RESOLUTION

Subject: Continuous Glucose Monitoring Sensors and Insurance Coverage

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, diabetes is an epidemic in the United States[1]. In Kentucky, according to 2024 data from the American Diabetes Association, approximately 486,200 adults have received a diagnosis of diabetes; and

WHEREAS, obesity, yet another epidemic, is associated with up to 53% of new diagnoses of type 2 diabetes every year, with approximately 1,325,800 adults in Kentucky being obese[1]; and

WHEREAS, each year in Kentucky, an estimated 20,700 adults are newly diagnosed with diabetes[1]; and

WHEREAS, complications of diabetes significantly increase the risk of cardiovascular disease, chronic kidney disease, stroke, neuropathy, diabetic ketoacidosis, diabetic-related eye conditions, and more[2]; and

WHEREAS, people with diabetes have an average medical expenditure 2.6 times higher than those without, with the total cost of diabetes in Kentucky being 5.1 billion[3]; and

WHEREAS, in 2022, the estimated cost of diagnosed diabetes in the U.S. was $412.9 billion[3]; and

WHEREAS, 33.8% of the adult population of Kentucky have prediabetes with elevated A-1c above 5.7[4]; and

WHEREAS, continuous glucose monitoring (CGM) sensors that provide real-time feedback about blood sugar levels can prevent conversion of prediabetes to diabetes and its attendant complications by inspiring lifestyle changes that could help both diabetes and obesity; and

WHEREAS, the use of CGM in patients with prediabetes to implement individualized lifestyle interventions to prevent diabetes would substantially improve the health of the population, while also decreasing cost of medical expenses[5]; and

WHEREAS, CGM for patients with prediabetes is not currently required to be covered by insurance companies as part of the Patient Protection and Affordable Care Act of 2010; and

WHEREAS, findings from a recent cost-effectiveness analysis demonstrated that interventions to prevent type 2 diabetes among high-risk and prediabetic individuals are highly cost-effective and practical in any given setting[6]; now, therefore, be it

RESOLVED, that KMA supports legislation encouraging the use of continuous glucose monitoring for patients with prediabetes; and be it further

RESOLVED, that insurance coverage for continuous glucose monitoring (CGM) sensors be mandatory for prevention of diabetes.

References:

1. The burden of diabetes in Kentucky. American Diabetes Association. 2024. Accessed July 3, 2025. https://diabetes.org/sites/default/files/2024-03/adv_2024_state_fact_kentucky.pdf.
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6. Zhou X, Siegel KR, Ng BP, et al. Cost-effectiveness of diabetes prevention interventions targeting high-risk individuals and whole populations: A systematic review. *Diabetes Care*. 2020;43(7):1593-1616. doi:10.2337/dci20-0018

RESOLUTION

Subject: Increasing Mandatory Minimum Personal Injury Protection (PIP) Coverage to Improve Access to Trauma and Rehabilitation Care in Kentucky

Submitted by: Northern Kentucky Medical Society

Referred to: Reference Committee

WHEREAS, Kentucky's mandatory minimum Personal Injury Protection (PIP) coverage of $10,000 per person per accident was established in 1975 and has never been indexed for inflation or rising healthcare costs, yet the mean one-year treatment cost per major trauma patient in the U.S. is $75,210 (2010 USD), meaning today's floor covers only about 13 percent of typical acute and post-acute care expenses[1,2]; and

WHEREAS, PIP serves as a no-fault safety net, covering medical expenses up to $10,000 and reimbursing lost wages at $200 per week (or 85 percent of income if lower), but these benefits are typically exhausted after the index hospitalization in moderate-to-severe crashes, leaving injured low-income Kentuckians underinsured and facing significant financial barriers [2,3]; and

WHEREAS, Kentucky's age-adjusted injury mortality rate is roughly 33 percent higher than the national average, and motor vehicle crashes remain a leading cause of traumatic injury that necessitates expensive rehabilitation and long-term support[4]; and

WHEREAS, increasing the PIP minimum to $50,000 per person per accident would cover roughly two-thirds of the average first-year trauma care cost, ensuring timely access to both acute treatment and essential post-acute rehabilitation for economically vulnerable patients, thereby reducing downstream disability burdens and long-term societal costs[1]; and

WHEREAS, concerns about potential insurance-premium increases have been mitigated in other no-fault states, most notably Michigan, where optional higher PIP tiers coexist with only 20–45 percent premium adjustments, and Minnesota, which sets a $40,000 floor with modest premium impacts, showing that higher PIP floors can remain affordable[5,6]; and

WHEREAS, stakeholder collaboration among insurers, healthcare providers, and consumer advocates is essential to design cost-effective implementation strategies, such as standardized billing protocols and public awareness campaigns, to support a smooth transition to higher PIP limits; and

WHEREAS, States like Michigan, Minnesota, and New York, which mandates a $50,000 "basic economic loss" floor, demonstrate that higher minimums can effectively cover trauma and rehabilitation costs without prohibitive premium spikes, offering models Kentucky can emulate to ensure equitable access for low-income drivers[5,6,7]; now, therefore, be it

RESOLVED, that the Kentucky General Assembly and Department of Insurance increase the mandatory minimum Personal Injury Protection (PIP) coverage to $50,000 per person per accident, with an interim floor of $25,000 per person per accident; and be it further

RESOLVED, that the Kentucky Department of Insurance conduct an annual study to monitor the impact of the increased Personal Injury Protection (PIP) minimum on insurance premiums, healthcare access, and patient outcomes.

References:

1. Weir S, Morris JA Jr, Pierce MC, et al. One-year treatment costs of trauma care in the USA. Expert Rev Pharmacoecon Outcomes Res. 2010;10(2):187–197. https://pubmed.ncbi.nlm.nih.gov/20384565/
2. Kentucky Department of Insurance, “Motor Vehicle Reparations Act (1975) – Personal Injury Protection (PIP),” https://insurance.ky.gov/PPC/newstatic_info.aspx?static_id=24
3. O’Connor Acciani & Levy, “Kentucky Personal Injury Protection (PIP) Benefits,” Apr 13, 2017. https://www.oal-law.com/blog/kentucky-personal-injury-protection-pip-benefits/
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5. Michigan Department of Insurance and Financial Services, “Choosing PIP Medical Coverage,” https://www.michigan.gov/autoinsurance/choosing-coverage/choosing-pip-med-coverag e
6. Minnesota Department of Commerce, “No-Fault Automobile Insurance – Personal Injury Protection,” Nov 2023. https://mn.gov/commerce/stat/pip/
7. FindLaw, “New York Consolidated Laws, Insurance Law § 5102 – Definitions (Basic Economic Loss up to $50,000),” https://codes.findlaw.com/ny/insurance-law/isc-sect-5102/

RESOLUTION

Subject: Achieving Equitable, Affordable, Efficient Healthcare

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, 55-87%[1] of Kentucky patients forgo medical care or medications secondary to cost; and

WHEREAS, the current U.S. healthcare financing system creates inherent vulnerabilities in continuity of coverage and access to care as evidenced by the estimated loss of coverage to 200,000-350,000 Kentuckians from recently passed federal Medicaid cuts and new regulations[2], with even more projected to lose coverage secondary to changes in Marketplace regulations[3]; and

WHEREAS, absence of care adversely affects healthcare outcomes; and

WHEREAS, the U.S. has the highest per capita healthcare costs[4], the lowest life expectancy[5], the greatest burden of chronic disease[5], and the highest maternal and infant mortality rates of peer high-income nations[5]; and

WHEREAS, healthcare costs and time off work due to illness are estimated to be responsible for two-thirds of U.S. bankruptcies[6]; and

WHEREAS, these problems do not exist in countries which provide universal coverage to their inhabitants; and

WHEREAS, a progressive tax-based system of health insurance financing is more equitable than the current system, would be easier to navigate for patients, and less cumbersome for providers, would ensure that everyone has healthcare coverage, would lower costs and save lives[7]; and

WHEREAS, seven state medical societies (Washington, Vermont, Illinois, Hawaii, New Hampshire, Maine, and Massachusetts) have already passed resolutions endorsing universal coverage and/or a single payer system; and

WHEREAS, private carriers are motivated to deny claims, found to be nearly 20% in 2023 for in-network services and as many as 37% for out-of-network services for those insured on the Marketplace[8], of which approximately 1% were appealed, in order to satisfy the financial returns demanded by shareholders; and

WHEREAS, current KMA policy only expresses support for “universal access,” which already exists and does not address the barriers of obtaining affordable or equitable care; now, therefore, be it

RESOLVED, that KMA endorse adoption of a system of universal healthcare coverage with comprehensive benefits in the U.S., and the elimination of financial barriers to care; and be it further

RESOLVED, that this does not preclude the availability of private payment or the purchase of private insurance for non-covered services for those who can afford and wish to obtain them.

References:

1. https://www.asclepiusinitiative.org/_files/ugd/cfb40c_105e50841e714c1396b58585cb050143.pdf\
2. https://www.kff.org/medicaid/issue-brief/allocating-cbos-estimates-of-federal-medicaid-spending-reductions-and-enrollment-loss-across-the-states/
3. https://www.cbo.gov/system/files/2025-06/Wyden-Pallone-Neal_Letter_6-4-25.pdf
4. https://data-explorer.oecd.org/vis?lc=en&fs[0]=Topic%2C1%7CHealth%23HEA%23%7CHealth%20expenditure%20and%20financing%23HEA_EXP%23&fs[1]=Measure%2C0%7CExpenditure%23EXP_HEALTH%23&pg=0&fc=Measure&snb=1&vw=br&df[ds]=dsDisseminateFinalDMZ&df[id]=DSD_SHA%40DF_SHA&df[ag]=OECD.ELS.HD&df[vs]=1.0&dq=.A.EXP_HEALTH.USD_PPP_PS%2BPT_B1GQ._T.._T.._T...&pd=2023%2C&to[TIME_PERIOD]=false
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6. https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2018.304901?role=tab
7. https://pmc.ncbi.nlm.nih.gov/articles/PMC8572548/
8. https://www.kff.org/affordable-care-act/press-release/healthcare-gov-insurers-denied-nearly-1-in-5-in-network-claims-in-2023-but-information-about-reasons-is-limited-in-public-data/

RESOLUTION

Subject: Increasing Medicaid Reimbursement for Obstetric Care in Rural Communities

Submitted by: Northern Kentucky Medical Society

Referred to: Reference Committee

WHEREAS, the Commonwealth of Kentucky has a maternal mortality rate of 34.6 per 100,000 births[1], while the national average is 23.2 per 100,000 births[1]; and

WHEREAS, over 70 of the 120 counties in Kentucky do not have a practicing obstetrician[2], rural counties are specifically, facing substantial barriers in accessing obstetric care due to provider shortage and hospital closures[3]; and

WHEREAS, Medicaid covers nearly half of births in rural communities in Kentucky[3], yet, low Medicaid reimbursements are a key driving force in nearly 20% of Kentucky's rural inpatient hospitals that are at risk for closure[4]; and

WHEREAS, increases in Medicaid reimbursement rates for obstetricians have increased providers' willingness to accept pregnant women with Medicaid in other states such as California[5]; now, therefore, be it

RESOLVED, that KMA advocate to the General Assembly for increasing Medicaid reimbursement of obstetric care in rural communities, to increase the number of obstetric providers in rural Kentucky in support of favorable maternal health outcomes.

References:

1. March of Dimes. "2024 March of Dimes Report Card for Kentucky." *March of Dimes | PeriStats*, www.marchofdimes.org/peristats/reports/kentucky/report-card. Accessed 30 June 2025.
2. Jett, Molly. "Research Shows 72 of Kentucky's 120 Counties Are without an OB-Gyn." *WDRB*, 4 Mar. 2023,www.wdrb.com/news/research-shows-72-of-kentuckys-120-counties-are-without-an-ob-gyn/article_ba838c2c-ba2d-11ed-83c1-5b37fd5e39e2.html.
3. Osorio, Joan Alker and Aubrianna, et al. "Medicaid Plays a Key Role for Maternal and Infant Health in Rural Communities." *Center For Children and Families*, 13 June 2025, ccf.georgetown.edu/2025/05/15/medicaid-plays-a-key-role-for-maternal-and-infant-health-in-rural-communities/.
4. Bluegrass live. "13 of Kentucky's 71 Rural Inpatient Hospitals at Risk of Closing." *Bluegrass Live*, 13 Aug. 2024, bluegrasslive.com/2024/08/13/13-of-kentuckys-71-rural-inpatient-hospitals-at-risk-of-closing/?utm.
5. Nesbitt, T S et al. "Obstetric care, Medicaid, and family physicians. How policy changes affect physicians' attitudes." *The Western journal of medicine* vol. 155,6 (1991): 653-7.

