162nd HOUSE OF DELEGATES

October 15-16, 2016

HYATT REGENCY SAVANNAH
SAVANNAH, GEORGIA
MAG Delegates and Alternate Delegates:

Please review the following information to prepare for the Medical Association of Georgia’s (MAG) House of Delegates (HOD) meeting that will take place at the Hyatt Regency Savannah on October 15-16.

You should contact your county medical society to see if it has already reserved a room for you at the Hyatt Regency Savannah since MAG’s block of rooms at the Hyatt is sold out. MAG meeting attendees who would like to be placed on a waiting list for a room at the Hyatt or need any other assistance with HOD lodging should contact Anita Amin at aamin@mag.org.

We encourage you to visit www.mag.org/HOD for the latest information on this year’s HOD meeting. This web page includes the meeting schedule, staff contacts, deadlines, and reports and resolutions. You can also get this information by downloading MAG’s new HOD meeting app by searching for ‘MAG HOD 2016’ in Apple iTunes or Google Play. Please contact Dayna Jackson at 678.303.9262 or djackson@mag.org with any questions related to the HOD meeting.

Sincerely,

Frank McDonald Jr., M.D.
Speaker of the House

Edmund R. Donoghue Jr., M.D.
Vice Speaker of the House
Handbook

The HOD handbook will be emailed to delegates and alternate delegates as a PDF. The handbook also will be posted at www.mag.org/HOD. Amendments to the handbook will be posted on this web page and emailed to delegates and alternate delegates on a regular basis.

Registration Desk

The HOD meeting registration desk will be located just outside of the Hyatt’s Regency Ballroom at the top of the lobby escalator. A temporary registration desk will also be set up in the Hyatt Regency lobby from 2 p.m. to 7 p.m. on Friday, October 14. The permanent registration desk will open at 6:30 a.m. on Saturday, October 15 and at 6:30 a.m. on Sunday, October 16. Please note that any delegate substitutions can only be made by the applicable society president or executive director at the registration desk.

Wireless Internet

Delegates can obtain free internet access by selecting the “Hyatt Meeting” network and using the password “HOD2016.”

Meeting Schedule

The HOD will convene in the Regency Ballroom at 8:30 a.m. sharp on Saturday, October 15. The opening session is scheduled to conclude by 10 a.m. The second session of the HOD will begin at 8:30 a.m. on Sunday, October 16.

Although subject to change, the reference committees are scheduled to convene at 10:30 a.m. on Saturday, October 15 as follows...

Reference Committee A – Health Care Policy
Reference Committee C – Legislation
Reference Committee F – Finance and Administration
Reference Committee S – Prescription Drug Abuse

The HOD will adjourn once its business is complete on Sunday, October 16.

Elections

Delegates who wish to nominate a MAG member for an elected office will have one minute to make a nominating speech during Saturday’s opening session. In the event that there is just one candidate nominated for an office, the election for that office will be uncontested and no second will be necessary. The nomination process will take place on Saturday, October 15. The election of officers for any contested races would then take place on Sunday, October 16.

The elections will be conducted under the supervision of the chief teller, the assistant election tellers, and the Constitution and Bylaws Committee. For contested elections, voting will take place using an electronic audience response system. For any runoff elections,
electronic handheld devices or paper ballots will only be distributed to the delegates who are seated in the House. Only duly credentialed delegates are permitted to cast a ballot. Alternate delegates who are seated for delegates must report to the registration desk to be properly credentialed and to receive a delegate’s ribbon. Alternate delegates may not vote on any matter unless they are properly credentialed as a delegate. Delegate substitutions can only be made by the applicable society president or executive director at the registration desk.

President’s Installation and Awards Reception & Dinner

The ceremony to install Steve M. Walsh, M.D., as MAG’s president for 2016-2017 will take place in the Scarborough Ballroom at 6 p.m. on Saturday, October 15. A reception will take place in the Harborside Ballroom Pre-Function area at 7 p.m., while the awards dinner will take place in the Harborside Ballroom beginning at 7:30 p.m. The cost to purchase tickets for the reception and dinner in advance is $75, which includes two drink coupons. Additional drinks may be purchased on a cash basis. Dinner tickets can be obtained by completing the online registration form, which should be done by Thursday, October 1. A limited number of dinner tickets will be available at the HOD registration desk for $125 per person.

Policy Compendium

The latest draft of the policy compendium is available on the new MAG HOD app and at www.mag.org/HOD. The final version of the policy compendium will be included with the handbook that will be emailed to delegates and posted on www.mag.org/HOD. The policy compendium will be updated after the meeting to account for any actions that are taken by the HOD.

Dress Code

The dress code for the meeting is business casual. The individuals who are seated on a reference committee or on the dais are asked to wear business professional attire (e.g., coat and tie for men). The dress code for the president’s installation ceremony and the awards dinner is black tie or business professional.

GAMPAC

GAMPAC will kick off its 2017 membership drive during the HOD meeting. GAMPAC is MAG’s non-partisan political action committee that elects pro-medicine candidates at the state level. GAMPAC membership levels include the Chairman’s Circle at $2,500, the Capitol Club at $1,000, GAMPAC membership at $250, and GAMPAC contributor at $95. GAMPAC members who are at the $250 level or higher are invited to attend an exclusive lunch that will take place in the Harborside Ballroom at 12:30 p.m. on Sunday, October 16. The lunch is free for GAMPAC members. You must be a GAMPAC member at the $250 level or higher to attend this lunch. The GAMPAC lunch will feature a unique health care panel discussion that will feature four congressional leaders, including Reps. Tom Price, M.D., and Buddy Carter from Georgia and Michael Burgess, M.D., and Phil Roe, M.D., from Texas and Tennessee. Contact Bethany Sherrer at 678.303.9273 or bsherrer@mag.org for additional information.
**MAG Mutual Insurance Company Lunch**

MAG Mutual Insurance Company is encouraging all delegates and alternate delegates to attend a complimentary lunch that it will host in the Harborside Ballroom at 12 p.m. on Saturday, October 15. The keynote speaker will be Alan Lembitz, M.D., who is COPIC’s chief medical officer. He will give a talk on “The Journey from Risk Management to Patient Safety.” Our sincere thanks to MagMutual for its ongoing support.

**MAG Foundation**

MAG HOD delegates and alternate delegates are encouraged to support the MAG Foundation’s "Think About It' campaign to reduce prescription drug abuse in the state and/or the Georgia Physicians Leadership Academy. The MAG Foundation's donor levels include the "1849 Club" ($100-$1,000), the "Leadership Society" ($2,500-$10,000), and the "Vanguard Society" ($25,000-$100,000). Contact Lori Cassity Murphy at 678.303.9282 or lmurphy@mag.org for additional information. Also go to http://www.themagfoundation.org/donate/ to make a donation.

Please note that the MAG Foundation will be conducting a special fundraising contest at this year's HOD meeting. Delegates are encouraged to visit the MAG Foundation exhibit on the mezzanine-level of the Hyatt to make a donation to the GPLA to honor outgoing, long-time GPLA Steering Committee Chair William Clark, M.D., for his dedication and service. Donors will automatically qualify for a raffle contest for a chance to win a weekend at The King & Prince Resort on St. Simons Island. There will also be a friendly, Olympics-themed contest to see which GPLA class can raise the most money for the GPLA during this year's HOD meeting.

**International Medical Graduate Section**

MAG’s International Medical Graduates (IMG) section will meet in the Vernon Room from 4 p.m. to 4:30 p.m. on Saturday, October 15. Contact Dayna Jackson at djackson@mag.org for more information.

**Resident Physician Section**

MAG’s Resident Physician Section (RPS) section will meet in the Scarbrough 1 Room from 9 p.m. to 10:00 p.m. on Friday, October 14. Contact Dayna Jackson at djackson@mag.org for more information.

**Medical Student Section**

MAG’s Medical Student Section (MSS) will meet in the Percival Room from 4:30 p.m. to 5 p.m. on Saturday, October 15. Contact Dayna Jackson at djackson@mag.org for more information.

This year’s HOD meeting will feature a MAG member medical student abstract competition. We encourage you to visit this exhibit, which will be set up in the hotel lobby. Click here for more details.
County Medical Society Caucuses

The county medical society caucuses will begin at 6:30 a.m. on Sunday, October 16. Download MAG’s new app or go to www.mag.org/HOD for additional information on the society caucus breakfast meetings.

AMA Delegation Caucus

The AMA Georgia Delegation caucus will begin at 6:30 a.m. on Sunday, October 16. Download MAG’s new app or go to www.mag.org/HOD for additional information on the breakfast caucus.

Special Events

Golf

There will not be a formal golf tournament in 2016 because MAG’s Board of Directors meeting has been moved to the afternoon of Friday, October 14. HOD attendees who have an interest in playing golf on the morning of Friday, October 14 can contact William Silver, M.D., at wesilver@aol.com.

MAG Past Presidents’ Dinner

The MAG Past Presidents’ Reception and Dinner will be held on Friday, October 14. It will take place from 7 p.m. to 9 p.m. at 45 Bistro, which is located at 123 East Broughton Street in Savannah. This is an invitation-only, black tie affair.

Friday Night Welcome Cocktail Reception

There will be a cocktail reception for all HOD attendees and their families and guests on the Garden Terrace on the fourth floor of the Hyatt Regency from 6 p.m. to 7:30 p.m. on Friday, October 14. Please be sure to get your registration packet at the registration desk prior to this reception as your drink tickets will be included in the packet.

