Adopted

2021-1

RESOLUTION

Subject: Bylaws Amendment to Increase Medical Student Delegate Representation

Submitted by: Alex Thebert (University of Kentucky College of Medicine, Lexington), Margo Nelis (University of Kentucky College of Medicine, Northern Kentucky), Rachel Whittaker (University of Kentucky College of Medicine, Bowling Green), Lisa Anakwenze (University of Louisville School of Medicine)

Referred to: Reference Committee

WHEREAS, in the past 3 years the University of Kentucky (UK) has added two new 4-year satellite campuses in Bowling Green and Northern Kentucky; and

WHEREAS, by 2024 each new campus will have between 120 and 140 medical students across the four years; and

WHEREAS, the regional campuses are recognized as their own AMA Medical Student Section chapters with executive boards and officers functioning independently from the UK Lexington campus; and

WHEREAS, current KMA Bylaws currently allow for only one delegate to represent all three UK campuses; and

WHEREAS, allowing for each campus to have their own delegate would increase the involvement of the regional campuses in the KMA House of Delegates and policy writing; and

WHEREAS, the KMA emphasizes early engagement of medical students in organized medicine in order to develop the next generation of physician leaders; now, therefore, be it

RESOLVED, that the KMA bylaws be amended as follows:

“Chapter 1, Section 2(f): “Student Members. Any student in an accredited medical school in Kentucky or any resident of Kentucky who is a student in an accredited medical school in the United States shall be eligible for membership in the Medical Student Section of the Kentucky Medical Association. This Medical Student Section shall be governed by its own Constitution and Bylaws, which Constitution and Bylaws shall not be in conflict with the Constitution, Bylaws and Board policies of the parent Kentucky Medical Association. Should any questions arise regarding the existence of a conflict, the KMA Board of Trustees shall be the final arbiter of such questions. Membership shall be coincident with the academic enrollment of the student. Student members may hold office within the Student Section in accord with the provisions of that Section’s Constitution and Bylaws. The Student Section will be represented in the KMA House of Delegates through one voting representative each from the University of Louisville School of Medicine, the University of Kentucky College of Medicine, the University of Pikeville Kentucky College of Osteopathic Medicine, and any four-year regional campus of said schools with a minimum of

80 (eighty) students across the 4 (four) years. The KMA Medical Student Section President, elected by the Governing Council of the KMA Medical Student Section, will represent the Section as a voting member of the KMA Board of Trustees.”

Adopted

2021-2

RESOLUTION

Subject: Bylaws Amendment to Make Language Gender Neutral

Submitted by: Alex Thebert, Nicole Czerner-Garcia (University of Kentucky College of Medicine, Lexington)

Referred to: Reference Committee

WHEREAS, 36.3% of active physicians are female, 45.8% of residents are female, and 52% of the 2020-2021 medical school class is female[1,2]; and

WHEREAS, the KMA bylaws use the gendered term “he” for all singular pronouns; and

WHEREAS, the gender-specific use of pronouns could be seen as non-inclusive to a large portion of physicians, residents, and medical students; and

WHEREAS, the AMA Constitution and Bylaws use either “he or she” or “they” as singular pronouns; and

WHEREAS, changing KMA bylaws to use gender-neutral language would promote inclusion within the organization; now, therefore, be it

RESOLVED, that the KMA bylaws be amended as follows:

“Chapter I, Section 1: Membership in this Association shall be coterminous with membership in a component county society. No physician shall be eligible for membership in this Association unless they are a member, in good standing of a component society, nor may they maintain membership in a component county society unless they are a member, in good standing of this Association.

When a physician who meets the qualifications hereinafter set forth, is certified to the Secretary-Treasurer as a member in good standing of a component society, properly classified as to type of membership, and when the dues pertaining to their membership classification have been received by the Secretary-Treasurer of the Association, the name of the member shall be included in the official roster of the Association and they shall be entitled to all the privileges of their class of membership. Provided, however, that members in good standing from other state societies may, if admitted to membership by a component society, be accepted by KMA for membership without paying dues for the remainder of the calendar year in which the transfer is made. Provided further, that the Board of Trustees shall have power, upon written application, approved annually by the county society of which the applicant is a member, to excuse any member from the payment of dues because of financial hardship.”; and be it further

RESOLVED, that the KMA bylaws be amended as follows: “Chapter I, Section 2(b): Life Members. Component societies may elect as a life member any doctor of medicine or osteopathy who

has served their profession with distinction and who has reached the age of 70 and has retired from active practice. Further, any member who has 25 years of continuous membership in a state medical society affiliated with the American Medical Association, who has reached the age of 65 and is fully retired, also may be elected as a life member. However, any member who had qualified as a life member at the time of the adoption of this amendment, September 26, 1990, shall continue to qualify as a life member. Life members shall have the right to vote and be entitled to the benefits of Chapter VI, Section 8, of these Bylaws, but shall not pay dues. They shall receive *The Journal* and other publications of the Association.", and be it further

RESOLVED, that the KMA bylaws be amended as follows: "Chapter I, Section 2(g): Service Members. Members of the Association in good standing who enter military service and are ineligible for Associate membership shall be classified as service members. Service Members shall not be required to pay dues. If a member in good standing enters service prior to March 1 and has paid their dues for that year, they shall receive all publications and other benefits applicable to their class of membership in the Association and shall owe no further dues until January 1 following their release. If a member in good standing enters service prior to March 1 without paying their dues for that year, they shall receive publications and other benefits but shall owe the dues applicable to their class of membership immediately following their release from active duty. Members whose dues have not been received by March 1 are not in good standing.", and be it further

RESOLVED, that the KMA bylaws be amended as follows: "Chapter I, Section 3: Hospital Medical Staff Section. There shall be a special section for hospital medical staff physicians who already hold membership in KMA. The Hospital Medical Staff Section (HMSS) shall be governed by its own Constitution and Bylaws, which Constitution and Bylaws shall not be in conflict with the Constitution, Bylaws and Board policies of the parent Kentucky Medical Association. Should any questions arise regarding the existence of a conflict, the KMA Board of Trustees shall be the final arbiter of such questions. The Hospital Medical Staff Section shall elect a Delegate and Alternate Delegate to the KMA House of Delegates. The Delegate to the KMA House of Delegates, or their Alternate as the case may be, shall be a voting member of the House and may present Resolutions on behalf of the HMSS.", and be it further

RESOLVED, that the KMA bylaws be amended as follows: "Chapter II, Section 2: The Annual Meeting shall consist of one or more education sessions, at least one meeting of the House of Delegates, and such other gatherings as may be authorized by the Board of Trustees. Each education session shall be presided over by the President or in their absence or disability or at their request by the President-Elect or such officers as the Board of Trustees may direct.", and be it further

RESOLVED, that the KMA bylaws be amended as follows: "Chapter II, Section 3: The name of a physician upon the properly certified roster of members or list of Delegates of a component society

which has paid its annual assessment, shall be prima facie evidence of their right to register at any meeting of this Association.", and be it further

RESOLVED, that the KMA bylaws be amended as follows: "Chapter II, Section 4: Each member in attendance at any meeting shall register indicating the component society of which they are a member. When their right to membership has been verified by reference to the roster of the society, they shall receive a badge which shall be evidence of their right to all privileges of membership at that meeting. No member or delegate shall take part in any of the proceedings of any meeting until they have complied with the provisions of this section.", and be it further

RESOLVED, that the KMA bylaws be amended as follows: "Chapter III, Section 4: The Speaker shall, by virtue of their office, be responsible for making all arrangements for all sessions, regular or special, of the House.", and be it further

RESOLVED, that the KMA bylaws be amended as follows: "Chapter IV, Section 1: The President-Elect and the Vice President shall be elected from the state at large for a term of one year, the President-Elect succeeding to the presidency at the expiration of their term as President-Elect. A majority vote of those attending and voting shall be required for the election of the President-Elect and the Vice President and on any ballot where a majority is not obtained, the candidate with the least votes shall be dropped and further balloting held until such time as one candidate receives a majority of the votes cast. Delegates to the AMA and their alternates shall be elected from the state at large for terms of two years with the provision that no more than one delegate and no more than one alternate delegate shall be elected from one component society except in the instance that a member of the Kentucky delegation is elected to the office of Speaker or Vice-Speaker of the American Medical Association House of Delegates, in which case, no more than two delegates and two alternate delegates shall be elected from any component society. All delegate and alternate terms shall be coterminous; all positions shall expire at the same time and all candidates must run for office at the same time every two years. The Speaker of the House of Delegates, the Vice-Speaker and the Secretary-Treasurer shall be elected for terms of three years. Trustees and their Alternates shall be elected for terms of three years and Trustees shall be limited to serving for not more than two consecutive full terms. The terms of the Trustees and their Alternates shall coincide and be so arranged that one-third of the terms expire each year, insofar as possible, provided, however, that nothing contained herein shall preclude an Alternate Trustee from serving two full terms as a Trustee. No member shall be eligible for the office of President, President-Elect, Vice-President, Secretary-Treasurer, Speaker or Vice-Speaker of the House of Delegates, Trustee or Alternate Trustee who has not been an active member of the Association for at least three years. Representatives of the KMA Resident and Fellows Section and the KMA Medical Student Section to the KMA Board of Trustees shall be elected for a term of one year.", and be it further

