IDAHO MEDICAL ASSOCIATION HOUSE OF DELEGATES

VIRTUAL MEETING – OCTOBER 9, 2020

RESOLUTION 101(20)

SUBJECT: TELEHEALTH DEREGULATION, PATIENT SAFETY AND PAYMENT PARITY

AUTHOR: TED EPPERLY, MD

SPONSORED BY: IDAHO ACADEMY OF FAMILY PHYSICIANS

WHEREAS, Telehealth technologies, including audio and video equipment permitting two-way, real-time interactive communication, can enhance patient-physician collaborations, increase access to care, and has been shown to improve health outcomes and patient safety by enabling timely care interventions, and reduce cost when utilized as a component of longitudinal care; and

WHEREAS, Telehealth service delivery has grown 40-fold since the beginning of the 2020 coronavirus (Covid-19) Public Health Emergency (PHE); and

WHEREAS, Telehealth has proven to be a vital tool to maintain access and continuity of patient care while providing high quality, high value and safe patient care during the PHE when face-to-face visits were unavailable or inadvisable; therefore, be it

ADOPTED

RESOLVED, Idaho Medical Association adopts policy supporting reimbursement by all private and governmental third-party payers for telehealth services equitable to their reimbursement for comparable non-telehealth services that meet the applicable Idaho community standard of care; and be it further

RESOLVED, Idaho Medical Association adopts policy in support of making permanent the telehealth coverage and payment policies enacted during the 2020 coronavirus (Covid-19) Public Health Emergency; and be it further

RESOLVED, Idaho Medical Association advocate to and with the Idaho Legislature, the Governor's Office, the Idaho Department of Insurance, commercial insurance providers, the American Medical Association, the Centers for Medicare & Medicaid Services and the United States Congress, as appropriate, to make permanent the telehealth coverage and payment policies enacted during the Public Health Emergency including:

1. Allowing verbal consent at time of service; and
2. Allowing Rural Health Clinics and Federally Qualified Health Centers as distant site providers; and
3. Removing the existing rural geographic restriction;

ADOPTED

and

4. Allowing list of diagnosis codes that count toward Hierarchical Condition Category scoring to be counted equally when provided by telehealth or other electronic means; and
5. Centers for Medicare & Medicaid Services and commercial insurance providers covering site of service payment parity for telehealth Evaluation and Management (E&M) services on par with established patient office visits of comparable length; and
6. When audio-only visits are provided in lieu of in-person or telehealth visits when both means of communication are not simultaneously available or advisable, they also be covered at parity with E&M services on par with established patient office visits of comparable length; and
7. Public and commercial insurance providers standardizing eligible patient originating and distant sites of service to include home and various work settings to deregulate telehealth and telephone services to provide high quality, safe and timely patient care.

EXISTING IMA POLICY:

IMA will sponsor legislation to seek reimbursement for the telehealth services code set that is eligible for coverage under Medicare. (BOT, Feb 2016).

IMA adopts policy supporting reimbursement by all private and governmental third-party payers for telehealth services for consultation or referral arrangements equitable to their reimbursement for comparable non-telehealth services that meet the applicable Idaho community standard of care. IMA will work with stakeholders, including the Idaho Telehealth Council, the Idaho Hospital Association, and others to seek reimbursement by all private and governmental third-party payers for telehealth services for consultation or referral arrangements equitable to their reimbursement for comparable non-telehealth services that meet the applicable Idaho community standard of care. (HOD 2015)

IMA FISCAL NOTE: $$$

STATE OF IDAHO FISCAL NOTE: $

IMA RESOURCE ALLOCATION: HIGH

DEGREE OF DIFFICULTY: MODERATE

IDAHO MEDICAL ASSOCIATION HOUSE OF DELEGATES

VIRTUAL MEETING - OCTOBER 9, 2020

RESOLUTION 102(20)