Georgia Physicians Leadership Academy Dinner

The Georgia Physicians Leadership Academy (GPLA) Steering Committee is inviting GPLA scholars, alumni and spouses to attend a reception and dinner at the Windows restaurant at the Hyatt Regency from 6:30 p.m. to 9:30 p.m. on Friday, October 14.

Exhibitors and Grand Prize Drawing

Exhibitions will be set up on the North Mezzanine, which is adjacent to the HOD meeting room. MAG and MAG Mutual Insurance Company will conduct a special contest for delegates. Each delegate’s registration packet will contain a gold-colored ticket, and delegates who have every exhibitor punch that ticket will qualify for a chance to win the grand prize – which is a $500 American Express gift card. Delegates must be present for the drawing at the end of the meeting on Sunday to qualify.
Airport

Savannah-Hilton Head International Airport
http://savannahairport.com

Hyatt Regency Savannah

2 W. Bay Street
Savannah, Georgia 31401
912.238.1234

Parking

The Hyatt Regency Savannah offers valet parking for $19 per day for standard cars and oversize vehicles/vans that are less than 7.5 feet tall. This includes unlimited in/out privileges. Self-parking is available in the Whitaker Street Garage – which is across the street and less than a block away – for $16 per night. In/out privileges do not apply.
<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Room</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Friday, October 14, 2016</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8:00 a.m. - 5:00 p.m.</td>
<td>MAG Student Room</td>
<td>Percival</td>
</tr>
<tr>
<td>8:00 a.m. - 11:30 a.m.</td>
<td>MAG Foundation Breakfast &amp; Meeting</td>
<td>Scarbrough 1-2</td>
</tr>
<tr>
<td>12:00 p.m. - 4:00 p.m.</td>
<td>MAG Board of Directors Meeting &amp; Working Lunch</td>
<td>Regency Ballroom</td>
</tr>
<tr>
<td>4:00 p.m. - 5:30 p.m.</td>
<td>GAMPAC BOD Meeting</td>
<td>Verelst</td>
</tr>
<tr>
<td>4:00 p.m. - 9:00 p.m.</td>
<td>Exhibitor Set-up</td>
<td>Mezzanine</td>
</tr>
<tr>
<td>4:00 p.m. - 7:00 p.m.</td>
<td>HOD Registration</td>
<td>Hotel Lobby</td>
</tr>
<tr>
<td>6:30 p.m. - 9:30 p.m.</td>
<td>GPLA Reception &amp; Dinner</td>
<td>Windows</td>
</tr>
<tr>
<td>6:00 p.m. - 7:30 p.m.</td>
<td>MAG Welcome Reception</td>
<td>Garden Terrace</td>
</tr>
<tr>
<td>7:00 p.m. - 9:00 p.m.</td>
<td>Past Presidents' Reception &amp; Dinner</td>
<td>45 Bistro</td>
</tr>
<tr>
<td>9:00 p.m. - 10:00 p.m.</td>
<td>Resident Physician Section Meeting</td>
<td>Scarbrough 1</td>
</tr>
<tr>
<td><strong>Saturday, October 15, 2016</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6:30 a.m. - 3:00 p.m.</td>
<td>Registration</td>
<td>Registration Booth</td>
</tr>
<tr>
<td>6:30 a.m. - 8:00 a.m.</td>
<td>HOD Breakfast</td>
<td>Mezzanine</td>
</tr>
<tr>
<td>6:30 a.m. - 1:00 p.m.</td>
<td>Exhibits</td>
<td>Mezzanine</td>
</tr>
<tr>
<td>7:00 a.m. - 8:00 a.m.</td>
<td>CME Session (sponsored by Medical College of Georgia)</td>
<td>Regency Ballroom</td>
</tr>
<tr>
<td>8:30 a.m. - 10:00 a.m.</td>
<td>House of Delegates (First Session)</td>
<td>Regency Ballroom</td>
</tr>
<tr>
<td>8:00 a.m. - 5:00 p.m.</td>
<td>MAG Student Room</td>
<td>Percival</td>
</tr>
<tr>
<td>8:00 a.m. - 5:00 p.m.</td>
<td>MAG Resident Room</td>
<td>Plimsoll</td>
</tr>
<tr>
<td>10:00 a.m. - 10:10 a.m.</td>
<td>HOD Picture</td>
<td>Hotel Lobby</td>
</tr>
<tr>
<td>10:30 a.m. - 12:30 p.m.</td>
<td>Reference Committee A</td>
<td>Scarbrough 3</td>
</tr>
<tr>
<td>10:30 a.m. - 12:30 p.m.</td>
<td>Reference Committee C</td>
<td>Scarbrough 4</td>
</tr>
<tr>
<td>10:30 a.m. - 12:30 p.m.</td>
<td>Reference Committee F</td>
<td>Verelst</td>
</tr>
<tr>
<td>10:30 a.m. - 12:30 p.m.</td>
<td>Reference Committee S</td>
<td>Regency Ballroom</td>
</tr>
<tr>
<td>12:30 p.m. - 1:45 p.m.</td>
<td>MAG Mutual - Delegates’ Luncheon</td>
<td>Harborside Center</td>
</tr>
<tr>
<td>12:00 p.m. - 2:30 p.m.</td>
<td>Student/Resident Poster Display</td>
<td>Hotel Lobby</td>
</tr>
<tr>
<td>2:00 p.m. - 4:00 p.m.</td>
<td>Reference Committee A, cont.</td>
<td>Scarbrough Three</td>
</tr>
<tr>
<td>2:00 p.m. - 4:00 p.m.</td>
<td>Reference Committee C, cont.</td>
<td>Scarbrough Four</td>
</tr>
<tr>
<td>2:00 p.m. - 4:00 p.m.</td>
<td>Reference Committee F, cont.</td>
<td>Verelst</td>
</tr>
<tr>
<td>2:00 p.m. - 4:00 p.m.</td>
<td>Reference Committee S, cont.</td>
<td>Regency Ballroom</td>
</tr>
<tr>
<td>4:00 p.m. - 4:30 p.m.</td>
<td>IMG Section Meeting</td>
<td>Vernon</td>
</tr>
<tr>
<td>4:30 p.m. - 5:00 p.m.</td>
<td>Medical Student Section Meeting</td>
<td>Percival</td>
</tr>
<tr>
<td>5:30 p.m. - 5:45 p.m.</td>
<td>Photography – New President’s Photos</td>
<td>Hotel Lobby</td>
</tr>
<tr>
<td>5:30 p.m. - 7:30 p.m.</td>
<td>Student/Resident Poster Display, cont.</td>
<td>Scarbrough 1-2</td>
</tr>
<tr>
<td>6:00 p.m. - 7:00 p.m.</td>
<td>Officer Installation</td>
<td>Harborside Center</td>
</tr>
<tr>
<td>7:00 p.m.- 7:30 p.m.</td>
<td>MAG Reception</td>
<td>Harborside Center</td>
</tr>
<tr>
<td>7:30 p.m.- 9:30 p.m.</td>
<td>MAG Awards Dinner</td>
<td>Harborside Center</td>
</tr>
<tr>
<td><strong>Sunday, October 16, 2016</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>Event</td>
<td>Location</td>
</tr>
<tr>
<td>--------------</td>
<td>---------------------------------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>6:30 a.m.</td>
<td>Distribution of Reference Committee Copies</td>
<td>Registration Booth</td>
</tr>
<tr>
<td>6:30 a.m. - 1:00 p.m.</td>
<td>Registration</td>
<td>Registration Booth</td>
</tr>
<tr>
<td>6:30 a.m. - 8:00 a.m.</td>
<td>Component Society Caucus Breakfasts</td>
<td>Vernon Room</td>
</tr>
<tr>
<td>6:30 a.m. - 8:00 a.m.</td>
<td>AMA Delegation Caucus</td>
<td>Vernon Room</td>
</tr>
<tr>
<td>6:30 a.m. - 8:00 a.m.</td>
<td>Cobb CMS Breakfast</td>
<td>Scarbrough 4</td>
</tr>
<tr>
<td>6:30 a.m. - 8:00 a.m.</td>
<td>DeKalb, Gwinnett-Forsyth, Hall CMS &amp; GA-ACC</td>
<td>Scarbrough 2</td>
</tr>
<tr>
<td>6:30 a.m. - 8:00 a.m.</td>
<td>MAA</td>
<td>Scarbrough 1</td>
</tr>
<tr>
<td>6:30 a.m. - 8:00 a.m.</td>
<td>Richmond CMS Breakfast</td>
<td>Scarbrough 3</td>
</tr>
<tr>
<td>6:30 a.m. - 8:00 a.m.</td>
<td>HOD Breakfast (non-caucus)</td>
<td>Mezzanine</td>
</tr>
<tr>
<td>6:30 a.m. - 1:00 p.m.</td>
<td>Exhibits</td>
<td>Mezzanine North</td>
</tr>
<tr>
<td>7:00 a.m. - 8:00 a.m.</td>
<td>Bibb, Muscogee &amp; Georgia CMS</td>
<td>Windows</td>
</tr>
<tr>
<td>8:30 a.m. - 12:15 p.m.</td>
<td>House of Delegates (Second Session)</td>
<td>Regency Ballroom</td>
</tr>
<tr>
<td>12:30 p.m. - 1:30 p.m.</td>
<td>GAMPAC Lunch</td>
<td>Harborside Center</td>
</tr>
<tr>
<td>2:00 p.m. - 5:00 p.m.</td>
<td>House of Delegates – 2nd Session Cont. if needed</td>
<td>Regency Ballroom</td>
</tr>
<tr>
<td>2:00 p.m. - 5:00 p.m.</td>
<td>BOD Organizational Meeting</td>
<td>Regency Ballroom</td>
</tr>
</tbody>
</table>
MAG HOUSE OF DELEGATES CAMPAIGN MATERIALS GUIDELINES

1. No campaign literature or communications (e.g., letters, information sheets, brochures) shall be distributed by any method unless it:
   a. Clearly delineates which candidate the communication is promoting;
   b. What position that candidate is running for; and
   c. Is signed or endorsed by the candidate that the communication is promoting.