RESOLVED, that the KMA bylaws be amended as follows: “Chapter IV, Section 5: Any member may make known their availability for any office within the Association. However, it would be regarded as unseemly for any member to actively campaign for their own election.”, and be it further

RESOLVED, that the KMA bylaws be amended as follows: “Chapter V, Section 1: Except as provided in Chapter II, Section 2 hereof, the President shall preside at all scientific sessions of the Association and shall appoint all committees not otherwise provided for. They shall deliver an annual address at such time as may be arranged and shall perform such duties as custom and parliamentary usage may require. They shall be the real head of the profession in the State during their term of office and so far as practicable, shall visit or cause to be visited on their behalf, the various sections of the State and assist the Trustees in building up the county societies and in making their work more practical and useful. They shall be reimbursed for their reasonable and necessary travel expense incurred in the performance of their duties as President.”, and be it further

RESOLVED, that the KMA bylaws be amended as follows: “Chapter V, Section 2: The President-Elect shall assist the President in visitation of county and other meetings. They shall become president of the Association at the next Annual Meeting following their election as president-elect. In the event of their death or resignation, or if they become permanently disqualified or disabled, their successor shall be elected by the House of Delegates and shall be installed as President of the Association at its next regular session.”, and be it further

RESOLVED, that the KMA bylaws be amended as follows: “Chapter V, Section 3: The Vice President shall assist the President in the discharge of their duties, and shall perform such other duties as may be prescribed by the Board of Trustees. In the event of a vacancy in the office of the President, the Vice-President shall succeed to the office of the President.”, and be it further

RESOLVED, that the KMA bylaws be amended as follows: “Chapter V, Section 5: The Speaker of the House shall preside at all meetings of the House of Delegates. They shall appoint all committees of the House of Delegates with the approval of the House of Delegates. They shall be a nonvoting member of said committees, and shall perform such other duties as custom and parliamentary usage may require.”, and be it further

RESOLVED, that the KMA bylaws be amended as follows: “Chapter V, Section 6: The Vice Speaker shall assume the duties of the Speaker in their absence and shall assist the Speaker in the performance of their duties. In the event of the death, disability, resignation, or removal of the Speaker, the Vice Speaker shall automatically become Speaker of the House of Delegates.”, and be it further

RESOLVED, that the KMA bylaws be amended as follows: “Chapter V, Section 7: The Secretary-Treasurer shall advise the Executive Vice President in all administrative matters of this Association and shall act as the corporate secretary insofar as the execution of official documents or institution of official actions are required. They shall perform such duties as are placed upon them by the

Constitution and Bylaws, and as may be prescribed by the Board of Trustees. The Secretary-Treasurer shall demand and receive all funds due the Association, including bequests and donations. They shall, if so directed by the House of Delegates, sell or lease any real estate belonging to the Association and execute the necessary papers and shall, subject to such direction, have the care and management of the fiscal affairs of the Association. All vouchers of the Association shall be signed by the Executive Vice President or their designee and shall be countersigned by the Secretary-Treasurer of the Association. When one or more of the above-named officials are not readily available, four specifically designated representatives of the Executive Committee are authorized to countersign the vouchers, provided that in any event all vouchers of the Association shall bear a signature and a countersignature. The four members of the Executive Committee authorized to countersign vouchers shall be designated by the Board during their reorganizational meeting in September and, whenever possible should be easily accessible from the KMA Headquarters Office. All those authorized to countersign vouchers shall be required to give bond in an amount to be determined by the Board of Trustees. The Secretary-Treasurer shall report the operations of their office annually to the House of Delegates, via the Board of Trustees, and shall truly and accurately account for all funds belonging to the Association and coming into their hands during the year. Their accounts shall be audited annually by a certified public accountant appointed by the Board of Trustees. The Association's annual audit shall be made available to the membership.", and be it further

RESOLVED, that the KMA bylaws be amended as follows: "Chapter VI, Section 3: Each Trustee shall be organizer, peacemaker and censor for their district. They shall hold at least one district meeting each year for the exchange of views on problems relating to organized medicine and for postgraduate scientific study. The necessary traveling expenses incurred by a Trustee in the line of their duties herein imposed may be paid by the Secretary-Treasurer upon a proper itemized statement but this shall not be constituted to include their expenses in attending the Annual Meeting of the Association.", and be it further

RESOLVED, that the KMA bylaws be amended as follows: "Chapter VI, Section 7: In the event of the death, resignation, removal or disability of a Trustee, between sessions of the House of Delegates, the Alternate Trustee shall succeed to the office of Trustee. In the case of disability, the Alternate shall serve until the disability is removed or the Trustee's term expires, and in the absence of the Trustee, the Alternate Trustee shall vote in their place and stead.", and be it further

RESOLVED, that the KMA bylaws be amended as follows: "Chapter VI, Section 9: The Board shall employ an Executive Vice President whose principal duty shall be to carry out and execute the policies established by the House of Delegates and the Board. Their compensation shall be fixed by the Board. The Executive Vice President shall act as general administrative officer and business manager of the Association and shall perform all administrative duties necessary and proper to the general

management of the Headquarters Office, except those duties which are specifically imposed by the Constitution and Bylaws upon the officers, committees, councils and other representatives of the Association. They shall refer to the various elected officials all administrative questions which are properly within their jurisdiction.

They shall attend the Annual Meeting, the meetings of the House of Delegates, the meetings of the Board, as many of the committee and council meetings as possible, and shall keep separately the records of their respective proceedings. They shall, at all times, hold themself in readiness to advise and aid, so far as is possible and practicable, all officers, committees, and councils of the Association in the performance of their duties and in the furtherance of the Association. They shall be allowed traveling expenses to the extent approved by the Board.

They shall be the custodian of the general papers and records of the Association (including those of the Secretary-Treasurer) and shall conduct the official correspondence of the Association. They shall notify all members of meetings, officers of their election, and committees and councils of their appointment and duties.

They shall account for and promptly turn over to the Secretary-Treasurer all funds of the Association which come into their hands. It shall be their duty to receive all bills against the Association, to investigate their fairness and correctness, to prepare vouchers covering the same, and to forward them to the Secretary-Treasurer for appropriate action. They shall keep an account with the component societies of the amounts of their assessments, collect the same, and promptly turn over the proceeds to the Secretary-Treasurer. They shall annually submit their financial books and records to a certified public accountant, approved by the Board, whose report shall be made available to the membership.

They shall keep a record of all physicians in the State by counties, noting on each their status in relation to their county society, and upon request shall transmit a copy of this list to the American Medical Association.

They shall act as Managing Editor, or otherwise supervise the publication of *The Journal of the Kentucky Medical Association* and such other publications as may be authorized by the House of Delegates, under the guidance and direction of the Board.

They shall perform such additional duties as may be required by the House of Delegates, the Board, or the President, and shall employ such assistants as the Board may direct. They shall serve at the pleasure of the Board, and in the event of their death, resignation, or removal, the Board shall have the power to fill the vacancy. From time to time, or as directed by the Board, they shall make written reports to the Board and House of Delegates concerning their activities and those of the Headquarters Office.”, and be it further

RESOLVED, that the KMA bylaws be amended as follows: “Chapter XI, Section 4: In sparsely settled sections two or more component societies may join for scientific programs, the election of officers, and such other matters as they may deem advisable. The component societies thus combined shall not lose any of their privileges or representation. The active members of each component society shall annually elect at least a Secretary and a Delegate for the transaction of its business with the Association.

Two or more adjacent component societies may also combine into one multi-county component society by adopting Resolutions to that effect at special meetings called for that purpose on at least ten days’ notice. Copies of the Resolution, certified as to their adoption by the Secretary of each society, shall be forwarded to the Headquarters Office. If approved by the Board of Trustees, the multi-county society shall thereupon be issued a charter, the consolidating county societies shall cease to exist and the multi-county society shall become a component society of this Association; provided, however, that the active members residing in each county comprising the multi-county society shall be entitled to elect a delegate or Delegates to the House of Delegates, as if each such county constituted a component society within the meaning of Section 11 of this Chapter; and provided, further, that multi-county societies may elect, at large, one alternate delegate for each delegate to which it is entitled under this section and such alternate may serve in the absence of the delegate for whom they are the designated alternate.