SUBJECT: MITIGATING THE NEGATIVE IMPACTS OF THE IDAHO PATIENT ACT

AUTHOR: IMA BOARD OF TRUSTEES

SPONSORED BY: IMA BOARD OF TRUSTEES

WHEREAS, The Melaleuca Corporation brought forward the Idaho Patient Act, which is an ambitious effort to revamp physician and hospital billing processes in response to concerns about medical debt collection practices; and

WHEREAS, Idaho Medical Association and Idaho Hospital Association spent many hours negotiating with Melaleuca representatives to educate them about medical billing practices and seeking to remove extremely burdensome provisions from the legislation. Most of IMA's and IHA's concerns were addressed, but key problems in the bill remain; and

WHEREAS, The Idaho legislature passed the Idaho Patient Act and it is now law with an effective date of January 1, 2021; and

ADOPTED

WHEREAS, IMA has identified three key areas of the Idaho Patient Act that create major problems for Idaho physicians: 1) Handicaps physicians' ability to fully pursue all collection avenues if a hospital or facility excludes the physician from the Consolidated Summary of Services, 2) Potential for increased software vendor costs of adding new elements of information to the Final Statement, and 3) Eliminates the ability to immediately pursue amounts owed when the patient passes a bad check; and

WHEREAS, After the passage of the Idaho Patient Act, the COVID-19 pandemic hit and caused a significant negative impact on the health care industry, with physician practice revenues dropping 60 percent on average, with many struggling to survive. 53 percent of physicians have had to furlough or lay off office staff. Many small rural hospitals are fighting to stay open and some are having significant cashflow problems. The larger hospitals are being pressured with increasing numbers of COVID-19 patients and the potential need to delay or suspend elective procedures; and

WHEREAS, Full compliance with the Idaho Patient Act by physicians and hospitals on January 1, 2021 will be even more difficult due to the impacts of the COVID-19 pandemic; therefore be it

RESOLVED, Idaho Medical Association immediately seek an extension to the effective date of the Idaho Patient Act beyond January 1, 2021; and be it further

RESOLVED, Idaho Medical Association continue to work with the Idaho Hospital Association and Melaleuca representatives to address the three areas of concern for physicians with the Idaho Patient Act: 1) Handicaps physicians' ability to fully pursue all collection avenues if a hospital or facility excludes the physician from the Consolidated Summary of Services, 2) Potential for increased software vendor costs of adding new elements of information to the Final Statement, and 3) Eliminates the ability to immediately pursue amounts owed when the patient passes a bad check.

EXISTING IMA POLICY: IMA has numerous policies raising concerns regarding increased administrative burdens on physician offices, leading to the cost of healthcare.

IMA FISCAL NOTE: $$

STATE OF IDAHO FISCAL NOTE: N/A

IMA RESOURCE ALLOCATION: MODERATE

DEGREE OF DIFFICULTY: MODERATE

ADOPTED

IDAHO MEDICAL ASSOCIATION HOUSE OF DELEGATES

VIRTUAL MEETING – OCTOBER 9, 2020

RESOLUTION 103(20)

SUBJECT: KRATOM SAFETY AND RISK DISCLOSURE STATEMENTS REQUIRED FOR RETAILERS

AUTHOR: JULIE FOOTE, MD

SPONSORED BY: ADA COUNTY MEDICAL SOCIETY

WHEREAS, Kratom is an herbal extract that comes from the leaves of an evergreen tree (Mitragyna speciosa) grown in Southeast Asia. Kratom leaves can be chewed and dry kratom can be swallowed or brewed. Kratom extract can be used to make a liquid product. The liquid form is often marketed as a treatment for muscle pain, or to suppress appetite and stop cramps and diarrhea. Kratom is also sold as a treatment for panic attacks; and

WHEREAS, Kratom is believed to act on opioid receptors. At low doses, kratom acts as a stimulant, making users feel more energetic. At higher doses, it reduces pain and may bring on euphoria. At very high doses, it acts as a sedative and can be deadly; and

