstrated that there is no increased crash risk between 20/40 and 20/70 resulting in several new state requirements" page 45.
3. Rubin, G., Ng, E., et al., (2007) A prospective, population-based study of the role of visual impairment in motor vehicle crashes among older drivers: the SEE Study. (Investigative Ophthalmology & Visual Sciences) 48, (4) :1483-1491. a. Essential Quote: "Conclusions: Glare sensitivity, visual field loss and UFOV (useful field of vision) were significant predictors of crash involvement. Acuity, contrast sensitivity and stereo acuity were not associated with crashes. These results suggest that current vision screening for driver's licensure, based primarily on visual acuity, may miss important aspects of visual impairment." Owsley, C., Mc Gwin, G., (2010) Vision and driving. (Vision Research) 50:2348-2361. a. Essential Quote: "Based upon the research to date it is clear that if there is an association between visual acuity and driver safety, it is at best weak,...how does one rectify this conclusion in light of the significant findings from performance-based studies? One important consideration in this regard is that visual acuity related driving skill (e.g., sign recognition many not be crucial to the safe operation of a vehicle. Reading signage may be important for route planning or maintaining regulatory compliance with the "rule of the road" but it may not be critical for collision avoidance. " Owsley, C., Wood,. J., et al., (2015). A road map for

interpreting the literature on vision and driving. (Survey of Ophthalmology) 60:250-262. Tervo, T., (2018) Driver's health and fitness as a cause of a fatal motor vehicle accident in Finland. (The Eye, The Brain, and The Auto) 2018 (Link and /or abstract available from CAR author PCH). Keeney, A., (1976) The visually impaired driver and physician responsibilities. (American Journal of Ophthalmology) 82 (5):799-801. Fonda, G., (1989) Legal blindness can be compatible with safe driving. (Ophthalmology) 96 (10):1457-1459. Appel, S., Brilliant, R., et al., (1990) Driving with visual impairment: Facts and Issues. (Journal of Visual Rehabilitation) 4: 19-31. Peli, E., (2008) Driving with low vision: who, where, when and why. In Robert Massof, editor. (Albert and Jokobiec's Principles and Practice of Ophthalmology) 3rd Ed. Philadelphia, PA. Elsevier, 5369-5376. PLoS ONE

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8. MSMS Resolution #8-2019 AMA Resolution #427, June 2019
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11. Council Advisory Recommendation. CAR: 21-03. Shinar, D., (1977) Driver Visual Limitations, Diagnosis and Treatment. (NHTSA, US Department of Transportation, National Technical Information Service, Springfield, VA).

RESOLUTION 03-21

Title: Oppose Routine Use of Gonad Shields

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

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

Referred To:

House Action:

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

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

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

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

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

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

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

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

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

Whereas, the gonad shield produces artifacts and can obscure relevant anatomy and diagnostic information, and

Whereas, non-diagnostic or obscured images may need to be repeated increasing patient dose when shields are used, and

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

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

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

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

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

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

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

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

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

Relevant MSMS Policy:
None

Relevant AMA Policy:
None

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12. https://www.asrt.org/main/news-publications/news/article/2021/01/12/asrt-statement-on-fetal-and-gonadal-shielding

RESOLUTION 04-21

Title: Dissemination of Information to County Medical Societies

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

Original Author: Christopher J. Allen, MD

Referred To:

House Action:

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

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

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

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

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

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

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

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

Whereas, the newly cited MSMS policy suggests CMS are “third parties” and not component partners in unified membership efforts; therefore be it

RESOLVED: That MSMS amend its Website Privacy Policy Information Sharing and Disclosure policy to affirm the County Medical Societies as component societies, and continue the transparent process of providing member and nonmember information to the Secretary and Executive Director/Administrator, if applicable, of the duly chartered County Medical Societies as requested without regard to the members' or nonmembers' county of origin; and be it further

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

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

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

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

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

Definitions: "Non-Personal Information" is information that is in no way personally identifiable and that is obtained automatically through your use of the Site with a Web browser. "Personally Identifiable Information" is non-public information that is personally identifiable and obtained in connection with providing a product or service to you. It may include information such as name and address.

Information collected: When you enter the Site, we collect Non-Personal Information, such as your browser type and IP address. Likewise, in order to offer you meaningful products and services and for other reasons, we may collect personally identifiable Information about you from the following sources: Information you give us on applications or other forms on the Site; or Information you send us via any medium, including, but not limited to email, telephone, and social media interaction. If you are a non-registered visitor to the Site, the only information we collect will be Non-Personal Information through the use of cookies and/or pixels. Information you provide to third-party websites is not within the control of the Michigan State Medical Society and you provide such information at your own risk. The terms and conditions of use and the privacy policies of those websites that you provide information to will govern their use of such information.

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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

RESOLUTION: 05-21

Title: Health Information Card

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

Original Authors: Mirna Kaafarani and Federico Mariona, MD

Referred To:

House Action:

Whereas, the SARS-CoV-2 novel coronavirus is the third highly transmissible pathogen in its class that has surfaced in the first 20 years of the 21st century and reached the level of a pandemic, causing the clinical disease known as Corona Virus Disease-19 (CoVid-19), and

Whereas, Covid-19 affects the health, society, education, economy, and security of the United States population, and

Whereas, accurate and consistent public information is of critical importance to identify, design, and implement programs and processes that are consistent with the needs of the state public health institutions to provide appropriate means to mitigate and implement statewide solutions to health crises and catastrophic events, and

Whereas, the public lacks confidence in the veracity and the consistency of the health information provided by the health authorities and the media, with conflicting and frequently changing advice increasing the health care, social, and economic uncertainty, and

Whereas, that a state Health Information Card should be implemented and equipped with programmed encrypted microchip technology to protect the identity of the holder. The card will allow for real time entry of health events and provide access to health information changes and contribute to build the state's public health system information network, assist in the implementation of strategic plans for public information, individual evidence-based treatment, guide public health advocacy, economic policies, national security integrity, and advanced planning, and

Whereas, a similar system has been tested, tried, and used in advanced industrialized countries in the world including the United States in Tennessee, and

Whereas, providing accurate information can be achieved, by the implementation of a system that allows for timely obtainment and recording of pertinent data gathering to construct epidemiological models avoiding poor methodology and variable definitions; therefore be it

RESOLVED: That MSMS encourage the state's public health authorities and the state legislature to work towards the implementation of a state Health Information Card, issued to each citizen in the state to contain the demographic and clinical information needed to allow for the

building of a standard system of health data collection and facilitate reporting of the state's population health status.

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

STATEMENT OF URGENCY: The SARS-CoV-2 novel coronavirus is the third highly transmissible pathogen in its class that has surfaced in the first 20 years of the 21st century and reached the level of a pandemic, causing the clinical disease known as Corona Virus Disease -19 (CoVid-19). Accurate and consistent public information tracking the virus is of critical importance. This resolution is time sensitive as it deals with developing a standard system of health data collection and facilitate reporting of the state's population health status regarding COVID-19. Similar systems have already been tested, tried and used in advanced industrialized countries. This identification card will allow for real time entry of health events and provide access to health information changes and contribute to build the state's public health system information network, assist in the implementation of strategic plans for public information, individual evidence-based treatment, guide public health advocacy, economic policies, national security integrity and advanced planning.

Relevant MSMS Policy:
None

Relevant AMA Policy:
None

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RESOLUTION 07-21

Title: COVID-19 Vaccine Entry Into MCIR

Introduced by: Neeli Thati, MD, for the Wayne County Delegation

Original Author: Neeli Thati, MD

Referred To:

House Action:

Whereas, the Affordable Care Act of 2010 establishes patient-centered outcomes for all ages, and

Whereas, the Patient Centered Medical Home is the vehicle to achieve patient centered outcomes, and

Whereas, the Patient Centered Medical Home is a health care setting where, among others, care is facilitated by registries, information technology, health information exchange, and other means, and

Whereas, the Michigan Care Improvement Registry (MCIR), through the careful tracking of immunization information provided by health care providers and making this information accessible to authorized users online, strives to reduce the occurrence of vaccine preventable illness, and

Whereas, patients typically do not keep records of their immunizations, and

Whereas, immunization information is an integral part of EHRs used in Michigan practices, and

Whereas, adult immunization, in contrast to pediatric immunization, is not mandated to be entered into the MCIR system within 72 hours, and

Whereas, Michigan's COVID-19 vaccine roll out is primarily through the local county health departments, hospitals and pharmacies. Although the number of doses is carefully being accounted for at each distribution center, efforts should be made to update this information in MCIR; therefore be it

RESOLVED: That MSMS support legislation for Michigan that mandates entry of COVID-19 Vaccine into the Michigan Care Improvement Registry (MCIR) system within 72 hours.

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

STATEMENT OF URGENCY: Adult immunization, in contrast to pediatric immunization, is not mandated to be entered into the MCIR system within 72 hours. COVID-19 Vaccine roll out is through the local county health departments and pharmacies. Although the number of doses are carefully being accounted for at each distribution center, it is crucial that efforts be made to update this information in MICR. This is a very time sensitive matter.