2. Only with the approval of MAG’s Executive Director will it be permissible for candidate-signed or candidate-approved materials (in accordance with paragraph 1 above) to be placed at delegate seats prior to any session or meeting of the House.

3. Under the direction of MAG’s Executive Director, any materials not in compliance with paragraph 1 and/or 2 above will be removed by MAG staff.

4. Any disputes or violations will be handled by the Credentials Committee.

Frank McDonald, M.D.
Speaker of the House of Delegates

Edmund Donoghue, M.D.
Vice Speaker of the House of Delegates
PROCEDURES OF
THE HOUSE OF DELEGATES FOR DELEGATES TO THE
MEDICAL ASSOCIATION OF GEORGIA

INTRODUCTION

The Medical Association of Georgia House of Delegates is the legislative body of our Association responsible for setting its policies. With the exception of the time during the War Between the States, our House of Delegates has met every year since 1849.

The House is a democratic institution. All county component medical societies in Georgia are entitled to representation in our House. Small societies (5 to 49 members) are entitled to one delegate. Larger societies (50 members or more) are entitled to one Delegate for every 25 active members. Additional delegates represent our several House Sections and Specialty Societies, so that our House consists of over two hundred voting delegates.

The House has two main functions: (1) to elect the Association’s officers for the coming year; and (2) to debate and vote on the various resolutions, reports and recommendations submitted to it. MAG officers, MAG committees, county societies (either through their officers or their Delegates to the MAG House), and specialties may submit resolutions, reports and recommendations.

Each year, the House of Delegates considers some 50 to 60 items of business. To expedite matters, each resolution or recommendation is assigned by the House Speaker to a REFERENCE COMMITTEE, composed of six to ten delegates. During the House, Reference Committees hold hearings so that any member of MAG (delegate or not) may express his or her opinion on the resolutions and recommendations. After testimony is heard, each Reference Committee evaluates all the opinions given, and drafts a report to the House recommending courses of action on the resolutions and recommendations. In so doing, the House sets MAG’s policy. Therefore, our House of Delegates meeting consists of a mix of representative democracy (through county and specialty society delegates) and direct democracy (through individual member’s right to speak at Reference Committees). As with all democratic bodies, our House depends on the individual’s expression of opinion.

The MAG House of Delegates exists to give you a means to express your ideas and an opportunity to implement those ideas into action by creating policy regarding the practice of medicine in our state.
ABOUT OUR PROCEDURES

Tradition governs a substantial portion of each formal session of the House of Delegates. Addresses by the President and President – Elect, remarks by the Speaker, recognition of distinguished guests, presentation and acceptance of awards, installation of officers, and the like, are done in this way. It is the prerogative of the Speaker to permit many of these niceties as he/she may feel to be appropriate without unduly intruding upon the time necessary for the House to accomplish its assigned business. In general, such items are scheduled in advance and are published in the Order of Business. Unscheduled presentations may be arranged, either with the Speaker, or by a request to hear them by unanimous consent of the House.

The House of Delegates of the Medical Association of Georgia transacts its business according to the American Institute of Parliamentarians Standard Code of Parliamentary Procedure by the American Institute of Parliamentarians. Parliamentary procedure serves to aid the House in the orderly, expeditious and equitable accomplishment of its desires. The majority opinion of the House, in determining what it wants to do and how it wants to do it, should always remain the ultimate determinant, yet the right of the minority must never be overlooked. It is the obligation of the Speaker to sense this will of the House to preside accordingly, and to hold his/her rulings ever subject to challenge from and reversal by the House.

INTRODUCTION OF BUSINESS

Business resolutions are brought by voting delegates, county societies, specialty societies or five active MAG members, and by recommendations from MAG Officers and Committee Chairman as part of their annual reports.

The essential element of a resolution is expressed in one or more “RESOLVE” clauses setting forth the author’s specific intent for action. The resolution may carry (a) prefatory statement(s) explaining the rationale of the resolution. These are usually written as a series of “WHEREAS” statements that appear before the “RESOLVE” clauses. There may also be included appendices of materials, which attempt to contribute to the understanding of the topic of the resolution.

In adopting a resolution, the House of Delegates formally adopts only the “RESOLVE” section(s) of the resolution. Consequently, the author’s specific intent for action must be stated fully and completely in the “RESOLVE” clauses(s). To say it another way, the “RESOLVE” clause(s) must be able to convey all concepts for action or policy when read alone. It is unnecessary to amend the language of the “WHEREAS” portions of a resolution since the House will only act on the “RESOLVE” portions as the official item of business. The ultimate question before the House is how to dispose of a specific “RESOLVE”.
REFERENCE COMMITTEE HEARINGS

Except under special circumstances, all resolutions and reports containing recommendations are referred to a Reference Committee so that hearings may be on their contents.

Reference Committees are groups of six to ten delegates selected by the Speaker to conduct open hearings on matters of business before the House. The items are usually divided up into groups containing similar topics. For instance, one Reference Committee may hear resolutions and recommendations pertaining to Legislative issues, another will hear resolutions and recommendations pertaining to Public Health issues and so forth. Having heard discussion on the resolutions and recommendations before it, the Reference Committee compiles a report with recommendations to the House for the disposition of its items of business.

Reference Committee hearings are open to all members of the Association and invited guests. Any member of the Association is encouraged to speak on the resolution or recommendation under consideration. Other non-members, upon recognition by the chairman, may also be permitted to speak.

Fair hearings are the responsibility of the Reference Committee Chairman. The committee may establish its own rules on the presentation of testimony with respect to the order of testimony, the order of consideration, limitation of time, repetitive statements, recesses, and the like. Following the open hearing, a Reference Committee will go into Executive Session for deliberation and preparation of its report. It may call into Executive Session anyone whom it may wish to hear from or question further. The Reference Committee submits a unanimous report to the House of Delegates recommending a disposition for each of the items of business assigned to it. Minority reports from a Reference Committee may be issued in circumstances where the Reference Committee cannot come to consensus on the disposition of an item of business.

REFERENCE COMMITTEE REPORTS

Reference Committee reports comprise the bulk of the official business of the House of Delegates.

Reference Committees have wide latitude in their efforts to facilitate expression of the will of the House on matters before them and give credence to the testimony they hear. They may amend resolutions, consolidate similar resolutions by constructing substitutes, and recommend the parliamentary procedure for disposition of the business before them, such as acceptance, rejection, amendment, referral, and the like for specific item of business.
Specifically, the Reference Committee may make the following recommendations to the House of Delegates:

a) adoption;

b) adoption as amended, with amendments drafted and submitted by the Reference Committee;

c) adoption by substitution, with a substitute resolution drafted and submitted by the Reference Committee;

d) not for adoption;

e) to be filed;

f) referral to Board of Directors/Executive Committee or other Committee

Reference Committee reports will be made available to Reference Committee members and delegates as soon as they are completed. The first reports should be available at the MAG Registration desk on the day of the second MAG House Session.

NOTE: During the reading of Reference Committee reports, the Speaker of the House urges delegates to refer to their Handbooks, following the specific resolution or recommendation under discussion. Reference Committee Report recommendations are just that, recommendations only, and do not become MAG policy until acted on by the House of Delegates. A Reference Committee recommendation is to be considered the main motion before the House and must be dealt with as such.

PARLIAMENTARY PROCEDURE ON THE HOUSE

It is imperative in an assembly of over 200 Delegates that each individual speaking to an issue be recognized by the Speaker, be at a microphone, and be properly identified for the information of those who transcribe the proceedings. In the absence of specific provisions to the contrary in the Bylaws of the Association or in this manual of “Procedures of the House of Delegates,” the House shall be governed by the American Institute of Parliamentarians Standard Code of Parliamentary Procedure by the American Institute of Parliamentarians. The following is based upon the aforementioned text.
CLASSIFICATION OF MOTIONS

Business is brought before the House, and acted upon, by the motions of Delegates. A motion is the formal statement of a proposal or question to the House for consideration and action.

Motions are classified into five groups: A) main motions; B) specific main motions; C) subsidiary motions; D) privileged motions; and E) incidental motions.

MAIN MOTIONS

Main motions are the most important and most frequently used. Their purpose is to bring substantive proposals before the House for consideration and action.

A main motion (or “question”) is presented for discussion by the following steps:

1. The Delegate rises and addresses the Speaker;
2. The Delegates is recognized by the Speaker;
3. The Delegates identifies himself/herself and their local society. The delegate then indicates if they are speaking on behalf of their society or as an individual, and identifies any potential conflict of interest he/she may have on the issues at hand.
4. The delegate proposes (“makes”) his/her motion;
5. Another Delegate seconds it;
6. The Speaker states the motion to the House.