WHEREAS, Kratom use is increasing. The Centers for Disease Control

ADOPTED

and Prevention (CDC) analyzed overdose deaths in which kratom was detected on postmortem toxicology testing and deaths in which kratom was determined by a medical examiner or coroner to be a cause of death. CDC data shows that in the 18-month period prior to April 2019, 91 Americans lost their lives to fatal overdoses in which kratom was a contributing factor. Victims in another 61 fatal overdoses were found to have kratom in their bloodstreams, although other drugs may have been primarily responsible for the deaths (report attached); and

WHEREAS, Kratom sellers and users claim kratom has healthful benefits but, at this time, studies have failed to show kratom has healthful benefits that are sufficient to offset its significant risks; and

WHEREAS, Kratom sellers should be required to provide information to their customers warning them of the dangers of kratom and the fact that there have been no controlled clinical trials conducted to determine its safety for human use; therefore, be it

RESOLVED, Idaho Medical Association opposes the sale or distribution of kratom by retailers in Idaho; and be it further

RESOLVED, Idaho Medical Association will work with stakeholders to require that Idaho retailers display warnings to the public in a conspicuous location near the point of sale inside their retail establishments regarding the potentially fatal dangers of kratom and the fact that there have been no controlled clinical trials conducted to determine its safety for human use.

EXISTING IMA POLICY: Idaho Medical Association support legislative or regulatory efforts to prohibit the sale or distribution of kratom in Idaho, provided proper scientific research is not inhibited by such legislative or regulatory efforts.

IMA FISCAL NOTE: $$$

STATE OF IDAHO FISCAL NOTE: $

IMA RESOURCE ALLOCATION: MODERATE

DEGREE OF DIFFICULTY: HIGH

ATTACHMENT

Notes from the Field

Unintentional Drug Overdose Deaths with Kratom Detected — 27 States, July 2016–December 2017

Emily O'Malley Olsen, PhD[1]; Julie O'Donnell, PhD[1]; Christine L. Mattson, PhD[1]; Joshua G. Schier, MD[1]; Nana Wilson, PhD[1]

Kratom (*Mitragyna speciosa*), a plant native to Southeast Asia, contains the alkaloid mitragynine, which can produce stimulant effects in low doses and some opioid-like effects at higher doses when consumed (*1*). Use of kratom has recently increased in popularity in the United States, where it is usually marketed as a dietary or herbal supplement (*1*). Some studies suggest kratom has potential for dependence and abuse (*1*,*2*). As of April 2019, kratom was not scheduled as a controlled substance. However, since 2012, the Food and Drug Administration has taken a number of actions related to kratom, and in November 2017 issued a public health advisory*; in addition, the Drug Enforcement Administration has identified kratom as a drug of concern. During 2011–2017, the national poison center reporting database documented 1,807 calls concerning reported exposure to kratom (*3*). To assess the impact of kratom, CDC analyzed data from the State Unintentional Drug Overdose Reporting System (SUDORS).

CDC funds 32 states and the District of Columbia to abstract into SUDORS detailed data on unintentional and undetermined intent opioid overdose deaths from death certificates and medical examiner and coroner reports, including postmortem toxicology results.† Although kratom is not an opioid, overdose deaths involving kratom (including nonopioid overdose deaths) are included in SUDORS.§ Although postmortem toxicology testing varies in scope among medical examiners and coroners, SUDORS records all substances detected on postmortem toxicology testing, along with overdose-specific circumstances. CDC analyzed overdose deaths in which kratom was detected on postmortem toxicology testing and deaths in which kratom was determined by a medical examiner or coroner to be a cause of death in 11 states during July 2016–June 2017 and in 27 states during July–December 2017.¶

Data on 27,338 overdose deaths that occurred during July 2016–December 2017 were entered into SUDORS, and 152 (0.56%) of these decedents tested positive for kratom on postmortem toxicology (kratom-positive). Postmortem toxicology testing protocols were not documented and varied among and within states. Kratom was determined to be a cause of death (i.e., kratom-involved) by a medical examiner or coroner for 91 (59.9%) of the 152 kratom-positive decedents, including seven for whom kratom was the only substance to test positive on postmortem toxicology, although the presence of additional substances cannot be ruled out (*4*).