RESOLUTION

Subject: Expanding Insurance Coverage of Anti-Obesity Pharmaceuticals

Submitted by: Claire Tinkler (MSS) and Monalisa Tailor, MD

Referred to: Reference Committee

WHEREAS, obesity affects millions of adults in the state of Kentucky, putting them at risk for chronic illness such as cancer, heart disease, and diabetes; and

WHEREAS, according to a study in the New England Journal of Medicine, the Kentucky obesity rate is projected to reach 54.8% by 2030[1]; and

WHEREAS, according to data from the CDC, obesity related medical costs $173 billion annually in the United States[2]; and

WHEREAS, the prescription of GLP-1 anti-obesity medications under proper supervision by a primary care physician or equivalent healthcare provider can improve obesity and obesity-related conditions when combined with lifestyle changes focusing on appropriate nutrition, exercise, and sleep; and

WHEREAS, almost 1.5 million Kentuckians rely on Medicaid for healthcare coverage[3]; and

WHEREAS, thirteen other states cover GLP-1 prescription coverage for obesity treatment under their state Medicaid programs as of August 2024[4]; and

WHEREAS, in alignment with American Medical Association policy supporting elimination of coverage exclusions for pharmacological treatment of obesity, and to support and cover chronic treatment of obesity with anti-obesity medications to maintain weight loss[5]; now, therefore, be it

RESOLVED, that KMA supports legislation to ensure coverage for long-term pharmacologic obesity treatment and to ensure that coverage is not removed once patients reach their weight loss goals; and be it further

RESOLVED, that this anti-obesity pharmaceutical coverage be included under Kentucky Medicaid.

References

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2. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0247307
3. https://www.chfs.ky.gov/agencies/dms/stats/KYDWMMCC202505.pdf
4. https://www.kff.org/medicaid/issue-brief/medicaid-coverage-of-and-spending-on-glp-1s/[1]
5. https://www.ama-assn.org/forums/house-delegates/reference-committee-b/res-230-advocating-expand-private-insurance-coverage?check_logged_in=1

RESOLUTION

Subject: Medicaid Cuts and Artificial Intelligence

Submitted by: Michael Kuduk, MD (KMA Immediate Past President)

Referred to: Reference Committee

WHEREAS, 1.4 million Kentuckians are covered by Medicaid, which is 31% of the total population; and

WHEREAS, H.R. 1 from the 2025 U. S. Congress (the Big Beautiful Bill) contains provisions for significant and permanent cuts to state Medicaid funding; and

WHEREAS, proposed Medicaid cuts will pose a significant threat to the Kentucky state budget; and

WHEREAS, proposed Medicaid cuts are projected to reduce federal funding to rural hospitals by $50.4 billion over 10 years, threatening access to care in underserved communities; and

WHEREAS, decrease in Medicaid funding is likely to cause reductions in the number of lives covered, benefits to those covered, or both; and

WHEREAS, artificial intelligence technologies, including eligibility engines and predictive analytics, have demonstrated the ability to streamline Medicaid administration, reduce fraud, produce cost savings, and improve patient outcomes; now, therefore be it

RESOLVED, that KMA urge the state legislature to work with relevant stakeholders to explore innovative strategies, including the responsible use of artificial intelligence, to enhance administrative efficiency, reduce costs, and improve care quality for Medicaid beneficiaries.

2025-7

RESOLUTION

Subject: Physician Trainees' Engagement in AI Governance and Medical Education

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, augmented intelligence (AI) is rapidly transforming healthcare delivery and medical education, introducing new opportunities and complex ethical challenges related to patient privacy, data security, clinical decision-making, and healthcare equity; and

WHEREAS, medical students and resident physicians are uniquely positioned on the front lines of clinical care and medical training, directly experiencing both the benefits and consequences of AI integration in patient care and medical education; and

WHEREAS, leading organizations such as the American Medical Association (AMA)[1], Association of American Medical Colleges (AAMC)[2], and National Academy of Medicine[3] have emphasized the urgent need for clear ethical frameworks to guide the use of AI in healthcare, including the importance of addressing issues of bias, transparency, data privacy, and human oversight; and

WHEREAS, the absence of medical students and resident physicians' input in the development and implementation of AI policies risks overlooking the practical realities, educational needs, and unique challenges faced by trainees, potentially impacting both patient safety and the quality of graduate medical education; and

WHEREAS, AI systems are only as reliable and equitable as the data and oversight that shape them, and human review – including that of physician trainees – is essential to prevent errors and bias in patient care; and

WHEREAS, meaningful physician trainee participation in AI policy and implementation development will ensure that future physicians are prepared to navigate the evolving landscape of technology in medicine, advocate for patient interests, and uphold the highest standards of ethical practice; now, therefore, be it

RESOLVED, that KMA supports the creation of a resident and medical student-led augmented intelligence (AI) review committee to ensure physician trainee participation in the development, implementation, and oversight of AI policies in clinical and educational setting for the Commonwealth; and be it further

RESOLVED, that KMA advocate for the integration of physician trainees' perspectives into all institutional and statewide augmented intelligence (AI) committees and support the development of educational modules on clinical implementation of AI co-designed by physician trainees.

KMA House of Delegates
August 2025

References:

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2. Principles for the Responsible Use of Artificial Intelligence in and for Medical Education. AAMC. January 3, 2025. https://www.aamc.org/about-us/mission-areas/medical-education/principles-ai-use
3. National Academy of Medicine. Health Care Artificial Intelligence Code of Conduct. October 23, 2024. https://nam.edu/our-work/programs/leadership-consortium/health-care-artificial-intelligence-code-of-conduct/

2025-8

RESOLUTION

Subject: Increase in Graduate Medical Education (GME) Funding for Dermatology Residency Programs

Submitted by: Northern Kentucky Medical Society

Referred to: Reference Committee

WHEREAS, the state of Kentucky has a higher melanoma incidence rate than the national average at a rate of 28.2 cases per 100,000 compared to 22.7 cases per 100,000[1]; and

WHEREAS, the average wait time to see a dermatologist is 35 days nationally and even longer in rural areas [2]; and

WHEREAS, Kentucky only has one Dermatology Residency program at the University of Louisville School of Medicine which offers only 2 postgraduate year (PGY) positions annually[3]; and

WHEREAS, the national average for dermatology residency spots is 13 positions per state while Kentucky has 2 positions[4]; and

WHEREAS, the incidence of skin cancer cases is expected to increase while a provider shortage becomes more prevalent, especially in rural settings; and

WHEREAS, Lexington, KY is one of the least dermatologist-dense areas in the United States with 0.3 dermatologists per 100,000 people. This can be compared to areas like Boston, MA and Palo Alto, CA which have 31.9 and 36.6 dermatologists per 100,000 people, respectively[5]; now, therefore, be it

RESOLVED, that KMA advocate to the General Assembly for increased Graduate Medical Education (GME) funding for dermatology residency programs to increase the number of Dermatology postgraduate year (PGY) spots in the state of Kentucky.

References:

1. https://statecancerprofiles.cancer.gov/quick-profiles/index.php?tabSelected=2&statenam e=kentucky
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3. https://louisville.edu/medicine/departments/medicine/divisions/dermatology/residency-pr ogram
4. https://www.nrmp.org/wp-content/uploads/2023/04/Advance-Data-Tables-2023_FINAL-2. pdf
5. https://jamanetwork.com/journals/jamadermatology/fullarticle/2599761

RESOLUTION

Subject: Safeguarding Kentucky's Physician Pipeline After Federal Loan Reform

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, Kentucky faces a critical physician workforce crisis, with 107 of 120 counties designated as health professional shortage areas and a projected deficit of 2,926 physicians[1], including 624 primary care providers by 2030[2], disproportionately affecting rural and underserved communities; and

WHEREAS, the "One Big Beautiful Bill Act" (2025) eliminates federal Grad PLUS loans and imposes a $200,000 lifetime cap on federal borrowing for medical students, which is significantly below the average medical school debt ($234,000)[3,4] and the median four-year cost of attendance ($286,454 public, $390,848 private)[3,4], creating a substantial funding gap for future trainees; and

WHEREAS, the intensity and demands of medical education make it impractical for most students to work during school, and few students have the personal or family resources to fund medical education without access to federal loans; and

WHEREAS, these new caps and elimination of federal loan programs will force many prospective and current medical students, especially those from disadvantaged backgrounds, into high-interest private loans or out of medicine altogether, undermining the sustainability of Kentucky's physician pipeline; and

WHEREAS, the loss of affordable, income-driven repayment options and the increased reliance on private loans will dramatically worsen the financial health and well-being of medical students, residents, and early-career physicians, increasing financial stress, delaying life milestones, and potentially deterring service in primary care and rural practice; and

WHEREAS, recent trends in state funding for higher education in Kentucky have shifted toward performance-based funding and capital allocations to select institutions, while failing to consistently support broad affordability in medical education; and

WHEREAS, these financial barriers threaten to exacerbate Kentucky's existing shortages, making it even more difficult to recruit and retain physicians in the communities that need them most; now, therefore, be it

RESOLVED, that KMA urgently advocate for the expansion of state-funded loan repayment and forgiveness programs for medical students and physicians who commit to practicing in medically underserved or rural areas of Kentucky; and be it further

RESOLVED, that KMA support the development of state-funded, need-based scholarships and tuition assistance programs to help offset the financial burden on medical students whose costs exceed the federal loan cap; and be it further

RESOLVED, that KMA collaborate with Kentucky's medical schools, residency programs, and health systems to provide financial counseling, support, and advocacy for current and future trainees affected by these federal changes; and be it further

RESOLVED, that KMA encourage the Kentucky General Assembly to ensure predictable and sufficient baseline public funding for the state's public medical schools to minimize the need for future tuition increases; and be it further

RESOLVED, that KMA support the implementation of tuition transparency and oversight measures for public medical schools in Kentucky, including the public reporting of tuition trends, cost of attendance, and justification for proposed increases; and be it further

RESOLVED, that KMA advocate for the establishment of a state-level commission or legislative task force to assess the long-term impact of federal student loan borrowing limits on Kentucky's medical education system and healthcare workforce, and to make policy recommendations that preserve access to medical training and protect the state's future physician pipeline; and be it further

RESOLVED, that KMA call upon state policymakers to recognize and address the immediate and long-term risks to Kentucky's healthcare workforce posed by these federal loan restrictions, and to prioritize solutions that protect access to care for all Kentuckians.

References:

1. Kentucky Physician Shortage Facts. Cicero Institute. April 28, 2025. Accessed June 19, 2025. https://ciceroinstitute.org/research/kentucky-physician-shortage-facts/
2. Robert Graham Center. Kentucky: Projecting Primary Care Physician Workforce. https://www.graham-center.org/content/dam/rgc/documents/maps-data-tools/state-collections/workforce-projections/Kentucky.pdf
3. Average Medical School Debt [2024]: Student Loan Statistics. Education Data Initiative. Accessed July 5, 2025. https://educationdata.org/average-medical-school-debt
4. Shah N. The Cost of Becoming a Physician: Analyzing Medical School Debt. February 5, 2025. Accessed July 5, 2025. https://www.physicianonfire.com/physician-medical-school-debt/

2025-10

RESOLUTION

Subject: Review of 201 KAR 9:270

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, according to the 2024 Kentucky Drug Overdose Fatality Report, 1,410 Kentuckians lost their lives last year to a drug overdose[1]; and

WHEREAS, buprenorphine treatment[2] has been associated with an approximate 60% reduction in the risk of opioid-involved overdose death; and

WHEREAS, 201 KAR 9:270 is a recognized barrier[3] to patients accessing treatment with buprenorphine; and

WHEREAS, the Kentucky Society of Addiction Medicine (KYSAM) and other field experts, have reviewed the Kentucky Board of Medical Licensure's (KBML) proposed changes to 201 KAR 9:270 and have concluded that the proposed changes will create environments unattractive to patients because of unnecessary and unhelpful regulatory burdens and will not bring the regulation in accord with evidence-based practice[4], but will instead create new treatment barriers and may even worsen Kentucky's overdose crisis; and

WHEREAS, in August 2024 the Kentucky Medical Association House of Delegates passed resolution 2024-12.2, calling for the same "RESOLVED" actions stated below; now, therefore, be it

RESOLVED, that KMA continues to support the implementation of effective and accessible treatment options for those addicted to opioids; and be it further

RESOLVED, that KMA continues to support the use of Buprenorphine as a vital tool in combating opioid use disorder; and be it further

RESOLVED, that KMA continues to support the KBML's outreach to and use of a broad array of subject matter experts, as well as accepted clinical standards and guidelines, to revise and update regulations regarding the use of Buprenorphine in treating those addicted to opioids; and be it further

RESOLVED, that KMA continues to encourage the KBML to seek a broader input of practitioners and content experts prior to finalizing the regulatory changes to 201 KAR 9:270.

