RESOLUTION

Subject: KMA Governance

Submitted by: Fred Williams, MD and David Bensema, MD

Referred to: Reference Committee

WHEREAS, current Kentucky Medical Association (KMA) bylaws stipulate that the governance structure exists for "the general direction of the association's affairs during the interim between meetings of the House." Constitution and Bylaws of the Kentucky Medical Association (revised September 2014); and

WHEREAS, professional association governance is increasingly transitioning toward competency-based structures. (Coerver, Harrison, and Mary Byers, CAE. *Race for Relevance.* Washington, DC, Center for Association Leadership, 2011); and

WHEREAS, KMA's Focus Forward Strategic Planning group in 2013-2014 discussed governance restructure and revision as a project for future consideration; and

WHEREAS, over the past 5 years KMA has developed programs designed to develop leadership skills for member physicians and medical students; and

WHEREAS, KMA's Medical Student Outreach and Leadership Program has graduated nearly 150 medical students to-date; and

WHEREAS, KMA's Community Connector Leadership Program has graduated 32 physician members who have displayed leadership in their communities and within the house of medicine; and

WHEREAS, KMA's Kentucky Physician Leadership Institute (KPLI) graduated 10 member physicians in its first class and is now entering its second year with 10 participants after a very successful first year; and

WHEREAS, current KMA governance structure does not formally incorporate these physician leadership programs and graduates, which are an outstanding way to foster the association's current and future leaders; now, therefore, be it

RESOLVED, that the Kentucky Medical Association (KMA) prepare a comprehensive report on KMA's current governance structure, and to consider possible revisions including the incorporation of graduates of KMA's leadership programs into its overall governance structure including committees, commissions, and Board of Trustees, and that the report and any recommendation for changes be presented to the 2019 House of Delegates.

KMA House of Delegates
August 2018

RESOLUTION

Subject: Opposition to Sexual Orientation and Gender Identity “Conversion Therapy”

Submitted by: Meghamsh Kanuparthy, Jacob Shpilberg, and Jerome Soldo
(University of Louisville School of Medicine)

Referred to: Reference Committee

WHEREAS, “conversion therapy” is defined as a pseudoscientific practice of trying to change an individual's sexual orientation or gender identity using psychological or spiritual interventions; and

WHEREAS, the conclusion of numerous meta-analyses[1] have found that this practice increases anxiety, depressive behavior, self-harm and suicidality and is ineffective at changing sexual orientation or gender identity; and

WHEREAS, medical professionals should not participate in, and should be a resolute voice against, practices that have repeatedly been shown to be detrimental to their patients’ wellbeing, in accordance with the dictum, “First, do no harm”; and

WHEREAS, in recent years, sixteen countries including Australia, Canada and the United Kingdom have imposed partial or complete bans on the practice of conversion therapy; and

WHEREAS, numerous scientific and professional bodies, including the World Psychiatric Association[2], the American Psychiatric Association[3], the American Psychological Association[4], and the American Academy of Pediatrics[5], have voiced their strong opposition to this practice; and

WHEREAS, the American Medical Association[6] “opposes, the use of ‘reparative’ or ‘conversion’ therapy for sexual orientation or gender identity”; and

WHEREAS, since 2012, thirteen states have enacted legislative bans on the practice; and

WHEREAS, this matter is in active discussion in state legislatures around the country and our Kentucky Medical Association should have clear and direct policy directives on the matter; now, therefore, be it

RESOLVED, that the Kentucky Medical Association joins the American Medical Association in strongly opposing the use of “reparative” or “conversion” therapy for sexual orientation or gender identity.

References

[1] Shidlo, Ariel; Schroeder, Michael (2002a), "Changing Sexual Orientation: A Consumers' Report", *Professional Psychology: Research and Practice*, **33** (3): 249–259.

[2] "WPA Position Statement on Gender Identity and Same-Sex Orientation, Attraction, and Behaviours",

[3] **American Psychiatric Association**, *Position Statement on Therapies Focused on Attempts to Change Sexual Orientation (Reparative or Conversion Therapies)* (2000)

[4] **American Psychological Association**, *Resolution on Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts* (2009)

[5] **American Academy of Pediatrics**, *Homosexuality and Adolescence*, 92 Pediatrics 631 (1993)

[6] Health Care Needs of Lesbian, Gay, Bisexual and Transgender Populations H-160.991

RESOLUTION

Subject: Pre-Exposure Prophylaxis to Prevent HIV Transmission

Submitted by: Meghamsh Kanuparthy, Jacob Shpilberg, and Jerome Soldo
(University of Louisville School of Medicine)

Referred to: Reference Committee

WHEREAS, Pre-exposure Prophylaxis, or PrEP, is a way for people who do not have human immunodeficiency virus (HIV) but who are at substantial risk of getting it to prevent infection by taking a daily pill (Truvada)[1]; and

WHEREAS, it is estimated that there are around 7,000 people living with HIV in Kentucky[2]; and

WHEREAS, the Centers for Disease Control and Prevention identified 220 counties nationwide, including 54 in Kentucky, acutely vulnerable to an HIV outbreak due to the high incidence of opioid injection coupled with the practice of sharing needles[3]; and

WHEREAS, when taken consistently, PrEP has been shown to reduce the risk of HIV infection in people who are at high risk by up to 92%[4]; and

WHEREAS, numerous studies[5] have found that PrEP is a cost-effective means of preventing HIV infections and reducing health care cost; and

WHEREAS, Truvada for HIV prevention has been approved by the U.S. Food and Drug Administration since 2012; and

WHEREAS, the American Medical Association “supports the coverage of PrEP in all clinically appropriate circumstances”, and “supports the removal of insurance barriers for PrEP such as prior authorization, mandatory consultation with an infectious disease specialist and other barriers that are not clinically relevant”[6]; now, therefore, be it

RESOLVED, that the Kentucky Medical Association supports educating physicians and the public about the effective use of Pre-exposure Prophylaxis (PrEP) for human immunodeficiency virus prevention and encourages physicians to consider prescribing PrEP when clinically indicated; and be it further

RESOLVED, that the Kentucky Medical Association joins the American Medical Association in support of removing barriers to prescribing Pre-exposure Prophylaxis (PrEP) and advocating that individuals not be denied any insurance coverage on the basis of PrEP use.

References

[1] CDC: https://www.cdc.gov/hiv/risk/prep/index.html

[2] https://www.courier-journal.com/story/news/2017/12/14/kentucky-appalachian-hills-next-big-hiv-outbreak/728725001/

[3] https://www.reuters.com/article/us-health-teens-prep/most-doctors-would-give-hiv-prevention-drugs-to-teens-idUSKBN1JL2Q9

[4] https://www.jahonline.org/article/S1054-139X(18)30142-3/abstract "Adolescent Health Providers' Willingness to Prescribe Pre-Exposure Prophylaxis (PrEP) to Youth at Risk of HIV Infection in the United States"

[5] http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001401#s4

[6] AMA Resolution: Pre-Exposure Prophylaxis (PrEP) for HIV H-20.895

RESOLUTION

Subject: Support for the Implementation of an Electronic Tracking System for Sexual Assault Evidence Kits

Submitted by: Jessica Geddes, Travis Combs, Mia MacDonald, Katherine Stockham, Cody Sutphin (University of Kentucky College of Medicine)

Referred to: Reference Committee

WHEREAS, a sexual assault evidence collection kit (aka “rape kit”) consists of preserved DNA evidence from a forensic examination conducted by a trained doctor or nurse[1]; and

WHEREAS, the evidence in a sexual assault evidence collection kit can be used by the police to identify the assailant, confirm a suspect’s contact with a victim, corroborate the victim’s account of the sexual assault, and exonerate innocent defendants[2]; and