In approximately 80% of kratom-positive and kratom-involved deaths in this analysis, the decedents had a history of substance misuse, and approximately 90% had no evidence that they were currently receiving medically supervised treatment for pain. Postmortem toxicology testing detected multiple substances for almost all decedents (Table). Fentanyl and fentanyl analogs were the most frequently identified co-occurring substances; any fentanyl was listed as a cause of death for 65.1% of kratom-positive decedents and 56.0% of kratom-involved decedents. Heroin was the second most frequent substance listed as a cause of death (32.9% of kratom-positive decedents), followed by benzodiazepines (22.4%), prescription opioids (19.7%),** and cocaine (18.4%).

* https://www.fda.gov/NewsEvents/PublicHealthFocus/ucm584952.htm.

† Whereas most states in SUDORS submit data on 100% of their unintentional and undetermined intent opioid-involved overdose deaths, Florida, Illinois, Missouri, Pennsylvania, and Washington submit data on a subset of counties that reflect at least 75% of drug overdose deaths in the state.

§ SUDORS records data on fatal unintentional and undetermined intent overdoses in which at least one opioid contributed to death, as well as fatal overdoses with no contributing opioid, if substances that have opioid-like properties (currently, kratom is the only such substance) contributed to death. For all included deaths, SUDORS records all substances testing positive on postmortem toxicology testing (including those that did and did not contribute to death).

¶ Twenty-seven states reported data for the period July 2016–December 2017. Eleven states reported deaths that occurred during the entire period: Kentucky, Maine, Massachusetts, Missouri, New Hampshire, New Mexico, Ohio, Oklahoma, Rhode Island, West Virginia, and Wisconsin. Sixteen additional states only reported deaths that occurred during July–December 2017: Alaska, Connecticut, Delaware, Florida, Georgia, Illinois, Indiana, Minnesota, New Jersey, North Carolina, Pennsylvania, Tennessee, Utah, Vermont, Virginia, and Washington. Data were current as of January 22, 2019.

** Substances coded as prescription opioids were oxycodone, oxymorphone, hydrocodone, hydromorphone, tramadol, buprenorphine, methadone, meperidine, tapentadol, dextrorphan, levorphanol, propoxyphene, pentazocine, and phenacetin. Also coded as prescription opioids were brand names (e.g., Opana), metabolites (e.g., nortramadol) of these substances, and these substances in combination with nonopioids (e.g., acetaminophen-oxycodone). Morphine and codeine were coded as prescription opioids if the scene or other evidence indicated their presence as a result of consumption of prescription morphine or codeine, rather than as a result of metabolism of or impurities of heroin, respectively. Fentanyl was coded as a prescription opioid if the scene or other evidence indicated likely consumption of prescription fentanyl rather than illicitly manufactured fentanyl. Decedents might have tested positive for other nonopioid substances. This analysis does not distinguish between prescription drugs prescribed to the decedent and those that were diverted.

TABLE. Co-occurrence of substances and circumstances among overdose decedents with kratom detected on postmortem toxicology — State Unintentional Drug Overdose Reporting System, 27 states,* July 2016–December 2017

Characteristic/Circumstance	Kratom detected on toxicology (n = 152) No. (%)	Kratom determined to be a cause of death (n = 91) No. (%)
Sex		
Male	116 (76.3)	69 (75.8)
Female	36 (23.7)	22 (24.2)
Race		
White†	119 (91.5)	81 (93.1)
Nonwhite	11 (8.5)	—§
Medically supervised pain treatment		
No evidence	138 (90.8)	80 (87.9)
Evidence	14 (9.2)	11 (12.1)
Previous overdose reported		
None	139 (91.5)	81 (89.0)
One or more	13 (8.5)	10 (11.0)
History of substance misuse reported (opioid and/or nonopioid)		
No evidence	29 (19.1)	20 (22.0)
Evidence	123 (80.9)	71 (78.0)
Co-occurring substances listed as a cause of death¶,**		
Any fentanyl (including analogs)	99 (65.1)	51 (56.0)
Heroin††	50 (32.9)	23 (25.3)
Benzodiazepines	34 (22.4)	24 (26.4)
Prescription opioids§§	30 (19.7)	22 (24.2)
Cocaine	28 (18.4)	15 (16.5)
Alcohol	19 (12.5)	11 (12.1)
Methamphetamine	13 (8.6)	—