References:

1. Kentucky 2024 Drug Overdose Fatality Report, Kentucky Office of Drug Control Policy https://odcp.ky.gov/Reports/2024%20Drug%20Overdose%20Fatality%20Report.pdf
2. Buprenorphine After Nonfatal Opioid Overdose: Reduced Mortality Risk in Medicare Disability Beneficiaries. American Journal of Preventive Medicine. Vol 65, Issue 1, P19-29, July 2023 https://www.ajpmonline.org/article/S0749-3797(23)00052-1/abstract#:~:text=Buprenorphine%20treatment%20after%20nonfatal%20opioid,of%20opioid%2Dinvolved%20overdose%20death
3. Improving Access to Opioid Use Disorder Treatment in Kentucky. The Pew Charitable Trusts https://odcp.ky.gov/Resources/Documents/Pew%20Kentucky%20Memo%20FINAL.pdf
4. KYSAM Comments on 201 KAR 9:270 Proposed Regulations, July 27, 2025 https://files.constantcontact.com/8e65fc57801/843d95e5-2dd6-4ca1-8958-36bc7c11d637.pdf?rdr=true

2025-11

RESOLUTION

Subject: Support For Prescribers of Medication for Opioid Use Disorder

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, according to the 2024 Kentucky Drug Overdose Fatality Report, 1,410 Kentuckians lost their lives last year to a drug overdose[1]; and

WHEREAS, buprenorphine treatment[2] has been associated with an approximate 60% reduction in the risk of opioid-involved overdose death; and

WHEREAS, compared to other treatment interventions, Medications for Opioid Use Disorder (MOUD) pharmaceuticals such as buprenorphine, have the strongest evidence for decreasing the risk of overdose[3]; and

WHEREAS, the existence of a state regulation governing the prescribing of buprenorphine for opioid use disorder acts as a barrier to treatment access, as prescribers may fear disciplinary action by the medical board[4]; and

WHEREAS, Kentucky House Bill 788 was filed by Representative Kim Moser in February 2025[5] stating that when a Kentucky a physician uses professional judgement to prescribe, dispense, or administer a specific dosage regimen of Buprenorphine-Mono-Product or Buprenorphine-Combined-with-Naloxone that best meets the treatment needs of a patient, the Kentucky Board of Medical Licensure shall not suspend, limit, or restrict a license or take other disciplinary action against that physician; now, therefore, be it

RESOLVED, that KMA supports the intent of Kentucky House Bill 788, as filed by Representative Kim Moser in February 2025 in the Kentucky General Assembly; and be it further

RESOLVED, that KMA will support legislation similar to House Bill 788 if and when such a bill is filed in the 2026 Kentucky General Assembly.

References:

1. Kentucky 2024 Drug Overdose Fatality Report, Kentucky Office of Drug Control Policy https://odcp.ky.gov/Reports/2024%20Drug%20Overdose%20Fatality%20Report.pdf
2. Buprenorphine After Nonfatal Opioid Overdose: Reduced Mortality Risk in Medicare Disability Beneficiaries. American Journal of Preventive Medicine. Vol 65, Issue 1, P19-29, July 2023 https://www.ajpmonline.org/article/S0749-3797(23)00052-1/abstract#:~:text=Buprenorphine%20treatment%20after%20nonfatal%20opioid,of%20opioid%2Dinvolved%20overdose%20death
3. Position Statement on Access to Evidence-Based Treatment for Opioid Use Disorder Adopted by FSMB House of Delegates, April 2024 https://www.fsmb.org/siteassets/advocacy/policies/position-statement-on-access-to-evidence-based-treatment.pdf
4. Assessing Waivered and Non-Waivered Physician Barriers to Treating Patients With Substance Use Disorders: A Cross-Sectional Kentucky Pilot. Thompson RA, Johnson D, Kizewski AL, et al. Journal of Addictive Diseases. 2022 Oct-Dec;40(4):518-526. doi:10.1080/10550887.2022.2035167.
5. House Bill 788 https://apps.legislature.ky.gov/record/25rs/hb788.html

2025-12

RESOLUTION

Subject: Buprenorphine for Pain

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, chronic pain affects approximately 20% of U.S. adults and remains a significant public health concern, with many patients requiring long-term pharmacologic management[1]; and

WHEREAS, buprenorphine is a partial μ-opioid receptor agonist with analgesic properties, approved by the U.S. Food and Drug Administration for both chronic pain (transdermal and buccal formulations) and opioid use disorder, and is available in other formulations that are used off-label for pain management[2]; and

WHEREAS, buprenorphine demonstrates a ceiling effect for respiratory depression and euphoria, further reducing the risk of fatal overdose and misuse, and is less likely to cause euphoriant effects in nondependent individuals[3]; and

WHEREAS, the U.S. Department of Veterans Affairs and Department of Defense Clinical Practice Guideline (2022) specifically recommends considering buprenorphine instead of full agonist opioids for patients receiving daily opioids for chronic pain, due to its superior safety profile[4]; and

WHEREAS, buprenorphine/naloxone, while not FDA-approved for pain, is used off-label for chronic pain management, particularly in patients with comorbid opioid use disorder, with evidence supporting its analgesic efficacy and safety[5]; and

WHEREAS, the off-label use of buprenorphine for pain management is limited in Kentucky by regulatory, insurance, and educational barriers, despite its evidence-based benefits and endorsement by major U.S. clinical guidelines[6,7]; now, therefore, be it

RESOLVED, that KMA supports evidence-based use of buprenorphine (including buprenorphine/naloxone) for the management of pain in appropriate patients, including off-label use when clinically appropriated.

References:

1. Buprenorphine for Pain: A Narrative Review and Practical Applications. Spinella S, McCarthy R. The American Journal of Medicine. 2024;137(5):406-413. doi:10.1016/j.amjmed.2024.01.022.
2. Buprenorphine for Chronic Pain Management: A Narrative Review. Vu PD, Bansal V, Chitneni A, et al. Current Pain and Headache Reports. 2023;. doi:10.1007/s11916-023-01185-4
3. Prevention of Opioid Overdose. Babu KM, Brent J, Juurlink DN. The New England Journal of Medicine. 2019;380(23):2246-2255 doi:10.1056/NEJMra1807054.
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5. Treatment of Acute Pain in Patients Receiving Buprenorphine/Naloxone. David Fiellin MD, A Benjamin Srivastava MD
6. 201 KAR 9:270 https://apps.legislature.ky.gov/law/kar/titles/201/009/270/
7. 201 KAR 9:260 https://apps.legislature.ky.gov/law/kar/titles/201/009/260/

2025-13

RESOLUTION

Subject: Prior Authorizations for Medications for Opioid Use Disorder (MOUD)

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, according to the 2024 Kentucky Drug Overdose Fatality Report, 1,410 Kentuckians lost their lives last year to a drug overdose[1]; and

WHEREAS, medications such as Methadone, Buprenorphine, and Naltrexone are evidence-based treatments for opioid use disorder, recognized for their effectiveness in reducing opioid misuse and overdose deaths[2]; and

WHEREAS, prior authorization requirements imposed by insurers can delay access to these critical medications, creating unnecessary barriers to treatment and increasing the risk of relapse or overdose; and

WHEREAS, the removal of such administrative barriers aligns with the best practices in addiction medicine and supports patient-centered care; and

WHEREAS, in 2019, the Kentucky Medical Association supported a bill filed in the Kentucky General Assembly (House Bill 121) that would have prohibited insurance company prior authorization requirements for medications for opioid use disorder, which stated in effect, that an insurer shall not require or conduct a prospective or concurrent review for a prescription drug that: (a) Is used in the treatment of opioid use disorder; and (b) Contains Methadone, Buprenorphine, or Naltrexone[3]; now, therefore, be it

RESOLVED, that KMA supports the enactment of legislation to prohibit insurance providers from requiring prior authorization for medications prescribed for the treatment of opioid use disorder.

References:

1. Kentucky 2024 Drug Overdose Fatality Report, Kentucky Office of Drug Control Policy https://odcp.ky.gov/Reports/2024%20Drug%20Overdose%20Fatality%20Report.pdf
2. Position Statement on Access to Evidence-Based Treatment for Opioid Use Disorder Adopted by FSMB House of Delegates, April 2024 https://www.fsmb.org/siteassets/advocacy/policies/position-statement-on-access-to-evidence-based-treatment.pdf
3. House Bill 121 https://apps.legislature.ky.gov/record/19rs/hb121.html

2025-14

RESOLUTION

Subject: Ensuring Physician Presence in Emergency Departments Across the Commonwealth

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, emergency medical care is a specialized field requiring immediate, life-saving decision-making to accurately diagnose and treat patients; and

WHEREAS, physicians have extensive training, experience, and decision-making abilities to manage the complex medical situations commonly encountered in emergency departments; and

WHEREAS, current standards in some emergency departments do not mandate a physician's physical presence, which may compromise the quality of emergency care; and

WHEREAS, a recent poll conducted by Mason-Dixon Polling & Strategy[1] found that 87% of respondents believe it is very important to have a physician physically present in the emergency department when they or their loved ones seek emergency care; and

WHEREAS, patients expect a highly qualified and experienced physician overseeing their care in emergency departments to ensure the highest quality of treatment; and

WHEREAS, physicians in the emergency department are often the sole clinician in rural hospitals overnight; and

WHEREAS, states such as Indiana[2] and Virginia[3] have enacted similar legislation requiring the physical presence of a physician in emergency departments; now, therefore, be it

RESOLVED, that KMA advocate for all emergency departments within the Commonwealth of Kentucky to be staffed by a physician who is physically present, on-site, and responsible for patient care at all times; and be it further

RESOLVED, that KMA work with state legislators to develop and support legislation mandating the physical presence of a physician in every emergency department in the Commonwealth of Kentucky.

References:

1. Mason-Dixon Polling & Strategy, Inc. Virginia Emergency Room Physician Presence Poll. Conducted December 15-19, 2023. Published January 2024. Accessed March 19, 2025. Available from: https://www.masondixonpolling.com.
2. Indiana General Assembly. Senate Bill No. 400. Health care matters; requires hospitals with emergency departments to have a physician on-site at all times. Indiana General Assembly website. Published May 5, 2023. Accessed March 19, 2025.
3. Virginia General Assembly. House Bill No. 353. Emergency department physician requirement; mandates 24/7 on-site physician presence. Virginia General Assembly website. Published April 2024. Effective July 1, 2025. Accessed March 19, 2025.

KMA House of Delegates
August 2025

RESOLUTION

Subject: Continued Commitment to Physician Wellness and Destigmatization

Submitted by: Shawn C. Jones, MD

Referred to: Reference Committee

WHEREAS, physician burnout has persisted as a significant concern for over two decades, with national studies documenting rising trends since the early 2000s, peaking during the COVID-19 pandemic and continuing at elevated levels in recent years; and

WHEREAS, physician burnout remains a critical issue, with 48.2% of physicians reporting at least one symptom of burnout in 2023, according to the American Medical Association, highlighting the ongoing need for systemic interventions despite slight improvements from previous years; and

WHEREAS, a 2024 study published in BMC Health Services Research introduced a validated measure of physician fortitude, finding significant correlations between lower fortitude and higher levels of emotional exhaustion, depersonalization, and turnover intent, underscoring the importance of resilience-building initiatives; and

WHEREAS, a 2024 survey by the Physicians Foundation revealed that over 50% of physicians knew a colleague who had considered, attempted, or died by suicide, with stigma around mental health and concerns about licensure and credentialing repercussions cited as major deterrents to seeking help; and

WHEREAS, the tragic suicide of Dr. Nakita Mortimer in 2025 brought national attention to the mental health struggles of medical residents, with a 2024 survey indicating that nearly a quarter of residents have considered self-harm, emphasizing the urgent need for cultural and institutional shifts to prioritize physician well-being; and

WHEREAS, the Kentucky Medical Association adopted policy in 2024 (Resolution 2024-23) supporting the removal of stigmatizing language in credentialing processes and advocating that only current, untreated conditions affecting a physician’s ability to practice should be considered relevant for credentialing purposes; now, therefore, be it

RESOLVED, that, in light of research and studies published since the adoption of Resolution 2024-23 showing that mental health challenges and burnout remain a significant and ongoing concern among physicians, the KMA reaffirm its current policy supporting statutory and regulatory changes to eliminate stigmatizing language in healthcare credentialing applications and to restrict personal health inquiries to current, untreated conditions that impair a physician’s ability to practice competently, ethically, and professionally; and be it further

RESOLVED, that KMA continue its efforts to raise awareness among physicians, credentialing bodies, and policymakers regarding physician wellness, burnout, and the critical need to address mental health concerns early to protect physician well-being and maintain safe, high-quality patient care.