Relevant MSMS Policy:
None

Relevant AMA Policy:
None

RESOLUTION 09-21

Title Repeal Safe Harbor Provisions

Introduced by: James Szocik, MD, for the Washtenaw County Delegation

Original Author: James Szocik, MD

Referred To:

House Action:

Whereas, group purchasing organizations (GPO) and pharmacy benefits managers (PBM) act as middlemen between producers of drugs and supplies and the consumers, hospitals and patients, and

Whereas, GPO and PBM propose to add value to the consumers by negotiating contracts, but in reality they extract "rent," limit innovation distort prices (IV saline is sold at below cost because it is "coupled" with other purchases), and contribute to drug shortage, and

Whereas, GPO and PBM further offer "rebates" to hospital systems and major consumers that would otherwise be categorized as "bribes" or "kick-backs" and are only allowed under special "safe harbor provisions" of U.S. law, and

Whereas, this results in increased costs for the end consumer, and

Whereas, the previous Administration supported and was working on eliminating these safe harbors, the current Administration has suspended all implementation of such changes; therefore be it

RESOLVED: That MSMS advocate for the repeal of the "Safe Harbors" under 42 CFR 1001.952(j) , 42 U.S.C. 1320a-7b(b)(3)(C) and any other state or federal statutes that may apply and support the substitution of rebates directly to the consumer and the public; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) urge our AMA to advocate for the repeal of the "Safe Harbors" under 42 CFR 1001.952(j) , 42 U.S.C. 1320a-7b(b)(3)(C) and any other state or federal statutes that may apply and support the substitution of rebates directly to the consumer and the public.

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

STATEMENT OF URGENCY: In November 2020, the HHS OIG finalized its previously abandoned 2019 proposal to exclude certain rebates paid by drug manufacturers from the discount safe harbor to the federal anti-kickback statute. The rule is expected to go into effect in January 2021.

Relevant MSMS Policy:
None

Relevant AMA Policy:
None

Sources:

1. https://www.modernhealthcare.com/article/20190119/NEWS/190119924/are-gpos-pbms-part-of-the-drug-cost-problem-or-the-solution
2. https://www.masimo.com/company/news/media-room/antitrust-litigation/
3. https://khn.org/wp-content/uploads/sites/2/2016/10/pipelinetoprofits.pdf
4. https://www.gao.gov/assets/590/589778.pdf
5. https://jamanetwork.com/journals/jama/fullarticle/2708613
6. https://www.jdsupra.com/legalnews/trump-administration-revives-rebate-84255/

RESOLUTION 10-21

Title: Financial Impact and Fiscal Transparency of the American Medical Association Current Procedural Terminology Program

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

Original Authors: Patrick Droste, MD, and Megan Edison, MD

Referred To:

House Action:

Whereas, the 2020 COVID-19 pandemic and restrictions brought unprecedented financial strain upon physicians, with the most recent Physician Foundation survey showing 12 percent of physicians either closing or planning to close their practice within the next year (75 percent of those physicians are in private practice), and nearly 75 percent of physicians reported lost income, and

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

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

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

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

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

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

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

Whereas, the new CPT® system awards higher levels of reimbursement for curb siding a specialist, thereby encouraging and codifying a system of uncompensated care by specialists, and

Whereas, while the intent of this coding change may have been noble, the fallout and failures need to be studied and modified to create a fair system among private and employed physicians, reflective of the complexity of care within all specialties, and respectful of uncompensated care by our specialist colleagues, and

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

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

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

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

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

Relevant MSMS Policy:
None

Relevant AMA Policy:

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

Preservation of Evaluation/Management CPT Codes H-70.985
It is the policy of the AMA to (1) oppose the bundling of procedure and laboratory services within the current CPT Evaluation/Management (E/M) services;
(2) oppose the compression of E/M codes and support efforts to better define and delineate such services and their codes;
(3) seek feedback from its members on insurance practices that advocate bundling of procedures and laboratory services with or the compression of codes in the CPT E/M codes, and express its views to such companies on behalf of its members;

(4) continue to work with the PPRC and all other appropriate organizations to insure that any modifications of CPT E/M codes are appropriate, clinically meaningful, and reflective of the considered views of organized medicine; and
(5) work to ensure that physicians have the continued opportunity to use CPT as a coding system that is maintained by the medical profession.

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

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

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

Source:
http://physiciansfoundation.org/wp-content/uploads/2020/08/20-1278-Merritt-Hawkins-2020-Physicians-Foundation-Survey.6.pdf

RESOLUTION 11-21

Title: Updates to Organ Donation and Transplant Policies

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

Original Author: Richard Burney, MD

Referred To:

House Action:

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

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

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

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

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

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

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

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

> MSMS opposes payment in any form to the donor, the donor's family members, or the donor's agents for organs used for transplant. **Payment does not mean provisions for donation-related expenses incurred by a living organ donor including, but not limited to medical expenses related to the donation or expenses incurred after the donation as a consequence of donation**; and be it further

RESOLVED: That MSMS actively advocate for and endorse legislation in Michigan that would enable organ transplants from HIV-positive donors to HIV-positive recipients.

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

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

Relevant MSMS Policy:

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

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

Relevant AMA Policy:

6.1.1 Transplantation of Organs from Living Donors
Donation of nonvital organs and tissue from living donors can increase the supply of organs available for transplantation, to the benefit of patients with end-stage organ failure. Enabling individuals to donate nonvital organs is in keeping with the goals of treating illness and relieving suffering so long as the benefits to both donor and recipient outweigh the risks to both.
Living donors expose themselves to harm to benefit others; novel variants of living organ donation call for special safeguards for both donors and recipients.
Physicians who participate in donation of nonvital organs and tissues by a living individual should:
(a) Ensure that the prospective donor is assigned an advocacy team, including a physician, dedicated to protecting the donor's well-being.
(b) Avoid conflicts of interest by ensuring that the health care team treating the prospective donor is as independent as possible from the health care team treating the prospective transplant recipient.
(c) Carefully evaluate prospective donors to identify serious risks to the individual's life or health, including psychosocial factors that would disqualify the individual from donating; address the individual's specific needs; and explore the individual's motivations to donate.
(d) Secure agreement from all parties to the prospective donation in advance so that, should the donor withdraw, his or her reasons for doing so will be kept confidential.
(e) Determine that the prospective living donor has decision-making capacity and adequately understands the implications of donating a nonvital organ, and that the decision to donate is voluntary.
(f) In general, decline proposed living organ donations from unemancipated minors or legally incompetent adults, who are not able to understand the implications of a living donation or give voluntary consent to donation.
(g) In exceptional circumstances, enable donation of a nonvital organ or tissue from a minor who has substantial decision-making capacity when:
(i) the minor agrees to the donation;
(ii) the minor's legal guardians consent to the donation;
(iii) the intended recipient is someone to whom the minor has an emotional connection.
(h) Seek advice from another adult trusted by the prospective minor donor when circumstances warrant, or from an independent body such as an ethics committee, pastoral service, or other institutional resource.
(i) Inform the prospective donor:

(i) about the donation procedure and possible risks and complications for the donor;
(ii) about the possible risks and complications for the transplant recipient;
(iii) about the nature of the commitment the donor is making and the implications for other parties;
(iv) that the prospective donor may withdraw at any time before undergoing the intervention to remove the organ or collect tissue, whether the context is paired, domino, or chain donation; and
(v) that if the donor withdraws, the health care team will report simply that the individual was not a suitable candidate for donation.
(j) Obtain the prospective donor's separate consent for donation and for the specific intervention(s) to remove the organ or collect tissue.
(k) Ensure that living donors do not receive payment of any kind for any of their solid organs. Donors should be compensated fairly for the expenses of travel, lodging, meals, lost wages, and medical care associated with the donation only.
(l) Permit living donors to designate a recipient, whether related to the donor or not.
(m) Decline to facilitate a living donation to a known recipient if the transplantation cannot reasonably be expected to yield the intended clinical benefit or achieve agreed on goals for the intended recipient.
(n) Permit living donors to designate a stranger as the intended recipient if doing so produces a net gain in the organ pool without unreasonably disadvantaging others on the waiting list. Variations on donation to a stranger include:
(i) prospective donors who respond to public solicitations for organs or who wish to participate in a paired donation ("organ swap," as when donor-recipient pairs Y and Z with incompatible blood types are recombined to make compatible pairs: donor-Y with recipient-Z and donor-Z with recipient-Y);
(ii) domino paired donation;
(iii) nonsimultaneous extended altruistic donation ("chain donation").
(o) When the living donor does not designate a recipient, allocate organs according to the algorithm that governs the distribution of deceased donor organs.
(p) Protect the privacy and confidentiality of donors and recipients, which may be difficult in novel donation arrangements that involve many patients and in which donation-transplant cycles may be extended over time (as in domino or chain donation).
(q) Monitor prospective donors and recipients in proposed nontraditional donation arrangements for signs of psychological distress during screening and after the transplant is complete.
(r) Support the development and maintenance of a national database of living donor outcomes to support better understanding of associated harms and benefits and enhance the safety of living donation.
AMA Principles of Medical Ethics: I,V,VII,VIII

6.2.2 Directed Donation of Organs for Transplantation

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

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

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

(a) Support ongoing collection of empirical data to monitor the effects of solicitation of directed donations on the availability of organs for transplantation.
(b) Support the development of evidence-based policies for solicitation of directed donation.

(c) Ensure that solicitations do not include potentially coercive inducements. Donors should receive no payment beyond reimbursement for travel, lodging, lost wages, and the medical care associated with donation.
(d) Ensure that prospective donors are fully evaluated for medical and psychosocial suitability by health care professionals who are not part of the transplant team, regardless of any relationship, or lack of relationship, between prospective donor and transplant candidate.
(e) Refuse to participate in any transplant that he or she believes to be ethically improper and respect the decisions of other health care professionals should they choose not to participate on ethical or moral grounds.
AMA Principles of Medical Ethics: VII,VIII,IX

Removing Financial Barriers to Living Organ Donation H-370.965
1. Our AMA supports federal and state laws that remove financial barriers to living organ donation, such as: (a) provisions for expenses involved in the donation incurred by the organ donor; (b) providing access to health care coverage of any medical expense related to the donation; (c) provisions for expenses incurred after the donation as a consequence of donation; (d) prohibiting employment discrimination on the basis of living donor status; (e) prohibiting the use of living donor status as the sole basis for denying or limiting health, life, and disability and long-term care insurance coverage; and (f) provisions to encourage paid leave for organ donation.
2. Our AMA supports legislation expanding paid leave for organ donation.
3. Our AMA advocates that live organ donation surgery be classified as a serious health condition under the Family and Medical Leave Act.