A multi-county component society may be disaggregated so that an individual county society may regain independent status when a majority of the members in that county indicate their desire to reorganize. At that time the members from the withdrawing county shall forward a petition containing the signatures of a majority of the members in that county to be validated by KMA. The withdrawing county shall further forward a Resolution to the KMA Headquarters Office to be submitted to the House of Delegates at its next regular meeting, requesting recognition as a county society and issuance of a charter, in accord with Chapter XII, Section 1 of the KMA Bylaws. Once this charter is issued, the new county society shall become a recognized entity at the beginning of the following KMA dues year and those counties remaining with the original multi-county unit may continue to function under their pre-existing charter.”, and be it further

RESOLVED, that the KMA bylaws be amended as follows: “Chapter XI, Section 5: Each component society shall be the sole judge of the qualifications of its own members. All members of component societies shall be members of the Kentucky Medical Association and shall be classified in accordance with Chapter I, Section 2 of these Bylaws, provided, however, that no physician who is under suspension or who has been expelled shall thereafter, without reinstatement by the Board of Trustees be eligible for membership in any component society. Any physician who desires to become a member of the Kentucky Medical Association shall first apply to the component society in the county in

which they reside, for membership therein. Except as hereinafter provided in Sections 6 and/or 8 of this chapter, no physician shall be an active member of a component society in any county other than the county in which they reside.", and be it further

RESOLVED, that the KMA bylaws be amended as follows: "Chapter XI, Section 6: Any physician who may feel aggrieved by the action of the component society of the county in which they reside~~s~~, in refusing them membership, shall have the right to appeal to the Board of Trustees, which, upon a majority vote, may permit them to apply for membership in a component society in a county which is adjacent to the county in which they reside~~s~~.", and be it further

RESOLVED, that the KMA bylaws be amended as follows: "Chapter XI, Section 7: When a member in good standing in a component society moves to another county in the State, their name, upon request, shall be transferred without cost to the roster of the component society into whose jurisdiction they move, if they are admitted to membership therein.", and be it further

RESOLVED, that the KMA bylaws be amended as follows: "Chapter XI, Section 8: A physician whose residence is closer to the headquarters of an adjacent component society than it is to the headquarters of the component society of the county in which they reside, may, with the consent of the component society within whose jurisdiction they reside, hold membership in said adjacent component society.", and be it further

RESOLVED, that the KMA bylaws be amended as follows: "Chapter XI, Section 9: Each component society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material conditions of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified physician in the county.

Upon reasonable notice and after a hearing, component societies may discipline their members by censure, fine, suspension or expulsion, for any breach of the Principles of Medical Ethics or any bylaw, rule or regulation lawfully adopted by such societies or this Association. At every hearing, the accused shall be entitled to be represented by counsel and to cross-examine witnesses, and the society shall cause a stenographic record to be made of the entire proceedings. The stenographer's notes need not be transcribed unless and until requested by the respondent member.

The resignation of a member against whom disciplinary charges are pending or who is in default of the disciplinary judgment of their county society, a district grievance committee or the Board of Trustees shall not be accepted and no member who is suspended or expelled may be reinstated or readmitted unless and until they comply with all lawful orders of their component society and the Board of Trustees.", and be it further

RESOLVED, that the KMA bylaws be amended as follows: "Chapter XI, Section 11: At the time of the annual election of officers, each component society shall elect a delegate or Delegates to

represent it in the House of Delegates. The term of a delegate shall commence on the first day of the regular session of the House following their election, and shall end on the day before the first day of the next regular session, provided, however, that component societies may elect Delegates for more than one term at any election. Each component society may elect one delegate for each 25 voting members in good standing, plus one delegate for one or more voting members in excess of multiples of 25, provided, however that each component society shall be entitled to at least one delegate regardless of the number of voting members it may have and that each multi-county society shall be entitled to the same number of Delegates as its component societies would have had. The secretary of the society shall send a list of such Delegates to the Secretary-Treasurer of this Association not later than 45 days before the next Annual Meeting. It shall be the obligation of a component society which elects Delegates to serve more than one year, to provide the KMA Headquarters Office with a certified list of its Delegates each year.", and be it further

RESOLVED, that the KMA bylaws be amended as follows: "Chapter XI, Section 12: The secretary of each component society shall keep a roster of its members and a list of nonaffiliated licensed physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary. They shall furnish an official report containing such information upon blanks supplied them for the purpose, to the Secretary-Treasurer of the Association, on the first day of January of each year or as soon thereafter as possible, and at the same time the dues accruing from the annual assessment are sent in. In keeping such roster the secretary shall note any change in the personnel of the profession by death or by removal to or from the county, and in making their annual report they shall be certain to account for every physician who has lived in the county during the year."

References:

[1] 2020 Physician Specialty Data Report Executive Summary. AAMC. Accessed July 8, 2021. https://www.aamc.org/data-reports/data/2020-physician-specialty-data-report-executive-summary

[2] 2020 FACTS: Enrollment, Graduates, and MD-PhD Data, Table B-1.2. AAMC. Accessed July 8, 2021. https://www.aamc.org/data-reports/students-residents/interactive-data/2020-facts-enrollment-graduates-and-md-phd-data

Adopted

2021-3

RESOLUTION

Subject: Changes and Programs to Promote Equity, Inclusiveness, and Physician Leadership

Submitted by: KMA Board of Trustees

Referred to: Reference Committee

WHEREAS, over the past year-and-a-half, society has been roiled by the Covid-19 pandemic; and

WHEREAS, government and private sector organizations, including the KMA, instituted many changes during the pandemic in order to continue operations in a safe and productive manner; and

WHEREAS, KMA implemented virtual meetings, including Continuing Medical Education (CME) in which more physicians participated than traditionally participate in live offerings; and

WHEREAS, to mirror similar programs being offered to physician members in urban areas, KMA and the Kentucky Foundation for Medical Care developed the Be Well. Stay Well. Physician Health Program to assist rural physicians with career burnout and the normal struggles of everyday life; and

WHEREAS, physicians around Kentucky stepped up in many ways during the pandemic to develop the best information, treatments, and collaboration to address the Covid- 19 pandemic; and

WHEREAS, KMA worked with a variety of physician members including KMA leaders and graduates of the Kentucky Physician Leadership Institute (KPLI) to help inform the public and enhance professional collaboration during the pandemic; and

WHEREAS, at the same time the pandemic swept the world, society took notice of the need for greater inclusivity and equity for all populations; and

WHEREAS, KMA recognized the need for greater inclusivity in health care by directing resources and working with other stakeholder groups to reach diverse populations around the state through public service campaigns highlighting topical public health issues, including vaccinations; and

WHEREAS, these campaigns reached more than three million Kentuckians, with a special emphasis on reaching minority and rural populations; now, therefore, be it

RESOLVED, that KMA study possible organizational changes to make the

Association more inclusive of all physicians regardless of demographics, location, or practice setting; and be it further

RESOLVED, that the KMA review lessons learned from the pandemic to enhance physician leadership skills in order to address and/or avoid future public health challenges; and be it further

RESOLVED, that KMA review lessons learned from the pandemic to enhance and focus KMA programs directed at the public, with a special emphasis on applying the success of reaching disparate populations, in order to improve public health for all Kentucky citizens and eliminate health inequities across the state.

Adopted as Amended

2021-4

RESOLUTION

Subject: Actualizing Health Equity through Patient Care, Research, and Medical Education

Submitted by: Lisa Anakwenze MPH, MS, Katarina Jones MPH (University of Louisville School of Medicine), Alex Thebert (University of Kentucky College of Medicine, Lexington)

Referred to: Reference Committee

WHEREAS, systemic racism and structural racism are synonymous and are generally defined as ways of maintaining racism at the population level socially, economically, politically, and legally[1]; and

WHEREAS, institutional racism is a form of structural racism that exists in institutions such as universities or health systems as policies and practices that discriminate against people based on race/ethnicity and give advantages to non-minorities, interpersonal racism occurs between individuals, and internalized racism occurs within the individual[1]; and

WHEREAS, one example of structural racism is residential racial segregation, which has led to reduced health outcomes influenced by environmental and city zoning issues such as the following: increased air pollution corresponding to asthma, lead toxicity corresponding to developmental delays, and limited access to healthy food corresponding to increasing non-communicable diseases such as diabetes, obesity, and hypertension[2]; and

WHEREAS, continued discussion on these issues is needed in organized medicine to further understanding and efforts towards diversity, inclusion, anti-racism, health equity, and learning[1,2]; and

WHEREAS, socioeconomic factors, such as income, education, race, ethnicity, and geographic location (i.e. social determinants of health) play a significant role in determining health outcomes[3-6]; and

WHEREAS, diversity in students and their learning environments has been shown to have higher learning outcomes as well as a self-perceived educational enhancement[7-9];

WHEREAS, a lack of diversity and inclusion in medical education materials and staff hinders medical student preparedness towards treating heterogeneous populations[10-14]; and

WHEREAS, diversity in physicians increases access to healthcare for minorities and the underserved as well as minority and underserved patient satisfaction and compliance[9,15]; and

WHEREAS, diversity in business increases profits, and while there is less research related to healthcare administration, there are positive associations between diversity, patient outcomes, quality care metrics, and financial performance[16,17]; and

WHEREAS, while diversity in the healthcare field is increasing, there is still progress to be made, as minority groups continue to be heavily underrepresented as medical students, physicians, and in healthcare leadership[18-21]; and

WHEREAS, to create and implement innovative solutions, more analyses on gaps in diversity, inclusion, and anti-racism in undergraduate (UME), graduate (GME), and continuing (CME) medical education as well as healthcare systems are needed[22,23]; and

WHEREAS, anti-racism is an action-oriented system that seeks to address and bring awareness to racism at many levels[24]; and

WHEREAS, an organization committed to anti-racism seeks to address racism at an institutional level through systemic changes[24]; and

WHEREAS, the University of Louisville (UofL) has established itself as an anti-racism institution across all campuses, and The University of Louisville School of Medicine (ULSOM) has launched an Anti-Racism Task Force to make improvements to UME such as curriculum language changes and immediate student reporting systems for racism in the learning environment[25]; and

WHEREAS, both UME and GME are also supported by the Cardinal Anti-Racist Agenda (CARA) committees that design research, craft policies, prepare trainings, and develop other materials to reduce racism across ULSOM[25,26]; and

WHEREAS, the AMA MSS has a policy (295.194MSS) supporting anti-racism competencies in undergraduate medical education, and the AMA has a policy (H-65.925) supporting programs that engender greater understanding and prevention of racism in UME, GME, and CME; now, therefore, be it

RESOLVED, that the KMA acknowledges that biases exist in the practice of medicine which can lead to inequities in healthcare; and be it further

RESOLVED, that the KMA amend the Equality Act policy adopted in 2019 to read "KMA opposes unjust treatment on any basis (e.g., race, ethnicity, religion, national origin, disability, education, socioeconomic factors, sex, sexual orientation, and gender identity)"; and be it further

RESOLVED, that the KMA amend the Equality and Fairness in Delivery of Medical Care policy last changed in 2019 to read "Unjust treatment and disparities in the delivery and rendering of medical care, are unjustifiable and must be eliminated. Physicians should examine their practices to ensure that prejudices and biases do not inadvertently affect clinical judgment in medical care. KMA supports the position that resources for medical research should be distributed in a manner, which promotes health equity of all individuals to the greatest extent possible"; and be it further

RESOLVED, the KMA supports research that explores patient, student, physician, staff, or healthcare leadership perspectives on ways to improve access to equitable care for all individuals in the Commonwealth of Kentucky; and be it further

RESOLVED, the KMA encourages Kentucky medical schools and training programs to consider implementation of anti-racism programs, practices, and curriculum.