Once a main motion has been brought before the House through the steps above, it is usually considered in the following way:

7. Delegates debate the motion;
8. The Speaker puts the question to a vote;
9. The Speaker announces the result of the vote.
SPECIFIC MAIN MOTIONS

Restorative Main Motions do not present a new proposal but concern actions that were previously taken. The five main motions have specific names:

a) Amend a Previous Action - to amend a main motion that was approved previously.

b) Adopt in-lieu-of – to introduce a main motion with the intent that its adoption will also dispose of one or more other main motions that are known to be coming before the assembly.

c) Ratify - to confirm and thereby validate an action that was taken in an emergency, or where a quorum was not present.

d) Recall from Committee – to enable an assembly to remove a motion or subject from a committee or board and present it before the assembly for consideration.

e) Reconsider – to enable the House to a set aside an earlier vote on a main motion, and to consider it again as though no vote had been taken on it.

f) Rescind – to repeal or nullify a main motion previously passed.

SUBSIDIARY MOTIONS

Subsidiary motions alter the main motion, or delay or hasten its consideration. They are:

a) Table – used to set aside a pending main motion, which can be taken up for further consideration at any time during the same meeting.

b) Close Debate – used to close discussion on the pending question or questions and to the pending question or questions them to an immediate vote.

c) Limit or Extend Debate – used to determine the time that will be devoted to the discussion of a pending motion or the time each speaker may discuss the motion or remove limitations already imposed on to its discussion.

d) Postpone to a Certain Time – used to delay further consideration of a pending main motion and to fix a definite time for its consideration.
e) Refer to Committee – used to transfer to another body of the organization (such as a committee, council, task force, or Board of Directors) the opportunity and responsibility of studying the proposal and reporting back to the House with recommendations. It can also be to conserve the time of the House by delegating the duty of deciding a proposal and sometimes of carrying out the decision to a smaller group.

f) Amend – used to change a motion that is being considered by the House so that it expresses, as closely as possible, exactly the will of the members.

**PRIVILEGED MOTIONS**

Privileged motions have no direct connection with the main motion before the House. They are motions of such urgency that they are entitled to immediate consideration. They relate to the members and to the organization rather than to particular items of business. Privilege motions would be main motions but for their urgency. Because of their urgency, they are given the privilege of being considered ahead of other motions that are before the House. Therefore, the following are privileged motions:

a) Adjourn – when no other motion is pending, the motion to adjourn is a main motion and is open to discussion and amendment. When a main motion is pending, however, the motion to adjourn becomes a privileged motion and outranks all other motions. If adopted, the privileged motion to adjourn requires that adjournment take place immediately. The privilege motion to adjourn cannot be debated but may be amended to establish the time when the interrupted meeting may continue.

b) Recess – used to provide an interlude in meeting. The length of the recess or the establishment of a definite time for resuming deliberations should be set.

c) Question of Privilege - to enable a member to secure immediate decision and action by the presiding officer on a request that concerns the comfort, convenience, rights or privileges of the assembly or of the member, or permission to present a motion of an urgent nature, even though other business is pending.
INCIDENTAL MOTIONS

Incidental Motions arise incidentally out of the business before the House. They do not relate directly to the main motion, but usually relate to matters incidental to the conduct of the meetings. Incidental motions may be offered whenever they are needed, and have no order of preference. Because of their very nature they may interrupt business and in some cases may interrupt the Speaker, and should be handled as soon as they arise.

Incidental Motions include:

a) Appeal – used to subject the ruling of the Speaker to examination by the House. Any member, suspecting that the Speaker has been mistaken or unfair in the ruling, may appeal that ruling of the House. The Speaker explains the reason for the ruling and allows the member to state his or her reasons for the appeal. After discussion by the members, the vote is taken, not on the appeal, but on sustaining the decision of the Speaker.

b) Suspended Rules – used to allow the House to take an action, which would otherwise be prevented by a procedural rule or by a program already adopted. A suspension of the rules makes temporarily ineffective whatever obstacle which otherwise would prevent the House from achieving its will. The effect of suspending the rules ends when that action is completed.

c) Consider Informally – used to allow the House to discuss an issue without the restrictions of parliamentary rules. It can be used if no motion is pending in the hope that unrestricted discussion will forge a consensus supporting the substance and the language of the motion that evolves. It also can be used even though a motion is under consideration. The pending motion is considered informally until the members decide to vote on it. This vote terminates the informal consideration.

d) Point of Order – used to get the Speaker’s and the House’s attention to the possibility that a violation of the rules, an omission or an error in the proceedings has occurred and to seek a ruling from the Speaker. A point of order must be raised immediately after the possible error or omission occurs. As soon as the Speaker has made a ruling on the point of order, the
business of the House resumes at the point at which it was interrupted.

e) Inquiries – used to acquire the Speaker’s opinion on a matter of parliamentary procedures as it relates to the business under discussion. It does not involve a ruling of the chair. Parliamentary inquiry can also be used to ask the Speaker or the maker of a motion a clarifying question about the pending motion. The request for a parliamentary inquiry may interrupt a speaker only when it requires an immediate answer. A parliamentary inquiry should always be addressed to the Speaker and answered by the Speaker. The Speaker may consult with anyone he or she wishes before answering the inquiry. A member who is interrupted by parliamentary inquiry, once the inquiry is resolved, retains the floor and continues his or her debate. The privilege of parliamentary inquiry should never be used or allowed as a means of delaying the proceedings or harassing a member.

f) Withdraw Motion – used to allow a member to remove from consideration of the House a motion, which, he or she has proposed. If the Speaker has not stated the motion to the House, permission to withdraw is not necessary.

g) Division of Question – used to divide a motion that is composed of two more independent parts into individual motions that may be considered and voted on separately. If the Speaker agrees that the motion contains at least two propositions, each of which can stand alone as a reasonable motion and each suitable for adoption should the other portion fail, he or she may grant this request.

h) Call for Division of Assembly – to verify an indecisive voice or hand vote by requiring voters to rise and, if necessary, to be counted. Any member concerned about the vote may call for a decision as soon as the motion is put to a vote and even before the vote has been announced. Just like any other mandatory requests, division of the assembly should not be used to delay the proceedings or to harass a member.
RULES GOVERNING MOTION AND REQUESTS

Many rules affect when a motion may be introduced, whether it must be seconded, whether it is debatable or amendable and what type of vote it requires for passage. Following is a summary of these rules, taken from the American Institute of Parliamentarians Standard Code of Parliamentary Procedure by the American Institute of Parliamentarians.

# # #
### BASIC RULES GOVERNING MOTIONS

<table>
<thead>
<tr>
<th>Order of Precedence</th>
<th>Can Interrupt?</th>
<th>Requires a Second?</th>
<th>Debatable</th>
<th>Amendable?</th>
<th>Vote Required?</th>
<th>Applies to what other motions?</th>
<th>Can have what other motions applied to it?</th>
<th>Renewable?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Privileged Motions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Adjourn</td>
<td>No</td>
<td>Yes</td>
<td>Yes²</td>
<td>Yes²</td>
<td>Majority</td>
<td>None</td>
<td>Amend, close debate, limit debate</td>
<td>Yes</td>
</tr>
<tr>
<td>2. Recess</td>
<td>No</td>
<td>Yes</td>
<td>Yes²</td>
<td>Yes²</td>
<td>Majority</td>
<td>None</td>
<td>Amend, close debate, limit debate</td>
<td>Yes⁵</td>
</tr>
<tr>
<td>3. Question of privilege</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Subsidiary Motions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Table</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>2/3</td>
<td>Main motion</td>
<td>None</td>
<td>No</td>
</tr>
<tr>
<td>5. Close debate</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>2/3</td>
<td>Debatable motions</td>
<td>None</td>
<td>Yes</td>
</tr>
<tr>
<td>6. Limit or Extend debate</td>
<td>No</td>
<td>Yes</td>
<td>Yes²</td>
<td>Yes²</td>
<td>Majority</td>
<td>Main motion</td>
<td>Amend, close debate, limit debate</td>
<td>Yes⁶</td>
</tr>
<tr>
<td>7. Postpone to a certain time</td>
<td>No</td>
<td>Yes</td>
<td>Yes²</td>
<td>Yes²</td>
<td>Majority</td>
<td>Main motion</td>
<td>Amend, close debate, limit debate</td>
<td>Yes⁶</td>
</tr>
<tr>
<td>8. Refer to committee</td>
<td>No</td>
<td>Yes</td>
<td>Yes²</td>
<td>Yes²</td>
<td>Majority</td>
<td>Main motion</td>
<td>Amend, close debate, limit debate</td>
<td>Yes⁶</td>
</tr>
<tr>
<td>9. Amend</td>
<td>No</td>
<td>Yes</td>
<td>Yes²</td>
<td>Yes²</td>
<td>Majority</td>
<td>Rewordable motions</td>
<td>Amend, close debate, limit debate</td>
<td>No²</td>
</tr>
<tr>
<td><strong>Main Motions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. a. The main motion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Amend a previous action</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
<td>None</td>
<td>Subsidiary</td>
<td>No</td>
</tr>
<tr>
<td>12. Adopt in-lieu-of</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Same Vote</td>
<td>Adopted main motion</td>
<td>Subsidiary</td>
<td>No</td>
</tr>
<tr>
<td>13. Ratify</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Same Vote</td>
<td>Adopted main motion</td>
<td>Subsidiary</td>
<td>No</td>
</tr>
<tr>
<td>14. Recall from committee</td>
<td>No</td>
<td>Yes</td>
<td>Yes²</td>
<td>No</td>
<td>Majority</td>
<td>Referred main motion</td>
<td>Close debate, limit debate</td>
<td>No</td>
</tr>
<tr>
<td>15. Reconsider</td>
<td>Yes³</td>
<td>Yes</td>
<td>Yes²</td>
<td>No</td>
<td>Majority</td>
<td>Vote on main motion</td>
<td>Close debate, limit debate</td>
<td>No</td>
</tr>
<tr>
<td>16. Rescind</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Same Vote</td>
<td>Adopted main motion</td>
<td>Subsidiary, except amend</td>
<td>No</td>
</tr>
</tbody>
</table>