WHEREAS, survivors of sexual assault who have reported their assault and consented to the extensive and invasive collection of a kit often are not informed by the authorities about the status of their kit or of their case[3] and may only receive information after contacting the authorities themselves[4]; and

WHEREAS, survivors who have been able to access information about their kit through their local police department report having to make multiple inquiries, which can be frustrating and time-consuming[5]; and

WHEREAS, according to a nurse who works with sexual assault survivors, lack of communication from the police can contribute to the self-blame and doubt that they feel, and being contacted by the police unexpectedly may reintroduce the trauma for the survivor[6]; and

WHEREAS, in a previous study, 53% of rape survivors self-report being distrustful of others as a result of their contact with legal system personnel, and contact with formal help systems, including the police, was associated with negative social reactions and increased post-traumatic stress disorder symptomatology[7]; and

WHEREAS, creating a secure and confidential electronic tracking system for sexual assault evidence kits that provides access to survivors on their own terms would give a small piece of control back to survivors[8]; and

WHEREAS, a tracking system for sexual assault evidence kits would allow victims to track the progress of DNA evidence in their cases, much like they would follow the path of a mail delivery online[9]; and

WHEREAS, electronic tracking systems for sexual assault evidence kits are already in use in California, Idaho, Illinois, and North Carolina and are in development in 18 other states[10]; and

WHEREAS, Idaho State Police Forensic Services will share their software with any public agency at no cost and has already been shared with several states; additionally, representatives from Kentucky have previously shown interest in the software[11]; and

WHEREAS, Kentucky has taken steps to help survivors of sexual assault, such as the passage of the Sexual Assault Forensic Evidence (SAFE) Act of 2016[12]; and

WHEREAS, an electronic tracking system would fulfill statute KRS15.440(1)(i)(5) of the Sexual Assault Forensic Evidence (SAFE) Act of 2016, which requires the eventual implementation of "a process for notifying the victim from whom the evidence was collected of the progress of the testing, whether the testing resulted in a match to other DNA samples, and if the evidence is to be destroyed"[13]; now, therefore, be it

RESOLVED, that the Kentucky Medical Association support the implementation of a secure and confidential electronic tracking system for sexual assault evidence kits.

References

1 Prevost O' Connor, K. ELIMINATING THE RAPE-KIT BACKLOG: BRINGING NECESSARY CHANGES TO THE CRIMINAL JUSTICE SYSTEM. *UMKC Law Review. 2003; 72(1):197. https://heinonline.org/HOL/Page?collection=journals&handle=hein.journals/umkc72&id=209.* Accessed July 21, 2018.

2 Tofte, S. *Testing Justice: The Rape-Kit Backlog in Los Angeles City and County.* New York, NY: Human Rights Watch; 1. 2009.

3 Tofte, S. *Testing Justice: The Rape-Kit Backlog in Los Angeles City and County.* New York, NY: Human Rights Watch; 5. 2009.

4 Locating a Rape Kit. End the Backlog.http://www.endthebacklog.org/information-survivors-survivors-rights/locating-rape-kit. Accessed July 21, 2018.

5 Locating a Rape Kit. End the Backlog.http://www.endthebacklog.org/information-survivors-survivors-rights/locating-rape-kit. Accessed July 21, 2018.

6 Tofte, S. *Testing Justice: The Rape-Kit Backlog in Los Angeles City and County.* New York, NY: Human Rights Watch; 52-53. 2009.

7 Campbell, R. The psychological impact of rape victims. *American Psychologist.* 2008; 63(8): 705. https://www.researchgate.net/publication/23478485_The_psychological_impact_of_rape_victims. Accessed July 20, 2018.

8 Rape Kit Tracking System: From Idea to Law.End the Backlog.http://www.endthebacklog.org/information-survivors-survivors-rights/locating-rape-kit. Accessed July 21, 2018.

9 Knox, A. Site helps sex assault survivors track rape kits.Deseret News Utah. https://www.deseretnews.com/article/900020855/site-helps-sex-assault-survivors-track-rape-kits.html. Published June 6, 2018. Accessed July 22, 2018.

10 End the Backlog.http://www.endthebacklog.org/information-survivors-survivors-rights/locating-rape-kit. Accessed July 21, 2018.

11 2017 SEXUAL ASSAULT KIT TRACKING REPORT. The State of Idaho. https://www.isp.idaho.gov/forensics/inc/documents/sakSpreadSheets/legislativeReport/SAK%20Annual%20Report%20Final%202017.pdf. Accessed July 22, 2018.

12 SAFE Kit Backlog. KY.gov. https://ag.ky.gov/justice-for-victims/rape-kit-backlog. Accessed July 20, 2018.

13 Statutory Guide to Sexual Assault Forensic Evidence ("SAFE") Act of 2016. Office of the Attorney General of Kentucky. https://ag.ky.gov/victims/toolkit/Documents/OVA-Statutory-Guide-to-SAFE-Act.pdf. Accessed July 20, 2018.

RESOLUTION

Subject: Qualified Medical Interpreters for Patients with Limited English Proficiency

Submitted by: Amanda Beering and Jerome Soldo
(University of Louisville School of Medicine)

Referred to: Reference Committee

WHEREAS, an individual with Limited English Proficiency (LEP) is a person whose primary language for communication is not English and who has a limited ability to read, write, speak, or understand English[1]; and

WHEREAS, Title VI of the Civil Rights Act of 1964 states that a LEP patient is entitled to professional medical interpreter services, at no cost to the patient, when accessing care from any health program or entity that receives funding from the Department of Health & Human Services[2]; and

WHEREAS, the use of family members, unqualified bilingual staff, and providers without adequate language skills (as determined by standardized, validated oral and written examination) as a primary language resource in medical encounters is noncompliant with Section 1557 of the Patient Protection and Affordable Care Act (ACA)[2]; and

WHEREAS, a report in 2010 evaluating 1,373 malpractice claims from 4 states found that 1 of every 40 claims were related, all or in part, to failure to provide appropriate language interpreter services[3]; and

WHEREAS, qualified medical interpreters, who have been formally trained and tested, provide accurate and timely communication between LEP patients and providers, improve patient satisfaction, prevent adverse events such as misdiagnoses and medication errors, and reduce costly emergency room visits and hospital readmissions[4,5]; and

WHEREAS, Kentucky’s healthcare providers, to be compliant with the ACA, must cover the cost of qualified medical interpreter services, even when the cost of those services is greater than what is reimbursed from payers; and

WHEREAS, fourteen states and the District of Columbia directly reimburse providers for language services used by patients on Medicaid and the Children's Health Insurance Program[3,5]; and

WHEREAS, Kentucky’s healthcare providers seek to provide exceptional care for patients of all cultural and linguistic backgrounds and should not be financially penalized for doing so; now, therefore, be it

RESOLVED, that the Kentucky Medical Association advocates for the use of face-to-face qualified medical interpreters whenever possible, and strongly opposes the use family members, unqualified bilingual staff, and providers without adequate language skills (as determined by

standardized, validated oral and written examination) as a primary language resource in medical encounters; and be it further

RESOLVED, that the Kentucky Medical Association supports continuing medical education for healthcare providers, as well as the incorporation of curriculum in Kentucky's allopathic and osteopathic medical schools, regarding effective use of medical interpreters to communicate with Limited English Proficiency patients; and be it further

RESOLVED, that the Kentucky Medical Association urges the Kentucky legislature to make professional language services a mandatory covered benefit under the state's Medicaid, Medicare, and Children's Health Insurance Programs.

References

[1] Federal Register. Nondiscrimination in Health Programs and Activities, Definitions. https://www.federalregister.gov/documents/2016/05/18/2016-11458/nondiscrimination-inhealth-programs-and-activities#page-31466. Updated May 16, 2016. Accessed July 13, 2018.