Sources:

1. https://www.kidneynews.org/kidney-news/cover-story/kidney-donation-costs-too-high-for-potential-donors-with-low-income#:~:text=For%20donors%2C%20however%2C%20the%20reported,month%27s%20salary%20for%20most%20donors
2. https://www.giftoflifemichigan.org/about-us
3. https://optn.transplant.hrsa.gov/learn/professional-education/hope-act/

RESOLUTION 12-21

Title: Standard Practice for Members Joining or Transferring Membership

Introduced by: Joseph Wilhelm, MD, for the Ingham County Delegation

Original Author: Joseph Wilhelm, MD

Referred To:

House Action:

Whereas, Article III, Section 1 of the Michigan State Medical Society (MSMS) Constitution states: DEFINITION—Component societies shall consist of those county medical societies which hold charters from this Society, and

Whereas, Article III, Section 2 of the MSMS Constitution states: GEOGRAPHICAL SCOPE-Not more than one component society shall be chartered in any county of the State. The House of Delegates may, however, in its discretion, grant a charter to a component society comprising two or more counties, and

Whereas, Section 2.20 of the MSMS Bylaws states: MEMBERSHIP PREREQUISITE-All members of the several component societies, when in good standing, are thereby and must be members of this Society. All members of this Society must be members of a component medical society or direct members through the Resident and Fellow Section or the Medical Student Section, and

Whereas, Section 2.30 of the MSMS Bylaws states: ACTIVE MEMBERS-To be eligible for active membership in any component society, doctors of medicine must hold an unrevoked, permanent license that is not currently under suspension in Michigan, or if unlicensed, must be engaged in academic teaching, research or administration. To maintain active membership in any component society, doctors of medicine must maintain active membership in this Society and comply with all the provisions of the Bylaws of this Society and the component society, and

Whereas, Section 4.10 of the MSMS Bylaws states: MEMBERSHIP AS PRIVILEGE - NOT RIGHT—Admission to membership in any component society is not a matter of right, but one of privilege, to be accorded or withheld at the sole discretion of such society. Each component society may determine the manner of electing its members and shall be the sole judge of the qualifications of applicants for membership therein. There shall be no discrimination on the basis of race, religion, sex, ethnic origin, or sexual orientation, and

Whereas, Section 4.20 of the MSMS Bylaws states: ADJOINING COUNTY—A doctor of medicine whose principal location of practice is near a county may, with the permission of the Board of Directors of this Society, and upon being duly elected thereto, hold membership in the component society most convenient for the member to attend, and

Whereas, it is the practice of our county medical societies and our MSMS that new members to the Michigan State Medical Society join the component medical society of the county

where they either live or primarily work and the MSMS website states, "When you become a member of MSMS, you also become a member of the county medical society in which you live or work," and

Whereas, any current member wishing to transfer membership to another county medical society must first receive a good standing certification from the former county medical society and approval from the new county medical society, and

Whereas, the county medical societies became aware in July 2020, of physician(s) and/or physician group(s) being allowed to join and/or to transfer membership to inactive counties (counties with no discernable county medical society leadership, structure, operations, or membership dues requirements) in which they did not live and/or primarily work, and

Whereas, MSMS staff did not notify the county medical societies when these members transferred membership, and

Whereas, the county medical societies initiated discussion about these aberrant situations with MSMS staff on July 20, 2020, and

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

Whereas, this practice of allowing physicians to join and/or transfer to counties in which they do not live and/or primarily work continues to occur since the October 2020, MSMS Board meeting, and

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

Whereas, this practice is disruptive and harmful to the integrity and vitality of the county medical societies and MSMS; therefore be it

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

2.20 MEMBERSHIP PREREQUISITE-All members of the several component societies, when in good standing, are thereby and must be members of this Society. All members of this Society must be members of a component medical society **where they live or primarily work** or direct members through the Resident and Fellow Section or the Medical Student Section.

4.10 MEMBERSHIP AS PRIVILEGE - NOT RIGHT—**A doctor of medicine may apply for component membership within the county of their residence or primary location of practice. Any exception would require written, mutual agreement between the physician and/or physician group, the MSMS, and the respective county(ies).**

Admission to membership in any component society is not a matter of right, but one of privilege, to be accorded or withheld at the sole discretion of such society. Each component society may determine the manner of electing its members and shall be the sole judge of the qualifications of applicants for membership therein. There shall be no discrimination on the basis of race, religion, sex, ethnic origin, or sexual orientation.

4.20 ADJOINING COUNTY—A doctor of medicine whose **residence or** principal location of practice is near ~~a county~~ **an active, chartered county medical society** may, with the permission of the Board of Directors of this Society, and upon being duly elected thereto, hold membership in the **nearest active, chartered** ~~component~~ **county medical** society most convenient for the member to attend.

5.10 CHANGE OF LOCATION – PROCEDURE—When a member of a component society, by reason of change of **residence or primary practice** location, desires to transfer membership to another component society, such member shall make application thereto accompanied by tender of dues for the remaining half of the current year (any major fraction of a half being regarded as a full half and any minor fraction being disregarded). Thereupon, the secretary of the society to which application is made shall request certification of standing from the Society from which the member desires to transfer and upon receipt of such request the secretary of the latter Society shall supply certification of good standing, provided the following requirements have been met:

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

STATEMENT OF URGENCY: The county medical societies became aware in July 2020 of physician(s) and/or physician group(s) being allowed to join and/or to transfer membership to inactive counties (counties with no discernable county medical society leadership, structure, operations, or membership dues requirements) in which they did not live and/or primarily work. MSMS staff did not notify the county medical societies when these members joined or transferred membership. The county medical societies initiated discussion about these aberrant situations with MSMS staff on July 20, 2020 and, following that discussion, the MSMS Board of Directors considered and approved a motion at the October 2020 Board meeting re-interpreting the bylaws stating "that the MSMS Board of Directors acknowledge MSMS Legal Counsel's interpretation that the MSMS Bylaws do not expressly require a physician to live or work in a county in order to hold membership in that county medical society." This practice of allowing physicians to join and/or transfer to counties in which they do not live and/or primarily work has continued to occur since the October 2020 MSMS Board meeting, creating an incentive for physicians and/or physician groups regardless of where they live or work to join inactive counties without membership dues to reduce their cost. This must be addressed at this House of Delegates as the practice is disruptive and harmful to the integrity and vitality of the county medical societies and MSMS.

Relevant MSMS Policy:
Over the past year, MSMS has deployed several strategies to address issues raised by county medical societies regarding state society operations and procedures relative to membership, advocacy, communications and the House of Delegates. Those strategies include weekly (spring 2020) and then bi-

weekly (summer 2020) virtual meetings between the MSMS CEO and county society staff, monthly meetings between MSMS departmental heads and county society staff (which have been ongoing since 2010), and a facilitator-led series of meetings to research state and county perspectives and host a series of meetings to work through how various issues will be handled going forward. The consultant work is ongoing, and the topic raised in this resolution has been part of that process. In addition, county concerns have been discussed broadly at MSMS Board meetings, the Chair and Vice Chair hosted a virtual meeting with Regional Directors representing five counties raising concerns, and the MSMS Executive Committee has also met to support strategies to establish best practices between state and county going forward.

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

Relevant AMA Policy:
None

Sources:
1. https://connect.msms.org/Membership/Join
2. Source: January 14, 2021 MSMS Board of Directors Meeting Packet

RESOLUTION 13-21

Title:	Upholding the Integrity and Vitality of the State and County Medical Societies
Introduced by:	Narasimha Gundamraj, MD, for the Ingham County Delegation, Christopher J. Allen, MD, for the Saginaw County Delegation, and Evelyn Eccles, MD, for the Washtenaw County Delegation
Original Author:	Evelyn Eccles, MD
Referred To:	
House Action:	

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

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

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

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

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

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

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

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

Whereas, the county medical societies have become aware of physician(s) and/or physician group(s) that belong to counties in which they potentially do not live and/or work prior to the October 2020, MSMS Board or Directors motion and approval and subsequently since, and

Whereas, the county medical societies have requested and received membership roster(s) within their districts and/or regions previously, but have been informed by MSMS that this is not in accordance with MSMS Bylaws and policies since October 2020; therefore be it

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

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

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

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

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

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

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

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

Relevant AMA Policy:
None

Sources:

1. https://www.msms.org/About-MSMS/News-Media/overview-of-the-2019-msms-house-of-delegates
2. https://www.msms.org/hodresolutions/2019/63.pdf
3. Source: January 14, 2021 MSMS Board of Directors Meeting Packet

RESOLUTION 14-21

Title: Disposition of Complaints

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

Original Author: Evelyn Eccles, MD

Referred To:

House Action:

Whereas, MSMS and/or county societies have a duty to investigate complaints brought against one of their members involving ethical or medical behavior, and

Whereas, in the event that such a complaint is brought, component societies will initiate such investigation with the understanding that should legal advice be needed, they will have the support of MSMS legal counsel, and that their decisions may be reviewed by the MSMS Judicial Committee, and

Whereas, MSMS and/or county societies do not have a duty to investigate or adjudicate complaints that do not involve one or more of its members, and such complaints if they involve a physician who is not a member of MSMS or county society should be referred to LARA for disposition, and

Whereas, in the event that a complaint is brought against a member but the complaint is unrelated to and does not involve any aspect of that member's medical practice, it should not be referred for disposition by MSMS to the county society in which the alleged activity occurred, but should be dismissed by MSMS, and

Whereas, referral by MSMS of a complaint to the county society for disposition when the dispute does not involve a county society member or is not related to medical practice or patient care, places an unnecessary expectation, administrative, and financial burden on that society; therefore be it

RESOLVED: That MSMS shall provide legal counsel and knowledgeable staff to the county medical society whenever a complaint is received involving a physician member in said county related to medical practice and/or medical ethics.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions requiring external consultants - $50,000+

STATEMENT OF URGENCY: Complaints are considered as regular medical society business. A standard, clear practice should be developed and communicated to protect the medical societies and members.