2025-16

RESOLUTION

Subject: Advancing Physician Wellness Through Credentialing Reform

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, physicians' mental health and well-being are critical to providing safe, high-quality patient care, and physician burnout and mental health challenges remain at high levels nationally and in Kentucky; and

WHEREAS, stigma and fear of professional repercussions, including intrusive mental health questions on credentialing, licensure, and peer review forms, are major barriers preventing physicians and other health professionals from seeking timely mental health care; and

WHEREAS, residents and early-career physicians face unique stressors and may be disproportionately affected by stigmatizing credentialing practices, thereby undermining their well-being and the future strength of Kentucky's medical workforce; and

WHEREAS, the Lorna Breen Foundation[1], American Medical Association[2], and Federation of State Medical Boards[3] recommend removing or revising intrusive mental health questions from credentialing and licensure applications to reduce stigma and promote physician well-being, and states of Virgina[4], Minnesota[5], Illinois[6], and others have enacted such reforms; and

WHEREAS, the World Federation for Medical Education's 2025 Declaration on Institutions' Responsibility to Support Medical Students, Physicians in Postgraduate Education and Physicians in Practice[7] calls on academic and health institutions worldwide to prioritize medical student and physician wellbeing in regulation, licensing, policymaking and accreditation as a shared institutional responsibility; and

WHEREAS, Kentucky has an opportunity to be a leader in supporting physician mental health by adopting the best practices in credentialing and institutional wellness, thereby improving recruitment, retention, and the overall health of the medical workforce; now, therefore, be it

RESOLVED, that KMA support the removal of intrusive or stigmatizing mental health questions from all physician credentialing, re-credentialing, and peer review forms in Kentucky, and advocate for the adoption of model language that only inquiries about current conditions that are not being appropriately treated and that are likely to impair the ability to practice medicine safely and competently; and be it further

RESOLVED, that KMA encourage all Kentucky health systems and credentialing bodies to audit and revise their applications and forms using available toolkits (such as those from the Lorna Breen

Foundation) to ensure compliance with best practices for mental health privacy and stigma reduction; and be it further

RESOLVED, that KMA encourages all Kentucky health systems to provide confidential mental health resources and support for physicians, in addition to revising credentialing forms; and be it further

RESOLVED, that KMA request health systems to report annually to the KMA on their progress in auditing and revising credentialing forms and in providing confidential mental health support.

References:

1. Improving Licensure & Credentialing Applications. Dr. Lorna Breen Heroes Foundation. Accessed June 19, 2025. https://drlornabreen.org/removebarriers/
2. AMA Physician Well-Being Program. American Medical Association. April 7, 2025. Accessed June 22, 2025. https://www.ama-assn.org/practice-management/physician-health/ama-physician-well-being-program
3. FSMB - Policy on Physician Illness and Impairment: Towards a Model that Optimizes Patient Safety and Physician Health. https://www.fsmb.org/siteassets/advocacy/policies/policy-on-physician-impairment.pdf
4. Simmons S, Feist JC, Segres A. Changing Licensing and Credentialing Applications to Promote Health Workers' Mental Health, Virginia, December 2022–September 2023. *Am J Public Health*. 2024;114(Suppl 2):152-155. doi:10.2105/AJPH.2023.307506
5. When Hospital Medical Staff Applications Seek Mental Health History of Practitioners. Procopio. Accessed June 22, 2025. https://www.procopio.com/resource/hospital-staff-query-practitioner-mental-health/
6. Lehmann C. Mental health questions cut from MD licensing applications in 21 states | MDedge. Accessed June 22, 2025. https://mdedge.com/internalmedicine/article/264043/business-medicine/mental-health-questions-cut-md-licensing
7. WFME Declaration on institutions' responsibility to support medical students, physicians in postgraduate education and physicians in practice - The World Federation for Medical Education. https://wfme.org/download/wfme-declaration-on-institutions-responsibility-to-support-medical-students-physicians-in-postgraduate-education-and-physicians-in-practice/

RESOLUTION

Subject: Terminology Clarification of the Term “Resident” Amongst Health Professionals in Training

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, a resident is a fully licensed physician who holds the degree of MD, DO, MBBS/MBCh, is undergoing postgraduate training and actively engaged in advanced clinical training in a specific medical specialty, often within a hospital setting under the supervision of a consultant physician[8]; and

WHEREAS, post graduate year students (PGY-X) are required to adhere to the standards and protocol of residency programs, as determined by the Accreditation Council for Graduate Medical Education (ACGME), including residency components, ACGME competencies, curriculum organization and residency responsibilities[1]; and

WHEREAS, a study conducted in 2021 in response to the COVID-19 pandemic highlighted the long-standing role confusion among patients in understanding the role of a resident[5]; and

WHEREAS, Nurse Anesthesia Resident (NAR) is a term that refers to a registered nurse pursuing advanced training to become a Certified Registered Nurse Anesthetist (CRNA)[4]; and

WHEREAS, a resident pharmacist is a term used for a newly qualified pharmacist who rotates through the various areas within the pharmacy following a structured training program[6]; and

WHEREAS, in the UK, the term "resident doctor" has recently replaced the previous term “junior doctor” to better reflect the expertise and responsibilities of these doctors. The British Medical Association (BMA) is now working with the National Health Service (NHS) and stakeholders including healthcare organizations, royal colleges, and media outlets to strongly encourage the wider adoption of the term “resident doctors” for which it has received support of the Secretary of State[7]; and

WHEREAS, according to survey conducted by the American Medical Association (AMA) between the years of 2008 and 2017, results show that 79% of patients responded with “Support” to the question of, “Would you support or oppose legislation in your state to require all health care advertising materials to clearly designate the level of education, skills and training of all health care professionals promoting their services?”[2]; and

WHEREAS, the AMA has engaged with academic institutional programs to promote educational programs and dissemination materials to “create alternative, clarifying nomenclature in place

of “resident,” “residency,” “fellow,” “fellowship,” “attending” and other related terms to reduce confusion among the public.”[2]; now, therefore, be it

RESOLVED, that KMA supports legislation to form clear distinction between the medical professional roles of attendings, residents, and all subsequent health care professionals to mitigate patient confusion and clarifying scope of practice for attending physicians; and be it further

RESOLVED, that KMA supports legislation that encourages a fully licensed physician be referred to as a “resident physician” to create a clear distinction between the various resident pharmacists and nurses in training who are non-physicians, while a resident physicians has undergone five years of medical education and adheres to the standards and protocol of residency programs, as determined by the Accreditation Council for Graduate Medical Education (ACGME); and be it further

RESOLVED, that KMA develop dissemination materials such as posters, brochures, and resources available to online platforms that inform patients about the subsequent role of each health care provider in a manner that clarifies expectations for both the patient and the provider; and be it further

RESOLVED, that KMA works with the Kentucky Hospital Association to provide clarification and transparency to patients regarding health professionals’ titles in the hospital setting.

References:

1. ACGME. (n.d.). *Common program requirements*. ACGME. https://www.acgme.org/programsand-institutions/programs/common-program-requirements
2. Ama-ASSN. (n.d.). https://www.ama-assn.org/sites/ama-assn.org/files/corp/mediabrowserpremium/arc/tia-survey_0.pdf
3. Jennifer Whitlock, R. (2025, June 15). *Resident vs. attending physician: What’s the difference?* Verywell Health. https://www.verywellhealth.com/types-of-doctors-residents-interns-andfellows-3157293
4. *Nurse anesthesia*. Columbia School of Nursing. (2025, May 15). https://www.nursing.columbia.edu/academics/academic-programs/doctor-nursingpractice/nurse-anesthesia#:~:text=year%20average:%2099%25-,Curriculum,contingent%20upon%20meeting%20academic%20policies
5. Shapiro, M.A. Competence vs. Identity, Trainees vs. Physicians: How COVID-19 Has Highlighted Role Confusion in Residency Training. *Acad Psychiatry* 45, 545–548 (2021). https://doi.org/10.1007/s40596-020-01346-2
6. Philadelphia College of Osteopathic Medicine. (2023, April 20). *Pharmacy residency programs - what is a residency?*. Pharmacy Residency Programs - What Is a Residency? https://www.pcom.edu/academics/programs-and-degrees/doctor-of-pharmacy/school-ofpharmacy/blog/pharmacy-residency-programs.html
7. The BMA. (2024, September 17). *Junior doctors are changing their title to “resident doctors.”* The British Medical Association is the trade union and professional body for doctors in the UK. https://www.bma.org.uk/news-and-opinion/junior-doctors-are-changing-their-title-to-residentdoctors
8. *What is a residency and how do I get one?*. ACCP. (n.d.). https://www.accp.com/stunet/compass/residency.aspx#:~:text=Completing%20a%20pharmacy%20residency%20after,supervision%20of%20an%20experienced%20preceptor

RESOLUTION

Subject: Publicizing, Supporting, and Promoting (Appropriate) AMA Member Physicians and Physician Spouses as Candidates for Local and State Offices

Submitted by: Northern Kentucky Medical Society

Referred to: Reference Committee

WHEREAS, medicine is under assault from all sides – from insurance companies to trial lawyers to onerous state and federal regulations; and

WHEREAS, the 118th United States Congress (1/3/23-1/3/25) enacted 209 public laws, which contrasts with approximately 16,000 items of state legislation passed annually[1,2,3]; and

WHEREAS, we do not have enough physicians in political office, on the local, state or federal levels; and in general, there may be some benefit to supporting "medicine-friendly" physicians and physician spouses who run for political office; and

WHEREAS, our medical societies have political action committees (such as AMPAC for AMA) to support "medicine-friendly" candidates running for office; and

WHEREAS, AMPAC holds an annual "Candidate Workshop" and "Campaign School" to support "medicine-friendly" candidates running for elected offices[4]; and

WHEREAS, there are few mechanisms to enable physician members of our state and national medical societies to network when running for state and federal office, and

WHEREAS, partly due to high educational debt loads, busy clinical schedules, challenges with work-life balance, and limited bandwidth to engage in political activity, physicians have traditionally had a low level of giving to candidates for local, state, and federal offices; and

WHEREAS, those of us who have more time than money could potentially help candidates for elected office with social media support (retweeting, likes, etc) and/or volunteer time; and

WHEREAS, "medicine-friendly" candidates for political office would be interested in meeting potential donors, as well as individuals who may be willing to volunteer to support their campaigns with volunteer time and social media support; and

WHEREAS, there is currently no "central repository" that lists physicians (or physician spouses) running for state and federal office in the United States; and

WHEREAS, non-member physicians (or physician spouses) who are running for local, state or federal office should also be encouraged to join the AMA, Alliance, and/or their state and specialty medical societies; and

WHEREAS, in this age of social media, it should be relatively easy to set up members-only websites with lists of (appropriate) physicians and physician spouses who are running for elected offices; and

WHEREAS, in the first version of this resolution (submitted to the Missouri State Medical Association in 2024), two major concerns were raised: (1) potential legal implications, regarding coordination between state PACs, specialty society PACS, and AMPAC, as well as (2) desire not to endorse physician candidates if they are not aligned with the policies of their state medical association and/or our AMA; and

WHEREAS, similar concerns were raised when a second version of this resolution was submitted to the Ohio State Medical Association, or OSMA) in 2025, including:

- *"an individual's campaign should do the work. Not every physician aligns with OSMA policy;"*
- *"promoting specific physicians or spouses as candidates risks alienating OSMA members with differing political views;"*
- *"It is more appropriate for OSMA to connect its members with opportunities to learn about candidacy;"* and

WHEREAS, recent events in Minnesota highlight the courage of anyone running for (and/or holding) local or state elected office(s), as they and their families are constantly in the spotlight (and potentially at risk); and

WHEREAS, given limited resources and bandwidth, it is likely that this proposal will need to be a collaborative effort between organized medicine and/or their respective political action committees; and

WHEREAS, it is unclear whether publicizing, supporting, and promoting such candidates should be a function of organized medicine (state and specialty societies, and our AMA) vs their respective political action committees (due to legal concerns, tax implications, etc); and

WHEREAS, state and specialty societies (or our AMA) may also determine that certain physicians or physician spouses who are running for elected office, may not merit recognition; and

WHEREAS, state and specialty societies (or our AMA) may also determine that certain words or actions of individuals running for elected office, should merit removal from such lists; and

WHEREAS, there is already a "National Council of State Legislators," and perhaps our AMA may wish to consider helping to organize a "National Convention of Physician (and Physician Spouse) State Legislators" (perhaps in conjunction with the annual AMA State Advocacy Summit?);" now, therefore, be it

RESOLVED, that our American Medical Association (AMA) collaborate with other interested organizations to facilitate opportunities for AMA physician-member and physician-spouse elected officials (at the local and state levels) to connect, exchange ideas, collaborate, and support each other to protect

our patients and our practices, such as with a “National Meeting of Physician State Legislators;” and be it further

RESOLVED, that our American Medical Association (AMA) study the:

(1) Feasibility of collaborating with state medical societies and specialty societies to assess appropriate AMA physician members and physician spouses running for state and local offices, and creating a “master list” to publicize, support, and promote those individuals; and

(2) Opportunities to publicize this list widely, to support appropriate physicians and physician spouses who are aligned with our priorities (and encourage financial and social media support of those candidates); with a report back at I-26; and be it further

RESOLVED, that KMA forward this resolution to the AMA-House of Delegates at the Interim-25 meeting.

2025-19

RESOLUTION

Subject: Informed Consent

Submitted by: Lexington Medical Society

Referred to: Reference Committee

WHEREAS, informed consent is the process by which a physician and a patient and/or a patient's legal representative, discuss risks, benefits, and alternatives of treatment, procedures, or research; and

WHEREAS, physicians undergo education regarding informed consent; and

WHEREAS, the patient and/or the patient's legal representative is/are informed of the nature of medical intervention; and

WHEREAS, the patient and/or the patient's legal representative have the ability to withdraw consent for certain medical interventions (for example, discontinuation of medications); and

WHEREAS, some medical interventions are irreversible such as vaccination, withdraw of life support and many surgical intervention and procedures; and

WHEREAS, consent for irreversible medical interventions cannot be revoked after the intervention has been completed; now, therefore, be it

RESOLVED, that KMA opposes legislation to permit retroactively withdrawn consent from irreversible medical interventions under any circumstances.