[2] U.S. Department of Health & Human Services. Section 1557: Ensuring Meaningful Access for Individuals with Limited English Proficiency. https://www.hhs.gov/civil-rights/for-individuals/section-1557/fs-limited-english-proficiency/index.html. Updated August 25, 2016. Accessed July 15, 2018.

[3] Jacobs B, Ryan AM, Henrichs KS, Weiss Barry D. Medical interpreters in outpatient practice. *Annals of Family Medicine.* 2018; 16(1): 70-76

[4] International Medical Interpreters Association. Advocacy. http://www.imiaweb.org/about/reimbursement.asp. Updated April 3, 2012. Accessed July 15, 2018.

[5] Rice, S. Hospitals often ignore policies on using qualified medical interpreters. Modern Healthcare website. http://www.modernhealthcare.com/article/20140830/MAGAZINE/308309945. August 30, 2014. Accessed July 15, 2018.

RESOLUTION

Subject: Expense of Complying with the ADA

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, Title VI of the Civil Rights Act of 1964 requires medical interpretive services without reimbursement; and

WHEREAS, under Title III of the Americans with Disabilities Act (ADA), physicians/health care providers are required to provide interpreters for medical visits and other medical-related situations without reimbursement; and

WHEREAS, Title III of the ADA prohibits discrimination against individuals with disabilities by places of public accommodation; and

WHEREAS, private health care providers are considered places of public accommodation; and

WHEREAS, the physician/health care provider must pay for the cost of an interpreter, even if the cost of the interpreter is more than the cost of the visit; and

WHEREAS, finding interpreters can be a barrier to providing patient care; and

WHEREAS, the American Medical Association (AMA) has previously conducted a state survey, which indicated that interpreter services consistently cost more than the total amount paid by Medicaid for the physician visit; and

WHEREAS, Policy 385.978 of the AMA states that the “AMA will work with government officials and other organizations to make language interpretive services a covered benefit for all health plans inasmuch as health plans are in a superior position to pass on the cost of these federally mandated services as a business expense”; now, therefore, be it

RESOLVED, that the Kentucky Medical Association advocate for approaches in which health plans operating in the state of Kentucky would be required to make language interpretive services a covered benefit.

RESOLUTION

Subject: Call to Action for School Safety

Submitted by: Northern Kentucky Medical Society

Referred to: Reference Committee

WHEREAS, since the infamous 1999 Columbine shootings, more than 215,000 students have experienced gun violence at school (the current count is 217 schools; 141 children, educators and others have been killed in assaults, and another 287 have been injured); and

WHEREAS, the Parkland Florida shooting this past February and the outcry from students following the event has led to a national call to action; and

WHEREAS, David O. Barbe, MD, MHA, Past President, American Medical Association (AMA) on February 15, 2018 in the AMA News stated “Gun violence in America today is a public health crisis, one that requires a comprehensive and far-reaching solution. And that is not just my own sentiment; that is the determination of the AMA House of Delegates. With more than 30,000 American men, women and children dying from gun violence and firearm-related accidents each year, the time to act is now”; and

WHEREAS, the CDC says that 98% of attackers experienced or perceived a major loss prior to the attack, 78% of attackers had a history of suicide attempts or suicidal thoughts prior to their attack, and 71% of attackers felt persecuted, bullied, threatened or attacked by others prior to the incident; and

WHEREAS, the Board of the Kentucky Academy of Family Physicians recently approved in response to a national call for action to support the following four calls to action:

- Label violence caused by the use of guns as a national public health epidemic;
- Fund appropriate research at the CDC as part of the 2018 federal budget to evaluate the causes and evidence- based remedies of this epidemic;
- Increase funding for training, for increasing providers, and for appropriate payment for mental health counseling and interventions;
- Evaluate in concert with law enforcement, educators and social services, the most appropriate responses to this epidemic; and

WHEREAS, it would be helpful to have a unified response from medical organizations in Kentucky around the issue of school safety; now, therefore, be it

RESOLVED, that the Kentucky Medical Association support efforts that improve school safety in the Commonwealth, and encourage legislation that:

- Labels violence caused by the use of guns as a national public health epidemic;

- Funds appropriate research at the Centers for Disease Control and Prevention to evaluate the causes and evidence-based remedies of this epidemic;
- Increases funding for training, for increasing providers, and for appropriate payment for mental health counseling and interventions; and
- Evaluates in concert with law enforcement, educators and social services, the most appropriate responses to this epidemic.

RESOLUTION

Subject: A Resolution to Educate Families about Gun Safety

Submitted by: Khalil U. Rahman, MD, MBA

Referred to: Reference Committee

WHEREAS, according to CNN there has been on average over 1 school shooting per week in the United States in 2018; and

WHEREAS, out of the 20 mass school shooting cases since 1990, 17 of the shooters acquired their firearm from home; and

WHEREAS, a study conducted by Every Town for Gun Safety confirmed that nearly 2 million American children live in homes that do not have adequate safety measures in place for storing firearms; and

WHEREAS, the *Journal of Trauma: Injury*, *Infection and Critical Care* found a direct correlation between firearm availability and accidental gun deaths among youth[1]; and

WHEREAS, according to the U.S. General Accounting Office 31% of accidental deaths caused by firearms could be prevented with the addition of a lock and an indicator showing whether the weapon is loaded[2;] and

WHEREAS, according to the Centers for Disease Control and Prevention yearly 500 children die from gun suicides annually; and

WHEREAS, states with safe storage laws (laws that require guns to be stored, locked and unloaded when any person prohibited from possessing a gun-i.e. minors-is present in the gun owners home) have had a decrease in accidental child firearm deaths by 23% and 14% decrease in youth suicide deaths[3]; now, therefore, be it

RESOLVED, that Kentucky shall administer a one-time education course regarding gun storage and safety around the home to all parents and guardians of all children who attend Kentucky public schools. Kentucky shall mandate that every parent or guardian of a student have a Commonwealth of Kentucky Gun Safety Certificate to attend school. The Kentucky Cabinet for Health and Family Services shall oversee the program in conjunction with the Kentucky Justice and Public Safety Cabinet who shall administer the program.

References

[1] https://journals.lww.com/jtrauma/Abstract/2002/02000/Firearm_Availability_and_Unintentional_Firearm.11.aspx

[2] https://www.gao.gov/products/PEMD-91-9

[3] https://economics.adelaide.edu.au/research/papers/doc/wp2001-06.pdf3

RESOLUTION

Subject: Health Risks of Recreational Fireworks

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, the use of recreational fireworks is a popular pastime in Kentucky, yet poses significant safety risks; and

WHEREAS, the Kentucky Medical Association “opposes the private use of all fireworks with the exception of approved professional displays”; and

WHEREAS, per the 2017 U.S. Consumer Product Safety Commission report on non-occupational firework injuries and deaths, there were 8 deaths and an estimated 12,900 emergency department (ED) visits in 2017 due to injuries sustained from all types of fireworks, with 36% of those injuries sustained by children younger than 15 years of age; and

WHEREAS, these statistics do not account for firework injuries that were not treated in the ED nor the potentially negative psychological effects of unanticipated fireworks (i.e. recreational fireworks used on non-holidays or outside legal hours) on those with post-traumatic stress disorder (PTSD) and certain other mental health disorders; and

WHEREAS, since some fireworks produce noises that sound similar to firearm discharges, unanticipated recreational fireworks can trigger distressing and possibly dangerous physical and mental symptoms in those suffering with PTSD, particularly those who have been victims of firearm violence and military combat veterans; now, therefore, be it

RESOLVED, that the Kentucky Medical Association partner with Kentucky Department for Public Health to advocate for public education initiatives that promote awareness of the health risks associated with recreational firework use including physical injury and death, mental health disorders including Post-Traumatic Stress Disorder, as well as promote best practices for safer use of fireworks for those who choose to use recreational fireworks.