Relevant MSMS Policy:

Judicial Commission Complaint Process

1. MSMS staff receive inquires from patients or physicians about filing a complaint for a physician, nurse, hospital, or any other healthcare facility.
2. If the complaint is about a physician, the staff member verifies that the physician is a MSMS member. If the physician is a member, the staff member explains that the Judicial Commission process is a peer review process which starts with the county society peer review committee. We encourage the complainant to personally discuss the issue with the physician. Finally, the staff member explains that the MSMS Judicial Commission does not have jurisdiction to award money damages, revoke, restrict or limit a physician's license.
3. Many times, when the complainant realizes it is a peer review process only, they decide not to proceed. If they decide to proceed, the staff member sends a complaint form to gather further information. The complainant has 30 days to submit the form with the detailed information.
4. Once the form is received by MSMS, the MSMS staff member determines the appropriate county medical society (CMS) who should review the complaint and forwards the information to that CMS. If there is not an active county medical society, the MSMS Judicial Commission reviews the complaint.
5. Each CMS has their own process for reviewing a complaint. The MSMS staff member stays in touch with the CMS staff member asking for updates.
6. Once the CMS peer review process makes their determination, they send information about the final decision to the MSMS staff member.
7. The MSMS staff member notifies the Judicial Commission chair about the decision. The Chair decides how the full Commission will be notified of the complaint.

Statistics on Complaints

Year	Forms Mailed	Forms Received	Full Complaint Process
2016	2	0	0
2017	1	1	1
2018	3	0	0
2019	1	0	0
2020	3	2	2

Relevant AMA Policy:
None

RESOLUTION 15-21

Title: Electronic Prescribing Waiver for Michigan's Free Clinics

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

Original Author: Michelle M. Condon, MD, FACP

Referred To:

House Action:

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

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

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

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

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

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

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

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

STATEMENT OF URGENCY: The business of the MSMS HOD addresses issues of physicians from all over Michigan, in a timely fashion, to improve the delivery of care, patient care issues and important policy and legislative issues affecting our members. Listening to the voice of physicians is paramount in organized medicine and is why many of our members participate at the county and state levels. Physician authors have taken the time during this busy and stressful time to articulate the issues. It is time to get back to the business of medicine for the sake of over-stressed

colleagues and their patients to address what is important to them, our members. The result can be improved transparency, updated physicians, or improved issues that affect patients in Michigan and/or across the country.

Relevant MSMS Policy:
None

Relevant AMA Policy:
None

RESOLUTION 16-21

Title: Medicaid Dialysis Policy for Undocumented Patients

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

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

Referred To:

House Action:

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

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

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

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

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

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

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

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

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask the AMA to work with the Center for Medicare and Medicaid Services and other state Medicaid programs to develop a dialysis policy for undocumented patients with end stage kidney disease as an emergency condition covered under Medicaid.

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

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

Relevant MSMS Policy:
None

Relevant AMA Policy:
None

RESOLUTION 17-21

Title: Surrogacy Options for Michigan Parents

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

Original Author: Adam J. Rush, MD

Referred To:

House Action:

Whereas, the AMA supports surrogate parenting "also termed Third Party Reproduction" as a form of assisted reproduction in which a woman agrees to bear a child on behalf of and relinquish the child to an individual or couple who intend to rear the child, and

Whereas, such arrangements can promote fundamental human values by enabling individuals or couples who are otherwise unable to do so to fulfill deeply held desires to raise a child, and

Whereas, gestational carriers in their turn can take satisfaction in expressing altruism by helping others fulfill such desires, and

Whereas, in the United States, individual states have the power to determine the legality of surrogacy agreements and surrogate compensation, and

Whereas, the state of Michigan is one of only three states that are outliers on surrogacy law, and

Whereas, in the state of Michigan statute prohibits compensated surrogacy contracts, and a birth certificate naming both intended parents cannot be obtained, and

Whereas, the state of New York in February 2021, made compensated surrogacy legal, and

Whereas, in 1998, MSMS endorsed the need to define and protect the legal status and rights of a child born as a result of surrogate parenting, and

Whereas, in 2018, Senator Rebekah Warren (D-Warren) introduced Senate Bill 1082 which to repeal Michigan's current law and replace it with the Gestational Surrogate Parentage Act, but it failed to advance; therefore be it

RESOLVED: That MSMS work with the Michigan legislature to amend the current law to assist parents and newborns in Michigan, clarify parenting rights, and support compensated surrogacy options.

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

STATEMENT OF URGENCY: This is a timely issue that should be addressed promptly for physicians and patients. In light of recent legislative discussions at the state and/or local level, physicians need to be involved in updating this legislation.

Relevant MSMS Policy:

Surrogate Parenting
MSMS endorses the need to define and protect the legal status and rights of a child born as a result of surrogate parenting. MSMS endorsement does not extend to the process of surrogate parenting. (Prior to 1990)

Relevant AMA Policy:

4.2.4 Third-Party Reproduction
Third-party reproduction is a form of assisted reproduction in which a woman agrees to bear a child on behalf of and relinquish the child to an individual or couple who intend to rear the child. Such arrangements can promote fundamental human values by enabling individuals or couples who are otherwise unable to do so to fulfill deeply held desires to raise a child. Gestational carriers in their turn can take satisfaction in expressing altruism by helping others fulfill such desires.

Third-party reproduction may involve therapeutic donor insemination or use of assisted reproductive technologies, such as in vitro fertilization and embryo transfer. The biological and social relationships among participants in these arrangements can form a complex matrix of roles among gestational carrier, gamete donor(s), and rearing parent(s).

Third-party reproduction can alter social understandings of parenthood and family structure. They can also raise concerns about the voluntariness of the gestational carrier's participation and about possible psychosocial harms to those involved, such as distress on the part of the gestational carrier at relinquishing the child or on the part of the child at learning of the circumstances of his or her birth. Third-party reproduction can also carry potential to depersonalize carriers, exploit economically disadvantaged women, and commodify human gametes and children. These concerns may be especially challenging when carriers or gamete donors are compensated financially for their services. Finally, third- party reproduction can raise concerns about dual loyalties or conflict of interest if a physician establishes patient-physician relationships with multiple parties to the arrangement.

Individual physicians who care for patients in the context of third-party reproduction should:

(a) Establish a patient-physician relationship with only one party (gestational carriers, gamete donor[s] or intended rearing parent[s]) to avoid situations of dual loyalty or conflict of interest.

(b) Ensure that the patient undergoes appropriate medical screening and psychological assessment.

(c) Encourage the parties to agree in advance on the terms of the agreement, including identifying possible contingencies and deciding how they will be handled.

(d) Inform the patient about the risks of third-party reproduction for that individual (those including individuals), possible psychological harms to the individual(s), the resulting child, and other relationships.

(e) Satisfy themselves that the patient's decision to participate in third-party reproduction is free of coercion before agreeing to provide assisted reproductive services.

Collectively, the profession should advocate for public policy that will help ensure that the practice of third-party reproduction does not exploit disadvantaged women or commodify human gametes or children.

Sources:

1. Third-Party Reproduction, The AMA Code of Ethics Opinion 4.2.4. www.ama-assn.org/delivering-care/ethics/third-party-reproduction
2. The United States Surrogacy Law Map. www.creativefamilyconnections.com/us-surrogacy-law-map
3. Surrogate Parenting Act. http://legislature.mi.gov/doc.aspx?mcl-act-199-of-1988
4. The Child-Parent Security Act. http://health.ny.gov/vital_records/child_parent_security_act
5. Senate Bill 1082 (2018). http://legislature.mi.gov/doc.aspx?2018-SB-1082

RESOLUTION 18-21

Title: Medical and Dental Care for Prisoners

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

Original Author: Patrick J. Droste, MS, MD

Referred To:

House Action:

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

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

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

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

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

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

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

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

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

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

STATEMENT OF URGENCY: We feel that the MSMS-HOD should hear and act on this resolution in 2021 and give it highest consideration, because prisoners are being denied timely and affordable

medical and dental care during their period of confinement. This neglect of care makes it more difficult for them to rehabilitate both inside the correction facilities and after their discharge.