### INCIDENTAL MOTIONS

<table>
<thead>
<tr>
<th>Motions</th>
<th>Can Interrupt?</th>
<th>Requires a Second?</th>
<th>Debatable</th>
<th>Amendable?</th>
<th>Vote Required?</th>
<th>Applies to what other motions?</th>
<th>Can have what other motions applied to it?</th>
<th>Renewable?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appeal</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Majority</td>
<td>Ruling of chair</td>
<td>Close debate, limit debate</td>
<td>No</td>
</tr>
<tr>
<td>Suspend the rules</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Majority</td>
<td>Procedural rules</td>
<td>None</td>
<td>Yes</td>
</tr>
<tr>
<td>Consider informally</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Majority</td>
<td>Main Motion or subject</td>
<td>None</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Requests</th>
<th>Can Interrupt?</th>
<th>Requires a Second?</th>
<th>Debatable</th>
<th>Amendable?</th>
<th>Vote Required?</th>
<th>Applies to what other motions?</th>
<th>Can have what other motions applied to it?</th>
<th>Renewable?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Point of order</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
<td>Procedural error</td>
<td>None</td>
<td>No</td>
</tr>
<tr>
<td>Inquiries</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
<td>All motions</td>
<td>None</td>
<td>No</td>
</tr>
<tr>
<td>Withdraw a motion</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
<td>All motions</td>
<td>None</td>
<td>No</td>
</tr>
<tr>
<td>Division of question</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
<td>Main motion</td>
<td>None</td>
<td>No</td>
</tr>
<tr>
<td>Division of assembly</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
<td>Indecisive vote</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

1. Motions are in order only if no motion higher on the list is pending. Thus, if a motion to close debate is pending, a motion to amend would be out of order; but a motion to recess would be in order, since it outranks the pending motion.
2. Restricted.
3. Is not debatable when applied to an undebatable motion.
4. A member may interrupt the proceedings but not a speaker.
5. Withdraw may be applied to all motions.
6. Renewable at the discretion of the presiding officer.
7. A tie or majority vote sustains the ruling of the presiding officer; a majority vote in the negative reverses the ruling.
8. If decided by the assembly, by motion, requires a majority vote to adopt.
## 2016 HOUSE OF DELEGATES
### Items of Business

<table>
<thead>
<tr>
<th>Officer</th>
<th>Reports</th>
<th>Reference Committee</th>
<th>Officer: 04.16 Treasurer</th>
<th>Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director: 01.16</td>
<td>First District Medical Society</td>
<td>Not Referred</td>
<td>Reference Committee F</td>
<td></td>
</tr>
<tr>
<td>Director: 02.16</td>
<td>Second District Medical Society</td>
<td>Not Referred</td>
<td>Reference Committee F</td>
<td></td>
</tr>
<tr>
<td>Director: 03.16</td>
<td>Third District Medical Society</td>
<td>Not Referred</td>
<td>Reference Committee F</td>
<td></td>
</tr>
<tr>
<td>Director: 04.16</td>
<td>Fourth District Medical Society (See DeKalb CMS 15.16)</td>
<td>Not Referred</td>
<td>Reference Committee F</td>
<td></td>
</tr>
<tr>
<td>Director: 05.16</td>
<td>Fifth District Medical Society (See MAA 20.16)</td>
<td>Not Referred</td>
<td>Reference Committee F</td>
<td></td>
</tr>
<tr>
<td>Director: 06.16</td>
<td>Sixth District Medical Society</td>
<td>Not Referred</td>
<td>Reference Committee F</td>
<td></td>
</tr>
<tr>
<td>Director: 07.16</td>
<td>Seventh District Medical Society</td>
<td>Not Referred</td>
<td>Reference Committee F</td>
<td></td>
</tr>
<tr>
<td>Director: 08.16</td>
<td>Eighth District Medical Society</td>
<td>Not Referred</td>
<td>Reference Committee F</td>
<td></td>
</tr>
<tr>
<td>Director: 09.16</td>
<td>Ninth District Medical Society</td>
<td>Not Referred</td>
<td>Reference Committee F</td>
<td></td>
</tr>
<tr>
<td>Director: 10.16</td>
<td>Tenth District Medical Society</td>
<td>Not Referred</td>
<td>Reference Committee F</td>
<td></td>
</tr>
<tr>
<td>Director: 11.16</td>
<td>Bibb County Medical Society</td>
<td>Not Referred</td>
<td>Reference Committee F</td>
<td></td>
</tr>
<tr>
<td>Director: 12.16</td>
<td>Clayton-Henry-Fayette Medical Society</td>
<td>Not Referred</td>
<td>Reference Committee F</td>
<td></td>
</tr>
<tr>
<td>Director: 13.16</td>
<td>Cobb County Medical Society</td>
<td>Not Referred</td>
<td>Reference Committee F</td>
<td></td>
</tr>
<tr>
<td>Director: 14.16</td>
<td>Crawford W. Long Medical Society</td>
<td>Not Referred</td>
<td>Reference Committee F</td>
<td></td>
</tr>
<tr>
<td>Director: 15.16</td>
<td>DeKalb Medical Society</td>
<td>Not Referred</td>
<td>Reference Committee F</td>
<td></td>
</tr>
<tr>
<td>Director: 16.16</td>
<td>Dougherty County Medical Society</td>
<td>Not Referred</td>
<td>Reference Committee F</td>
<td></td>
</tr>
<tr>
<td>Director: 17.16</td>
<td>Georgia Medical Society</td>
<td>Not Referred</td>
<td>Reference Committee F</td>
<td></td>
</tr>
<tr>
<td>Director: 18.16</td>
<td>Gwinnett-Forsyth County Medical Society</td>
<td>Not Referred</td>
<td>Reference Committee F</td>
<td></td>
</tr>
<tr>
<td>Director: 19.16</td>
<td>Hall County Medical Society</td>
<td>Not Referred</td>
<td>Reference Committee F</td>
<td></td>
</tr>
<tr>
<td>Director: 20.16</td>
<td>Medical Association of Atlanta</td>
<td>Not Referred</td>
<td>Reference Committee F</td>
<td></td>
</tr>
<tr>
<td>Director: 21.16</td>
<td>Muscogee County Medical Society</td>
<td>Not Referred</td>
<td>Reference Committee F</td>
<td></td>
</tr>
<tr>
<td>Director: 22.16</td>
<td>Peachbelt County Medical Society</td>
<td>Not Referred</td>
<td>Reference Committee F</td>
<td></td>
</tr>
<tr>
<td>Director: 23.16</td>
<td>Richmond County Medical Society</td>
<td>Not Referred</td>
<td>Reference Committee F</td>
<td></td>
</tr>
<tr>
<td>Section: 02.16</td>
<td>International Medical Graduate Section</td>
<td>Not Referred</td>
<td>Reference Committee F</td>
<td></td>
</tr>
<tr>
<td>Section: 04.16</td>
<td>Resident Physician and Fellow Section</td>
<td>Not Referred</td>
<td>Reference Committee F</td>
<td></td>
</tr>
<tr>
<td>Section: 05.16</td>
<td>Medical Student Section</td>
<td>Not Referred</td>
<td>Reference Committee F</td>
<td></td>
</tr>
<tr>
<td>Special: 01.16</td>
<td>Executive Committee</td>
<td>Not Referred</td>
<td>Reference Committee F</td>
<td></td>
</tr>
<tr>
<td>Special: 02.16</td>
<td>Medical Association of Georgia Foundation</td>
<td>Not Referred</td>
<td>Reference Committee F</td>
<td></td>
</tr>
<tr>
<td>Special: 03.16</td>
<td>Medical Association of Georgia Alliance</td>
<td>Not Referred</td>
<td>Reference Committee F</td>
<td></td>
</tr>
<tr>
<td>Special: 04.16</td>
<td>Policy Sunset &amp; Reaffirmation Report</td>
<td>Consent Calendar</td>
<td>Reference Committee F</td>
<td></td>
</tr>
<tr>
<td>Special: 05.16</td>
<td>Department of Communications</td>
<td>Not Referred</td>
<td>Reference Committee F</td>
<td></td>
</tr>
<tr>
<td>Special: 06.16</td>
<td>Department of Membership and Marketing</td>
<td>Not Referred</td>
<td>Reference Committee F</td>
<td></td>
</tr>
<tr>
<td>Special: 07.16</td>
<td>Georgia Physicians Leadership Academy</td>
<td>Reference Committee F</td>
<td>Reference Committee F</td>
<td></td>
</tr>
<tr>
<td>Special: 08.16</td>
<td>The Physicians’ Institute for Excellence in Medicine</td>
<td>Not Referred</td>
<td>Reference Committee F</td>
<td></td>
</tr>
<tr>
<td>Special: 09.16</td>
<td>The Physicians Foundation</td>
<td>Not Referred</td>
<td>Reference Committee F</td>
<td></td>
</tr>
<tr>
<td>Special: 10.16</td>
<td>Department of Third Party Payer Advocacy and Health Policy</td>
<td>Not Referred</td>
<td>Reference Committee F</td>
<td></td>
</tr>
<tr>
<td>Special: 11.16</td>
<td>Georgia Medical Political Action Committee</td>
<td>Not Referred</td>
<td>Reference Committee F</td>
<td></td>
</tr>
</tbody>
</table>
## 2016 HOUSE OF DELEGATES
### Items of Business