2025-20

RESOLUTION

Subject: Ivermectin Being Sold Over the Counter

Submitted by: Monalisa Tailor, MD

Referred to: Reference Committee

WHEREAS, the U.S. Food and Drug Administration (FDA) has the critical responsibility of ensuring the safety and effectiveness of drugs available to the public; and

WHEREAS, the FDA has not authorized or approved ivermectin for use in preventing or treating COVID-19 in humans or animals; and

WHEREAS, ivermectin is used off-label for parasitic infections and dosed based on weight; and

WHEREAS, large doses of ivermectin can be dangerous and potentially lead to serious side effects including nausea, vomiting, diarrhea, hypotension, allergic reactions, dizziness, ataxia, seizures, coma, and Steven Johnson syndrome; and

WHEREAS, some ivermectin products are specifically formulated for animal use and can contain concentrations and inactive ingredients that are unsafe for human consumption; and

WHEREAS, off-label use of drugs carries inherent risks, and the unregulated sale of ivermectin over the counter could exacerbate these risks and potentially lead to misuse; and

WHEREAS, the state of Tennessee, Arkansas, Louisiana, and Idaho have passed legislation to allow ivermectin to be sold over the counter to patients; now, therefore, be it

RESOLVED, that KMA oppose legislation approving the over-the-counter sale of ivermectin for human use, especially for conditions not approved by the U.S. Food and Drug Administration (FDA); and be it further

RESOLVED, that KMA urge individuals to consult with their healthcare providers before taking any medication, including ivermectin, to ensure its appropriate use and minimize potential risks.

2025-21

RESOLUTION

Subject: Reestablish National Funding of SNAP (Supplemental Nutrition Assistance Program)

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, the U.S. House Committee on Agriculture plans to shift funding for the Supplemental Nutrition Assistance Program (SNAP) to the Kentucky budget; and

WHEREAS, the state of Kentucky would need to fund $150 million annually by 2028 just to maintain current benefits; and

WHEREAS, in Kentucky more than 753,000 residents or 1 in 7 persons are food insecure (14.2%) and 1 in 5 children are food insecure (19.0 %); now, therefore, be it

RESOLVED, that KMA advocates that the U.S. Congress fund the Supplemental Nutrition Assistance Program (SNAP); and be it further

RESOLVED, that KMA work with Kentucky Congress and legislators to reestablish the national funding of the Supplemental Nutrition Assistance Program (SNAP).

References:

1. https://www.courier-journal.com/story/opinion/contributors/2025/05/30/kentucky-snap-federal-funding-cuts-hunger-food-banks/83878753007/?gnt-cfr=1&gca-cat=p&gca-uir=true&gca-epti=z116232p000750c000750e005900v116232b00xxxxd11xx65&gca-ft=157&gca-ds=sophi

2025-22

RESOLUTION

Subject: Sun-safe Behavior in School-Aged Children

Submitted by: Alicia Fields and Jacqueline Leon (Medical Student Section)

Referred to: Reference Committee

WHEREAS, exposure to ultraviolet (UV) radiation is a well-established risk factor for skin cancer[1]; and

WHEREAS, rates of skin cancer are increasing in young adults, with sunburns during childhood or adolescence increasing the odds of developing skin cancer later in life[2,3]; and

WHEREAS, sunscreen use is limited in school settings as it is classified as an over-the-counter drug product regulated by the US Food and Drug Administration[1]; and

WHEREAS, Kentucky has above average UV levels measured in erythemally-weighted daily dose[1]; and

WHEREAS, Kentucky has higher rates of melanoma, the deadliest form of skin cancer, than Texas, California, Arizona, and Florida at a rate of 28.2 cases per 100,000 people annually[4]; and

WHEREAS, 29 states and Washington D.C. have legislation which allows children access to sunscreen in schools[5]; and

WHEREAS, Kentucky currently does not have legislation regarding sunscreen use in schools[5]; and

WHEREAS, the American Academy of Dermatology Association supports state-wide policies that allow students to use sunscreen and sun protective clothing during the school day without physician authorization[6]; and

WHEREAS, the American Medical Association Policy H-440.841 titled “Permitting Sunscreen in Schools” encourages schools to allow unrestricted access to sunscreen without requiring physician authorization[7]; now, therefore, be it

RESOLVED, that KMA advocates for passage of state legislation that allows students to have UV protection at school, including personal sunscreen without a prescription or physician’s note.

References:

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3. Watts CG, Drummond M, Goumas C, et al. Sunscreen Use and Melanoma Risk Among Young Australian Adults. JAMA Dermatol. 2018;154(9):1001-1009. doi:10.1001/jamadermatol.2018.1774
4. National Cancer Institute and Centers for Disease Control and Prevention. Kentucky—Quick Profiles. State Cancer Profiles. Updated June 30, 2025. Accessed July 1, 2025. https://statecancerprofiles.cancer.gov/quick-profiles/index.php?tabSelected=2&statename=kentucky
5. American Society for Dermatologic Surgery Association. New Jersey becomes 30th jurisdiction to implement ASDSA’s SUNucate legislation. Published April 1, 2025. Accessed July 1, 2025. https://www.asds.net/skin-experts/news-room/press-releases/new-jersey-becomes-30th-jurisdiction-to-implement-asdsas-sunucate-legislation
6. American Academy of Dermatology Association. Access to Sunscreen and Sun-Protective Clothing Policy Statement. Accessed July 1, 2025. https://server.aad.org/forms/policies/Uploads/PS/PS-Access%20to%20Sunscreen_Sun%20Protective%20Clothing.pdf
7. American Medical Association. Permitting Sunscreen in Schools H-440.841. AMA PolicyFinder. Accessed July 1, 2025. https://policysearch.ama-assn.org/policyfinder/detail/sunscreen?uri=%2FAMADoc%2FHOD.xml-0-3857.xml

2025-23

RESOLUTION

Subject: Optimal Level of Water Fluoridation

Submitted by: Michael Kuduk, MD (KMA Immediate Past President)

Referred to: Reference Committee

WHEREAS, the public health benefits of adding fluoride to community drinking water to prevent dental caries are well established; and

WHEREAS, community water fluoridation remains a cost-effective public health measure that benefits populations with limited access to dental care; and

WHEREAS, a 2024 *Cochrane* review noted that many foundational studies on fluoridation were conducted before the widespread availability of fluoridated toothpaste, raising questions about the continued applicability of some older data; and

WHEREAS, a 2024 meta-analysis published in *JAMA Pediatrics* suggested a possible association between water fluoridation and a slight decrease in childhood IQ, although the study acknowledged the need for further investigation due to high heterogeneity and risk of bias in many included studies as well as no findings of significant association between fluoride exposure and IQ at levels below 1.5 mg/L; and

WHEREAS, eliminating fluoride from drinking water is projected to increase expenditures on dental care by an estimated $23.00 per Kentuckian annually; and

WHEREAS, while the optimal concentration of fluoride to maximize dental health benefits and minimize the risk of fluorosis and other potential adverse effects is not definitively known, current guidelines recommend a level equal to or less than 0.7 mg/L; and

WHEREAS, the U.S. Department of Health and Human Services (HHS) has recently withdrawn its formal recommendation for community water fluoridation, and the Environmental Protection Agency (EPA) is currently reviewing fluoride safety standards; now, therefore, be it

RESOLVED, that KMA advocate for the continued provision of water fluoridation at levels demonstrated to promote optimal dental health based on current evidence and best practices; and be it further

RESOLVED, that KMA support ongoing monitoring and public reporting of community water fluoride levels and associated health outcomes to ensure transparency and public trust.

References:

1. Iheozor-Ejiofor, Z., Walsh, T., Lewis, S. R., Riley, P., Boyers, D., Clarkson, J. E., Worthington, H. V., Glenny, A.-M., & O'Malley, L. (2024, October 4). *Water fluoridation for the prevention of dental caries* (Review). Cochrane Database of Systematic Reviews. https://doi.org/10.1002/14651858.CD010856.pub3
2. Taylor, K. W., Eftim, S. E., Sibrizzi, C. A., et al. (2025). Fluoride exposure and children's IQ scores: A systematic review and meta-analysis. *JAMA Pediatrics*, *179*(3), 282–292. https://doi.org/10.1001/jamapediatrics.2024.5542

2025-24

RESOLUTION

Subject: Childhood Water Safety

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, over ten percent (10%) of the pediatric deaths in the last decade in Kentucky were from drowning. Drowning is the third most leading cause of unintentional injury death for all children in the Commonwealth over the last decade; and

WHEREAS, swimming is the only sport which can save your life; now, therefore, be it

RESOLVED, that KMA advocate for a law requiring all public and charter schools to provide information regarding water safety education courses and swimming lessons and diving safety to a parent, legal guardian or person standing in loco parentis on the important role that water safety education courses and swimming lessons play in saving lives. This information must be supplied electronic or hardcopy, and identify options, if available within the vicinity of the public school or local school system, for age-appropriate water safety education courses and swimming lessons. This information shall be provided directly to students 18 years of age or older or under the age of 21 enrolled in adult education classes with the same specifications.

References:

1. The Mortality Report for Kentucky AAP 2023
2. Every Child a Swimmer Program – Casey McGovern, Executive Director
3. Referencing Proposals for this purpose for Georgia, Florida and Arkansas

2025-25

RESOLUTION

Subject: School Health

Submitted by: Michael Kuduk, MD (KMA Immediate Past President)

Referred to: Reference Committee

WHEREAS, the continued trend of shortening school lunch periods is growing, resulting in barely minimal time for students to eat lunch; and

WHEREAS, multiple studies have reinforced the importance of regular health maintenance visits for children; and

WHEREAS, regular physical examinations play a key role in assessing a child's development, including educational performance and diagnosis of developmental disorders such as dyslexia; now, therefore, be it

RESOLVED, that KMA reaffirms policy HOD 2015-11 which advocates for a minimum of 30 minutes for lunches in K-5 schools; and be it further

RESOLVED, that KMA reaffirms policy HOD 2015-14 which advocates for the continued requirement for physical examinations upon kindergarten and sixth grade entry and further advocates for physical examinations for students entering the third and ninth grades.

RESOLUTION

Subject: Promoting Online Safety Literacy in Kentucky Public Schools

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, children and adolescents in Kentucky are increasingly exposed to online risks, such as cyberbullying, grooming, sextortion, and misinformation, as digital platforms become a central part of their daily lives; and

WHEREAS, the National Center for Missing & Exploited Children (NCMEC) and the U.S. Federal Bureau of Investigation (FBI) report that more than 80% of child victims of online exploitation are between the ages of 8 and 17[1,2]; and

WHEREAS, Kentucky currently does not have a mandated statewide curriculum for online safety literacy, despite having a voluntary digital citizenship course that is optional to students across school districts[6]; and

WHEREAS, the state's last major legislative update on internet education was in 1998 (Senate Bill 230), which mandated internet filtering but did not address the rise of social media, cyber exploitation, or modern digital communication platforms[5]; and

WHEREAS, organizations such as the American Academy of Pediatrics, Cybersecurity and Infrastructure Security Agency (CISA), and the U.S. Department of Education recommend early and age-appropriate digital literacy education to help protect children from online harm[3,4]; now, therefore, be it

RESOLVED, that KMA advocate for the implementation of mandatory, age-appropriate online safety and digital literacy curriculum in all public schools in Kentucky, beginning in elementary school and continuing through high school; and be it further

RESOLVED, that KMA support updating the state education policy to include policies on digital privacy, cyberbullying prevention, recognizing online grooming and misinformation, and respectful digital communication; and be it further

RESOLVED, that KMA encourage collaboration among educators and the state education board, healthcare professionals, and cybersecurity experts to develop an evidence-based curriculum using the current digital citizenship course as a framework to be updated according to national guidelines.