Relevant MSMS Policy:
None

Relevant AMA Policy:
None

Source:
Kimberly Norris, MD, of Barry County

RESOLUTION 19-21

Title: De-professionalization of the Medical Profession

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

Original Author: Patrick J. Droste, MS, MD

Referred To:

House Action:

Whereas, physicians attend medical school, complete an internship, and residency training before being credentialed as a fully licensed physician, and

Whereas, physicians complete a rigorous series of board examinations during medical school, internship, and residency to certify their ability to diagnosis and treat patients, and

Whereas, physicians are regarded as the legal entity that is ultimately responsible for patient care, and

Whereas, health care workers are encouraged to address physicians by their first name rather than doctor, in order to lessen the "authority gradient" related to patient safety, and

Whereas, physicians-in-training are being encouraged to perform as active team members in patient care and are not being recognized as medical students or resident physicians, which potentially leads to confusion about leadership and accountability within the team, and

Whereas, medical schools are utilizing Advanced Practice Professionals as educators for future physicians, implying that the training of Advanced Practice Professionals is equivalent to the training of physicians, and

Whereas, physicians are still held professionally and legally accountable for outcomes, including adverse outcomes, of team-based care due to the higher level of training involved and the role as the team leader; therefore be it

RESOLVED: That MSMS supports only the use of titles and descriptors that align with a physician or non-physician provider's state issued licenses or credentials; and be it further

RESOLVED: That MSMS actively oppose efforts to diminish the qualifications and training of physicians by hospital administrators, insurance companies, and governmental regulatory agencies who require physicians be referenced as medical providers, team members, health care providers, or any other reference in lieu of the legal title of physician or doctor; and be it further

RESOLVED: That MSMS seek legislation which provides that professionals in a clinical health care setting clearly and accurately identify to patients their qualifications and degree(s) attained as follows:

1. Wear an identification badge which indicates the individual's name and credentials as appropriate (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc.), to differentiate between those who have achieved a Doctorate, and those with other types of credentials. The font size of their credentials shall be greater than the front size used for their name for the purpose of role definition and patient safety.
2. Anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor," and who has not received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine, shall specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.

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

STATEMENT OF URGENCY: We encourage the highest consideration for this resolution to be evaluated and acted upon by the Michigan State Medical Society-House of Delegates-2021. The medical profession has been victim of a well-organized downgrading of professional merit and expertise by providers who want to pay less for physician provided medical services by comparing them to advanced practice providers (APP). Hospital administrators want to decrease the "authority gradient" by removing titles in correspondence and video meetings and calling physicians by their first name. Pharmacists, physical therapists and nurses all offer doctorate degrees and want their graduates to be recognized by the public and hospitals as "Doctors." This creates a very confusing environment for patient satisfaction and safety and a very disturbing environment for physicians. This movement has been growing for over thirty years, with little tangible resistance by the medical profession and we feel that something legislative needs to be started this year by the MSMS to start reversing this overt devaluation of our profession.

Relevant MSMS Policy:

Calling Physicians by their First Name
MSMS discourages policies that require physicians to be called by their first names in professional settings such as their workplace. (Res42-16)

Physician Not Labeled as Provider
MSMS opposes the current custom by government and insurance companies of labeling physicians as providers and encourages proper identification of physicians and/or surgeons.
MSMS supports physicians who request they be identified as "physicians" apart from other "providers" on any contracts or documents they are asked to sign. (Res38-90A) – Amended 1993 – Edited 1998 -Reaffirmed (Sunset Report 2020)

Relevant AMA Policy:

"Doctor" as a Title H-405.992
The AMA encourages state medical societies to oppose any state legislation or regulation that might alter or limit the title "Doctor," which persons holding the academic degrees of Doctor of Medicine or Doctor of Osteopathy are entitled to employ.

Clarification of the Title "Doctor" in the Hospital Environment D-405.991

1. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement standards for an identification system for all hospital facility staff who have direct contact with patients which would require that an identification badge be worn which indicates the individual's name and credentials as appropriate (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), to differentiate between those who have achieved a Doctorate, and those with other types of credentials.

2. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement new standards that require anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor," and who is not a "physician" according to the AMA definition (H-405.969, ?that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine?) must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.

3. Our AMA will request the American Osteopathic Association (AOA) to (1) expand their standards to include proper identification of all medical staff and hospital personnel with their applicable credential (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), and (2) Require anyone in a hospital environment who has direct contact with a patient presenting himself or herself to the patient as a "doctor", who is not a "Physician" according to the AMA definition (AMA Policy H-405.969 .. that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine) must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.

RESOLUTION 20-21

Title: Designated Directors Serving as Chair of the MSMS Board of Directors

Introduced by: Betty S. Chu, MD, MBA

Original Author: Betty S. Chu, MD, MBA

Referred To:

House Action:

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

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

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

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

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

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

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

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

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

14.10 ORGANIZATION—The Board of Directors is the executive body of the Society. Subject only to the following, it shall determine the times and places of its meetings. At its first meeting immediately following the Annual Session of the House of

Delegates, the Board of Directors shall elect Secretary and Treasurer, who shall serve for a term of office of one year or until a successor is elected and takes office. At the same meeting, the Board of Directors shall elect a Chair, a Vice-Chair, a Chair of the Finance Committee, a Chair of the Health Care Delivery Committee, a Chair of the Legislative Policy Committee, and a Chair of the Scientific and Educational Affairs Committee, who shall be duly elected Regional Directors **or Designated Directors**, each to take office immediately and to serve for a term of one year or until a successor is elected and takes office.

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

Relevant MSMS Policy:
None

Relevant AMA Policy:
None

RESOLUTION 21-21

Title: Address Adolescent Telehealth Confidentiality Concerns

Introduced by: Mara Darian, for the Medical Student Section

Original Authors: Meredith Hengy, Aayush Mittal, and Samantha Rea

Referred To:

House Action:

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

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

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

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

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

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

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

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

Whereas, additional suggestions to provide confidential care to adolescents through telehealth include asking the adolescent to move to a more private area of the home, providing suggestions on unique areas that patients may go to ensure privacy, the use of headphones and

chat features, the use of yes or no answers, asking the adolescent for a 360 degree video view to understand who is in the room, and having the parent and adolescent call from separate devices to easily facilitate the transition to confidential discussions, and

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

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

Confidential Health Services for Adolescents H-60.965
Our AMA:
(1) reaffirms that confidential care for adolescents is critical to improving their health;
(2) encourages physicians to allow emancipated and mature minors to give informed consent for medical, psychiatric, and surgical care without parental consent and notification, in conformity with state and federal law;
(3) encourages physicians to involve parents in the medical care of the adolescent patient, when it would be in the best interest of the adolescent. When, in the opinion of the physician, parental involvement would not be beneficial, parental consent or notification should not be a barrier to care;
(4) urges physicians to discuss their policies about confidentiality with parents and the adolescent patient, as well as conditions under which confidentiality would be abrogated. This discussion should include possible arrangements for the adolescent to have independent access to health care (including financial arrangements);
(5) encourages physicians to offer adolescents an opportunity for examination and counseling apart from parent. The same confidentiality will be preserved between the adolescent patient and physician as between the parent (or responsible adult) and the physician;
(6) encourages state and county medical societies to become aware of the nature and effect of laws and regulations regarding confidential health services for adolescents in their respective jurisdictions. State medical societies should provide this information to physicians to clarify services that may be legally provided on a confidential basis;
(7) urges undergraduate and graduate medical education programs and continuing education programs to inform physicians about issues surrounding minors' consent and confidential care, including relevant law and implementation into practice;
(8) encourages health care payers to develop a method of listing of services which preserves confidentiality for adolescents; and
(9) encourages medical societies to evaluate laws on consent and confidential care for adolescents and to help eliminate laws which restrict the availability of confidential care; and
(10) encourages physicians to recognize the unique confidentiality concerns of adolescents' and their parents associated with telehealth visits; and
(11) encourages physicians in a telehealth setting to offer examination and counseling apart from others in the home and to ensure that the adolescent is in a private space.

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

Relevant MSMS Policy:
None

Relevant AMA Policy:
See above.

Sources:

1. Daley AM, Polifroni EC, Sadler LS. The Essential Elements of Adolescent-friendly Care in School-based Health Centers: A Mixed Methods Study of the Perspectives of Nurse Practitioners and Adolescents. J Pediatr Nurs. 2019 Jul-Aug;47:7-17. doi: 10.1016/j.pedn.2019.03.005. Epub 2019 Apr 11. PMID: 30981090.
2. Zucker NA, Schmitt C, DeJonckheere MJ, Nichols LP, Plegue MA, Chang T. Confidentiality in the Doctor-Patient Relationship: Perspectives of Youth Ages 14-24 Years. J Pediatr. 2019 Oct;213:196-202. doi: 10.1016/j.jpeds.2019.05.056. Epub 2019 Jun 21. PMID: 31230890.
3. Fuzzell L, Fedesco HN, Alexander SC, Fortenberry JD, Shields CG. "I just think that doctors need to ask more questions": Sexual minority and majority adolescents' experiences talking about sexuality with healthcare providers. Patient Educ Couns. 2016 Sep;99(9):1467-72. doi: 10.1016/j.pec.2016.06.004. Epub 2016 Jun 14. PMID: 27345252.
4. Fuentes L, Ingerick M, Jones R, Lindberg L. Adolescents' and Young Adults' Reports of Barriers to Confidential Health Care and Receipt of Contraceptive Services. J Adolesc Health. 2018 Jan;62(1):36-43. doi: 10.1016/j.jadohealth.2017.10.011. Epub 2017 Nov 20. PMID: 29157859; PMCID: PMC5953199.
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RESOLUTION 22-21

Title: Expanding Access to Medication for the Treatment of Opioid Use Disorder

Introduced by: Mara Darian, for the Medical Student Section

Original Authors: May Chammaa and Brianna Sohl

Referred To:

House Action:

Whereas, in 2017, there were 21.2 opioid overdose deaths per 100,000 persons in Michigan, which is higher than the national rate of 14.6 deaths per 100,000 persons; nationally, more than 2 million people have an opioid use disorder (OUD) but fewer than 10 percent have accessed treatment, and