* Twenty-seven states reported data for the period July 2016–December 2017. Eleven states reported deaths that occurred during the entire period: Kentucky, Maine, Massachusetts, Missouri, New Hampshire, New Mexico, Ohio, Oklahoma, Rhode Island, West Virginia, and Wisconsin. Sixteen additional states only reported deaths that occurred during July–December 2017: Alaska, Connecticut, Delaware, Florida, Georgia, Illinois, Indiana, Minnesota, New Jersey, North Carolina, Pennsylvania, Tennessee, Utah, Vermont, Virginia, and Washington. Data were current as of January 22, 2019.

† Non-Hispanic. Race/ethnicity data were missing for 22 decedents.

§ Number of deaths was <10.

¶ Identified as a cause of death by a medical examiner or coroner.

** Multiple substances could be listed as a cause of death; therefore, the substances are not mutually exclusive.

†† Substances coded as heroin were heroin and 6-monoacetylmorphine. In addition, morphine and codeine were coded as heroin if the scene or other evidence indicated their presence as a result of consumption in conjunction with evidence of heroin use, injection, or illicit drug use, and no evidence of prescribed morphine or codeine.

§§ Substances coded as prescription opioids were oxycodone, oxymorphone, hydrocodone, hydromorphone, tramadol, buprenorphine, methadone, meperidine, tapentadol, dextrorphan, levorphanol, propoxyphene, pentazocine, and phenacetin. Also coded as prescription opioids were brand names (e.g., Opana), metabolites (e.g., nortramadol) for these substances, and these substances in combination with nonopioids (e.g., acetaminophen-oxycodone). Morphine and codeine were coded as prescription opioids if the scene or other evidence indicated their presence as a result of consumption of prescription morphine or codeine, rather than as a result of metabolism of or impurities of heroin, respectively. Fentanyl was coded as a prescription opioid if the scene or other evidence indicated likely consumption of prescription fentanyl rather than illicitly manufactured fentanyl. Decedents might have tested positive for other nonopioid substances. This analysis does not distinguish between prescription drugs prescribed to the decedent and those that were diverted.

Kratom-positive deaths accounted for <1% of all SUDORS overdose deaths during July 2016–December 2017. Identification of kratom is method-dependent (*5*); therefore, these data might underestimate the number of kratom-positive deaths, although the extent cannot be determined. However, because SUDORS records results of jurisdiction-specific postmortem toxicology testing, as well as overdose-specific circumstances, it is possible to ascertain that kratom was present primarily in deaths that occurred as a result of overdoses related to substance misuse and that kratom was most often detected in combination with multiple other substances.

The type and number of substances detected in kratom-involved deaths can inform overdose prevention strategies (*6*). Documentation of postmortem toxicology testing protocols is needed to further clarify the extent to which kratom contributes to fatal overdoses.

Acknowledgments

States participating in the State Unintentional Drug Overdose Reporting System and participating state agencies, including state health departments, vital registrar offices, and coroner and medical examiner offices; Bruce Goldberger, University of Florida College of Medicine, Gainesville, Florida.

Corresponding author: Emily O'Malley Olsen, eolsen@cdc.gov, 404-498-0716.

[1]Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control, CDC.

All authors have completed and submitted the ICMJE form for disclosure of potential conflicts of interest. No potential conflicts of interest were disclosed.