RESOLUTION

Subject: Support for Permitting Free Sunscreen Use in Public Schools

Submitted by: Lydia Livas (University of Kentucky College of Medicine)

Referred to: Reference Committee

WHEREAS, although most skin cancer is preventable, from 2008 to 2018 the number of new melanoma diagnosed annually increased by 53 percent, amounting to an estimated 178,560 cases of melanoma that will be diagnosed in the U.S. this year[1]; and

WHEREAS, an estimated 9,320 people will die of melanoma in the U.S. in 2018[1]; and

WHEREAS, in Kentucky, in 2015 there were 1,366 new cases of melanomas of the skin and 160 people died of melanomas of the skin[2]; and

WHEREAS, a person's risk for melanoma doubles if he or she has had more than five sunburns in their lifetime[3]; and

WHEREAS, daily regular use of an SPF 15 or higher reduces the chance of developing squamous cell carcinoma by 40%[4] and reduces the chance of developing melanoma by 50%[5]; and

WHEREAS, the Centers for Disease Control and Prevention recommends applying sunscreen every time a child goes outside and suggests community encouragement of sunscreen and other sun protection in play areas in order to prevent the development of melanoma[6]; and

WHEREAS, the Food and Drug Administration currently defines sunscreen as an over the counter medication meaning that school districts across the country can put limitations on students using sunscreen in public schools[7]; and

WHEREAS, current policy in Kentucky Public schools requires parent permission for students to freely apply sunscreen[7]; and

WHEREAS, due to advocacy from the American Academy of Dermatology Association and the American Society for Dermatologic Surgery Association, many states across the country (Alabama, Arizona, Florida, Louisiana, Utah, New York, Oregon, Texas, California and Washington) have passed laws creating an exemption for sunscreen as an over the counter medication, therefore allowing children to freely apply sunscreen in school without a doctor’s note[7]; and

WHEREAS, HB107-18RS introduced in the Kentucky State House in January of this year amended the definition of "medication" and "sunscreen", required local boards of education to adopt policy allowing students to carry and self-administer sunscreen and permits teachers to voluntarily assist with application while including voluntarily assisting with the application of sunscreen in liability protection for teachers[8]; and

WHEREAS, the American Medical Association policy H-440.841 supports the exemption of sunscreen from over the counter medication bans in schools and encourages schools to allow students to possess sunscreen on campus without required physician authorization; now, therefore, be it

RESOLVED, that the Kentucky Medical Association supports the reclassification of sunscreen as an exemption to over the counter medication provisions, allowing students to freely bring and apply sunscreen while at school without physician authorization or a permission slip from his or her parents.

References

[1] Cancer Facts and Figures 2018. American Cancer Society. https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2018/cancer-facts-and-figures-2018.pdf. Accessed July 17th, 2018

[2] U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool, based on November 2017 submission data (1999-2015): U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; www.cdc.gov/cancer/dataviz, June 2018.

[3] Pfahlberg A, Kölmel KF, Gefeller O. Timing of excessive ultraviolet radiation and melanoma: epidemiology does not support the existence of a critical period of high susceptibility to solar ultraviolet radiation-induced melanoma. *Br J Dermatol* 2001; 144:3:471-475.

[4] Green A, Williams G, Neale R, et al. Daily sunscreen application and betacarotene supplementation in prevention of basal-cell and squamous-cell carcinomas of the skin: a randomized controlled trial. *The Lancet* 1999; 354(9180):723-729.

[5] Green AC, Williams GM, Logan V, Strutton GM. Reduced melanoma after regular sunscreen use: randomized trial follow-up. J Clin Oncol 2011; 29(3):257-263.

[6] Vital Signs: Preventing Melanoma. (2015, June 02). Retrieved July 13, 2017, from https://www.cdc.gov/vitalsigns/melanoma/index.html

[7] Spears, V. H. (2018, January 07). Permission slips for sunscreen? Bill would make it easier for students to apply some SPF. Retrieved July 13, 2018, from https://www.kentucky.com/news/local/education/article193445669.htm

[8] Reed, B. (n.d.). 18RS - Legislative Record Online. Retrieved from http://www.lrc.ky.gov/record/18RS/HB107.htm

RESOLUTION

Subject: Food Deserts

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, the Kentucky Medical Association (KMA) recognizes that food deserts are urban neighborhoods and rural towns with constrained or limited access to affordable and nutritious food; and

WHEREAS, the KMA recognizes that, as of 2016, the state of Kentucky ranked 7th in the United States for obesity and 5th in the United States for diabetes. Food access has a direct impact on community and individual health. As an example, in 2015, 16.12% of residents in Jefferson County had low access to a local grocery store; and

WHEREAS, most Americans fail to meet recommendations for diet quality, with disparities evident by race/ethnicity, socioeconomic status, and use of nutrition assistance programs; and

WHEREAS, closure of supermarkets and local grocers continue to plague communities and limit access to fresh, healthy foods. Few local initiatives exist to address food deserts, such as community gardens, farmers markets, and food assistance programs; now, therefore, be it

RESOLVED, that the Kentucky Medical Association collaborate with local public health departments and other stakeholders to improve access to healthy foods and work to reduce food deserts in the Commonwealth of Kentucky.

RESOLUTION

Subject: Medication Education

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, the Internet has become an immediate and widespread resource to the public; and

WHEREAS, there are resources on the Internet that are more reliable and credible, especially in regards to medical information; and

WHEREAS, patients tend to use the Internet as a way to find information about their medications which may or may not be accurate depending on the source; and

WHEREAS, medical specialties and non-profit organizations like the American Heart Association or the American Diabetes Association have websites that are reliable sources of information; now, therefore, be it

RESOLVED, that the Kentucky Medical Association partner with the Kentucky Pharmacists Association to promote a public health campaign to promote reliable sources of medical information.

RESOLUTION

Subject: Affirming Methadone Maintenance Therapy is Evidence-Based Treatment to be Reimbursed by Third Party Payers

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, the Kentucky Medical Association affirms that addiction is a chronic brain disease amenable to treatment overseen by a physician with biological, psychological, and social approaches; and

WHEREAS, Kentucky is suffering from an epidemic of opioid and heroin use as evidenced by the increase in drug overdoses and untimely deaths, as well as emergency room visits and hospitalizations due to opioid and heroin use; and

WHEREAS, the Kentucky Medical Association recognizes that quickly attending to the treatment of addiction is necessary for the health of our patients; and

WHEREAS, methadone maintenance treatment, when used as part of a comprehensive treatment approach, continues to accrue evidence for its effectiveness in engaging and retaining patients in treatment, reducing withdrawal and craving symptoms, reducing opioid misuse, and reducing many opioid addiction-related health and social problems, particularly risk of infectious diseases; now, therefore, be it

RESOLVED, that the Kentucky Medical Association supports the use of Methadone Maintenance Therapy as a part of evidence-based addiction treatment and is a service that should be reimbursed by third party payers.