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

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

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

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

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

Whereas, implementing point of care initiation of buprenorphine treatment and referral such as within the emergency department is hindered by factors including the buprenorphine

waiver and thus loses a significant setting for intervention that, when utilized, has shown to reduce one-year mortality, and

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

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

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

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

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

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

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

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

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

RESOLVED: That MSMS advocates for the elimination of the requirement for obtaining a waiver to prescribe buprenorphine for the treatment of opioid use disorder; and be it further

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

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

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

Relevant MSMS Policy:
None

Relevant AMA Policy:

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

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22. U.S. Department of Health and Human Services, "HHS Expands Access to Treatment for Opioid Use Disorder," Jan. 2021
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RESOLUTION 23-21

Title: Licensure of Nutritionists and Dietitians

Introduced by: Michael Moentmann, for the Medical Student Section

Original Author: Michael Moentmann

Referred To:

House Action:

Whereas, Michigan is one of three states which has no formal licensing requirements or title protections for nutritionists and dietitians, and

Whereas, licensure assures health insurance companies, state, and federal governments that practitioners who are being reimbursed for nutrition care services meet standards of professional competence, and

Whereas, without proper training, individuals can present fringe nutritional practices as evidence-based, or misinterpret current nutritional research and misapply the findings, and

Whereas, without formal licensing, individuals who claim to have expertise in nutrition cannot be prevented from making misleading claims regarding nutrition supplements or weight loss plans that could be contraindicated with certain medical conditions, and

Whereas, registered dietitians have formal professional, educational, and ethical standards, including continuing professional education, and

Whereas, in previous legislation, licensing requirements and regulation did not apply to business people involved in the distribution of health-related products, so long as they did not identify themselves by the title of "dietitian" or "nutritionist," and

Whereas, MSMS maintains positions on licensing for other health-related fields, supporting the licensure and definition of scope of practice for legitimate professionals such as genetic counselors and nurse anesthetists, while opposing licensure for unproven health practitioners such as naturopaths; therefore be it

RESOLVED: That MSMS supports formal educational requirements and subsequent licensure of dietitians and nutritionists.

WAYS AND MEANS COMMITTEE FISCAL NOTE: None

Relevant MSMS Policy:

Licensure and Reimbursement for Certified Genetic Counselors
MSMS supports the licensure of certified genetic counselors. (Res36-16)

Certified Anesthesiologist Assistants
MSMS supports the licensure of "certified anesthesiologist assistants" (CAA), who would practice anesthesiology under the supervision of an anesthesiologist, consistent with other MSMS policy relative to scope of practice. (Board-Oct17)

Licensure of Naturopaths
MSMS opposes the use of licensing as a pathway for expanding the scope of practice of persons practicing naturopathic medicine. (Board-July2018)

Health Profession Boards Need to Protect Patients
MSMS opposes efforts by licensing boards of non physicians to establish their own scope of practice, and expansion in non-physicians scope of practice may only occur with approval of the Boards of Medicine, the respective non-physician licensing board, and the Legislature. (Res20-12)

Oppose Scope of Practice Expansion for Allied Health Care Professionals
MSMS opposes scope of practice changes for non-physician health care professionals that are not supported by their level of education and training. (Res89-16) - Amended (Res59-18)

Relevant AMA Policy:
None

Sources:

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RESOLUTION 24-21

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

Introduced by: Alangoya Tezel, for the Medical Student Section

Original Author: Sarosh Irani

Referred To:

House Action:

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

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

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

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

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

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

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

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

Whereas, a December 2020 survey found that while 58 percent of white Michigan voters plan to get the vaccine, only 33 percent of Black respondents intend to get the vaccine, with 26.1 percent saying "it depends," and

Whereas, the Minnesota Immunization Networking Initiative (MINI) successfully reached vulnerable communities to administer influenza vaccines through building relationships with community leaders, especially in faith communities, and holding clinics in these community-based settings, and

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

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

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

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

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

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

Relevant MSMS Policy:

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

Relevant AMA Policy:
None

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RESOLUTION 25-21

Title: Public Health Considerations to Reduce Harm in Encampment Removals

Introduced by: Mara Darian, for the Medical Student Section

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

Referred to:

House Action:

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

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

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

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

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

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

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

Whereas, the U.S. Interagency Council on Homelessness (USICH) stated in 2015, "The forced dispersal of people from encampment settings is not an appropriate solution or strategy ... and can

make it more difficult to provide such lasting solutions to people who have been sleeping and living in the encampment" and that "government agencies, service providers, [and] law enforcement ... should work together to understand the needs of those living in an encampment while assessing the needs of the service providers themselves," and

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

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

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

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

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

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

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

RESOLVED: That MSMS oppose the removal and relocation of encampments in Michigan without the involvement of public health departments to mitigate potential risks and harms to those living in affected encampments, in following with CDC guidelines; and be it further

RESOLVED: That for any planned encampment sweeps, MSMS advocates for the announcement of the planned removal to affected parties with at least 48-hour notice in order to minimize the disruptive and harmful nature of encampment removal on people experiencing homelessness; and be it further

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

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

Relevant MSMS Policy:
None

Relevant AMA Policy:

Eradicating Homelessness H-160.903
Our AMA:
(1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;
(2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless;
(3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;
(4) recognizes the need for an effective, evidence-based national plan to eradicate homelessness;
(5) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;
(6) will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs;
(7) encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;
(8) encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;
(9) (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; and
(10) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods.
Res. 401, A-15; Appended: Res. 416, A-18; Modified: BOT Rep. 11, A-18; Appended: BOT Rep. 16, A-19; Appended: BOT Rep. 28, A-19

Eradicating Homelessness: 440.048MSS
AMA-MSS will ask the AMA to: (1) support improving the health outcomes and decreasing the health care costs of treating the chronically homeless through

housing first approaches; and (2) support the appropriate organizations in developing an effective national plan to eradicate homelessness. MSS Res 33, A-14; Reaffirmed: MSS GC Rep A, I-19

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

AMA-MSS will ask that our AMA amend policy H-160.903 by addition and deletion to read as follows:
Eradicating Homelessness H-160.903
Our American Medical Association: (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services; (2) will work with state medical societies to advocate for legislation implementing stable, affordable housing and appropriate voluntary social services as a first priority in the treatment of chronically-homeless individuals, without mandated therapy or services compliance and (3) supports the appropriate organizations in
developing an effective national plan to eradicate homelessness. MSS Res 38, I-16; AMA Res 208, A-17 Referred

Opposition to Measures That Criminalize Homelessness: 440.066MSS

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

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RESOLUTION 26-21

Title: Decarceration During an Infectious Disease Pandemic

Introduced by: Sanjay Das, for the Medical Student Section

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

Referred To:

House Action:

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

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

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

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

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

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

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

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

Whereas, a 2020 report from a consensus panel of the National Academy of Sciences, Engineering, and Medicine recognized that reducing the size of the incarcerated population could

help increase the penetration and effectiveness of standard prevention measures in jails and prisons, such as testing, quarantining, and medical isolation for those who remain, and

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

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

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

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

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

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

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

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

Relevant MSMS Policy:
None

Relevant AMA Policy:

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

Support Public Health Approaches for the Prevention and Management of Contagious Diseases in Correctional and Detention Facilities H-430.979
1. Our AMA, in collaboration with state and national medical specialty societies and other relevant stakeholders, will advocate for the improvement of conditions of incarceration in all correctional and

immigrant detention facilities to allow for the implementation of evidence-based COVID-19 infection prevention and control guidance.
2. Our AMA will advocate for adequate access to personal protective equipment and SARS-CoV-2 testing kits, sanitizing and disinfecting equipment for correctional and detention facilities.
3. Our AMA will advocate for humane and safe quarantine protocols for individuals who are incarcerated or detained that test positive for or are exposed to SARS-CoV-2, or other contagious respiratory pathogens.
4. Our AMA supports expanded data reporting, to include testing rates and demographic breakdown for SARS-CoV-2 and other contagious infectious disease cases and deaths in correctional and detention facilities.
5. Our AMA recognizes that detention center and correctional workers, incarcerated persons, and detained immigrants are at high-risk for COVID-19 infection and therefore should be prioritized in receiving access to safe, effective COVID-19 vaccine in the initial phases of distribution, and that this policy will be shared with the Advisory Committee on Immunization Practices for consideration in making their final recommendations on COVID-19 vaccine allocation.

Health Care While Incarcerated H-430.986
1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA supports partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. That our AMA encourage state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
5. Our AMA encourages states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal justice system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA urges Congress, the Centers for Medicare & Medicaid Services (CMS), and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from adult and juvenile correctional facilities in order to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism.
7. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of incarcerated women and adolescent females, including gynecological care and obstetrics care for pregnant and postpartum women.
8. Our AMA will collaborate with state medical societies and federal regulators to emphasize the importance of hygiene and health literacy information sessions for both inmates and staff in correctional facilities.
9. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance abuse disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; and (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community.