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IDAHO MEDICAL ASSOCIATION HOUSE OF DELEGATES

VIRTUAL MEETING – OCTOBER 9, 2020

RESOLUTION 104(20)

SUBJECT: NO SUBSTITUTIONS OF PRIMARY CARE PHYSICIANS BY INSURERS

AUTHOR: A. PATRICE BURGESS, MD

SPONSORED BY: IDAHO ACADEMY OF FAMILY PHYSICIANS

WHEREAS, The physician-patient relationship is pivotal for the best possible patient care and patient and physician satisfaction; and

WHEREAS, The physician-patient relationship is mutually agreed upon by the physician and the patient and can be terminated by either party; and

WHEREAS, The patient centered medical home is key to providing high quality care and avoiding excess costs with duplicate tests, etc.; and

WHEREAS, Continuity of care has been shown to reduce mortality and hospital admissions; and

WHEREAS, There have been instances where insurance companies have unilaterally reassigned patients to a different primary

ADOPTED AS AMENDED

care physician (PCP) without the patient's or the physician's consent or awareness; therefore, be it

RESOLVED, Idaho Medical Association oppose the practice of insurance companies changing a patient's primary care physician without the consent of the patient; and be it further

RESOLVED, Idaho Medical Association will communicate to the Idaho Department of Insurance and insurance companies doing business in Idaho this policy in opposition to insurers changing a patient's primary care physician without the consent of the patient and communication with the physician and the patient; and be it further

RESOLVED, Idaho Medical Association communicate with the American Medical Association to request they communicate at the national level similar opposition to insurers changing a patient's primary care physician without the consent of the patient and communication with the physician and the patient.

EXISTING IMA POLICY: NONE

ADOPTED AS AMENDED

IMA FISCAL NOTE: $

STATE OF IDAHO FISCAL NOTE: N/A

IMA RESOURCE ALLOCATION: LOW

DEGREE OF DIFFICULTY: LOW

ADOPTED AS AMENDED

IDAHO MEDICAL ASSOCIATION HOUSE OF DELEGATES

VIRTUAL MEETING – OCTOBER 9, 2020

RESOLUTION 105(20)

SUBJECT: RECOGNITION AND SUPPORT OF HEALTH EQUITY

AUTHOR: IMA BOARD OF TRUSTEES

SPONSORED BY: IMA BOARD OF TRUSTEES

WHEREAS, Health equity, at its most basic level, is defined as optimal health for all. The World Health Organization defines health equity as the "absence of unfair and avoidable or remediable differences in health among social groups." The American Medical Association has adopted policies and made a strong commitment to ensuring equal access to health care for people of every ethnicity and social class, and embedding health equity in every aspect of its work; and

WHEREAS, Racial and ethnic health disparities are a major public health problem in the United States and can be a barrier to effective medical diagnosis and treatment. These disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race; and

ADOPTED

WHEREAS, Physicians should examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment, and professional organizations should help increase awareness of racial disparities in medical treatment decisions by facilitating discussions about the issue; therefore be it

RESOLVED, Idaho Medical Association maintains a position of zero tolerance toward racially or culturally based disparities in care and supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons; and be it further

RESOLVED, Idaho Medical Association supports and adopts the American Medical Association policy on Health Equity, which is defined as optimal health for all, a goal we will work towards by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity; and be it further

RESOLVED, Idaho Medical Association will assess its Strategic Plan and incorporate aspects of health equity in the priorities, goals,

strategies, and tactics contained therein.

ADOPTED

EXISTING IMA POLICY: IMA adopts policy in support of high-quality healthcare provided with equity and respect for lesbian, gay, bisexual, and/or transgender patients. Further, IMA will oppose legislative and regulatory proposals related to healthcare services that discriminate against lesbian, gay, bisexual, and/or transgender individuals and will, when directed by IMA Board of Trustees, engage in lobbying activities on such proposals. (HOD 2019)

IMA FISCAL NOTE: $

STATE OF IDAHO FISCAL NOTE: N/A

IMA RESOURCE ALLOCATION: MODERATE

DEGREE OF DIFFICULTY: LOW

IDAHO MEDICAL ASSOCIATION HOUSE OF DELEGATES

VIRTUAL MEETING – OCTOBER 9, 2020

RESOLUTION 106(20)