References:

1. National Center for Missing & Exploited Children (NCMEC) – https://www.missingkids.org
2. FBI Public Safety Alert on Sextortion (2022) – https://www.fbi.gov/news/press-releases/press-releases/fbi-issues-warning-on-sextortion-schemes
3. American Academy of Pediatrics (AAP) – Media Use in School-Age Children and Adolescents (2016) - https://publications.aap.org/pediatrics/article/138/5/e20162592/60321/Media-Use-in-School-Aged-Children-and-Adolescents
4. Cybersecurity & Infrastructure Security Agency (CISA) – https://www.cisa.gov
5. Kentucky Senate Bill 230 (1998) – https://www.education.ky.gov/districts/tech/pages/senate-bill.aspx
6. Kentucky Department of Education – Digital Citizenship Guidance – https://www.education.ky.gov/school/diglrn/digcitizen/Pages/default.aspx

2025-27

RESOLUTION

Subject: Supporting Implementation of Mandatory Physical Education Programs

Submitted by: Chloe Ditka, Emma Higgins (Medical Student Section)

Referred to: Reference Committee

WHEREAS, childhood obesity is a serious health problem in the US, as it is estimated that 32.2% of children and adolescents ages 2 to 19 are overweight or obese from an analysis of data from the National Health and Nutrition Examination Survey[1]; and

WHEREAS, current data in children and adolescents in the US shows declines in physical activity and corresponding increases in sedentary behaviors, as well as increasing rates of overweight and obesity and related health problems such as cardiovascular disease[1]; and

WHEREAS, a systematic review and meta-analysis found that 55% of obese children will still be obese as adolescents, and 80% of obese adolescents will be obese as adults, although 70% of obese adults were not obese as children, which demonstrates the necessity for increasing healthy habit-building strategies for all children[2]; and

WHEREAS, current law in Kentucky does not mandate physical education for elementary or middle school students, although some guidelines exist, such as that high school students must complete 0.5 credit hours of physical education to graduate and K-5 schools must provide a maximum of 30 minutes of time for physical activity per day[3]; and

WHEREAS, after the COVID-19 pandemic, physical education programs for grades K-12 were disrupted[4]; and

WHEREAS, a qualitative study with semi-structured Zoom interviews was conducted with 11 K-12 PE teachers in Ventura County, Southern California, which showed significant declines in student physical fitness post-pandemic with reduced endurance, flexibility, strength, student motivation, engagement, along with increased sedentary behaviors and deepening socioeconomic disparities[4]; and

WHEREAS, there is a necessity for systemic reforms for PE programs such as increased funding, improved facilities, reduced class sizes, consistent policy enforcement, and more administrative support[4]; and

WHEREAS, the American Medical Association (AMA) has recognized the importance of the implementation of quality physical education programs both on the state and local level for all students, including those ungraded classes, throughout grades kindergarten through twelve, including those

students with physical, developmental, intellectual challenges, or other special needs[5]; now, therefore, be it

RESOLVED, that KMA encourage physicians to educate patients on the benefits of regular physical activity in children and support the AMA's involvement in the implementation of high-quality physical education programs for all students from grades kindergarten through twelve.

References:

1. Wong, S.S. (2017, November 1). Community-Based Healthy Living Medicine, With a Focus on K-12, Physical Education, and Nutrition. *Progress in Cardiovascular Diseases, 60*(3), 450-455. https://www.clinicalkey.com/#!/content/playContent/1-s2.0-S0033062017301433
2. Simmonds, M., et al. (2016, February). Predicting adult obesity from childhood obesity: a systematic review and meta-analysis. *Obes Rev., 17*(2), 97-107. https://pubmed.ncbi.nlm.nih.gov/26696565/
3. Shape of the Nation. (2016). *State Profile: Kentucky*. https://www.shapeamerica.org/Common/Uploaded%20files/document_manager/advocacy/son/2016/SON_-Kentucky_-2016.pdf
4. Templeton, D., Korchagin, R., & Valla, B. (2025, May 5). Left Behind in Lockdown: How COVID-19 Deepened the Crisis in K-12 Physical Education. *Children (Basel), 12*(5), 603. https://pubmed.ncbi.nlm.nih.gov/40426782/
5. AMA Policy Finder. (2022). *Mandatory Physical Education H-470.975*. https://policysearch.ama-assn.org/policyfinder/detail/mandatory%20physical%20education?uri=%2FAMADoc%2FHOD. xml-0-4291.xml

2025-28

RESOLUTION

Subject: Teenage Pregnancy Reduction

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, the rate of teenage pregnancy in Kentucky remains to be among the highest in the country, ranked as number four in the country and eight points higher than national average, approximating 3,500 teenage pregnancies[1,2]; and

WHEREAS, in the state of Kentucky, the rate of adolescent pregnancy has decreased substantially from 2008 to 2019 as proactive and preventative measures broadened their educational approach towards mitigating pregnancy[1]; and

WHEREAS, in 2018 the state of Kentucky has recognized the need for sexual education to encompass aspects of healthy relationships when the state introduced House Bill 80 which requires education on the "development of relationship and communication skills necessary to form healthy relationships free of violence, coercion, and intimidation,"[4]; and

WHEREAS, in 2023, Senate Bill 150 was enacted into law which prohibits sexual education in kindergarten through fifth grade, restricts discussion about sexual orientation and sexual identity, and establishes an "opt-in" system[5]; and

WHEREAS, Kentucky has resisted adhering to any of the National Sex Education standards in the second edition written to be implemented in K-12 schools[3,5]; now, therefore, be it

RESOLVED, that KMA advocate for Kentucky public schools to initially implement the proposed standards from the National Sex Education guidelines regarding consent and healthy relationships, sexual health, and interpersonal violence; and be it further

RESOLVED, that KMA develop medically accurate sex education instruction in collaboration with the Division of Maternal and Child Health, the Adolescent Health Program, and educators to amend the current Kentucky Academic Standards for Physical Education for age-appropriate sexual education.

References:

1. "Adolescent Health Program - Cabinet for Health and Family Services." *Ky.gov*, 2019, www.chfs.ky.gov/agencies/dph/dmch/cfhib/Pages/ah.aspx.
2. Centers for Disease Control and Prevention. "CDC WONDER." *Cdc.gov*, CDC.gov, 2021, wonder.cdc.gov/.
3. *Kentucky Academic Standards Physical Education*.
4. Kentucky Legislative Research Commission. "18RS HB 80." *Ky.gov*, 2018, apps.legislature.ky.gov/record/18RS/hb80.html. Accessed 16 June 2025.
5. "Kentucky State Profile." *SIECUS*, siecus.org/stateprofiles/kentucky-state-profile-23/.

2025-29

RESOLUTION

Subject: Addressing E-Cigarette Use Among Kentucky Youth

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, the Centers for Disease Control and Prevention (CDC) reports that 1.63 million middle and high school students in the United States used e-cigarettes in 2024, with flavored disposable vapes being the most common[1]; and

WHEREAS, Kentucky has one of the highest youth vaping rates in the country, with 19.7% of high schoolers currently using e-cigarettes[1]; and

WHEREAS, E-cigarettes contain high levels of nicotine, an addictive substance, which can interfere with adolescent brain development[2]; and

WHEREAS, there is growing evidence that e-cigarette aerosols contain harmful substances like heavy metals, ultrafine particles, and chemicals linked to lung injury and cardiovascular disease[2]; and

WHEREAS, despite these risks, many teens perceive vaping or smokeless tobacco as less harmful than traditional smoking, highlighting the need for stronger education and prevention strategies[3]; and

WHEREAS, the U.S. Food and Drug Administration (FDA) launched the Youth Tobacco Prevention Plan in 2024 to address youth access, education, and marketing restrictions for e-cigarettes and related products, reinforcing the urgency of coordinated state-level action[4]; and

WHEREAS, there is a growing market for “healthy” vapes including those containing essential oils, melatonin, caffeine, or vitamins that falsely claim health benefits, despite not being approved by the FDA[5]; and

WHEREAS, the current Kentucky law does not mandate tobacco or vaping cessation education curriculum and only recommends distribution of materials and resources; and

WHEREAS, current KMA policy does not recommend a mandated course in Kentucky public schools on the dangers of using electronic nicotine delivery systems, electronic non-nicotine delivery systems and associated products[6]; now, therefore, be it

RESOLVED, that KMA support efforts to educate Kentucky youth about the health risks of e-cigarettes, including those often marketed as "healthy” vapes and all other nicotine and tobacco products; and be it further

RESOLVED, that KMA advocate for the integration of vaping and tobacco and nicotine prevention education into Kentucky school health curriculum beginning in middle school and continuing through high school; and be it further

RESOLVED, that KMA encourage a mandatory, evidence-based course that is integrated into the Kentucky public school curriculum warning children of the health risks of smoking and/or using tobacco or nicotine products; and be it further

RESOLVED, that KMA continues to support policies to enforce stricter age verification and marketing regulations to restrict the sale of flavored vaping products.

References:

1. Centers for Disease Control and Prevention. Tobacco Product Use Among Middle and High School Students – United States, 2024. Accessed July 7, 2025. https://www.cdc.gov/tobacco/e-cigarettes/youth
2. American Academy of Pediatrics. Protecting Children and Adolescents From Tobacco Products. *Pediatrics*. 2023;151(5):e2023061804. Accessed July 7, 2025. https://publications.aap.org/pediatrics/article/151/5/e2023061804/191066/Protecting-Children-and-Adolescents-From-Tobacco
3. Kentucky Department of Education. 2023 Youth Risk Behavior Survey – High School Summary Tables. Accessed July 7, 2025. https://www.education.ky.gov/curriculum/WSCC/data/Documents/2023%20High%20School%20Summary%20Tables.pdf
4. U.S. Food and Drug Administration. FDA's Youth Tobacco Prevention Plan. Accessed July 7, 2025. https://www.fda.gov/tobacco-products/youth-and-tobacco/fdas-youth-tobacco-prevention-plan
5. U.S. Food and Drug Administration. E-Cigarettes, Vapes, and Other Electronic Nicotine Delivery Systems (ENDS). Accessed July 7, 2025. https://www.fda.gov/tobacco-products/products-ingredients-components/e-cigarettes-vapes-and-other-electronic-nicotine-delivery-systems-ends
6. Lexington Medical Society. KMA Resolution on E-Cigarettes. Published September 24, 2019. Accessed July 7, 2025. https://www.lexingtondoctors.org/2019/09/24/kma-resolution-on-e-cigarettes/

2025-30

RESOLUTION

Subject: Protecting Kentucky's Children from Counterfeit Car Seats

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, motor vehicle crashes remain a leading cause of death and injury for children in the United States; and

WHEREAS, properly installed and federally approved car seats reduce the risk of injury and death by up to 71% for infants and 54% for toddlers; and

WHEREAS, counterfeit car seats, often sold online through third-party marketplaces, do not meet federal safety standards set by the National Highway Traffic Safety Administration (NHTSA); and

WHEREAS, counterfeit car seats may visually resemble legitimate products but frequently lack key safety features such as proper harness systems, energy-absorbing foam, and secure installation mechanisms; and

WHEREAS, these counterfeit products often enter the market without regulation, are difficult to detect by the average consumer, and can fail catastrophically in a crash; and

WHEREAS, pediatricians and other healthcare providers are often trusted sources of safety information for families and can play a key role in identifying and reporting counterfeit car seats; and

WHEREAS, current public awareness campaigns on car seat safety do not adequately address the growing prevalence and dangers of counterfeit car seats; now, therefore, be it

RESOLVED, that KMA recognize the threat posed by counterfeit car seats to child passenger safety and public health; and be it further

RESOLVED, that KMA support public education efforts to raise awareness about counterfeit car seats, including how to identify them and where to purchase safe, National Highway Traffic Safety Administration (NHTSA) compliant car seats; and be it further

RESOLVED, that KMA advocate for policies that require greater oversight of online marketplaces to prevent the sale of counterfeit car seats and promote enforcement of federal safety standards; and be it further

RESOLVED, that KMA advocate for the placement of visible disclaimers or safety alerts on online retail platforms warning consumers about the risks of counterfeit car seats and directing them to certified vendors; and be it further

RESOLVED, that KMA encourage car seat manufacturers to provide and publicize tools for consumers to verify the authenticity of their products (e.g., serial number lookups or QR codes); and be it further

RESOLVED, that KMA encourage its members, especially pediatricians and family physicians, to counsel families on proper car seat use and how to avoid counterfeit products; and be it further

RESOLVED, that KMA collaborate with the Kentucky Office of Highway Safety, local health departments, and child passenger safety coalitions to develop and disseminate public awareness campaigns on counterfeit car seats; and be it further

RESOLVED, that KMA support increased funding and training opportunities for child passenger safety technicians (CPSTs) in Kentucky, especially in underserved areas, to aid families in proper car seat use and detection of counterfeit products; and be it further

RESOLVED, that KMA support funding mechanisms—through public grants, private partnerships, or legislative advocacy—to ensure that clinics, hospitals, and child passenger safety technicians (CPSTs) have access to safe, National Highway Traffic Safety Administration (NHTSA) approved car seats for distribution to families in need, particularly when a counterfeit or expired seat has been identified; and be it further

RESOLVED, that KMA advocate for state-level budget appropriations or child safety grant programs to expand access to low- or no-cost car seats for eligible families across Kentucky.