References:

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Adopted as Amended

2021-5

RESOLUTION

Subject: Support for Education and Awareness of Sudden Infant Death Syndrome

Submitted by: Margo Nelis, Morgan Syndor (University of Kentucky College of Medicine, Northern Kentucky), Alex Thebert (University of Kentucky College of Medicine, Lexington)

Referred to: Reference Committee

WHEREAS, Sudden Infant Death Syndrome (SIDS) is defined as an unexpected death of an infant under one year old, and is responsible for more infant deaths than any other causes during infancy[1]; and

WHEREAS, the leading theory for what causes SIDS is infant exposure to triggers such as unsafe sleep positions, unsafe sleep environments, and maternal smoking[2]; and

WHEREAS, research has shown a decreased risk of SIDS by having an infant sleep on their back, sleep without bedding or soft cushions, and reducing exposure to cigarette smoke[3]; and

WHEREAS, it was found that bedding in the sleeping environment of an infant increases SIDS risk fivefold and the risk increases to 21-fold when the infant is placed prone[3]; and

WHEREAS, research has shown that after the initiation of the “Back-to-Sleep” campaign (now termed “Safe-to-Sleep”) in 1993, rates of infants sleeping on their back increased from 17% to 73% leading to a decrease of 2,063 infant deaths per year from SIDS[4]; and

WHEREAS, the crude infant mortality rate by SIDS in the United States is 91.7 while Kentucky’s is 133.3 per 100,000 live births, which is the 9th highest in the nation[5]; and

WHEREAS, there are 14 states that have laws requiring SIDS education programs for parents and healthcare providers in hospitals and/or daycares, Kentucky currently has neither [6]; and

WHEREAS, the AMA supports the education of parents in safe sleep practices to eliminate Sudden Infant Death Syndrome risk factors (H-245.977)[7]; now, therefore, be it

RESOLVED, that KMA supports promoting awareness and educating parents and/or caregivers, health care professionals, and childcare professionals regarding safe practices to reduce Sudden Infant Death Syndrome by eliminating the risk factors associated.

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Adopted as Amended

2021-6

RESOLUTION

Subject: Support for Issuing Nickel Allergen Advisory and Limiting the Quantity of Nickel in Products with Prolonged Skin Contact

Submitted by: Abigail Durbin, Cody Estep, Jarod Griffin (University of Kentucky College of Medicine, Lexington)

Referred to: Reference Committee

WHEREAS, nickel allergy is estimated to affect about 10% of the population in the United States and is the leading allergen in both children and adults[1]; and

WHEREAS, nickel is present in a myriad of commonly used items that often impose prolonged skin contact, including but not limited to jewelry, zippers, household pots and pans, metal tools, cell phones, eyeglass frames, coins, and many food products[2]; and

WHEREAS, nickel allergy is non life-threatening in the majority of cases, it can cause a delayed inflammatory response that can exacerbate asthma symptoms, and cause an extremely uncomfortable rash that can be persistent and debilitating and potentially lead to infection[6]; and

WHEREAS, the American Contact Dermatitis Society has demonstrated that contact dermatitis disproportionately affects women and people of lower socioeconomic status, and Kentucky is the fourth most impoverished state in the nation[3]; and

WHEREAS, production workers have a high rate of contact dermatitis related to their occupation with one of the most common allergens being nickel[4]; and

WHEREAS, a substantial amount of the workforce in Kentucky is in production with estimates of 79,000 people working in construction, 243,000 people working in manufacturing, and 405,000 people working in transportation and utilities[5]; and

WHEREAS, Orthopaedics Today declared nickel allergy a crisis in 2019 because it has been demonstrated that after total knee replacement, incidence of nickel hypersensitivity increases to 20%,[1] and the need for total joint replacement is anticipated to quadruple by 2040[8]; and

WHEREAS, there is no cure for a nickel allergy; the best way to prevent the allergic reaction is to avoid exposure[7]; and

WHEREAS, the European Union issued a directive in 2001 that both limited the use of nickel in products and increased education about the prevalence of nickel allergy and has since seen a reduction in nickel allergy incidence[9]; now, therefore, be it

RESOLVED, the KMA encourages promoting education and awareness about the medical implications of prolonged skin contact with nickel-containing products and the subsequent delayed hypersensitivity reaction that remains lifelong after initial sensitization.

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[1] Orthoapedics today: Metal Allergy: A Clinical Conundrum (January 16, 2019) https://www.healio.com/news/orthopedics/20190111/metal-allergy-a-clinical-conundrum

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Adopted as Amended

2021-7

RESOLUTION

Subject: Support for Promoting Frequent Skin Examinations for Early Detection of Skin Cancer

Submitted by: Abigail Durbin, Cody Estep, Jarod Griffin (University of Kentucky College of Medicine, Lexington)

Referred to: Reference Committee

WHEREAS, skin cancer has become the most common cancer in the world; it is estimated that one in five people will develop skin cancer in their lifetime[1]; and

WHEREAS, the primary culprit of skin cancer is UVB radiation from the sun that people are exposed to in high volumes while merely performing daily activities such as driving[2]; and

WHEREAS, human activity has led to stratospheric ozone depletion, which has allowed greater volumes of UVB radiation to penetrate the Earth and thereby has led to an increase in skin cancer incidence worldwide over the last few decades[3]; and

WHEREAS, Kentucky has a vast population who works in jobs such as agriculture and construction that require working for extensive periods in the direct sunlight, posing a greater risk for developing skin cancer[4]; and

WHEREAS, the Skin Cancer Foundation has stated that 99% of skin cancer deaths are preventable if the skin cancer is detected in the early stages and therefore recommends that every individual thoroughly scans their skin from head to toe monthly for any suspicious lesions[1]; and

WHEREAS, the Kentucky Skin Cancer Center delineates a head to toe skin examination that includes areas that the general population who is not well-informed on the matter might not think to examine, such as fingernails, scalp, and genitals, which emphasizes the importance of promoting skin cancer screening education for Kentuckians[9]; and

WHEREAS, the Skin Cancer Foundation also recommends that physicians routinely examine their patients' skin in order to help them discover potentially cancerous lesions as early as possible, which would make a great impact on early skin cancer detection given the shortage of Dermatologists in Kentucky[1]; and

WHEREAS, Melanoma is the deadliest of skin cancers due to its potential to quickly and aggressively metastasize to vital organs such as the lungs, giving patients a five-year survival rate of only 27% if it is not treated prior to metastasis[5]; and

WHEREAS, the incidence of Melanoma in Kentucky is 27.3%, and the death rate is 17% higher than the national average, making Melanoma a significant health burden on Kentuckians that needs to be addressed[6]; and

WHEREAS, the age-adjusted mortality rate for Melanoma for individuals less than 65 years of age in Kentucky is 66% as compared to the overall rate in the nation of 46%, which demonstrates that Melanoma affects Kentuckians at younger ages than many other cancers[6]; and

WHEREAS, skin cancer screening is a form of preventative care that the general population is recommended to get annually by the second decade of life, and even sooner if individuals have risk factors such as a family history of Melanoma, many moles, or prolonged sun exposure, which many hardworking Kentuckians have[7]; and

WHEREAS, the Kentucky Cancer Program distributes skin cancer screening and prevention materials along with materials about the cancers that the KMA already supports screening for such as prostate, cervical, breast, and colon, highlighting the growing significance of skin cancer[8]; and

WHEREAS, KMA current cancer screening policy states that the KMA "recognizes the necessity for and supports expansion of cancer screening"; now, therefore, be it

RESOLVED, in an effort to detect skin cancer in the early stages, the KMA encourages physicians to follow their specialty's standards of acceptable and prevailing medical practice when performing skin examinations and educating patients regarding monthly skin self-examinations.