<table>
<thead>
<tr>
<th>Committee</th>
<th>Reports</th>
<th>Reference Committee Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Committee: 04.16</td>
<td>Committee on Council on Legislation</td>
<td>Not Referred</td>
</tr>
<tr>
<td>Committee: 05.16</td>
<td>Committee on Continuing Medical Education</td>
<td>Not Referred</td>
</tr>
<tr>
<td>Committee: 06.16</td>
<td>Committee on Correctional Medicine</td>
<td>Not Referred</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Resolutions</th>
<th>Reference Committee Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>101A.16</td>
<td>Georgia Medical License for International Medical School Graduates</td>
</tr>
<tr>
<td>102A.16</td>
<td>Improving Communications Among Health Care Clinicians</td>
</tr>
<tr>
<td>103A.16</td>
<td>Signing of Death Certificates</td>
</tr>
<tr>
<td>104A.16</td>
<td>Physician Shortage</td>
</tr>
<tr>
<td>105A.16</td>
<td>MACRA</td>
</tr>
<tr>
<td>106A.16</td>
<td>Distracted Driver Reduction</td>
</tr>
<tr>
<td>107A.16</td>
<td>Control Cost of Brand and Generic Medications</td>
</tr>
<tr>
<td>108A.16</td>
<td>Access to Cosmetic Product Ingredients</td>
</tr>
<tr>
<td>109A.16</td>
<td>Electronic Health Records</td>
</tr>
<tr>
<td>110A.16</td>
<td>Physician Practice Bill of Rights</td>
</tr>
<tr>
<td>111A.16</td>
<td>Nonpayment for Unspecified Codes by Third Party Payers</td>
</tr>
<tr>
<td>112A.16</td>
<td>Electronic Medical Records Recovery Fees</td>
</tr>
<tr>
<td>301C.16</td>
<td>MAG Alignment with the Medical Practice Act</td>
</tr>
<tr>
<td>302C.16</td>
<td>Network Transparency and Management to Benefit Patients</td>
</tr>
<tr>
<td>303C.16</td>
<td>Maintenance of Certification (MOC)</td>
</tr>
<tr>
<td>304C.16</td>
<td>Advertisement of Board Certification in Georgia</td>
</tr>
<tr>
<td>305C.16</td>
<td>Protection for Visiting Athletes and Team Physicians</td>
</tr>
<tr>
<td>306C.16</td>
<td>Nurse Protocol Agreement</td>
</tr>
<tr>
<td>307C.16</td>
<td>Review of Delegated Medical Acts</td>
</tr>
<tr>
<td>308C.16</td>
<td>Health Care Insurer Contracts</td>
</tr>
<tr>
<td>309C.16</td>
<td>Step Therapy Protocols with First Fail Protocols</td>
</tr>
<tr>
<td>310C.16</td>
<td>Protect Physician Practices from MOC</td>
</tr>
<tr>
<td>311C.16</td>
<td>Physician Control of Admissions to Hospital</td>
</tr>
<tr>
<td>312C.16</td>
<td>Improving Access to Health Care in Georgia</td>
</tr>
</tbody>
</table>

### Officers
- **Officer: 04.16**  Treasurer | Reference Committee F
- **Officer: 06.16**  Chairman, AMA Delegation | Reference Committee F
- **Special: 07.16**  Georgia Physicians Leadership Academy | Reference Committee F
- **401F.16**  Charter Rome Area Medical Society | Reference Committee F
- **402F.16**  Charter North Georgia Mountains Medical Society | Reference Committee F
- **601S.16**  Controlled Drug Disposal for Pharmacies | Reference Committee S
- **602S.16**  Substance Abuse Curriculum and CME Opportunities | Reference Committee S
- **603S.16**  Expansion of Project DAN (Deaths Avoided by Naloxone) | Reference Committee S
# 2016 HOUSE OF DELEGATES
## Items of Business

<table>
<thead>
<tr>
<th>Resolutions</th>
<th>Reference Committee Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>604S.16</td>
<td>Prescription Drug Abuse Education in Medical School</td>
</tr>
<tr>
<td>605S.16</td>
<td>Position on CDC Opioid Prescription Guidelines</td>
</tr>
<tr>
<td>606S.16</td>
<td>Mandatory Opioid Prescribing CME</td>
</tr>
<tr>
<td>607S.16</td>
<td>Over-the-Counter Naloxone</td>
</tr>
<tr>
<td>608S.16</td>
<td>Hepatitis C Reduction</td>
</tr>
</tbody>
</table>
## Reference Committee A

| Resolution: 101A.16 | Georgia Medical License for International Medical School Graduates |
| Resolution: 102A.16 | Improving Communications Among Health Care Clinicians |
| Resolution: 103A.16 | Signing Death Certificates |
| Resolution: 104A.16 | Physician Shortage |
| Resolution: 105A.16 | MACRA |
| Resolution: 106A.16 | Distracted Driver Reduction |
| Resolution: 107A.16 | Control Cost of Brand and Generic Medications |
| Resolution: 108A.16 | Access to Cosmetic Product Ingredients |
| Resolution: 109A.16 | Electronic Health Records |
| Resolution: 110A.16 | Physician Practice Bill of Rights |
| Resolution: 111A.16 | Nonpayment for Unspecified Codes by Third Party Payers |
| Resolution: 112A.16 | Electronic Medical Records Recovery Fees |

## Reference Committee C

| Resolution: 301C.16 | MAG Alignment with the Medical Practice Act |
| Resolution: 302C.16 | Network Transparency and Management to Benefit Patients |
| Resolution: 303C.16 | Maintenance of Certification (MOC) |
| Resolution: 304C.16 | Advertisement of Board Certification in Georgia |
| Resolution: 305C.16 | Protection for Visiting Athletes and Team Physicians |
| Resolution: 306C.16 | Nurse Protocol Agreement |
| Resolution: 307C.16 | Review of Delegated Medical Acts |
| Resolution: 308C.16 | Health Care Insurer Contracts |
| Resolution: 309C.16 | Step Therapy Protocols with First Fail Protocols |
| Resolution: 310C.16 | Protect Physician Practices from MOC |
| Resolution: 311C.16 | Physician Control of Admissions to Hospital |
| Resolution: 312C.16 | Improving Access to Health Care in Georgia |

## Reference Committee F

| Officer: 04.16 | Treasurer |
| Officer: 06.16 | Chairman, AMA Delegation |
| Special: 07.16 | Georgia Physicians Leadership Academy |
| Resolution: 401F.16 | Charter Rome Area Medical Society |
| Resolution: 402F.16 | Charter North Georgia Mountains Medical Society |

## Reference Committee S

| Resolution: 601S.16 | Controlled Drug Disposal for Pharmacies |
| Resolution: 602S.16 | Substance Abuse Curriculum and CME Opportunities |
| Resolution: 603S.16 | Expansion of Project DAN (Deaths Avoided by Naloxone) |
| Resolution: 604S.16 | Prescription Drug Abuse Education in Medical School |
| Resolution: 605S.16 | Postimg on CDC Opioid Prescription Guidelines |
| Resolution: 606S.16 | Mandatory Opioid Prescribing CME |
| Resolution: 607S.16 | Over-the-Counter Naloxone |
| Resolution: 608S.16 | Hepatitis C Reduction |
ORDER OF BUSINESS
CALL TO ORDER E. Frank McDonald Jr., M.D. 
Speaker, House of Delegates

Edmund R. Donoghue Jr., M.D. 
Vice Speaker, House of Delegates

INVOCATION Chaplain Dorothy Jones

PRESENTATION OF COLORS Chatham County Sheriff’s Department

INTRODUCTION OF OFFICERS AND GUESTS E. Frank McDonald Jr., M.D. 
Speaker, House of Delegates

NEW RESOLUTIONS

CREDENTIALS REPORT Fonda Ann Mitchell, M.D. 
Chair, Credentials Committee

STATE OF THE ASSOCIATION ADDRESS John S. Harvey, M.D. 
President

EXECUTIVE DIRECTOR’S REPORT Donald J. Palmisano Jr. 
Executive Director/CEO

NOMINATIONS OF CANDIDATES FOR OFFICERS 
AND AMA DELEGATES/ALTERNATE DELEGATES E. Frank McDonald Jr., M.D. 
Speaker, House of Delegates

ANNUAL SESSIONS CONSENT CALENDAR E. Frank McDonald Jr., M.D. 
Speaker, House of Delegates

INTRODUCTION OF NEW BUSINESS E. Frank McDonald Jr., M.D. 
Speaker, House of Delegates

ANNOUNCEMENTS E. Frank McDonald Jr., M.D. 
Speaker, House of Delegates

RECESS FOR REFERENCE COMMITTEE MEETINGS E. Frank McDonald Jr., M.D. 
Speaker, House of Delegates
MEDICAL ASSOCIATION OF GEORGIA
162ND ANNUAL SESSION - HOUSE OF DELEGATES
ORDER OF BUSINESS
6:00 P.M., SATURDAY, OCTOBER 15, 2016
HYATT REGENCY SAVANNAH
PRESIDENT'S INSTALLATION & AWARDS

WELCOME
E. Frank McDonald Jr., M.D.
Speaker, House of Delegates

CALL TO ORDER
E. Frank McDonald Jr., M.D.
Speaker, House of Delegates
Edmund R. Donoghue Jr., M.D.
Vice Speaker, House of Delegates

PRESIDENT’S FAREWELL ADDRESS
John S. Harvey, M.D.