RESOLUTION

Subject: Removing Prior Authorization for Medication-Assisted Treatment for Substance Use Disorders

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, the Kentucky Medical Association affirms that addiction is a chronic brain disease amenable to treatment overseen by a physician with biological, psychological, and social approaches; and

WHEREAS, prior authorization requirements are common among medications for the treatment of opioid use disorder and often require days or weeks for approval, while patients remain at-risk for relapse, overdose, or death; and

WHEREAS, American Medical Association model state legislation advocates that "medication-assisted treatment services shall not be subject to prior authorization, as well as any behavioral, cognitive, or mental health services prescribed in conjunction with or supplementary to the medication-assisted treatment services for the purpose of treating a substance use disorder; and

WHEREAS, outpatient treatment with buprenorphine improves six-month treatment engagement, significantly reduces cravings and illicit opioid use; improves psychosocial outcomes; and those receiving medications as part of their treatment are seventy-five percent less likely to die because of addiction than those not receiving medications; and

WHEREAS, extended-release injectable naltrexone can essentially eliminate the rewarding effects of self-administered opioids, thereby dramatically reducing opioid use and opioid-related health and social problems; now, therefore, be it

RESOLVED, that the Kentucky Medical Association supports the prohibition of insurers, nonprofit health service plans, and health maintenance organizations from applying a prior authorization requirement for a prescription drug used for the treatment of an opioid use disorder that contains methadone, buprenorphine, or naltrexone.

RESOLUTION

Subject: Opioid Use Disorder Education

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, many patients suffering from opioid use disorder (OUD) do not disclose their addiction to health care providers or seek medical care for their addiction due to stigma and fear of repercussions from their health care providers; and

WHEREAS, some medical students and resident physicians report that they are exposed to bias against patients suffering from OUD early in their medical careers due to negative interactions they observe between teaching physicians and patients with OUD, which subsequently affects the way they approach patients suffering with addiction; and

WHEREAS, unrecognized and untreated OUD can lead to significant morbidity and mortality, has led to a multifaceted public health crisis in Kentucky, and has been deemed a chronic illness by the American Medical Association, American Society of Addiction Medicine and the American College of Physicians; and

WHEREAS, U.S. Surgeon General Jerome Adams, MD, has called on American Medical Association members to work to eliminate the stigma associated with OUD and make treatment more accessible; now, therefore, be it

RESOLVED, that the Kentucky Medical Association work with the Kentucky Board of Medical Licensure, the Kentucky Hospital Association, and Kentucky medical schools and residency programs to advocate that all medical students, resident physicians, and teaching physicians receive education about opioid use disorder (OUD) in order to improve patient care by eliminating the stigma and biases associated with OUD and by increasing student and physician knowledge on OUD diagnosis and treatment; and be it further

RESOLVED, that the Kentucky Medical Association partner with the Kentucky Board of Medical Licensure, the Kentucky Hospital Association, and Kentucky medical schools and residency programs to establish basic opioid use disorder (OUD) education guidelines for Kentucky medical students, resident physicians, and teaching physicians with a focus on emphasizing addiction as a chronic medical illness and not a character flaw, education about the potential medical and psychological complications of OUD, and education on evidence-based treatments for OUD.

RESOLUTION

Subject: Treatment of Opioid Use Disorder in Hospitals

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, the opioid epidemic has become a critical threat to public health in the U.S. and Kentucky; and

WHEREAS, hospitalizations have been rapidly increasing for opioid overdose and for infectious complications of injection drug use such as hepatitis C, human immunodeficiency virus and deep-tissue bacterial infections, reaching 1.27 million emergency room and inpatient stays in 2014; and

WHEREAS, inpatient costs in the U.S. among those with opioid use disorder almost quadrupled to $15 billion between 2002 and 2012; and

WHEREAS, there is a high risk of repeated hospitalization and overdose death following hospitalization due to loss of opioid tolerance, and hospitals rarely address the underlying chronic disease of opioid use disorder; and

WHEREAS, medications approved by the Food and Drug Administration for treating opioid use disorder (buprenorphine, methadone and naltrexone) reduce illicit opioid use; opioid agonist therapy (buprenorphine or methadone) reduces opioid overdose death by 50 percent in part by preventing loss of opioid tolerance; and buprenorphine provides further protection because of its high receptor affinity and ceiling effect on respiratory depression; and

WHEREAS, initiation of buprenorphine in the emergency department and inpatient setting and linkage to ongoing comprehensive treatment as an outpatient is an effective means for engaging patients and reducing illicit opioid use; and

WHEREAS, no Kentucky Medical Association policy addresses the central role that hospitals should play in treating opioid use disorder as a chronic disease; now, therefore, be it

RESOLVED, that the Kentucky Medical Association work together with the Kentucky Hospital Association and other relevant organizations to identify best practices that are being used by hospitals and others to treat opioid use disorder as a chronic disease, including identifying patients with this condition; initiating or providing opioid agonist, partial agonist, or antagonist therapy in inpatient, obstetric and emergency department settings; providing cognitive and behavioral therapy as well as other counseling as appropriate; establishing appropriate discharge plans, including education about opioid use disorder; and participating in community-wide systems of care for patients and families affected by this chronic medical disease; and be it further

RESOLVED, that the Kentucky Medical Association advocate for Kentucky agencies to collaborate with relevant organizations to evaluate programs that currently exist or have received federal or state funding to assist physicians, hospitals and their communities to coordinate care for patients with the chronic disease of opioid use disorder.

RESOLUTION

Subject: Encourage Hepatitis A Vaccination

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, Hepatitis A is a highly contagious virus spread from infected food and/or water that affects the liver and is a short-lived virus compared to the other hepatitis viruses; and

WHEREAS, Hepatitis A vaccination has been an optional vaccination, typically recommended for foreign travel; and

WHEREAS, Hepatitis A has made a resurgence in the United States with Kentucky now leading the country in terms of Hepatitis A cases; now, therefore, be it

RESOLVED, that the Kentucky Medical Association encourage and promote Hepatitis A vaccination for all Kentuckians; and be it further

RESOLVED, that the Kentucky Medical Association work with the public health departments in our state to encourage and promote Hepatitis A vaccination.

RESOLUTION

Subject: Physician Supervision and Authority Over Non-Physician Prescribing

Submitted by: Truman Perry, MD

Referred to: Reference Committee

WHEREAS, the Commonwealth of Kentucky continues to grapple with the overwhelming effects of the nation's latest and most severe opiate-related epidemic; and

WHEREAS, according to the Kentucky Office of Drug Control Policy's 2016 Overdose Fatality Report, there were 1,404 opiate-related overdose deaths in Kentucky during 2016, which represents a 7.4 percent increase versus the previous year; and

WHEREAS, in recent years, the Kentucky General Assembly and relevant state licensing boards have passed an array of legislation and regulations designed to increase oversight of the prescribing and dispensing of controlled substances, with a particular emphasis on opioids; and

WHEREAS, as the state attempts to find ways to curb the tide of the opioid crisis, non-physician practitioners simultaneously promote legislation that would allow them new or expanded authority to prescribe controlled substances without a supervising or collaborative agreement with a physician; and

WHEREAS, at this particular moment in our state's history, health care provider organizations should be joining together to address the opioid scourge instead of proposing policies that could further complicate this significant public health issue; and

WHEREAS, in furtherance of providing high quality, patient-centered care and improving the health status of the Commonwealth's citizens, the Kentucky General Assembly should designate one authority to oversee the prescribing and dispensing of controlled substances; and

WHEREAS, the Kentucky Board of Medical Licensure has the most extensive knowledge and expertise in regulating the prescribing and dispensing of controlled substances; now, therefore, be it

RESOLVED, that the Kentucky Medical Association continue to educate policymakers and the public regarding issues surrounding opioid abuse disorder and, when appropriate, offer policymakers evidenced-based solutions designed to curtail the opioid epidemic; and be it further

RESOLVED, that the Kentucky Medical Association continue to oppose ongoing legislative and regulatory efforts by non-physician practitioners to establish or expand prescriptive authority related to Schedule II through Schedule V controlled substances without a supervising or collaborative agreement with a physician; and be it further

RESOLVED, that the Kentucky Medical Association work with the Kentucky Academy of Family Physicians, the Kentucky Academy of Physician Assistants, and other state specialty societies to

develop specific strategies aimed at strengthening physicians' role in leading, supervising, or collaborating with non-physician practitioners who are currently authorized to prescribe Schedule II through Schedule V controlled substances; and be it further

RESOLVED, that the Kentucky Medical Association support statutory revisions conferring authority to the Kentucky Board of Medical Licensure to establish standards, investigate complaints and, when necessary, initiate disciplinary procedures related to the prescribing and dispensing of Schedule II through Schedule V controlled substances by all practitioners, including non-physician practitioners who are currently permitted to prescribe such drugs.