References:

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4 "The Cancer Crisis in Appalachia: Kentucky Students Take Action" The University Press of Kentucky (2020)
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7 Dermatology Treatment and Research Center (2021) https://www.dallasdermcenter.com/blog/the-importance-of-annual-skin-exams/
8 "Prevention and Screening" The Kentucky Cancer Program https://www.kycancerprogram.org/community-programs
9 Kentucky Skin Cancer Center https://www.kentuckyskincancercenter.com/services/skin-cancer-screeni

Adopted as Amended

2021-8

RESOLUTION

Subject: Prevention and Treatment of Obesity in the Commonwealth of Kentucky

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, the prevalence of severe obesity has nearly doubled from 4.7 % to 9.2% between 1999-2018. Obesity-related conditions range from heart disease, stroke, diabetes, and cancer. They are also some of the leading causes of preventable deaths[1], disability, and unemployment benefits[2]; and

WHEREAS, the estimated annual medical cost of obesity in the United States was $190.2 billion (21% of annual medical spending). These costs will continue to rise; and

WHEREAS, the current state is that our patients have a brief 10-15 minute lifestyle change education during an office visit. They wind up trying fad diets, possibly take supplements on their own, and continue to search for quick fixes such as pharmaceutical options, and/or surgery that may or may not be covered by insurance; and

WHEREAS, obesity is a chronic preventable disease that ideally needs a whole system approach to tackle. From food policy and public health initiatives; regulatory government, community campaigns, employer initiatives; insurance plan initiatives; now, therefore, be it

RESOLVED, that the KMA work with other organizations and government agencies to develop a public campaign targeted to prevent obesity; and be it further

RESOLVED, that the KMA promote evidence-based guidelines regarding the treatment of obesity.

References:

1 https://www.cdc.gov/obesity/adult/index.html

2 https://www.healthycommunitieshealthyfuture.org/learn-the-facts/economic-costs-of-obesity/

Adopted as Amended

2021-9

RESOLUTION

Subject: Comprehensive Trauma-Informed Care Practices

Submitted by: Lisa Anakwenze MPH MS, Manasaa Kannan, Tasneem Karim, Ingrid Okonta MS MS (University of Louisville School of Medicine)

Referred to: Reference Committee

WHEREAS, trauma is a physical or psychological response to a stressful event such as abuse, witnessing of violence, familial instability and incarceration, displacement, familial substance use, over policing of neighborhoods, food insecurity, or racism/discrimination [1-3]; and

WHEREAS trauma-Informed Care (TIC) is a clinical approach that asks patients' what happened to you' instead of asking 'what is wrong with you,' and recognizes the presence of trauma symptoms in an individual's life and health [1-3]; and

WHEREAS, TIC helps address the complex combination of social, behavioral, and physical factors affecting patients' well being [4,5]; and

WHEREAS, in 2017 and 2019, it was estimated that 25.8% of Kentucky youth ages 0 to 17 experienced two or more adversities; including witnessing domestic violence, witnessing community violence, living with someone with mental illness, and racial/ethnic discrimination[6,7]; and

WHEREAS, trauma, especially incurred during childhood, can lead to increased risks of health issues such as chronic liver and lung disease as well as a higher likelihood of depression, sexually transmitted diseases, and substance use [7]; and

WHEREAS, many marginalized and minority communities face higher rates of trauma, while healthcare institutions that have gaps in TIC screening and treatment may lead to the re-traumatization of patients and a failure to provide appropriate referrals [5-12];

WHEREAS, healthcare providers have limited opportunities to receive regular training in TIC [13]; and

WHEREAS, there is limited community-based research on TIC in marginalized populations; therefore, evidence-based interventions have limited generalizability [14,15]; and

WHEREAS, comprehensive TIC for children is financed through sources such as Medicare, Medicaid, commercial insurance, out of pocket payment, state and federal grants, private philanthropy, and military funding[16]; and

WHEREAS, there are a range of billing codes that cover TIC screenings, group sessions, evidence-based treatments, and referrals for children [16]; now, therefore, be it

RESOLVED, that the KMA supports educating physicians regarding the importance of trauma-informed care in the treatment of victims of physical and psychologic trauma, including but not limited to the COVID-19 pandemic; and be it further

RESOLVED, that the KMA supports the use of evidence-based trauma-informed care and safety practices in health care settings.

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[5] Accounting, N. (2020, July 1). *Building Resilience Through Trauma-Informed Care*. National Alliance for Mental Illness Dane County. https://www.namidanecounty.org/blog/2020/6/15/building-resilience-through-trauma-informed-care

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Adopted as Amended

2021-10

RESOLUTION

Subject: Kentucky Board of Medical Licensure (KBML) Officers and Panel Chairs Restricted to Physician KBML Members

Submitted by: Lexington Medical Society

Referred to: Reference Committee

WHEREAS, the Kentucky Board of Medical Licensure (KBML) is legislatively mandated to be comprised of 9 physician members and 2 consumer non-physician members appointed to the KBML by the Governor in addition to voting ex-officio members to include the deans of the 3 medical schools in Kentucky and the Kentucky Commissioner of Public Health; and

WHEREAS, the KBML currently includes 3 officers, president, vice president, and secretary/treasurer and 2 panel chairs, panels A and B, who are elected to their position by the KBML from the 11 appointed members by the Governor; and

WHEREAS, the officers and panel chairs frequently have to make immediate decisions about Kentucky physician licensees between KBML meetings that require medical knowledge, training, and judgement; and

WHEREAS, in 2019-20 a consumer KBML non-physician member was elected vice president and panel A chair; now, therefore, be it

RESOLVED, that the KMA work with the Kentucky Board of Medical Licensure (KBML) to ensure that KBML officers and panel chairs be limited to MDs and DOs.

Adopted as Amended

2021-11

RESOLUTION

Subject: Recognition of Efforts During the COVID-19 Pandemic

Submitted by: Donald R. Wilson, M.D. FACOG

Referred to: Reference Committee

WHEREAS, beginning in late 2020 and continuing to present day, Governor Andy Beshear (Governor Beshear) and Doctor Steve Stack (Dr. Stack) acted with clarity and alacrity to diminish the impact of COVID-19 (SARS-CoV-2) to the citizens of the Commonwealth of Kentucky; and

WHEREAS, Governor Beshear and Dr. Stack's swift action led to an untold estimated decrease in the cases and fatalities from COVID-19, thereby protecting the citizens of the Commonwealth of Kentucky; and

WHEREAS, Governor Beshear and Dr. Stack have acted in the best interest of the citizens of the Commonwealth of Kentucky based on science and rational action, thereby saving Kentucky physicians, nurses, other health care workers, facilities, and hospitals incalculable costs and cases in personnel and patients; now, therefore, be it

RESOLVED, that the KMA hereby expresses to the many elected officials, public health officials, and healthcare providers a sentiment of profound appreciation for the actions they have taken during the COVID-19 pandemic to protect the health and well-being of the Commonwealth and its citizens in the face of such an historic challenge.

Adopted

2021-12

RESOLUTION

Subject: Adoption of a “Clear and Convincing” Standard of Proof in Medical Liability Cases

Submitted by: Northern Kentucky Medical Society

Referred to: Reference Committee

WHEREAS, research on solving the malpractice crisis by Eli Engel, MD, PhD, and Edward H. Livingston, MD, published in the Archives of Surgery, Volume 45 (No 3), March 2010, introduced the idea of requiring a “clear and convincing” evidence standard in medical liability cases; and

WHEREAS, the American Medical Association (AMA) has incorporated the concept of raising the evidentiary burden of proof to a “clear and convincing” standard as part of the AMA’s principles regarding liability safe harbors for the practice of evidence-based medicine; and

WHEREAS, the Kentucky Medical Association (KMA) House of Delegates adopted policy in 2011 in support of the application of a “clear and convincing” standard of proof in medical liability cases to improve access to care and to help stabilize medical liability insurance premiums; and

WHEREAS, KMA recognizes the medical liability environment in Kentucky continues to adversely affect access to care for patients; and

WHEREAS, the Annual Rate Survey of the *Medical Liability Monitor* found that in 2019 and 2020, the proportion of premiums that increased year-to-year reached levels not seen since the early 2000s with more than 30% of premiums increasing over the previous year in 2020, potentially signaling the early stages of a hard market indicative of the last the liability “crisis” 20 years ago; and

WHEREAS, in the 14 states where premium increases of 10% or more were reported in 2020, Kentucky ranked first by share of comparisons with 29.6% of comparisons increasing by 10% or more, and third in the number of comparisons (55.6%) experiencing an increase of any size; now, therefore, be it

RESOLVED, that the KMA reaffirm current policy in supportof the application of a “clear and convincing” standard of proof in medical liability cases to help stabilize medical liability insurance premiums; and be it further

RESOLVED, that the KMA support the American Medical Association’s principles of increased liability protections for physicians who adhere to evidence- based medical guidelines, including the application of a “clear and convincing” evidentiary standard in such cases; and be it further

RESOLVED, that the KMA work with the Partnership for Commonsense Justice, a coalition of business and healthcare organizations concerned about Kentucky’s liability climate, in advocating for tort reform, including increased evidentiary standards, before the legislative and judicial branches of

state government.