References:

1. **National Highway Traffic Safety Administration (NHTSA).** *"Car Seat Recommendations for Children."* https://www.nhtsa.gov/equipment/car-seats-and-booster-seats – Offers federal car seat safety standards and guidelines.
2. **American Academy of Pediatrics (AAP).** *"Car Seats: Information for Families."* https://www.healthychildren.org/English/safety-prevention/on-the-go/Pages/Car-Safety-Seats-Information-for-Families.aspx – Provides expert pediatric guidance on child passenger safety.
3. **U.S. Consumer Product Safety Commission (CPSC).** *"Counterfeit Products."* https://www.cpsc.gov/Safety-Education/Safety-Guides/General-Information/Counterfeit-Products – Addresses the risks of counterfeit goods, including children's products.
4. **The Washington Post.** *"Counterfeit car seats are being sold online — and putting children in danger."* (October 2022) https://www.washingtonpost.com/parenting/2022/10/13/counterfeit-car-seats-online/ – Investigative journalism piece highlighting real-world risks and parent experiences.
5. **Today Show / NBC News.** *"Counterfeit car seats being sold on Amazon and Walmart pose dangers to kids."* (February 2020) https://www.today.com/parents/fake-car-seats-being-sold-online-pose-dangers-kids-t173361 – Describes widespread availability and dangers of fake seats on major platforms.
6. **The Center for Countering Digital Hate.** *"Who's Selling Fake Car Seats?"* (2023) – Research into the proliferation of counterfeit car seats on e-commerce sites. [Note: if not available online, cite as unpublished or check for a similar consumer safety org.]
7. **Safe Kids Worldwide.** *"Car Seat Safety Tips."* https://www.safekids.org/car-seat – Offers education on proper car seat use and how to spot unsafe or counterfeit products.
8. **U.S. Department of Transportation, NHTSA.** *"Counterfeit Child Safety Seats – Safety Alert."* https://www.nhtsa.gov/press-releases/child-passenger-safety-week-counterfeit-car-seats – Federal government alert warning consumers and offering detection tips.

2025-31

RESOLUTION

Subject: Inclusion of Additional Adverse Childhood Experiences (ACEs) Categories

Submitted by: Maggie Stull, Emma Higgins, Miguel Abascal (Medical Student Section)

Referred to: Reference Committee

WHEREAS, the term Adverse Childhood Experiences, or ACEs, was coined in 1998 after a survey of over 9,000 U.S. adults found that over half of participants reported at least one adverse childhood experience and that there was a statistically significant relationship between the number of ACEs an individual was exposed to and their disease status and risk-taking behaviors as an adult[1]; and

WHEREAS, the conventional ACEs model is categorized as psychological, physical, sexual, and household dysfunction, with household dysfunction including abuse, mental illness, household violence, and household criminal activity[1]; and

WHEREAS, a systemic review of 25 studies and a meta-analysis of 8 studies found that 48.1% of study participants had at least one ACE and that there was a significant dose-dependent relationship between ACE exposure and experiencing multiple long-term comorbidities as an adult ($p < 0.001$), with every additional ACE exposure adding a 12.9% (95% CI 7.9 to 17.9%) increased odds of comorbidities[2]; and

WHEREAS, early studies on ACEs were largely focused on white and middle-to-upper-class individuals, and it has been shown that expanding ACEs categories to include experiencing racism, witnessing community violence, living in an unsafe neighborhood, experiencing bullying, and having a history with foster care helps to capture the experiences of an additional 13.9% of people[3]; and

WHEREAS, a culturally relevant ACE questionnaire was used for a population of Mexican adolescents and found that 90% had 1 or more ACEs, demonstrated that the ACEs experienced in low- or middle-income populations can be drastically different than ACEs experienced in middle- or high-income populations, necessitating the need for expanding the current ACE framework[4]; and

WHEREAS, conventional ACE surveys may not fully assess an individual's experiences and risks due to the age of the individual being surveyed and complex socioeconomic and racial determinants, such that one study showed a significantly improved association (from $R^2 = 0.21$ to $R^2 = 0.34$) when the categories of peer rejection, peer victimization, community violence exposure, school performance, and socioeconomic status were used in place of some standard ACE categories for youth ages 10 to 17 years old[5]; and

WHEREAS, a scoping review of 19 studies found that exposure to community violence (ECV) was the most frequently added category to the existing ACEs structure, followed by economic hardship in childhood (EHC), bullying, absence/death of parent or significant others, and discrimination[6]; and

WHEREAS, the American Medical Association (AMA) has expressed support for expanding ACE categories and continuing to research the long-term health implications of and solutions for combatting ACEs[7]; now, therefore, be it

RESOLVED, that KMA advocate to expand the use of additional Adverse Childhood Experiences (ACE) categories to reflect the diverse experiences of individuals.

References:

1. Felitti, V.J., et al. (1998, May). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. *American Journal of Preventive Medicine*, 14(4), 245-258. https://www.ajpmonline.org/article/S0749-3797(98)00017-8/fulltext
2. Senaratne, D.N.S., et al. (2024, August 15). The impact of adverse childhood experiences on multimorbidity: a systematic review and meta-analysis. *BMC Med.*, 22(315). https://pmc.ncbi.nlm.nih.gov/articles/PMC11325707/
3. Cronholm, P.F., et al. (2015, September). Adverse Childhood Experiences. *American Journal of Preventive Medicine*, 49(3), 354-361. https://www.ajpmonline.org/article/S0749-3797(15)00050-1/abstract
4. Casas-Muñoz, A., et al. (2024, April). ACE-IQ extended version validation and ACE's frequency in Mexican adolescents. *Child Abuse & Neglect*, 150. https://www.sciencedirect.com/science/article/pii/S0145213423004805?via%3Dihub
5. Finkelhor, D., et al. (2013, January). Improving the Adverse Childhood Experiences Study Scale. *JAMA Pediatrics*, 167(1), 70-75. https://jamanetwork.com/journals/jamapediatrics/fullarticle/1393429
6. SmithBattle, L., et al. (2021, May 6). Evidence for Revising the Adverse Childhood Experiences Screening Tool: a Scoping Review. *J Child Adolesc Trauma*, 15(1), 89-103. https://pmc.ncbi.nlm.nih.gov/articles/PMC8837767/
7. AMA Policy Finder. (2023). Adverse Childhood Experiences and Trauma-Informed Care H-515.952. https://policysearch.ama-assn.org/policyfinder/detail/adverse%20childhood%20experiences%20?uri=%2FAMADoc%2FHOD.xml-H-515.952.xml

2025-32

RESOLUTION

Subject: Cannabis Product Packaging

Submitted by: Michael Kuduk, MD (KMA Immediate Past President)

Referred to: Reference Committee

WHEREAS, the legalization of medical cannabis in the Commonwealth has resulted in the wider distribution of products containing tetrahydrocannabinol (THC); and

WHEREAS, some of these preparations are in the form of gummies or other items that resemble candy, increasing their appeal to children; and

WHEREAS, a 2023 study published in *Pediatrics* reported a 1,375% increase in the number of pediatric THC exposures and ingestions between 2017 and 2021; and

WHEREAS, both children's hospitals in Kentucky are experiencing an increase in hospitalizations due to pediatric THC ingestion, with some cases resulting in critical illness; and

WHEREAS, unintentional pediatric exposures to THC disproportionately affect children in households with limited access to secure storage or public health education; and

WHEREAS, THC edibles are often marketed with flavors, colors, and packaging that resemble popular candies, increasing the risk of accidental ingestion by children; and

WHEREAS, Kentucky regulations require child-resistant, tamper-evident, opaque, and non-appealing packaging for THC products to reduce pediatric exposure and accidental ingestion; now, therefore be it

RESOLVED, that KMA support enforcement and public awareness of existing state packaging regulations to ensure compliance and protect children; and be it further

RESOLVED, that KMA advocate for public education campaigns and data collection on pediatric cannabis exposures to inform future prevention strategies.

References:

1. Tweet, M. S., Nemanich, A., & Wahl, M. (2023). Pediatric edible cannabis exposures and acute toxicity: 2017–2021. Pediatrics, 151(2), e2022057761. https://doi.org/10.1542/peds.2022-057761
2. Ramsey, S. (2025, July 16). Cannabis-related emergency department visits climb in Kentucky, especially among youth. Kentucky Injury Prevention and Research Center.
3. Mannering, M. (2024, March 11). KY poison control sees increase in kids ingesting medicated gummies. LEX18 News.
4. Kentucky Administrative Regulations. (n.d.). 915 KAR 1:100. Packaging and labelling of medical cannabis. https://apps.legislature.ky.gov/law/kar/915/001/100.pdf

KMA House of Delegates
August 2025

RESOLUTION

Subject: Transfer of Cannabis to Schedule III Controlled Substance

Submitted by: Donnie Stacy, MD

Referred to: Reference Committee

WHEREAS, on May 21, 2024 the Department of Justice proposed to transfer cannabis from schedule I of the Controlled Substances Act (CSA) to schedule III of the CSA, consistent with the view of the Department of Health and Human Services (HHS) that cannabis has a currently accepted medical use (CAMU) and a potential of abuse less than the drugs or other substances in schedules I and II (Schedules of Controlled Substances: Rescheduling of Marijuana 21 CFR Part 1308 [Docket No. DEA-1362; A.G. Order No. 5931-2024]); and

WHEREAS, the Kentucky Medical Association (KMA) advocates for further clinical research of cannabis in the treatment of medical conditions (Res 2015-16, 2015 HOD); and

WHEREAS, the rescheduling of cannabis to schedule III would allow for more extensive clinical research and pharmaceutical companies could submit Investigational New Drug Applications (INDs) and New Drug Applications (NDAs) for cannabis-based products to demonstrate their safely, efficacy, and manufacturing quality (https://www.mwe.com/insights/doj-proposes-to-reschedule-marijuana-cannabis-to-schedule-iii/); now, therefore, be it

RESOLVED, that KMA supports the transfer of cannabis from schedule I of the Controlled Substances Act (CSA) to schedule III.

RESOLUTION

Subject: Promotion of Universal Lead Screening in High-Risk Kentucky ZIP Codes

Submitted by: Daniel Hughes, Michael Long, Benjamin Bowling, Laura Nazzarine, and Armaghan Fazal (Medical Student Section)

Referred to: Reference Committee

WHEREAS, lead poisoning remains a serious and preventable public health threat to children, with no safe level of lead exposure and irreversible effects on neurodevelopment, behavior, and overall health; and

WHEREAS, children under six years of age are particularly vulnerable to lead poisoning due to their developing nervous systems and frequent hand-to-mouth behavior; and

WHEREAS, older housing stock built before 1978, especially in impoverished urban neighborhoods and rural Appalachian communities in Kentucky, frequently contains lead-based paint, a major source of exposure[2]; and

WHEREAS, from 2005 to 2021, nearly 10,000 children in Louisville tested positive for elevated blood lead levels[3]; and

WHEREAS, children living in the northwest area of Louisville are almost 10 times more likely to develop lead poisoning than those in other areas with mainly five ZIP codes—40203, 40210, 40211, 40212, and 40215—having the highest concentration of housing built before 1978[1]; and

WHEREAS, a lead level of >3.5 µg/dL is considered an elevated blood lead level[5]; and

WHEREAS, the CDC and AAP recommend targeted screening and intervention in areas with high prevalence of lead exposure, yet many children in Kentucky's highest-risk ZIP codes are not routinely tested for lead[4]; and

WHEREAS, universal blood lead level (BLL) screening in high-risk ZIP codes would enable early identification and intervention to prevent long-term harm and reduce disparities in health outcomes; and

WHEREAS, Kentucky currently lacks a mandate for universal screening of all children in high-risk geographic areas despite significant environmental and socioeconomic risk factors; now, therefore, be it

RESOLVED, that KMA support legislation and public health initiatives to implement universal blood lead level screening for all children under the age of six living in ZIP codes identified as high-risk due to older housing, poverty, and other environmental risk factors; and be it further

RESOLVED, that KMA encourage partnerships between the Kentucky Department for Public Health, local health departments, and pediatric providers to develop and maintain a dynamic, data-informed list of high-risk ZIP codes requiring screening; and be it further

RESOLVED, that KMA support integration of blood lead level screening alerts into electronic medical record (EMR) systems for pediatric providers in Kentucky to improve compliance and follow-up.

References:

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RESOLUTION

Subject: Expanding Recommendations for Routine Hearing Screenings in Asymptomatic Adults

Submitted by: Emma Higgins, Naiya Sims (Medical Student Section)

Referred to: Reference Committee

WHEREAS, age-related hearing loss (presbycusis), a progressive and often bilateral condition, affects approximately one-third of adults between 65 and 74 years old, which can lead to difficulties with communication, personal safety, and physical and mental health[1]; and

WHEREAS, a scoping review of 26 studies across 12 countries found that there is a statistically significant association between age-related hearing loss and cognitive impairment (OR 2.00, 95% CI 1.39-2.89 for cross-sectional studies; OR 1.22, 95% CI 1.09-1.26 for prospective cohort studies) and dementia (OR 2.42, 95% CI 1.24–4.72 for cross-sectional studies; OR 1.28, 95% CI 1.02-1.59 for prospective cohort studies)[2]; and

WHEREAS, current guidelines state that hearing loss at or below 25 dB is considered “normal” hearing, but even subclinical hearing loss (under 25 dB) has been linked to cognitive and mental health decline, and subclinical hearing loss can onset decades prior to age 65, which is often the age when routine hearing loss screening exams are recommended[3]; and

WHEREAS, the Lancet Commission identified hearing loss to be the most prevalent (31.7%) modifiable risk factor in adults aged 45-65 years old and with the highest associated relative risk for dementia (1.9, 95% CI 1.4-2.7), with even subclinical levels of hearing loss to be associated with cognitive decline, and that hearing aid use is protective against developing dementia[4]; and

WHEREAS, hearing loss screening is non-invasive with little to no identified adverse effects of screening[5]; and

WHEREAS, the US Preventive Services Task Force’s recommendations regarding screening for asymptomatic age-related hearing loss before age 50 is listed as an “I” recommendation, stating insufficient evidence, but the American Academy of Otolaryngology recently reduced their screening guidelines from age 60 to age 40, notably despite the US Preventive Services Task Force’s decree of insufficient evidence[6,7]; and

WHEREAS, considering the new evidence linking hearing loss to dementia, the American Medical Association (AMA) has urged the US Preventive Services Task Force to reassess its guidelines for not recommending hearing loss screening for asymptomatic adults under 65, as well as expressed support for physician and patient education on this matter[8]; now, therefore, be it

RESOLVED, that KMA encourage physicians to educate patients on age-related hearing loss, and advocate for and support the AMA's effort to expand hearing loss screening guidelines.