RESOLUTION

Subject: Support for the Delegation of Informed Consent Procurement

Submitted by: Andrew Wodrich, Patrick Keller, Lincoln Shade, TJ Libecap, Marcus Rommelman, and Rachel Whittaker (University of Kentucky College of Medicine)

Referred to: Reference Committee

WHEREAS, informed consent, as outlined in the Kentucky Revised Statute (KRS) 304.40-320, is deemed to have been given when, "[t]he action of the health care provider in obtaining the consent of the patient ... was in accordance with the accepted standard of medical or dental practice … and a reasonable individual, from the information provided by the health care provider under the circumstances, would have a general understanding of the procedure and medically or dentally acceptable alternative procedures or treatments and substantial risks and hazards inherent in the proposed treatment or procedures"[1]; and

WHEREAS, the role of the physician in obtaining informed consent is, "to present the medical facts accurately to the patient … and to make recommendations for management in accordance with good medical practice … [and] to help the patient make choices from among the therapeutic alternatives consistent with good medical practice . . . [and to] sensitively and respectfully disclose all relevant medical information to patients"[2]; and

WHEREAS, the Kentucky Medical Association currently supports the movement towards "physician-led, patient-centered, team-based medical care in Kentucky"[3]; and

WHEREAS, the facts of the case of *Shinal v. Toms*, a recent court case focused on informed consent heard in the Supreme Court of Pennsylvania, are that Ms. Shinal sued Dr. Toms, a neurosurgeon, for damages after he performed surgery on Ms. Shinal that resulted in permanent neurological impairment; Dr. Toms had answered Ms. Shinal's questions, reviewed risks of the procedure, and explained alternative treatment options; and Dr. Toms had his physician-assistant answer further questions and obtain Ms. Shinal's consent for the surgery[4]; and

WHEREAS, the Supreme Court of Pennsylvania ruled in *Shinal v. Toms* that "the trial court committed an error of law when it instructed the jury to consider information provided by defendant surgeon's qualified staff in deciding the merits of the informed consent claim [b]ecause a physician's duty to provide information to a patient sufficient to obtain her informed consent is non-delegable"[5]; and

WHEREAS, prior to the *Shinal v. Toms* decision, it was not uncommon for qualified staff who were part of a medical care team to aid the treating physician in "providing the requisite information or answering follow-up questions" in the process of obtaining informed consent[6]; and

WHEREAS, following the ruling in *Shinal v. Toms*, "Pennsylvania physicians are legally required to perform [the informed consent procurement] on their own"[7]; and

WHEREAS, surgeons currently work between 50-60 non-call hours per week, and a similar ruling to *Shinal v. Toms* in Kentucky mandating that treating physicians cannot delegate aspects of the informed consent process would place an undue burden upon physicians' limited time[8]; and

WHEREAS, the American Medical Association and the Pennsylvania Medical Society filed an amicus brief prior to the ruling in *Shinal v. Toms* arguing in favor of Dr. Toms that, "[t]here is nothing unusual about the physician having a duty, and the ultimate liability, but also having the authority to delegate performance of the duty. The 'captain of the ship' doctrine reflects precisely that point"[9]; and

WHEREAS, while concern has been raised that junior medical staff such as residents may have not yet had specialized training in informed consent, undertaking this role under the supervision of the treating physician is an important part of their learning about the informed consent process[10]; and

WHEREAS, although others have raised concerns that non-physician staff lack the medical knowledge to provide patients with information during the informed consent process, staff such as Dr. Toms' physician assistant, who had aided Dr. Toms in the informed consent process up to 40 times prior to Ms. Shinal's operation, are indeed qualified to assist as members of the patient care team[11]; and

WHEREAS, a study focused on patient learning showed that during informed consent discussions, the total time a medical professional spent with a patient was the strongest predictor of patient comprehension[12]; and

WHEREAS, patients can benefit from supplementary communication and exploration of their preferences provided by qualified staff[13]; now, therefore, be it

RESOLVED, that the Kentucky Medical Association support the right of a treating physician to delegate aspects of the task, but not the responsibility nor liability, of obtaining informed consent from a patient to a qualified and supervised patient care team member.

References

[1] KRS 304.40-320

[2] Opinion 8.08- Informed Consent. (2013). *American Medical Association Code of Medical Ethics*. *Virtual Mentor, 15(1),*1301.

[3] KMA Res. 2012-10

[4] *Shinal v. Toms*, 152 A.3d 429 (Pa. 2017).; Lynch, H.F., Joffe, S., Feldman, E.A. (2018). Informed consent and the role of the treating physician. *The New England Journal of Medicine, 378,* 2433-2438.

[5] *Shinal v. Toms*, 152 A.3d 429 (Pa. 2017).

[6] Robeznieks, A. (2017, August 8). Informed-consent ruling may have "far-reaching, negative impact." *AMA Wire.*

[7] Lynch, H.F. et al. (2018). Informed consent and the role of the treating physician.

[8] Surgical Career Lifestyle Issues. (n.d.). *American College of Surgeons.*

[9] Brief for the American Medical Association and the Pennsylvania Medical Society as *Amicus Curiae*, *Shinal v. Toms*, No. 31 MAP, Supreme Court of Pennsylvania (2016).

[10] Anderson, O.A., & Wearne, M.J. (2007). Informed consent for elective surgery--what is best practice? *Journal of the Royal Society of Medicine*, *100(2)*, 97-100.; Wood, F., Martin, S.M., Carson-Stevens, A., Elwyn, G., Precious, E., & Kinnersley, P. (2016). Doctors' perspectives of informed consent for non-emergency surgical procedures: a qualitative interview study. *Health Expectations, 19(3),* 751-761.

[11] Wells, J. (2018, June 22). In NEJM, did authors get it wrong on informed consent? *American Council on Science and Health.*; *Amicus Curiae, Shinal v. Toms* (2016).

[12] Fink, A.S., Prochazka, A.V., Henderson, W.G., Bartenfield, D., Nyirenda, C., Webb, A.,...Parmelee, P. (2010). Predictors of comprehension during surgical informed consent. *Journal of the American College of Surgery, 210(6),* 919-926.

[13] Bernat, J.L., & Peterson, L.M. (2006). Patient-centered informed consent in surgical practice. *The Archives of Surgery, 141(1),* 86-92.

RESOLUTION

Subject: Training for Clinical Ethics Committee Members

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, clinical ethics committees (CEC) satisfy the Joint Commission for the Accreditation of Healthcare Organization's (JCAHO) mandate that all United States hospitals have a mechanism for hospital personnel to consider and educate its personnel on medical ethics issues; and

WHEREAS, CECs play an important role in providing education on medical ethics topics, developing institutional guidelines and policies concerning medical ethics issues, and providing case reviews for difficult patient cases that pose ethical dilemmas; and

WHEREAS, CECs play a vital role in the ethical life of a healthcare organization, many CEC members have engaged in little or no formal study of medical ethics and instead rely on their own concept of ethics when making determinations about medical ethics issues; and

WHEREAS, there is no standardized or required medical ethics training for members of United States CECs; now, therefore, be it

RESOLVED, that the Kentucky Medical Association work with the Kentucky Hospital Association and other stakeholders to advocate for the development of online training modules for members of Kentucky Clinical Ethics Committees (CECs) that cover basic medical ethics concepts including but not limited to familiarity with classic ethical theories, fundamental principles in medical ethics, familiarity with ethical reasoning and dialogue, familiarity with the processes of a CEC, and familiarity with relevant national law and policies pertaining to medical ethics.