Adopted

2021-13

RESOLUTION

Subject: Promotion of Physician Well-Being

Submitted by: Shawn C. Jones, MD

Referred to: Reference Committee

WHEREAS, multiple national studies indicate that at least 50% of U.S. physicians are experiencing burnout[1,2]; and

WHEREAS, burnout is primarily a system-level problem driven by excess job demands associated with inadequate resources and support[3], not individual problems prompted by personal deficiencies or frailty[4]; and

WHEREAS, studies reporting associations between physician burnout, quality of care and patient outcomes have resulted in physician wellnessbeing labeled the missing quality indicator[5]; and

WHEREAS, strong evidence has linked burnout in doctors to broken relationships, problematic alcohol use, depression and suicide[6,7] and physician burnout has been identified as a major driver of physician turnover[8,9] and the costs of physician turnover can be staggering[10]; and

WHEREAS, Significant barriers exist which tend to prevent physicians from seeking help when suffering distress from burnout[11]; now, therefore, be it

RESOLVED, the KMA support state and federal legislation that allocates sufficient financial resources for the education, training, development, recruitment, and retention of physicians to meet the medical needs of Kentucky's population, especially citizens who reside in underserved areas; and be it further

RESOLVED, the KMA continue to promote wellness programs, such as the KMA's Be Well Stay Well Physician Health Program, that assist physicians in the management of physical, emotional, and psychological impacts associated with career fatigue, burnout, and other behavioral health issues; and be it further

RESOLVED, the KMA support state legislation that ensures strict confidentiality of a physician's participation in a wellness program that is designed to address issues related to physician career fatigue, burnout, and other behavioral health issues.

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Adopted as Amended

2021-14

RESOLUTION

Subject: Support for Expungement of Criminal Records

Submitted by: Alex Thebert, Joshua Musalia, Curtis Bethel, Nicole Czerner-Garcia (University of Kentucky College of Medicine, Lexington), Onu Udoh, Zoha Mian (University of Louisville School of Medicine)

Referred to: Reference Committee

WHEREAS, criminal records generally include all criminal convictions and charges, even if they were later dismissed or acquitted[1,2]; and

WHEREAS, having a criminal record can restrict access to employment, stable housing, nutrition, and education[2,3]; and

WHEREAS, poverty, homelessness, and lower education are all associated with decreased health[4,5,6,7,8,9]; and

WHEREAS, the U.S. Commission on Civil Rights found that the collateral consequences of a criminal record exacerbate punishment beyond the original conviction, and are in many cases unrelated to the original crime and public safety[3]; and

WHEREAS, expungement is the legal process to completely remove a charge or conviction from a criminal record[10]; and

WHEREAS, in 2020 Kentucky passed a law granting automatic expungement of cases 30 days after they were acquitted or dismissed[11,12]; and

WHEREAS, if someone is convicted of a crime, expunging their record requires petitioning the court a minimum of 5 years after completing their sentence or parole, except in cases of an abuse of public office, a sex offense, or offense committed against a child, which cannot be expunged[11,12]; and

WHEREAS, there are still major barriers to expungement of criminal records, such as cost, time, access to the legal system, and the knowledge needed to navigate it[8]; and

WHEREAS, automatic expungement would eliminate the need for an individual to petition a court for expungement, eliminate costs associated with it, and improve the ability for the person to reintegrate into society; and

WHEREAS, there are currently 12 states with automatic expungement of certain convictions[13]; and

WHEREAS, KMA policy supports efforts to mitigate criminal legal barriers which are preventing Kentuckians who are struggling with substance use disorder from acquiring gainful employment (Res 2019-21); now, therefore, be it

RESOLVED, that KMA recognizes criminal records as a negative determinant of health; and be it further

RESOLVED, that KMA support removing socioeconomic barriers from the process of expunging criminal records.

References:

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Adopted as Amended

2021-15

RESOLUTION

Subject: Support for Removing Financial Barriers to Living Organ Donation

Submitted by: Alex Thebert, Abby Durbin (University of Kentucky College of Medicine, Lexington), Margo Nelis (University of Kentucky College of Medicine, Northern Kentucky), Nic Kemper (University of Louisville School of Medicine)

Referred to: Reference Committee

WHEREAS, nearly 110,000 people are on the national organ transplant waiting list and 17 people die each day waiting for a transplant[1]; and

WHEREAS, 83% of those are waiting for kidney transplants and 11% are waiting for liver transplants[1]; and

WHEREAS, living organ donation is where organs are taken from a live donor and most commonly occurs with whole kidney, liver lobe, and partial lung transplants[2]; and

WHEREAS, of the 18,315 organ donors in 2020, roughly 3 in 10 were living donors[1]; and

WHEREAS, living organ donors are estimated to take on over thousands of dollars in direct and indirect non-medical costs from organ donation due to transportation, food, lodging, and lost wages[3,4,5]; and

WHEREAS, the National Living Donor Assistance Center (NLDAC) is funded by the federal government through grants to help low-income donors with travel expenses, however there are many other unreimbursed costs, such as lost wages, and payouts are capped at $6000[6]; and

WHEREAS, states mainly use two methods to decrease the financial costs of living organ donation, paid leave and tax credits or deductions for unreimbursed expenses[7]; and

WHEREAS, there are 37 states with laws supporting paid leave and 22 states with laws supporting tax incentives, Kentucky currently has neither[7]; and

WHEREAS, the American Society of Transplant Surgeons and American Society of Transplantation support removing financial barriers to living organ donation[8,9] ; and

WHEREAS, the AMA supports removing financial barriers to living organ donations (H-370.965); and

WHEREAS, the KMA supports protecting organ donors from denial of insurance coverage or escalation of premiums (Res 2018-28); now, therefore, be it

RESOLVED, that the KMA supports removing financial barriers to organ donation and making organ donation financially neutral through methods including, but not limited to, paid leave and tax credits.

KMA House of Delegates
August 2021

Adopted

2021-16

RESOLUTION

Subject: Elimination of Medicaid Reimbursement Limits on Complex Evaluation and Management Services

Submitted by: KMA Board of Trustees

Referred to: Reference Committee

WHEREAS, Kentucky regulations place a limit on Medicaid reimbursement of Evaluation and Management (E&M) office visits with a Current Procedural Terminology (CPT®) code of 99214 or 99215 to two per recipient, per provider, per calendar year and reduces reimbursement for claims in excess of this established limit to the CPT® code 99213, a less complex service; and

WHEREAS, Kentucky has some of the highest rates of chronic illness in the country, with many Medicaid patients diagnosed with two or more chronic conditions that require regular provider office visits of high complexity to ensure disease control, reduce prevalence of complications, and encourage medication compliance; and

WHEREAS, existing coding rules and E&M documentation guidelines provide safeguards against the inappropriate use of CPT® codes 99214 and 99215 as providers are required to meet all clinical, medical coding, and documentation guidelines for the specific code level billed in order to justify reimbursement and are also subject to audits by MCOs; and

WHEREAS, the enforcement of this regulation has resulted in significant issues for providers, including MCOs denying, rather than reducing, reimbursement for complex E&M services in excess of the limit, the implementation of confusing pre and post payment audits that vary by MCO, and MCOs incorrectly advising providers to “change” the coding for complex visitsto a lesser CPT® code in violation of coding and E&M documentation guidelines; and

WHEREAS, arbitrary limitations on complex E&M office visits create an access to care issue for Medicaid patients with chronic health conditions and discourage provider participation in the Medicaid program by failing to properly reimburse providers based on the documented level of services performed; now, therefore, be it

RESOLVED, that the KMA advocate for state regulatory or legislative action to eliminate the Medicaid reimbursement limits for Evaluation and Management (E&M) office visits with a Current Procedural Terminology (CPT®) code of 99214or 99215 in order to increase access to high-level care for Medicaid patients, promote accurate coding and documentation for all E&M office visits, and ensure physician reimbursement appropriately reflects the level of care provided to patients.

KMA House of Delegates
August 2021

References:

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[2] Donate Organs While Alive | organdonor.gov. Accessed July 8, 2021. https://www.organdonor.gov/learn/process/living-donation

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Adopted

2021-17

RESOLUTION

Subject: Medicare Supplement Plans and Pre-existing Conditions

Submitted by: Eugene Shively, M.D.

Referred to: Reference Committee

WHEREAS, insurance companies in Kentucky can refuse to sell Medicare supplement (Medigap) policies to seniors, or charge them more, because of pre-existing conditions; and

WHEREAS, when a person first turns 65, federal regulations protect against such discrimination, but if a person has been in a Medicare Advantage plan and later chooses to return to traditional Medicare, that protection no longer exists[1]; and

WHEREAS, there are four states in the United States where there is protection against discrimination for pre-existing conditions under these circumstances; and

WHEREAS, such discrimination for pre-existing conditions is harmful to seniors and should be unlawful[2]; and

WHEREAS, an overwhelming majority of Kentuckians are opposed to charging outrageous rates or refusing to sell policies to people because they are, or have been, sick; and

WHEREAS, Kentucky needs state legislation to outlaw this inhumane and harmful discrimination; now, therefore, be it

RESOLVED, that the KMA support state legislation to prohibit Medicare supplement plans from denying coverage or determining premiums based on an applicant's pre-existing conditions.