INSTALLATION OF NEW PRESIDENT
Steven M. Walsh, M.D.

PRESIDENT’S ADDRESS
Steven M. Walsh, M.D.

RECEPTION
7:00 p.m. - 7:30 p.m.

AWARDS DINNER
7:30 p.m. - 9:30 p.m.

PRESENTATION OF AWARDS
E. Frank McDonald Jr., M.D.
Speaker, House of Delegates
John S. Harvey, M.D.
Immediate Past President

ADJOURNMENT
E. Frank McDonald Jr., M.D.
Speaker, House of Delegates
CALL TO ORDER
E. Frank McDonald Jr., M.D.
Speaker, House of Delegates

Edmund Donoghue Jr., M.D.
Vice Speaker, House of Delegates

CREDENTIALS REPORT
Fonda Ann Mitchell, M.D.
Chair, Credentials Committee

REFERENCE COMMITTEE REPORTS
E. Frank McDonald Jr., M.D.
Speaker, House of Delegates
(order determined and announced by the Speaker)

AMPAC REPORT
Stephen Imbeau, M.D.
Board Member, AMPAC

GAMPAC REPORT
Michelle Zeanah, M.D.
Chair, GAMPAC

MAG FOUNDATION REPORT
Jack M. Chapman Jr., M.D.
President, MAG Foundation

MAG ALLIANCE REPORT
Merrilee Gober
President, MAG Alliance

CONTESTED ELECTIONS
E. Frank McDonald Jr., M.D.
Speaker, House of Delegates

INSTALLATION OF NEW OFFICERS
Steven M. Walsh, M.D.
President

NEW BUSINESS
E. Frank McDonald Jr., M.D.
Speaker, House of Delegates
(for information, emergency
or unanimous consent of House)

ADJOURNMENT
E. Frank McDonald Jr., M.D.
Speaker, House of Delegates
### 2016 County Medical Society
**Members of the House of Delegates**

<table>
<thead>
<tr>
<th>County Medical Society</th>
<th>Delegates</th>
<th>Alternate Delegates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baldwin County Medical Society</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entitlement: 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Barrow County Medical Society</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entitlement: 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bartow County Medical Society</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entitlement: 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ben Hill-Irwin Medical Society</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entitlement: 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bibb County Medical Society</td>
<td>Maria Hernandez Bartlett, M.D.</td>
<td>Woodrow Wilson Gray Jr., M.D.</td>
</tr>
<tr>
<td>Entitlement: 12</td>
<td>William P. Brooks, M.D.</td>
<td>Zachary David Lopater, M.D.</td>
</tr>
<tr>
<td></td>
<td>Madalyn Davidoff, M.D.</td>
<td>Edward Young, M.D.</td>
</tr>
<tr>
<td></td>
<td>Michael E. Greene, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Billie Luke Jackson, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Robert C. Jones, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>William Robert Lane Jr., M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sid Moore Jr., M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rana Kay Munna, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Darl Wayne Rantz, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>John Eric Roddenberry, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Issam John Shaker, M.D.</td>
<td></td>
</tr>
<tr>
<td>Blue Ridge Medical Society</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entitlement: 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carroll County Medical Society</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entitlement: 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cherokee-Pickens Medical Society</td>
<td>William P. Marks Jr., M.D.</td>
<td></td>
</tr>
<tr>
<td>Entitlement: 2</td>
<td>Michael Joseph Litrel, M.D.</td>
<td></td>
</tr>
<tr>
<td>County Medical Society</td>
<td>Delegates</td>
<td>Alternate Delegates</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>Clayton-Fayette-Henry Medical Society</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entitlement: 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cobb County Medical Society</td>
<td>Nydia Maria Bladuell, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Richard William Cohen, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Despina Demestihas Dalton, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Royden Daniels III, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Masoumeh Ghaffari, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Thomas Lamb Haltom, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Noel Holtz, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Steven Mark Huffman, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dirk Erik Huttenbach, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>James Robert Malcolm, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gerardo Parada, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Jeffrey Craig Stone, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>James Mason Tallman, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Roger Williams, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Scott Robert Wottrich, M.D.</td>
<td></td>
</tr>
<tr>
<td>Entitlement: 31</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coffee County Medical Society</td>
<td>W. Charles Miller Jr. M.D.</td>
<td></td>
</tr>
<tr>
<td>Entitlement: 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colquitt County Medical Society</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entitlement: 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coweta County Medical Society</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entitlement: 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CW Long Medical Society</td>
<td>Alexander Ashford, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sarah Elizabeth Ashford, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Andrew H. Herrin, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Robert Patrick Lucas, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gary Richard Walton, M.D.</td>
<td></td>
</tr>
<tr>
<td>Entitlement: 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decatur County Medical Society</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entitlement: 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>County Medical Society</td>
<td>Delegates</td>
<td>Alternate Delegates</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>DeKalb County Medical Society</td>
<td>Gary Robert Botstein, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Robin Henry Dretler, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Kathryn Cynette Elmore, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Eric Matthew Erickson, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>William R. Hardcastle, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gulshan Harjee, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Andrea Palmer Juliao, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Brian Allen Levitt, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Joy A. Maxey, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Qammar Noorul Rashid, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Stanley W. Sherman, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Donald Carl Siegel, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>William C. Tippins Jr., M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Roy W. Vandiver, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Joseph Daniel Weissman, M.D.</td>
<td></td>
</tr>
<tr>
<td>Dougherty County Medical Society</td>
<td>Henry Harris Barnard, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gurinder Jit Singh Doad, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Harry Neil Dorsey, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Karen E. Lovett, M.D.</td>
<td></td>
</tr>
<tr>
<td>East Georgia Medical Society</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>East Metro Medical Society</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elbert County Medical Society</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flint County Medical Society</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Floyd-Polk-Chattooga Medical Society</td>
<td>Anne Cowan, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>John Alfred Cowan, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>County Medical Society</td>
<td>Delegates</td>
<td>Alternate Delegates</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Georgia Medical Society</td>
<td>Patrick Leroy Blohm, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vernon Thomas Bryant, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Luke J. Curtsinger, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fred Lester Daniel, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>E. Daniel DeLoach, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Edmund Donoghue Jr., M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Kelly Ann Erola, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Joshua Terry Mckenzie, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>David Steven Oliver, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Carl Benjamin Pearl, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Stephen Perry Rashleigh, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Roland S. Summers, M.D.</td>
<td></td>
</tr>
<tr>
<td>Glynn County Medical Society</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Entitlement: 2</td>
<td></td>
</tr>
<tr>
<td>Gordon County Medical Society</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Entitlement: 1</td>
<td></td>
</tr>
<tr>
<td>Gwinnett-Forsyth Medical Society</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Entitlement: 8</td>
<td></td>
</tr>
<tr>
<td>Habersham County Medical Society</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Entitlement: 1</td>
<td></td>
</tr>
<tr>
<td>Hall County Medical Society</td>
<td>Michael H. Callahan, M.D.</td>
<td>Donal Joe Campbell, M.D.</td>
</tr>
<tr>
<td></td>
<td>Jack M. Chapman Jr., M.D.</td>
<td>Kommerina Daling, M.D.</td>
</tr>
<tr>
<td></td>
<td>Thomas Fassuliotis, M.D.</td>
<td>Alfredo Jorge Jaume, M.D.</td>
</tr>
<tr>
<td></td>
<td>E. Frank McDonald Jr., M.D.</td>
<td>Brett Alan Krummert, M.D.</td>
</tr>
<tr>
<td></td>
<td>Andrew B. Reisman, M.D.</td>
<td>Charles D. Procter Sr., M.D.</td>
</tr>
<tr>
<td></td>
<td>Karl Daniel Schultz Jr., M.D.</td>
<td>Jeff Charles Reinhardt, M.D.</td>
</tr>
<tr>
<td></td>
<td>P. Tennent Slack, M.D.</td>
<td></td>
</tr>
<tr>
<td>Jackson-Banks Medical Society</td>
<td>Lionel Dain Meadows, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Entitlement: 1</td>
<td></td>
</tr>
<tr>
<td>Laurens County Medical Society</td>
<td>Sandra L. Hollander, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Entitlement: 2</td>
<td></td>
</tr>
<tr>
<td>County Medical Society</td>
<td>Delegates</td>
<td>Alternate Delegates</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Medical Association of Atlanta</td>
<td>Thomas Edward Bat, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Kenneth Braunstein, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Peter Francis Burns, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lawrence E. Cooper, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Kelly DeGraffenreid, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Michael Doherty, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rutledge Forney, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sandra Fryhofer, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Jonathan Gibson, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Henry Fred Gober Jr., M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>John Abner Goldman, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maighan Guffey, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Miriam Gwathney, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Matthews Weber Gwynn, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Magdi M. Hanafi, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>William Bradford Harper, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>John S. Harvey, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clarence Alvin Head, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Michael C. Hilton, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maggie Hopkins, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nikki Hughes, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Albert Farah Johary, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>John Alexander Johnson, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Carmen Michelle Kavali, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Faria Memnun Khan, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>D. Kay Kirkpatrick, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Deborah Ann Martin, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cody McClatchey, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Adrienne Denise Mims, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fonda Ann Mitchell, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Terence Moraczewski, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Elena A. Morgan, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Elizabeth Morgan, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lajune Benja Oliver, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lisa Perry-Gilkes, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Quentin Pirkle Jr., M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Alan L. Plummer, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ali Rahimi, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Alan R. Redding, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>David R. Redding, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gary C. Richter, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Randy Frank Rizor, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Shah A. Shoheb, M.D.</td>
<td></td>
</tr>
</tbody>
</table>
| Medical Association of Atlanta, Continued | Stacy Elizabeth Seikel, M.D.  
Neha Sharma, M.D.  
William E. Silver, M.D.  
Anna Skold, M.D.  
Peter Daniel Steckl, M.D.  
Earl Thurmond Jr., M.D.  
Steven Michael Walsh, M.D.  
Bingyan Wang, M.D.  
Martha Mary Wilber, M.D.  
Charles Inman Wilmer, M.D.  
W. Hayes Wilson, M.D. |
| Muscogee County Medical Society | Michael Jay Borkat, M.D.  
Frederick Flandry, M.D.  
Glenn Edward Fussell, M.D.  
James Davant Majors, M.D.  
W. Frank Willett III, M.D.  
Joseph Robert Zanga, M.D. |
| Oconee Valley Medical Society | S. William Clark III., M.D.  
Keith Johnson, M.D. |
| Ogeechee River Medical Society | Deepti Bhasin, M.D.  
Santanu Das, M.D.  
Ayman Rihawi, M.D.  
Manoj H. Shah, M.D.  
Walter Steven Wilson, M.D.  
Thekkepat G. Sekhar, M.D.  
Karunaker Sripathi, M.D.  
Joseph Cavan Woods, M.D. |
<table>
<thead>
<tr>
<th>County Medical Society</th>
<th>Delegates</th>
<th>Alternate Delegates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Richmond County</td>
<td>Joseph P. Bailey Jr., M.D.</td>
<td></td>
</tr>
<tr>
<td>Medical Society</td>
<td>Benjamin Bashinski III, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Robert Adair Blackwood, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Peter F. Buckley, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bashir Chaudhary, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Michael J. Cohen, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Terrence J. Cook, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Donnie P. Dunagan, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bennett S. Greenspan, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Joseph W. Griffin Jr., M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Jill P. Hauenstein, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Randy Hensley, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clarence Joe, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Robert Joseph Kaminski, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Jonathan Seth Krauss, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Donald Loebl Sr., M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Charles A. Meyer Jr., M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Peter Michael Payne, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>George Pursley, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>James Vincent Rawson, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Deborah Kay Richardson, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>John Frederick Salazar, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Kailash B. Sharma, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Norman B. Thomson III, M.D.</td>
<td></td>
</tr>
<tr>
<td>South Georgia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Society</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entitlement: 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SE Georgia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Society</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entitlement: 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spalding County</td>
<td>Kevin Tawn Napier, M.D., FACP</td>
<td></td>
</tr>
<tr>
<td>Medical Society</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entitlement: 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>St. Johns Parish</td>
<td>Drazen Marijan Jukic, M.D.</td>
<td></td>
</tr>
<tr>
<td>Medical Society</td>
<td>Richard Peele James, M.D.</td>
<td></td>
</tr>
<tr>
<td>Entitlement: 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>County Medical Society</td>
<td>Delegates</td>
<td>Alternate Delegates</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>----------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>Stephens-Rabun Medical Society</td>
<td>Ramana Puppala, M.D.</td>
<td></td>
</tr>
<tr>
<td>Entitlement: 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sunter County Medical Society</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entitlement: 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thomas Area Medical Society</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entitlement: 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tift County Medical Society</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entitlement: 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Troup County Medical Society</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entitlement: 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upson County Medical Society</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entitlement: 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walker-Catoosa-Dade Medical Society</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entitlement: 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wayne County Medical Society</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entitlement: 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whitfield-Murray Medical Society</td>
<td>John S. Antalis, M.D.</td>
<td></td>
</tr>
<tr>
<td>Entitlement: 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>County Medical Society</td>
<td>Delegates</td>
<td>Alternate Delegates</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>--------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Stephens-Rabun Medical Society</td>
<td></td>
<td>Ramana Puppala, M.D.</td>
</tr>
<tr>
<td>Entitlement: 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sumter County Medical Society</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entitlement: 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thomas Area Medical Society</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entitlement: 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tift County Medical Society</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entitlement: 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Troup County Medical Society</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entitlement: 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upson County Medical Society</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entitlement: 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walker-Catoosa-Dade Medical Society</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entitlement: 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wayne County Medical Society</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entitlement: 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whitfield-Murray Medical Society</td>
<td></td>
<td>John S. Antalis, M.D.</td>
</tr>
<tr>
<td>Entitlement: 2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## 2016 Section Members of the House of Delegates