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RESOLUTION 27-21

Title: Pictorial Health Warnings on Alcoholic Beverages

Introduced by: Alangoya Tezel, for the Medical Student Section

Original Author: Taania Girgla

Referred To:

House Action:

Whereas, excessive alcohol use is responsible for more than 95,000 deaths annually, making it a leading cause of preventable death in the U.S., and

Whereas, more than half of alcohol related deaths are linked to a rising number of life-threatening medical conditions - such as liver cirrhosis, cancer, cardiovascular disease, and stroke - with prolonged use of excessive alcohol linked to dementia and neuropathy, and use of excessive alcohol during pregnancy linked to fetal alcohol syndrome, the leading cause of intellectual disability in the U.S., and

Whereas, nationally, excessive alcohol use leads to a shortened lifespan by approximately 29 years, for a total of 2.8 million years of potential life lost, and in Michigan, excessive alcohol use results in 2,945 deaths and 84,215 years of potential life lost each year, and

Whereas, the economic burden of alcohol misuse is significant, costing the U.S. $249 billion in 2010 alone - of which, three-quarters of the total cost was related to binge drinking - and in Michigan, excessive alcohol use cost $8.2 billion, or $2.10 per drink, in 2010 alone - of which, three-quarters of the total cost was related to binge drinking, and

Whereas, In 2018, 5.8 percent of adults ages 18 and older nationally had alcohol use disorder, 26.45 percent of people ages 18 or older reported that they engaged in binge drinking in the past month, and 6.6 percent reported that they engaged in heavy alcohol use in the past month, and

Whereas, binge drinking specifically is responsible for more than half the deaths and two-thirds of the years of potential life lost resulting from excessive alcohol use, and in Michigan, 19.7 percent of adults and 17.8 percent of high school students reported binge drinking in 2011, and

Whereas, in Michigan, the alcohol-induced crude mortality rates have been steadily increasing for the last 40 years, and

Whereas, these numbers remain so despite a congressional "Alcoholic Beverage Labeling Act" (ABLA) passed in 1988 requiring health warning statements to appear on the labels of all containers of alcohol beverages for sale or distribution in the U.S., signifying that this label failed to warn against several of the medical consequences of excessive alcohol consumption, as it was required to only appear in text, and

Whereas, only 35 percent of all adults in the summer of 1991 reported having seen the warning label, signifying that these labels have done little to reduce rates of alcohol-related risky behaviors, rates of consumption, or alcohol-related poor health outcomes during this period, and

Whereas, MSMS current policy supports requiring a text-only warning statement on all advertising for alcoholic beverages regarding fetal alcohol syndrome, and

Whereas, during this same time, studies repeatedly showed that (1) larger pictorial and symbolic health warnings on tobacco packaging were more effective at reducing tobacco use than smaller text-only warnings, and (2) a mixture of health-related and social-related graphic health warnings on tobacco packaging were most effective at reducing tobacco use, and

Whereas, experts have recommended and studies have shown that the use of pictorial health warning on alcoholic beverages lead to improve health outcomes, and

Whereas, in the past decade several studies have predicted and proven that negative pictorial health warnings are associated with significantly increased perceptions of the health risks of consuming alcohol as well as greater intentions to reduce and quit alcohol consumption compared to the control, and

Whereas, though critics cite the somatic benefits of alcohol in moderation and question the need for health warnings on alcoholic beverages, research shows that there are adverse effects related to cancer at any level of alcohol consumption, and though critics argue that alcohol can still be consumed in bars and pubs without drinkers seeing the packaging, research actually shows that alcohol purchased from supermarkets is more than twice the level of alcohol consumed in bars/pubs, and

Whereas, MSMS supports a healthy lifestyle related to nutrition and exercise and the avoidance of alcohol and tobacco; therefore be it

RESOLVED: That MSMS will advocate for the implementation of pictorial health warnings on alcoholic beverages for sale in containers in Michigan, including but not limited to images such as a cirrhotic liver and dilated cardiomyopathy secondary to excessive alcohol use, a car crash, or an animation of a baby in the womb; and be it further

RESOLVED: That MSMS will advocate for the amendment of current MSMS policy, titled Fetal Alcohol Syndrome, Board-May94, to include language advocating for pictorial warnings of fetal alcohol syndrome from alcohol use during pregnancy; and be it further

RESOLVED: That MSMS will continue to support the use of health warnings on alcoholic beverages for sale in Michigan.

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

Relevant MSMS Policy:

Fetal Alcohol Syndrome
MSMS supports requiring a warning statement on all advertising for alcoholic beverages regarding fetal alcohol syndrome (FAS). (Board-May94)

Relevant AMA Policy:
None

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RESOLUTION 28-21

Title: Access to Menstrual Products in Correctional Facilities

Introduced by: Mara Darian, for the Medical Student Section

Original Authors: Yasmine Abushukur, Kaylie Bullock, Anne Grossbauer, Alice Hou, Yousef Ibrahim, Tiffany Loh, Dana Rector, Leah Rotenbakh and Manraj Sekhon

Referred To:

House Action:

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

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

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

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

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

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

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

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

Whereas, only 13 percent of an approximately $2 billion Michigan state corrections facilities budget is allocated to health care services for inmates, and

Whereas, 73 percent of women in state prisons struggle with mental health disorders, compared to 12 percent in the general population, and the symptoms of these disorders may be perpetuated when access to menstrual health and hygiene products is limited, and

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

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

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

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

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

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

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

Relevant MSMS Policy:
None

Relevant AMA Policy:

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

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RESOLUTION 29-21

Title: Fertility Treatment Coverage

Introduced by: Micaela Stevenson, for the Medical Student Section

Original Author: Micaela Stevenson

Referred To:

House Action:

Whereas, infertility is defined as the inability to conceive after one year of regular sexual intercourse without using birth control and can affect any age and sex, and

Whereas, involuntary childlessness due to infertility can profoundly impact people's lives, causing medical, social, economic, and psychological harm, and

Whereas, lack of insurance coverage often leads some women to take risks that will increase their chances of becoming pregnant such as implanting multiple embryos at one time, and

Whereas, implanting multiple embryos may cause multiple gestations, increasing the risk for maternal and fetal complications, as well as increased medical care expenditures due to these complications, and

Whereas, the majority of patients who wish to undergo fertility treatment, such as IVF, must pay out of pocket due to lack of health insurance or having insurance policies that do not cover infertility treatment, with the median price of a cycle of IVF in the United States, including medications, at $19,200, and

Whereas, Medicaid covers preconception care and contraceptives as part of family planning services, but infertility testing and treatments are rarely considered family planning services and rarely covered by Medicaid, and

Whereas, 16 states (not including Michigan) have passed laws that require insurers to either cover or offer coverage for infertility diagnosis and treatment. Fourteen of these require insurance companies to cover infertility treatment and two requiring insurance companies to offer coverage for infertility treatment; therefore be it

RESOLVED: That MSMS supports that Michigan health plans including Medicaid cover fertility treatment, such as in vitro fertilization and other treatments for fertility preservation.

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

Relevant MSMS Policy:
None

Relevant AMA Policy:
None

Sources:

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RESOLUTION 30-21

Title: Over the Counter Hormonal Contraception

Introduced by: Alangoya Tezel, for the Medical Student Section

Original Author: Micaela Stevenson

Referred To:

House Action:

Whereas, contraceptive vaginal rings and contraceptive patches have been available for almost 20 years via prescription, and

Whereas, contraceptive rings and patches are documented to have relatively few side effects, and

Whereas, these contraceptive methods have been linked to reduced rates of ovarian and endometrial cancer, and

Whereas, these devices are effective forms of contraception with failure rates comparable to those of combined oral contraceptive pills, and

Whereas, the United States continues to have the highest rates of unintended pregnancy in the industrialized world, with 54.7 percent of all pregnancies unplanned in 2011, and

Whereas, unintended pregnancies are associated with delays in initiating prenatal care, reduced likelihood of breastfeeding, increased risk of maternal depression, and increased risk of physical violence during pregnancy, and

Whereas, reducing the unintended pregnancy rate is a national priority reflected in the Healthy People 2020 goal, and

Whereas, unintended pregnancies disproportionately affect low-income women, Black women, and women who have not completed high school, and

Whereas, cost of medical appointments and access to physicians is commonly cited as barriers to receiving adequate contraceptive care, and

Whereas, the American College of Obstetricians and Gynecologists (ACOG) are in favor of making all hormonal contraceptives available over the counter as stated in committee opinion 788, and

Whereas, MSMS has already supported the ACOG Committee Opinion 544, to make oral contraceptives available over the counter; therefore be it

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

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

Relevant MSMS Policy:

Oral Contraceptives Available Over-the-Counter
MSMS supports the American College of Obstetricians and Gynecologists' committee opinion 544 which supports making oral contraceptives available as over the counter medication. (Res95-16)

Over the Counter Contraception (The Morning After Pill)
MSMS supports the concept of making the "morning after" contraceptive pill an over the counter medication. (Res6--06A)

Relevant AMA Policy:

Over-the-Counter Access to Oral Contraceptives D-75.995
Our AMA:
1. Encourages manufacturers of oral contraceptives to submit the required application and supporting evidence to the US Food and Drug Administration for the Agency to consider approving a switch in status from prescription to over-the-counter for such products.
2. Encourages the continued study of issues relevant to over-the-counter access for oral contraceptives.