References:

[1] Kaiser Family Foundation. "In All But Four States, Seniors on Medicare Can Be Denied a Medigap Policy Due to Pre-existing conditions, Except During Specified Windows of Opportunity." Jul 11, 2018. https://www.kff.org/medicare/press-release/in-all-but-four-states-seniors-on-medicare-can-be-denied-a-medigap-policy-due-to-pre-existing-conditions-except-during-specified-windows-of-opportunity/

[2] Clark, Cheryl. "Medicare Advantage Enrollees Discover Dirty Little Secret—Getting Out Is a Lot Harder Than Getting In." *MedPage Today*, 3 Dec. 2019. https://www.medpagetoday.com/publichealthpolicy/medicare/83661

Adopted

2021-18

RESOLUTION

Subject: Certificate of Need

Submitted by: Northern Kentucky Medical Society

Referred to: Reference Committee

WHEREAS, large hospital systems control the type of care delivered to the majority of the citizens in the Commonwealth; and

WHEREAS, hospitals are major employers of physicians, nurses, pharmacists and other health care providers resulting in limited employment opportunities for same; and

WHEREAS, the certificate of need required by the Commonwealth of Kentucky is ineffective in controlling over-utilization or improving quality of care in many states of the Union; and

WHEREAS, the certificate of need imposes an unnecessary regulatory burden upon those who wish to establish health care facilities in order to provide medical services to the citizens of this Commonwealth; and

WHEREAS, a recent study in the Journal of the American Medical Association compared metrics in states with and without the certificate of need, and found no difference in respect to hospital procedural volume, 30 day mortality, surgical site infection or re-admission rates; now, therefore, be it

RESOLVED, that the KMA work with the Kentucky legislature and all interested parties to modify or eliminate the certificate of need as a requirement to build a health care facility in the Commonwealth of Kentucky.

Adopted as Amended

2021-19

RESOLUTION

Subject: Personal Protective Equipment

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, the 2020 SARS-CoV-2 coronavirus pandemic depleted personal protective equipment in hospitals across the United States of America; and

WHEREAS, the World Health Organization has stated that the shortage of personal protective equipment has left physicians, nurses and other frontline workers dangerously ill-equipped to care for COVID-19 patients due to limited access to gloves, masks, respirators, goggles, face shields, and gowns; and

WHEREAS, the effects of the SARS-CoV-2 have disrupted supply chains of personal protective equipment globally, nationally, and locally; and

WHEREAS, the American Medical Association issued a statement in support of health care workers using their own face masks and respirators when such critical resources were unavailable nor provided by their employer; and

WHEREAS, physicians, nurses, respiratory therapists, and other allied medical and support professionals were required to reuse personal protective equipment in less than ideal containment; and

WHEREAS, states and other localities have had to compete in order to acquire personal protective equipment and are outbid for the purchase of personal protective equipment by the Federal Emergency Management Agency (FEMA); and

WHEREAS, the threat of another global pandemic is constantly evolving now, therefore, be it

RESOLVED, that the KMA advocate the Commonwealth of Kentucky and state-based hospitals maintain a strategic personal protective equipment supply, including N-95 masks, gowns, face masks, face shields, and gloves, for use by physicians and other health care personnel to sustain statewide hospital and pre-hospital operations during a declared emergency.

Adopted as Amended

2021-20

RESOLUTION

Subject: Lung Cancer Prevention by Creating a Research Trust & Raising Excise Taxes

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, Kentucky (KY) has the highest incidence of all states for lung and bronchial cancer, and the highest incidence of all states for adult smokers (23.4%), and the highest incidence (with West VA.) of all states for under-age smokers (14.3%); and

WHEREAS, health care and lost productivity costs of US smoking born by providers, taxpayers and employers annually is enormous, at $168 billion for health care and $300 billion total, (which translates to $19.16 per pack smoked); and

WHEREAS, purchase price increases, including excise taxes, of cigarettes and nicotine delivery agents have been shown as the greatest deterrent to begin their use, and the greatest incentive to quit using; and

WHEREAS, KY's low excise tax of $1.10 per pack is insufficient deterrence, being $0.81 below average of all US states ($1.91), and $3.14 below the highest tier states (NY, CT, RI, MD + DC) for deterrence strength through excise tax rates ($4.24 average); and

WHEREAS, funding of research greatly enhances prevention and treatment; as exemplified by the nationally acclaimed Kentucky Spinal Cord and Head Injury Trust; and

WHEREAS, KMA 2021-2 President Neal Moser, MD, has designated lung health as a key focus of his presidency; now, therefore, be it

RESOLVED, that KMA strongly support President Neal Moser, MD's focus on lung health, including lung and bronchial cancer; and be it further

RESOLVED, that KMA support legislation to establish a Kentucky Lung Health Trust that awards grants for cancer research, nicotine delivery epidemiology and environmental lung injury studies, funded by an increase on excise taxes on cigarettes and nicotine delivery agents to above the national average.

Adopted

2021-21

RESOLUTION

Subject: Modifier 25

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, patients frequently present to their physicians expecting management of multiple complaints, which may be treated medically or require a diagnostic or treatment procedure on the same date of service; and

WHEREAS, during the course of a physical exam the clinician may identify pathology that necessitates a biopsy and/or other procedure; and

WHEREAS, performance of a medically necessary procedure on the same day as a separate evaluation and management (E/M) service is generally done to facilitate a prompt diagnosis, to streamline treatment of complex conditions and to save patients return visits and copayments; and

WHEREAS, per the CPT definition, Modifier 25 is utilized to indicate a distinct and separate E/M service performed on the same date of service as a minor procedure (those procedures with zero- or ten-day global periods) or a separately identifiable E/M service; and

WHEREAS, when CPT codes typically reported on the same date of service as an E/M code are reviewed by the AMA RUC, overlapping value between an E/M and the procedure is eliminated. Overlapping direct practice expense and physician time is methodically removed from the code value, in turn reducing the indirect practice expense component of the procedural value, ensuring that physicians do not receive duplicative reimbursement for work or practice expense when modifier 25 is used. This reduction holds even if the procedure is billed in isolation, resulting in physician underpayment; and

WHEREAS, appropriate use of modifier 25 is essential to efficient, patient-centered care; now, therefore, be it

RESOLVED, that the KMA advocates that separate services should be reimbursed appropriately and in accordance with established CPT coding conventions and guidelines, including modifier 25 and additional modifiers; and be it further

RESOLVED, that the KMA supports legislation to establish that public and private payers operating in the Commonwealth must follow established CPT coding and reimbursement guidelines and may not reduce or deny reimbursement for medical services based on their own metrics.

Adopted as Amended

2021-22

RESOLUTION

Subject: Prior Authorization Denials

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, physicians across all specialties see many patients in a clinic day and have to balance patient calls and paperwork throughout the day; and

WHEREAS, among the many things that consumes an office are prior authorizations for medications, medical equipment/supplies, and diagnostic tests with repeated denials without explanation; and

WHEREAS, the process begins with a communication that a prior authorization is needed, and then a non-standard form is filled out answering basic questions which then gets submitted by the clinical staff. When the denial letter comes from the insurance company, there is no explanation of why it was denied nor indicate suggested alternatives, rather more grievance is required to be filled out; and

WHEREAS, this comes at the expense of office staff time and timely patient care. This leaves the patient without prompt access to testing/medications/supplies/equipment that leads to reduced patient adherence to treatment, delay in treatment, and reduced satisfaction with their clinical team; now, therefore, be it

RESOLVED, that to reduce delays in patient care, the KMA reaffirms its support for regulatory and statutory requirements mandating that health plans provide timely prior authorization notification – 24-hour relating to urgent care and 5-day relating to non-urgent care - for medications, equipment and supplies, procedures, treatments, and all other health care services, including diagnostic testing and surgical services; and be it further

RESOLVED, that to reduce the administrative burden of prior authorization, the KMA reaffirms its support for regulatory and statutory requirements mandating that health plans – when denying prior authorization requests – provide correspondence to the requesting clinician that contains an explanation of denial and lists alternatives for the denied medications, equipment and supplies, procedures, treatments, and all other health care services, including diagnostic testing and surgical services; and be it further

RESOLVED, that the KMA engage its membership and other relevant stakeholders to gather data that can be utilized in determining the extent to which commercial health plans are in compliance with the requirements of 2019 Senate Bill 54, a legislative enactment relating to prior authorizations, and

based on such information, communicate the Association's concerns regarding the implementation of 2019 Senate Bill 54 to the appropriate state agency.

Adopted as Amended

2021-23

RESOLUTION

Subject: Advocacy for All Health Plans to Provide Chronic Care Management Services Without Co-pay For Their Insured Patients

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, 6 in 10 adults in the United States have a chronic disease and 4 in 10 adults have two or more chronic diseases. Chronic conditions are the leading cause of death and disability and are responsible for 90% of the nation's $3.8 trillion in annual healthcare expenditures[1]; and

WHEREAS, in effort to reduce healthcare cost and improve patient outcomes, in 2015 CMS began the Chronic Care Management (CCM) program. CCM are for eligible patients with 2 or more chronic conditions; must last at least 12 months or until death; and that place the patients at significant risk of death, acute exacerbation/decompensation, or functional decline; and

WHEREAS, CCM are non-face-to-face-services provided by clinical staff under the direction of eligible healthcare clinicians, per calendar month. Services can include: an electronic, centered care plan tracking; education; preventative services; medication management and reconciliation; transitional care management; coordination of home/community based clinical service; and

WHEREAS, the effectiveness of the CCM program saves Medicare approximately $74 per patient, per month;[3] reduces unnecessary hospital visits by 4.7%, ED visits by 2.3%[4], and manages health problems with an extra level of care. In turn, patients are healthier, more connected, and save on healthcare costs annually, healthcare practitioners feel supported; and

WHEREAS, practices and vendors who provide CCM face an enormous hurdle due to the monthly required patient co-pay that it has been harder to enroll patients and therefore not beneficial for healthcare systems to implement and costly to our patients. Also, CCM services are only covered by select insurance companies; now, therefore, be it

RESOLVED, that the KMA supports the elimination of all cost sharing requirements for Chronic Care Management services.