SUBJECT: SUPPORT FOR SCIENCE AS BASIS FOR PUBLIC HEALTH DECISIONS

AUTHOR: IMA BOARD OF TRUSTEES

SPONSORED BY: IMA BOARD OF TRUSTEES

WHEREAS, Healthcare policy, access and delivery in the United States have become significantly politicized in the recent past. The rhetoric surrounding healthcare on the political stage is doing nothing to support the development of scientifically solid health policies and improving the health of Americans; and

WHEREAS, The COVID-19 pandemic has exacerbated this situation and created even more divisiveness in the United States over emerging new scientific information about the coronavirus and corresponding new recommendations to keep individuals safe and our economy open; and

WHEREAS, There are extremely complicated issues in healthcare policy that require serious focus and a solid process to ensure that public health and patient safety are top priorities. According to research published by Frontiers in Public Health Services

ADOPTED

and Systems Research at the University of Kentucky[i], there are key characteristics of evidence-based decision making:

- Making decisions based on the best available peer-reviewed evidence (both quantitative and qualitative research);
- Using data and information systems systematically;
- Applying program planning frameworks (that often have a foundation in behavioral science theory);
- Engaging the community in assessment and decision making;
- Conducting sound evaluation;
- Disseminating what is learned to key stakeholders and decision makers; and
- Synthesizing scientific skills, effective communication, common sense, and political acumen in making decisions; and

WHEREAS, The political atmosphere in our country and in Idaho is becoming ever more polarized and angry, less conducive to bipartisan discussion and compromise, and there is decreasing consideration of evidence-based decision making when it comes to forming public health policy; therefore be it

ADOPTED

RESOLVED, Idaho Medical Association strongly supports the use of scientific, evidence-based decision making for developing healthcare policies that impact our public health systems, healthcare providers, schools and universities, businesses, our economy, and our citizens; and be it further

RESOLVED, Idaho Medical Association urge policy makers and elected officials to seek consultation and work closely with local physicians and other medical experts in creating public policies and guidelines that impact the health and safety of our citizens.

EXISTING IMA POLICY: NONE

IMA FISCAL NOTE: $

STATE OF IDAHO FISCAL NOTE: N/A

IMA RESOURCE ALLOCATION: LOW

DEGREE OF DIFFICULTY: MODERATE

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[i] **Brownson RC, Fielding JE, Maylahn CM. Evidence-based Decision Making to Improve Public Health Practice. Front Public Health Serv Syst Res 2013; 2(2). DOI: 10.13023/FPHSSR.0202.02**

IDAHO MEDICAL ASSOCIATION HOUSE OF DELEGATES

VIRTUAL MEETING – OCTOBER 9, 2020

RESOLUTION 107(20)

SUBJECT: HONORING CHRISTINE HAHN, MD, FOR HER TIRELESS DEDICATION TO THE PUBLIC HEALTH AND SAFETY OF IDAHO CITIZENS

AUTHOR: ZACHARY WARNOCK, MD

SPONSORED BY: SOUTHEASTERN IDAHO DISTRICT MEDICAL SOCIETY

WHEREAS, Christine Hahn, MD, is the State Epidemiologist for Idaho, as well as the Medical Director for the Idaho Department of Health and Welfare Division of Public Health. She has worked in public health in Idaho for nearly 25 years and is known statewide for her common-sense approach to very challenging situations; and

WHEREAS, Dr. Hahn has worked side-by-side with Idaho Governor Brad Little and other state leaders to develop policy to lead the state through the pandemic caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), which causes the coronavirus disease COVID-19. Dr. Hahn is dedicated to maintaining focus on science and data rather than politics, emotion, or distorted evidence; and

ADOPTED

WHEREAS, Members of the Idaho Medical Association are profoundly grateful for the dedication and wisdom Dr. Hahn has shown every day throughout the COVID-19 pandemic. Idaho physicians rest easier knowing that Governor Little has an advisor of Dr. Hahn's caliber; and