Sources:

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RESOLUTION 31-21

Title: Availability of Medical Respite Centers

Introduced by: Katanya C. Alaga, for the Medical Student Section

Original Author: Katanya C. Alaga

Referred To:

House Action:

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

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

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

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

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

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

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

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

Whereas, medical respite care for homeless patients has been shown to reduce hospital re-admittance rates and length of stay, increase outpatient provider visits, and decrease health care charges, and

Whereas, a program in Boston demonstrated that patients discharged to a homeless respite program experienced an approximate 50 percent reduction in readmission rates at 90 days post-discharge, compared to those discharged to streets and shelters, and

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

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

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

Whereas, our AMA supports "improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches" and "development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to hospital," and

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

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

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

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

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

Relevant MSMS Policy:
None

Relevant AMA Policy:

Eradicating Homelessness H-160.903

Our AMA:

(1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;

(2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless;

(3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;

(4) recognizes the need for an effective, evidence-based national plan to eradicate homelessness;

(5) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;

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

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

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

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

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

Sources

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RESOLUTION 32-21

Title: Access to Affordable Housing

Introduced by: Laura Carravallah, MD

Original Authors: Brittany Herron, Jaslyn Morris, Sunny Panh, and Laura Carravallah, MD

Referred To:

House Action:

Whereas, there is a need among low-income Michigan renters for affordable housing in decent, safe, and sanitary units, as more than 8,000 people in Michigan are experiencing homelessness on any given night; further, more than 61,000 Michiganders experienced homelessness in 2019, and

Whereas, homelessness is a barrier to primary and emergency health care that is associated with numerous health disparities; as such, more than 40 percent of people experiencing homelessness in Michigan have long term mental and physical health conditions, and

Whereas, having access to affordable, quality housing helps people with chronic mental and physical health conditions improve and maintain their health and overall well-being, while reducing their utilization of emergency health systems and health related costs, and

Whereas, the Michigan Housing and Community Development Fund (MHCDF) was created to meet the affordable housing needs of low income, homeless, or disabled households; in addition, funds were used to rehabilitate neighborhoods to increase appeal for local business and habitation, and

Whereas, the MHCDF did not have strict requirements for allocation of funds for housing versus community rehabilitation, and

Whereas, the MHCDF was only funded twice (once in 2008 and 2012); in 2012, $3.7 million from the Homeowner Protection Fund was allocated to the MHCDF, but only 9 out of 65 projects submitted were able to receive funding due to the limited resources of the MHCDF, and

Whereas, in 2008, the MHCDF served more than 130 low-income households and prevented homelessness for 78 households, and

Whereas, to date, no action has been taken by the U.S. House of Representatives and the U.S. Senate on recently proposed bills to end or mitigate homelessness; therefore be it

RESOLVED: That MSMS support and advocate for recognition of homelessness as a social determinant of mental and physical health disparities in Michigan; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) urge our AMA to support and advocate for recognition of homelessness as a social determinant of mental and physical health disparities in the United States; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) support and advocate for timely review of legislation designed to eliminate or reduce homelessness; and be it further

RESOLVED: That MSMS support and advocate for creation of a permanent funding source for the Michigan Housing and Community Development Fund (MHCDF) with at least 66 percent of that funding allocated for the development, rehabilitation, and maintenance of permanent housing for Michiganders with disabilities or experiencing homelessness.

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

Relevant MSMS Policy:
None

Relevant AMA Policy:

Eradicating Homelessness H-160.903
Our AMA:
(1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;
(2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless;
(3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;
(4) recognizes the need for an effective, evidence-based national plan to eradicate homelessness;
(5) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;
(6) will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs;
(7) encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;
(8) encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;
(9) (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; and
(10) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods.

Sources:

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RESOLUTION 33-21

Title: Participation in Alliance for Innovation on Maternal Health Safety Bundles

Introduced by: Laura Carravallah, MD

Original Authors: Kathleen Dinh, Irene Lieu, Jennifer Chinchilla-Perez, and Laura Carravallah, MD

Referred To:

House Action:

Whereas, pregnancy-related mortality rate per 100,000 live births (PRMR) has peaked in the United States over the past decade and hovers at 17 percent, the highest of any industrialized country, with pregnancy-related mortality defined as "death of a woman while pregnant or within 1 year of the end of pregnancy from any cause related to or aggravated by the pregnancy," and

Whereas, Michigan ranks as the eighth worst state for maternal mortality rate and third worst for Black mothers in the entire U.S., with additional disparities existing in age and educational level, and

Whereas, more than 50 percent of all maternal deaths in Michigan are preventable, with leading causes of death attributable to obstetric hemorrhage, hypertension, pulmonary embolism, amniotic fluid embolism, infection, and a worsening of pre-existing chronic conditions, and

Whereas, the Michigan Alliance for Innovation on Maternal Health (MI-AIM), pioneered by Robert Sokol, MD; Dawn Shanafelt, MPA, BSN, RN; Jody Jones, MD; Mary Schubert; and Michigan Maternal Mortality Surveillance (MMMS) initiatives have led to the creation of "patient safety bundles" in 2015 to address leading causes of mortality that have led to a 10.5 percent overall decrease in maternal death rates in Michigan by participating birthing institutions, and

Whereas, despite success at institutions that have implemented MI-AIM's safety bundles, only 50 percent have complete adoption and no standardization of data collection exists to measure outcomes, and

Whereas, racial/ethnic disparities in maternal mortality and morbidity for Black and American Native/American Indian mothers in Michigan have improved from five times that of white mothers in 2007-2010 to 2.7 times in 2013-2017, yet still persist, since the startup of MI-AIM, and

Whereas, Texas has achieved 99 percent of participation from all of its birthing centers into AIM since expanded Medicaid reimbursement to adopting centers, and

Whereas, California, which currently has the lowest maternal mortality rate, created the California Maternal Quality Care Collaborative (CMQCC), whose fully implemented programs at 95 percent of their birthing centers include required implicit bias training for all health care workers involved in perinatal care and ongoing studies assessing racial/ethnic differences in pregnancy outcomes for those with comorbidities, and

Whereas, the mission of MSMS is to improve the lives of physicians so they may best care for the people they serve in the state of Michigan and advocate on behalf of both physicians and their patients; therefore be it

RESOLVED: That MSMS will support the participation in Michigan Alliance for Innovation on Maternal Health safety bundles by all birthing institutions in the state of Michigan; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) urge the AMA to recognize the need for all birthing institutions in the United States to participate in the Alliance for Innovation on Maternal Health and implement patient safety bundles; and be it further

RESOLVED: That MSMS will support Medicaid coverage for birthing centers who become active members of Michigan Alliance for Innovation on Maternal Health in order to improve full participation rates; and be it further

RESOLVED: That MSMS will support the Michigan requirement of all health care workers to undergo implicit bias training to further close the racial/ethnic gap in maternal mortality.

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

Relevant MSMS Policy:

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

Relevant AMA Policy:
None

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6. MMMS M. Maternal Deaths in Michigan, 2013-2017 Data Update
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9. Michigan State Medical Society. First 50 Years of MSMS - In Brief. https://www.msms.org/About-MSMS/News/ID/126 Published July 2, 2013. Accessed February 18, 2021

RESOLUTION 34-21

Title: Use Term "Deaf and Hard of Hearing" in lieu of "Hearing Impaired"

Introduced by: Laura Carravallah, MD

Original Authors: Jong Hyon Lee, Irene Lieu, and Laura Carravallah, MD

Referred To:

House Action:

Whereas, 7.4 percent of the population in Michigan identify as deaf, deafblind, or hard of hearing, representing a growing community that has been drastically underestimated in the state census, and

Whereas, the terms deaf and hard of hearing not only describe individuals with the audiological condition of not hearing or mild-to-moderate hearing loss, but more importantly embody the knowledge, beliefs, identity and cultural practices of deaf people, and

Whereas, the term "impaired" is defined as "being in less than perfect or whole condition; as disabled or functionally defective," by Merriam-Webster, and

Whereas, the term "hearing impaired" inherently demeans and labels patients as their disability, focuses on what they cannot do, and establishes "hearing" as the standard and anything different as less than or "impaired," and

Whereas, the World Federation of the Deaf and National Association of the Deaf has taken a stance that the term "hearing impaired" is no longer accepted by the Deaf and Hard of Hearing community as they do not see themselves as "less" or "broken," and

Whereas, fear, mistrust, and frustration toward health care providers are commonly experienced by deaf and hard of hearing individuals due to lack of provider knowledge regarding sociocultural aspects of deafness, and

Whereas, other states (Utah, New Hampshire, New York, and Virginia) have adopted a more sensitive and accepted term "Deaf and Hard of Hearing" in lieu of "hearing impaired" in their state laws despite having a smaller deaf population compared to Michigan; therefore be it

RESOLVED: That MSMS recommends that physicians adopt the term, "deaf and hard of hearing" and/or "persons with hearing loss" instead of "hearing impairment" in clinical settings; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to recommend that physicians adopt the term "deaf and hard of hearing" and/or "persons with hearing loss" instead of "hearing impairment" in clinical settings.

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

Relevant MSMS Policy:
None

Relevant AMA Policy:
None

Sources:

1. MDCR - MDCR Division on Deaf, Deaf, Blind and Hard of Hearing Reveals Results of Year-Long Census and Needs Assessment for Community. Michigan Department of Civil Rights. Accessed February 9, 2021. https://www.michigan.gov/mdcr/0,4613,7-138--507797--,00.html
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4. Bennett R. Time for Change: Rethinking the Term "Hearing Impaired." The Hearing Journal. 2019;72(5):16. doi:10.1097/01.HJ.0000559500.67179.7d

RESOLUTION 35-21

Title: COVID-19 Vaccine Distribution Regarding People Experiencing Homelessness

Introduced by: Laura Carravallah, MD

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

Referred To:

House Action:

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

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

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

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

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

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

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

RESOLVED: That MSMS support increased access to vaccines for people experiencing homelessness by advocating for the provision of vaccines at sites easily accessible to people experiencing homelessness such as shelters, food distribution centers, and community centers.

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

Relevant MSMS Policy:
None

Relevant AMA Policy:
None

Sources:

1. Michigan homelessness Statistics. (n.d.). Retrieved February 08, 2021, from https://www.usich.gov/homelessness-statistics/mi/
2. Defining homelessness. (n.d.). Retrieved February 08, 2021, from http://www.housingaccess.net/defining-homelessness.html
3. Hadden, K., Partlow, D., Liverett, H., Payakachat, N., Jha, B., & Lipschitz, R. (2020, June 11). Addressing homelessness and covid-19 quarantine: A streamlined assessment and referral process. Retrieved February 08, 2021, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7371311/
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