References:

1. National Institute on Deafness and Other Communication Disorders. (2023, March 17). *Age- related Hearing Loss (Presbycusis)*. https://www.nidcd.nih.gov/health/age-related-hearing-loss
2. Loughrey, D.G. et al. (2018, February 1). Association of Age-Related Hearing Loss With Cognitive Function, Cognitive Impairment, and Dementia: A Systematic Review and Meta- analysis. *JAMA Otolaryngol Head Neck Surg., 144*(2), 115-126. https://pubmed.ncbi.nlm.nih.gov/29222544/
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8. AMA Policy Finder. (2024). *Hearing Aid Coverage H-185.929*. https://policysearch.ama-assn.org/policyfinder/detail/hearing%20loss%20health%20insurance?uri=%2FAMADoc%2FHO D.xml-0-1107.xml

2025-36

RESOLUTION

Subject: Alternatives to Body Mass Index for Assessing Long-Term Risks of Obesity

Submitted by: Emma Higgins, Naiya Sims (Medical Student Section)

Referred to: Reference Committee

WHEREAS, in 2021, Kentucky was ranked as the 8th state most impacted by obesity and greater than 34% of Kentuckians are considered obese (BMI > 30)[1]; and

WHEREAS, there are considerable health risks associated with high Body Mass Index (BMI) and obesity, leading to increased risk for cardiovascular disease, diabetes, cancer mortality, lower quality of life, osteoarthritis, autoimmune diseases, and increased associated costs due to healthcare spending, workplace absenteeism, and disability[2,3]; and

WHEREAS, BMI is defined as weight divided by height squared, and is a standardized tool that is widely used to group people into “underweight”, “healthy”, “overweight”, or “obese” categories, which is then often extrapolated to try and assess a person’s risk of various diseases or health outcomes[4]; and

WHEREAS, BMI is commonly used in population surveys and primary healthcare screenings because only height and weight is required, but there are limitations when determining the risk of chronic disease and does not directly measure the body's composition of fat[2,5]; and

WHEREAS, Pearson’s correlation has demonstrated that BMI, along with either waist circumference or waist-stature ratio, was significantly highly correlated with total percentage of body fat, greater than any metric alone[5]; and

WHEREAS, body fat percentage and waist circumference have been shown to be more statistically significant in predicting mortality than BMI in young adults, as body fat percentage had an adjusted 15-year all-cause mortality hazard ratio of 1.78 (95% CI 1.28-2.47) and waist circumference had an adjusted hazard ratio of 4.01 (95% CI 1.94-8.27), while BMI had no significant relationship with 15-year all-cause mortality[6]; and

WHEREAS, considering the historical harms of BMI, the American Medical Association (AMA) has recognized the limitations of BMI and suggests that BMI be used in conjunction with other measures, such as visceral fat, body composition, waist circumference, and genetic/metabolic factors[7]; now, therefore, be it

RESOLVED, that KMA advocate for the education of physicians on the limitations of Body Mass Index (BMI) alone and support AMA’s suggestion to standardize the use of other metrics to determine body composition along with BMI in clinical practice to better understand the long-term risk factors at the individual level due to obesity.

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August 2025

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2025-37

RESOLUTION

Subject: Addressing the Rising Incidence of Pertussis and Protecting Vulnerable Infants in Kentucky

Submitted by: Daniel Hughes, Michael Long, Benjamin Bowling, Laura Nazzarine, and Armaghan Fazal (Medical Student Section)

Referred to: Reference Committee

WHEREAS, pertussis (whooping cough), a highly contagious respiratory disease caused by Bordetella pertussis, is experiencing a resurgence in the United States, with over 10,000 cases reported nationwide in 2024[1]; and

WHEREAS, infants under 12 months of age are at the greatest risk for hospitalization, complications, and death from pertussis, particularly before they complete their primary DTaP (diphtheria, tetanus, acellular pertussis) vaccination series[4]; and

WHEREAS, the CDC recommends maternal Tdap (tetanus, diphtheria, acellular pertussis) vaccination during every pregnancy, ideally between 27–36 weeks gestation, to provide passive immunity to newborns, yet uptake rates remain suboptimal in many states, including Kentucky[3]; and

WHEREAS, pertussis vaccination coverage in adults and adolescents remains below national targets, decreasing herd immunity and increasing risk for transmission to vulnerable populations; and

WHEREAS, Kentucky has historically lagged behind national averages in adult Tdap vaccination rates, which may contribute to greater community spread and increased infant exposure; and

WHEREAS, two unvaccinated infants have died from whooping cough in the last six months and are the first whooping cough-related deaths in Kentucky since 2018[2]; and

WHEREAS, recent state data and public health reports highlight the need for increased awareness, education, and immunization efforts targeting both expectant mothers and close contacts of infants; now, therefore, be it

RESOLVED, that KMA advocate for increased public education campaigns and provider-level interventions to improve maternal diphtheria, tetanus, acellular pertussis (DTaP) vaccination rates during pregnancy; and be it further

RESOLVED, that KMA support statewide efforts to improve surveillance and timely reporting of pertussis cases, particularly among infants; and be it further

RESOLVED, that KMA work with state legislators and public health officials to prioritize pertussis prevention as a public health concern and support funding for immunization access and education initiatives across Kentucky.

KMA House of Delegates
August 2025

References:

1. Centers for Disease Control and Prevention. (2025, April 22). Pertussis cases reported to CDC – United States, 2025. Retrieved from https://www.cdc.gov/pertussis/php/surveillance/index.html
2. WDRB News Staff. (2025, June 6). *Health officials say 2 Kentucky infants have died from whooping cough in last 6 months.* https://www.wdrb.com/news/health-officials-say-2-kentucky-infants-have-died-from-whooping-cough-in-last-6-months/article_71a62c1f-4a1d-454d-8bb1-bf140b6eb81e.html
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2025-38

RESOLUTION

Subject: Increasing Awareness of the National Suicide Prevention Lifeline (988 Lifeline)

Submitted by: Emma Higgins, Naiya Sims (Medical Student Section)

Referred to: Reference Committee

WHEREAS, suicide is a rising issue in Kentucky, and youth are a population of high concern[1]; and

WHEREAS, suicide is the second highest cause of death in children and young adults, with 1 in 7 high school students having considered suicide and 1 in 5 middle schoolers having considered suicide[1]; and

WHEREAS, the National Suicide Prevention Lifeline was first established in 2005, and now consists of over 200 crisis centers available 24/7 via phone calls, texts, or chat to serve as emergency support to prevent suicide across the United States[2]; and

WHEREAS, the National Suicide Prevention Lifeline is effective, with 88.1% of callers reporting that their call stopped them from killing themselves and over half of callers stating that their suicidal thoughts did not recur after their call[3]; and

WHEREAS, the National Suicide Prevention Lifeline's primary age demographic is people aged 18-24 (42.2%), which is an identified at-risk population, and the line is also utilized by a wide range of ages, genders, and ethnicities[3]; and

WHEREAS, the National Suicide Hotline Improvement Act of 2018 mandated that the National Suicide Prevention Lifeline switch to using a simple three-digit number (988), which was only launched in July of 2022, and therefore, additional advertisement and promotion would help to increase public awareness of how to access the service[2,4]; and

WHEREAS, the American Medical Association (AMA) updated its policy in 2022 to reflect the switch to using 988 for the National Suicide Prevention Lifeline and advocate for increased funding and support for the suicide prevention safety net[5]; now, therefore, be it

RESOLVED, that KMA dedicate resources to help promote the 988 National Suicide Prevention Lifeline and advocate for increased funding and support of the suicide safety net prevention network.

References:

1. Njenga, R. (2025, July 15). *Suicide Prevention and Awareness*. Kentucky Department of Education. https://www.education.ky.gov/school/sdfs/Pages/Suicide-Prevention-and- Awareness.aspx
2. 988 Lifeline. (n.d.). *About 988*. https://988lifeline.org/about/
3. Gould, M.S., et al. (2025, June). National Suicide Prevention Lifeline (Now 988 Suicide and Crisis Lifeline): Evaluation of Crisis Call Outcomes for Suicidal Callers. *Suicide and Life- Threatening Behavior, 55*(3), e70020. https://onlinelibrary.wiley.com/doi/full/10.1111/sltb.70020
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2025-39

RESOLUTION

Subject: Community Violence Intervention Program Support

Submitted by: Lexington Medical Society

Referred to: Reference Committee

WHEREAS, in 2023 over 13,000 Kentuckians suffered from assault-related injuries resulting in Emergency department (ED) visits or inpatient hospitalization; and

WHEREAS, on April 22, 2025, the Federal government terminated 373 federal grants from the Department of Justice's Office of Justice Programs (OJP) worth over $800 million dollars; and

WHEREAS, the terminated OJP grants provided support for violence reduction, policing and prosecution, victims' services, juvenile justice and child protection, substance use and mental health treatment, corrections and reentry, justice system enhancements, research and evaluation, and other state- and local-level public safety functions; and

WHEREAS, among all states Kentucky was the 2nd largest recipient of OJP grant funding, amounting to over $89 million dollars cut from public safety efforts; and

WHEREAS, JAMA Pediatrics reported that youth violence alone costs the United States over $100 billion dollars annually; and

WHEREAS, community violence interventions have historically had broad bipartisan support in the state and national political climate; now, therefore, be it

RESOLVED, that KMA endorse for the reinstatement of the Department of Justice's Office of Justice Programs (OJP) grant funding which supports prevention of violence-related injury and death.

2025-40

RESOLUTION

Subject: Ensuring Robust Standards for Additional CME Requirements

Submitted by: Monalisa Tailor, MD

Referred to: Reference Committee

WHEREAS, continuing medical education (CME) plays a critical role in ensuring that physicians remain current with medical advancements, enhance clinical skills, and maintain the highest standards of patient care; and

WHEREAS, the healthcare landscape is constantly evolving due to new research, practices, and technologies, necessitating ongoing adaptation by healthcare professionals; and

WHEREAS, state medical boards, such as the Kentucky Board of Medical Licensure, have established specific CME requirements for license renewal and maintenance of certification; and

WHEREAS, the Accreditation Council for Continuing Medical Education (ACCME) sets standards for accredited CME, focusing on content validity, preventing commercial bias, and identifying and mitigating relevant financial relationships; and

WHEREAS, the current CME landscape includes various requirements from federal entities, states, and medical specialty boards, which can be complex and sometimes overlapping, particularly for physicians practicing in multiple states; and

WHEREAS, any proposed additions to CME requirements should be carefully considered to ensure they are evidence-based, address identified practice gaps, and do not create undue burden on physicians; now, therefore, be it

RESOLVED, that KMA advocate for the following principles to guide the addition of new continuing medical education (CME) requirements:

1. Needs-Based Justification: Any proposed new CME requirement should be clearly justified by a demonstrated need, such as a significant knowledge gap, a critical patient safety issue, or a new medical innovation, supported by evidence and data, rather than popular opinion.
2. Alignment with Existing Standards: New requirements should align with established accreditation standards, such as those set by the Accreditation Council for Continuing Medical Education (ACCME), to ensure the quality and integrity of CME activities.

3. Physician Input and Feasibility: Healthcare professionals should be actively involved in the development and review of new CME requirements to ensure their relevance, practicality, and feasibility within the context of clinical practice.
4. Emphasis on Outcomes: New CME requirements should prioritize demonstrable improvements in physician competence, performance, or patient health outcomes, moving beyond simply tracking hours or attendance.
5. Minimizing Administrative Burden: The addition of new requirements should consider their impact on physicians' time and workload, exploring ways to streamline processes and utilize technology to minimize administrative burden; and be it further

RESOLVED, that KMA encourages ongoing collaboration among state medical boards, medical specialty boards, and accrediting bodies to streamline and standardize continuing medical education (CME) requirements where appropriate, ultimately enhancing physician education and patient care outcomes.