WHEREAS, Dr. Hahn has always been a strong IMA partner and frequently works in tandem with IMA leadership to communicate with Idaho physicians and to advise or assist the IMA with policy development on issues of epidemiology or other public health concerns; and

WHEREAS, Dr. Hahn attended medical school at Michigan State University and completed her residency in internal medicine at the Mayo Clinic's Graduate School of Medicine. She then completed a fellowship in infectious diseases at Duke University Medical Center. After a two-year training program as an Epidemic Intelligence Service Officer with the Centers for Disease Control and Prevention (CDC), she accepted the position of Idaho State Epidemiologist; and

WHEREAS, Dr. Hahn has or currently serves on many committees, boards, programs and panels at the local, state and national level, including (to name just a few) the Idaho Refugee

Health Screening Program, the CDC's Advisory Committee for the Elimination of Tuberculosis, the Council of State and Territorial Epidemiologists, the CDC's Advisory Committee on Immunization Practices, infection prevention committees at Saint Alphonsus and St. Luke's Regional Medical Centers in Boise, and the Board of Idaho's Immunization Policy Commission; therefore be it

RESOLVED, That Idaho Medical Association recognize and sincerely honor the significant achievements of Christine Hahn, MD, in her role as Idaho State Epidemiologist and Medical Director of the Division of Public Health and extend to her the appreciation and gratitude of Idaho Medical Association members and staff for her years of dedication and service to Idaho's medical community and to the state of Idaho and its citizens.

EXISTING IMA POLICY: N/A

IMA FISCAL NOTE: $

STATE OF IDAHO FISCAL NOTE: N/A

IMA RESOURCE ALLOCATION: LOW

DEGREE OF DIFFICULTY: LOW

ADOPTED

IDAHO MEDICAL ASSOCIATION HOUSE OF DELEGATES

VIRTUAL MEETING – OCTOBER 9, 2020

RESOLUTION 108(20)

SUBJECT: HONORING NEVA SANTOS FOR HER DECADES OF SERVICE TO IDAHO'S MEDICAL COMMUNITY

AUTHOR: MARY BARINAGA, MD

SPONSORED BY: MARY BARINAGA, MD

WHEREAS, Neva Santos, former Executive Director of the Idaho Academy of Family Physicians (IAFP), retired in June 2020 after a distinguished 22-year career with the organization; and

WHEREAS, Neva is a believer in collaboration and has participated in countless task forces, work groups and coalitions addressing a wide range of healthcare issues, from the patient-centered medical home to Medicaid expansion. She has earned respect within the healthcare community both in Idaho and on a national level for her zealous advocacy for and dedication to family physicians and the importance of their role as gatekeepers to the public's health; and

WHEREAS, Under Neva's leadership, the IAFP had three national American Academy of Family Physicians (AAFP) Physicians' of the Year and one President and Board Chair of the AAFP.

ADOPTED

This is quite an achievement for a state the size of Idaho; and

WHEREAS, Under Neva's leadership, the IAFP has had a very successful track record on legislative initiatives, statewide campaigns and policy issues, and has become the voice of family physicians in Idaho; and

WHEREAS, Neva and her husband, Tim, live in Eagle and are looking forward to a retirement that will include more time with family and friends at their cabin in Cascade, and more recreational activities and travel; therefore be it

RESOLVED, That Idaho Medical Association recognize and sincerely honor the career achievements of Neva Santos during her tenure at the Idaho Academy of Family Physicians. IMA extends to her the appreciation and gratitude of our members and staff for her years of dedication and service to Idaho's family medicine physicians and the Idaho medical community as a whole.

EXISTING IMA POLICY: N/A

IMA FISCAL NOTE: $

STATE OF IDAHO FISCAL NOTE: N/A

ADOPTED

1 IMA RESOURCE ALLOCATION: LOW

2 DEGREE OF DIFFICULTY: LOW