References:

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[4] Mathematic Policy Research. November 2, 2017. Evaluation of the Diffusion and Impact of Chronic Care Management (CCM) Services: Final Report. Retrieved from https://innovation.cms.gov/Files/reports/chronic-care-mngmt-finalevalrpt.pdf

Adopted as Amended

2021-24

RESOLUTION

Subject: Healthcare Access for All

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, 11 years after adoption of the ACA, 10% of the US population remains uninsured; and

WHEREAS, lack of health insurance is associated with poor health status, less likely to receive medical care, more likely to be diagnosed later in their course of illness, and more likely to die early[1]; and

WHEREAS, of the 50 US states (2019 data), Kentucky has the 2nd highest cancer mortality rate, and is in the top 10 for mortality from chronic lower respiratory diseases, diabetes, heart disease, and stroke[2]; and

WHEREAS, a recent study done by researchers at Yale demonstrated that a single payer, universal health care program, such as the Medicare for All Act, would actually cost $450 billion less, and save 68,000 lives per year compared to the status quo[3]; and

WHEREAS, as physicians and leaders, we have the moral and ethical obligation to advocate for the health and well-being, including affordability and access to care, of all Kentuckians; and

WHEREAS, governmental insurance programs have administrative overhead of 1.5-2%, compared to the 12-18% overhead of commercial insurers,[4] which translates to a substantial amount of commercial health insurance dollars NOT being spent on actual healthcare; now, therefore, be it

RESOLVED, that the KMA express its support for universal access to comprehensive, affordable, high-quality health care.

References:

1 https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services
2 https://www.cdc.gov/nchs/pressroom/states/kentucky/ky.htm
3 Galvani, Alison et al; Improving the Prognosis of Health care in the USA; The Lancet; Vol 395, Feb 15, 2020, pp 524-533
4 https://www.politifact.com/factchecks/2017/sep/20/bernie-sanders/comparing-administrative-costs-private-insurance-a/

Referred to the Board of Trustees for Action

2021-25

RESOLUTION

Subject: Soda Tax

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, at least 11 regions in the United States has some form of sugar tax, including Tennessee and West Virigina[1]; and

WHEREAS, Arkansas raised $13 million from its soda tax in its first year of inception in the early 1990's that directly funded the Medicaid Trust Fund and grew to $267 million in 2013[1,2]; and

WHEREAS, diabetes is a public health epidemic in our nation. Kentucky ranks 8th highest in diabetes prevalence. In 2017, Kentucky had the 5th highest death rate in the nation due to diabetes and was the 3rd leading cause of death in African Americans. Diabetes cost Kentucky $5.16 billion in total medical expenditures, lost work and wages in 2017[3]; and

WHEREAS, complications of diabetes includes heart disease, stroke, blindness, kidney failure, lower-limb amputation and ketoacidosis[3]; and

WHEREAS, a study performed by the United States Department of Agriculture in 2016 found that across all households, more money was spent on sugary drinks in both SNAP and non-SNAP households[4]; and

WHEREAS, a soda tax may prevent consumers from purchasing sugary drinks or, otherwise, will help fund Medicaid to treat diabetes and its complications; now, therefore, be it

RESOLVED, that the KMA support a soda tax imposed upon soft drink manufacturers and distributors in which a "Medicaid Trust Fund" would be created to receive all proceeds.

References:

1 https://www.thetaxadviser.com/issues/2017/jun/soda-taxes.html
2 https://talkbusiness.net/2013/07/jim-guy-tucker-for-two-decades-the-soda-tax-has-served-arkansaswell/
3 https://chfs.ky.gov/agencies/dph/dpqi/cdpb/dpcp/diabetesfactsheet.pdf
4 https://fns-prod.azureedge.net/sites/default/files/ops/SNAPFoodsTypicallyPurchased.pdf

Adopted

2021-26

RESOLUTION

Subject: Refusal of Licensed Vaccines

Submitted by: Michael Kuduk, MD

Referred to: Reference Committee

WHEREAS, licensed vaccines prevent diseases that could otherwise cause serious illness, disability or death; and

WHEREAS, licensed vaccines in current use have been very successful as well as cost effective in mitigating serious and lethal illnesses, particularly in children; and

WHEREAS, the current burden of disease which can be prevented by licensed vaccines in the Commonwealth is low due to the success of its vaccination program; and

WHEREAS, the role that licensed vaccines play in promoting positive public health is invaluable; and

WHEREAS, any laws or regulations which result in impairing the effectiveness of Kentucky's vaccination program will inevitably result in an increase in disease, disability, and death from vaccine preventable diseases; and

WHEREAS, unvaccinated individuals possess increased capability to spread vaccine preventable disease, and by exercising their choice to not be vaccinated therefore impair the right of all citizens of the Commonwealth to be free from the peril posed by these diseases; now, therefore, be it

RESOLVED, that the KMA shall continue to oppose legislation which would create a protected legal status or civil right for unvaccinated individuals; and be it further

RESOLVED, that the KMA shall continue to oppose legislation which permits refusal of licensed vaccines solely on the basis of conscientious objection or conscientiously held beliefs.

Adopted

2021-27

RESOLUTION

Subject: Memorial to Naren James, MD

Submitted by: KMA Board of Trustees

Referred to: Reference Committee

WHEREAS, Naren James, MD, served Lincoln, Boyle, and Casey Counties as a family physician for 24 years; and

WHEREAS, Naren James, MD, remained active throughout his career in local, state, and national politics as a community activist and staunch advocate on behalf of his patients and profession; and

WHEREAS, in addition to his medical practice, Naren James, MD, brought about positive change in his community through his work as a Stanford City Council member, a Lincoln County Board of Health member, a Lincoln County Ambulance Board member, and as a member of the Lincoln County Public Library Board; and

WHEREAS, among his many accomplishments, Naren James, MD, worked tirelessly to raise awareness with local citizens regarding the benefits of health education and physical activity and joined with other council members to pass a city-wide smoking ban; and

WHEREAS, Naren James, MD, served on the Kentucky Medical Association Board of Trustees as the Twelve (12th) District Trustee and Alternate Trustee for 15 years and was a longtime contributor to the Kentucky Physicians Political Action Committee; and

WHEREAS, in addition to his service to the Kentucky Medical Association, Naren James, MD, was recognized by the Kentucky Academy of Family Physicians as the 2017 Citizen Doctor of the Year, which honors an outstanding, community-minded family physician of strong moral values whose deeds and actions exemplify the characteristics of service before self; and

WHEREAS, over his many years of service, Naren James, MD, led by example through his unwavering devotion to his family, faith, profession, and patients; and

WHEREAS, Naren James, MD, passed from this life on March 28, 2021; now, therefore, be it

RESOLVED, that the KMA House of Delegates honors the memory of Doctor Naren James and expresses its deepest sympathy to his wife, Mrs. Hannah James, daughter, Ms. Alicia Shanti James, extended family, friends, and colleagues; and be it further

RESOLVED, that in gratitude for Doctor James' contributions and extraordinary service to his patients, profession, and state, a copy of this resolution be presented to the family of Naren James, MD, and that this resolution be made a permanent part of the records of this Association.

KMA House of Delegates
August 2021

Adopted

2021-28

RESOLUTION

Subject: Memorial to Truman Perry, MD

Submitted by: KMA Board of Trustees

Referred to: Reference Committee

WHEREAS, Truman Perry, MD, served Corbin, Kentucky, and the surrounding area as a family physician for 24 years; and

WHEREAS, in addition to serving his community, Truman Perry, MD, also honorably served his country as a member of the United States Navy completing his Family Practice residency at the Naval Hospital in Jacksonville, Florida; and

WHEREAS, following his residency training, Truman Perry, MD, continued his service as a Navy physician in Guantanamo Bay, Cuba, and Cherry Point, North Carolina; and

WHEREAS, upon his return to Corbin, Kentucky, Truman Perry, MD, became a partner at Barton, Watts, & Perry, P.S.C., and was instrumental in growing it to be the largest family practice in Corbin before joining Grace Health in 2016; and

WHEREAS, Truman Perry, MD, served on the Kentucky Medical Association Board of Trustees as the Fifteenth (15th) District Trustee and Alternate Trustee for 18 years and was a longtime contributor to the Kentucky Physicians Political Action Committee; and

WHEREAS, Truman Perry, MD, was greatly respected by his colleagues for his exemplary commitment to family practice and his high standard of quality; and

WHEREAS, in addition to his contributions to the medical profession, Truman Perry, MD, was highly regarded in his community as a loving father, devoted friend, and faithful servant who was always willing to help those in need; and

WHEREAS, Truman Perry, MD, passed from this life on April 11, 2021; now, therefore, be it

RESOLVED, that the KMA House of Delegates honors the memory of Doctor Truman Perry and expresses its deepest sympathy to his children, Ryan and Megan Perry; sister, Lisa Perry; girlfriend, Dawn Sizemore; stepdaughter, Kayla Cox; grandchildren, Peyton and Emma; and extended family, friends, and colleagues; and be it further

RESOLVED, that in gratitude for Doctor Truman Perry's contributions and extraordinary service to his patients, profession, country, and state, a copy of this resolution be presented to the family of Truman Perry, MD, and that this resolution be made a permanent part of the records of this Association.

KMA House of Delegates
August 2021