RESOLUTION

Subject: Addressing Impediments to Patient Referrals Patterns

Submitted by: Lexington Medical Society

Referred to: Reference Committee

WHEREAS, patients depend on their physician to make referrals in the patient's best clinical and financial interest; and

WHEREAS, according to the 2017 American Medical Association updated data on physicians practice arrangements, physician ownership of their practice has dropped below 50 percent; and

WHEREAS, Kentucky Hospital Association commissioned a study revealing that hospitals are losing more than $100,000 per employed physician creating a strong financial incentive to make up the difference through physician generated income; and

WHEREAS, hospitals have become better at monitoring physician productivity and referral patterns and have put in place programs to minimize "leakage"; and

WHEREAS, mandated electronic health records (EHR) can be designed such that referrals outside an entity or hospital become onerous and time consuming, again creating a disincentive to refer to physicians not employed or who are not on the drop-down list of the EHR; and

WHEREAS, long established patient physician relationships are being broken because of the disincentives to referral mentioned above; and

WHEREAS, the Kentucky Medical Association is dedicated to keeping the patient physician relationship sacrosanct; now, therefore, be it

RESOLVED, that the Kentucky Medical Association (KMA) Commission on Physician Licensure and Workforce form a sub-committee to address the significant hindrances physicians employees experience in making referrals based on their expertise and best judgment instead of the multifactorial control large organizations have on their employed physicians. The sub-committee will both assess and make recommendations to the KMA House of Delegates within one year.

RESOLUTION

Subject: Continuity of Health Care in the Event of Disruptions in Medical Care

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, the Kentucky Medical Association recognizes that disruptions in medical care preparedness and a critical function for the medical system in the United States; and

WHEREAS, the rapid development and unpredictable nature of disruptions in medical care affecting health care systems, such as weather phenomena, medical personnel illnesses/deaths, or failure of electronic health record systems, require urgent and precise care on part of the medical system to have contingency plans in place to protect patient continuity of care; now, therefore, be it

RESOLVED, that the Kentucky Medical Association advocate for contingency plans to ensure the medical community is prepared to address disruptions in medical care affecting health care delivery systems and to recommend safeguards to protect patient continuity of care if health care systems fail in the Commonwealth of Kentucky.

RESOLUTION

Subject: Compassion is Good Medicine

Submitted by: Lexington Medical Society

Referred to: Reference Committee

WHEREAS, compassion is at the very heart of medicine, *Primum non nocere- First do no harm*; and

WHEREAS, perceived stress, vicarious trauma, and burnout can lead to physicians' compassion fatigue, substance misuse, family discord, burnout, leaving medicine and suicide[1]; and

WHEREAS, in the last year, an American Psychological Association report found that more than half of Americans (59 percent) said they consider this the lowest point in U.S. history that they can remember[2]; and

WHEREAS, in the last year, an American Psychiatric Association poll found anxiety levels in Americans have increased sharply over the past year, up 5 points since 2017[3]; and

WHEREAS, in the last year, a Blue Cross Blue Shield report found that diagnoses of major depression have risen dramatically by 33 percent since 2013. This rate is rising even faster among millennials (up 47 percent) and adolescents (up 47 percent for boys and 65 percent for girls)[4;] and

WHEREAS, in the last year, a Cigna survey found that loneliness is at epidemic levels in America[5]; and

WHEREAS, the Centers for Disease Control and Prevention (CDC) reported that suicide rates have increased by 30% since 1999. Nearly 45,000 lives were lost to suicide in 2016 alone[6]; and

WHEREAS, the National Alliance on Mental Illness (NAMI) reports that more than half of people (54%) who died by suicide did not have a known mental health condition[7]; and

WHEREAS, Harvard Medical School and Cambridge Health Alliance recently created the Center for Mindfulness and Compassion, grounded in the value that mindfulness and compassion are innate human capacities that support health and well-being[8]; and

WHEREAS, Stanford Medical School's Center for Compassion and Altruism Research and Education investigates methods for cultivating compassion and promoting altruism within individuals and society through rigorous research and provides a compassion cultivation program[9]; and

WHEREAS, the Kentucky Medical Association, Lexington Medical Association and University of Louisville School of Medicine supported a The Health Care Leadership School retreat for an international group of medical students and physicians in the summer of 2017 to cultivate compassion in medicine globally[10]; and

WHEREAS, Louisville and Lexington are participants in the international Compassionate Cities Campaign of the Charter for Compassion[11]; and

WHEREAS, the health benefits of volunteering are well-documented[12]; and

WHEREAS, both Lexington and Louisville support voluntary acts of compassion year-round and especially during designated weeks set aside each spring[13]; now, therefore, be it

RESOLVED, that the Kentucky Medical Association engage and support member physicians in the creative nurturing of acts of kindness, compassion, self-compassion, service and volunteerism for themselves, their co-workers, their staff, their patients, their families and their communities.

References

[1] *Physician burnout- Stop blaming the individual*, New England Journal of Medicine video 9:35, https://catalyst.nejm.org/videos/physician-burnout-stop-blaming-the-individual/

[2] *"Stress in America™: The State of Our Nation",* American Psychological Association, http://www.apa.org/news/press/releases/2017/11/lowest-point.aspx

[3] *Americans say they are more anxious that a year ago; Baby boomers report greatest increase in anxiety*, American Psychiatric Association, https://www.psychiatry.org/newsroom/news-releases/americans-say-they-are-more-anxious-than-a-year-ago-baby-boomers-report-greatest-increase-in-anxiety

[4] *Major Depression: Impact on Overall Health,* Bluecross Blueshield, https://www.bcbs.com/sites/default/files/file-attachments/health-of-america-report/HoA_Major_Depression_Report.pdf

[5] New Cigna study reveals loneliness at epidemic levels in America, Survey February 21 – March 6, 2018, https://www.cigna.com/newsroom/news-releases/2018/new-cigna-study-reveals-loneliness-at-epidemic-levels-in-america

[6] Suicide rising across the US- More than a mental health concern, CDC Vital Signs, https://www.cdc.gov/vitalsigns/suicide/index.html

[7] Risk of suicide, National Alliance on Mental Illness, https://www.nami.org/Learn-More/Mental-Health-Conditions/Related-Conditions/Risk-of-Suicide

[8] Harvard Medical School/Cambridge Health Alliance, Center for Mindfulness and Compassion, https://www.chacmc.org

[9] Stanford Medical School Center for Compassion and Altruism Research and Education, http://ccare.stanford.edu/about/mission-vision/

[10] The Health Care Leadership School, http://passporthealthplan.com/north-americas-first-healthcare-leadership-school-date-announced/

[11] The Charter for Compassion- Compassionate Communities, https://charterforcompassion.org/communities

[12] The health benefits of volunteering are well-documented, https://www.nationalservice.gov/pdf/07_0506_hbr.pdf

[13] Lexington- Lex Give Back- Putting Compassion into Action https://lexgiveback.org/, Louisville- Mayor's Give a Day Week, https://louisvilleky.gov/search/site/give%20a%20day%20week

RESOLUTION

Subject: Retaining Medical Students in Kentucky for Residency

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, Kentucky's medical schools, both allopathic and osteopathic, annually produce medical school graduates that greatly outnumber available entry-level residency spots in Kentucky; and

WHEREAS, the number of available entry-level residency positions in Kentucky for the medical schools' Classes of 2020 is anticipated to be 344 while the number of graduating medical students in Kentucky that year is expected to be 463 (a ratio of approximately 0.74 positions: 1 student)[1]; and

WHEREAS, nearly 53% of residents chose to stay in the state where they complete their residency[2]; and

WHEREAS, based on the Commonwealth's Workforce Capacity Study performed by Deloitte in 2012, the Commonwealth faces a need of more than 3,500 additional physicians to meet workforce demands[3]; now, therefore, be it

RESOLVED, that the Kentucky Medical Association communicate with the Kentucky Hospital Association and perform a benefit-cost analysis of Graduate Medical Education programs in the Commonwealth and report findings at the 2019 Annual Meeting; and be it further

RESOLVED, the Kentucky Medical Association encourages the Kentucky Legislature to consider options for adding new entry-level residency positions, such as by providing direct monetary incentives for hospitals to develop residency programs and/or increasing residency positions and funding established by KRS 164.927 and KRS 164.929 to programs already in existence.

References

[1] AAMC 2017 State Physician Workforce Data Report

[2] Starting a new residency program: a step-by-step guide for institutions, hospitals, and program directors. Barajaz & Turner, 2016.

[3] The Commonwealth of Kentucky Health Care Workforce Capacity Report (2012), pp 15-17

RESOLUTION

Subject: Community Health Workers

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, the Kentucky Medical Association recognizes that within different regions and populations of the Commonwealth of Kentucky there exists inequities in health outcomes; and

WHEREAS, these inequities increase overall healthcare costs and adversely impact physician compensation; and

WHEREAS, though there are multiple factors contributing to these poor health outcomes one of the most significant and perhaps easiest to affect is health literacy; and

WHEREAS, there already exist a few isolated programs within the Commonwealth of Kentucky and in other states to train lay people as "Community Health Workers" to work with physicians and hospitals to increase patient health literacy, responsibility and cooperation with treatment plans; and

WHEREAS, Community Health Workers working with physicians and hospitals within the Commonwealth of Kentucky and other states have shown measurable improvements in health outcomes, and realized both a decrease in healthcare costs that well exceed the costs of the workers, and an improvement in physician and hospital value-based scores; now, therefore, be it

RESOLVED, that the Kentucky Medical Association recognize the role of Community Health Workers as non-clinical adjuncts to physician practices and by virtue of its imprimatur encourage the use of Community Health Workers, when appropriate, by member physicians; and be it further

RESOLVED, that the Kentucky Medical Association support efforts for the training of Community Health Workers in the Commonwealth of Kentucky and compensation from private and government health agencies for delivered services.

RESOLUTION

Subject: State-Based Individual Mandate

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, the Tax Cuts and Jobs Act of 2017 eliminated the financial penalty of the Affordable Care Act's individual mandate; and

WHEREAS, in Kentucky by 2019 this will result in an increase number of uninsured, an increase in uncompensated care, including emergency department care, at rural and safety net hospitals placing those hospitals at risk of financial insolvency, fewer people in the insurance pool thus driving up health insurance premiums for employers, and for those who obtain insurance as individuals, and decrease access to care for patients in rural communities; and

WHEREAS, Massachusetts and New Jersey have implemented state-based individual mandates and additional states (Washington, Vermont, Connecticut, Maryland, Hawaii, and the District of Columbia) are exploring implementing their own individual mandates; and

WHEREAS, the Urban Institute, a Washington, D.C. – based think tank that carries out economic and social policy research, studied how state-based individual mandates would affect health insurance coverage and premium costs and found that by 2019, for Kentucky, a state-based individual mandate, compared to current law, would decrease the number of uninsured by 21.2% (53,000 people) and by 34.8% (107,000 people) by 2022, decrease the average monthly single premium for a single 40-year-old adult from $470 to $390 (a decrease of 16.7%), increase federal spending to Kentucky through Medicaid, Children's Health Insurance Program (CHIP) and Tax Credits by $81 million (0.9%), increase Kentucky's obligation through Medicaid and CHIP by only $16 million (0.7%) and subsidies, and decrease uncompensated care from $720 million to $549 million (a net of $171 million); now, therefore, be it

RESOLVED, that the Kentucky Medical Association support a state-based individual insurance mandate as a way to improve access to health care, stabilize the insurance marketplace and lower the rate of rise for health insurance premiums, and to improve the financial health of rural and safety net hospitals.

RESOLUTION

Subject: Advocacy of Emergency Departments

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, emergency departments serve as the safety net for patients in a fragmented health care system caring for urgent and emergent conditions. Emergency departments often are patients only source of care, an extension for primary care providers, a point of entry into inpatient treatment, and a referral source for multiple medical specialties or community resources; and

WHEREAS, emergency care is provided 24/7 to patients who perceive they or their family member require immediate attention guiding by the prudent layperson definition; and

WHEREAS, federal EMTALA law mandates that every patient coming to an emergency department be seen without regard to insurance status, ability to pay or whether or not there is a contract with a particular insurer; now, therefore, be it

RESOLVED, that the Kentucky Medical Association advocate that health insurance companies recognize the importance and value of emergency departments, that health insurance companies recognize and adhere to the prudent layperson definition, and fairly reimburse for care provided in emergency departments without retrospective denials or undervalued payments.

RESOLUTION

Subject: Living Organ and Bone Marrow Donor Protection

Submitted by: Lexington Medical Society

Referred to: Reference Committee

WHEREAS, the number of patients in need of solid organ and bone marrow transplantation continues to increase; and

WHEREAS, there continues to be an organ shortage with transplantable organs available to only about 20% of patients in need of them; and

WHEREAS, there is past evidence that altruistic donors have been denied coverage or have had life, long-term care or disability insurance premiums increased and have been denied full access to family medical leave; and

WHEREAS, the benefits of live organ donation and transplantation, such as improved health and survival benefit, quality of life and cost of care savings are well documented; and

WHEREAS, the University of Kentucky has recently enacted a policy to guarantee 30 days medical leave to any solid organ donor and an additional 5 days medical leave to any bone marrow donor; now, therefore, be it

RESOLVED, that the Kentucky Medical Association will consider convening a task force to draft and support potential legislation clarifying organ and bone marrow donation as a serious health condition under the Family Medical Leave Act (FMLA), and to assure the donors will be protected from denial of insurance coverage be it life, health, long-term care or disability, or from escalation of premiums related thereto; and be it further

RESOLVED, that further legislation be proposed to provide donors with full access to the provisions of the Family Medical Leave Act (FMLA), and that a state-wide model for extended medical leave for altruistic donors be adopted.

RESOLUTION

Subject: Protection of Kentuckians with Organ Failure and Assuring Access to Transplantation

Submitted by: Tom Waid, MD

Referred to: Reference Committee

WHEREAS, the incidence of organ failure continues to increase, and the number of patients in need of kidney, pancreas, liver, heart, or lung transplantation continues to rise; and

WHEREAS, the benefits of transplantation, such as improved health and survival, improved quality of life, and cost of care savings, are well documented; and

WHEREAS, there is an increasing need of organ donation and retention of organs donated within local communities; and

WHEREAS, with proposed implementation of broader organ allocation policy, where there is evidence to show that more kidneys, livers, and lungs have be removed from the Commonwealth to be transplanted in other states; and

WHEREAS, there is a growing national trend to take organs from underserved/rural communities such as Kentucky and allocate organs to large urban areas in the Northeast and West Coast; now, therefore, be it

RESOLVED, that the Kentucky Medical Association will consider convening a task force to draft and support legislation to ensure retention of donated organs in our local communities and to ensure the ability of local transplant centers to provide care to the citizens of this Commonwealth suffering from organ failure; and be it further

RESOLVED, that the Kentucky Medical Association will propose and support potential legislation, including invoking the Doctrine of States Rights, declaring that donated organs are local gifts and resources intended to help the citizens of the Commonwealth.