<table>
<thead>
<tr>
<th>Section</th>
<th>Delegate</th>
<th>Alternate Delegate</th>
</tr>
</thead>
<tbody>
<tr>
<td>International Medical School Graduate Section</td>
<td>Dilip C. Patel, M.D.</td>
<td>Arvind Gupta, M.D.</td>
</tr>
<tr>
<td>Entitlement: 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Student Section</td>
<td>Ebony Caldwell</td>
<td></td>
</tr>
<tr>
<td>Entitlement: 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resident/Fellow Section</td>
<td>Shamie Das, M.D.</td>
<td>Chetan R. Patel, M.D.</td>
</tr>
<tr>
<td>Entitlement: 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Young Physicians Section</td>
<td>Manuel Rodriguez, D.O.</td>
<td></td>
</tr>
<tr>
<td>Entitlement: 1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2016 Specialty Society
Members of the House of Delegates

<table>
<thead>
<tr>
<th>Specialty Society</th>
<th>Delegates</th>
<th>Alternate Delegates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Georgia Society of Anesthesiologists</td>
<td>Justin Ford, M.D.</td>
<td></td>
</tr>
<tr>
<td>Entitlement: 1</td>
<td>Gerald Moody, M.D.</td>
<td></td>
</tr>
<tr>
<td>Georgia Chapter, American College of Cardiology</td>
<td>Abhishek Gaur, M.D.</td>
<td>Jonathan Murrow, M.D.</td>
</tr>
<tr>
<td>Entitlement: 2</td>
<td>Joseph Sealy Wilson Jr., M.D.</td>
<td>Donald A. Page Jr., M.D.</td>
</tr>
<tr>
<td>Georgia Society of Dermatology</td>
<td>Katarina Lequeux-Nalovic, M.D.</td>
<td></td>
</tr>
<tr>
<td>Entitlement: 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Georgia Society of Emergency Physicians</td>
<td>James Lofton Smith Jr., M.D.</td>
<td>Johnny Sy, M.D.</td>
</tr>
<tr>
<td>Entitlement: 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Georgia Academy of Family Physicians</td>
<td>Loy Dekle Cowart III, M.D.</td>
<td>Wayne Hoffman, M.D.</td>
</tr>
<tr>
<td>Entitlement: 3</td>
<td>Donald Lowell Fordham, M.D.</td>
<td>Eddie Richardson, M.D., MBBS</td>
</tr>
<tr>
<td></td>
<td>Mitzi Beth Rubin, M.D.</td>
<td></td>
</tr>
<tr>
<td>Georgia Society of the American College of Surgeons</td>
<td>Stephen Jarrard, M.D.</td>
<td></td>
</tr>
<tr>
<td>Entitlement: 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>American College of Physicians, Georgia Chapter</td>
<td>Jacqueline Winfield Fincher, M.D.</td>
<td></td>
</tr>
<tr>
<td>Entitlement: 3</td>
<td>Jay Leonard Lichtenfeld, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clyde Watkins Jr., M.D.</td>
<td></td>
</tr>
<tr>
<td>Georgia Neurosurgical Society</td>
<td>Roger Frankel, M.D.</td>
<td></td>
</tr>
<tr>
<td>Entitlement: 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Georgia Obstetrical and Gynecological Society</td>
<td>Ruth Cline, M.D.</td>
<td></td>
</tr>
<tr>
<td>Entitlement: 2</td>
<td>Carla Roberts, M.D.</td>
<td></td>
</tr>
<tr>
<td>Georgia Society of Ophthalmology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entitlement: 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialty Society</td>
<td>Delegates</td>
<td>Alternate Delegates</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>----------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Georgia Orthopedic Society</td>
<td>Jennifer Tucker, M.D.</td>
<td>Xavier Duralde, M.D.</td>
</tr>
<tr>
<td></td>
<td>Samuel Willimon, M.D.</td>
<td></td>
</tr>
<tr>
<td>Georgia Society of Otolaryngology</td>
<td>Arthur Torsiglieri, M.D.</td>
<td></td>
</tr>
<tr>
<td>Georgia Chapter, American Academy of Pediatrics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Georgia Society of Plastic Surgeons</td>
<td>Jeffrey D. Zwiren, M.D.</td>
<td></td>
</tr>
<tr>
<td>Georgia Psychiatric Physicians Association</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Georgia Radiological Society</td>
<td>Bruce Hershatter, M.D.</td>
<td></td>
</tr>
<tr>
<td>OFFICE</td>
<td>CANDIDATE</td>
<td></td>
</tr>
<tr>
<td>------------------------------</td>
<td>------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>President-Elect</td>
<td>E. Frank McDonald, Jr., Gainesville</td>
<td></td>
</tr>
<tr>
<td></td>
<td>____________________________</td>
<td></td>
</tr>
<tr>
<td>First Vice President</td>
<td>Steven Mark Huffman, Marietta</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Automatic Succession)</td>
<td></td>
</tr>
<tr>
<td>Second Vice President</td>
<td>Lisa Perry-Gilkes, Atlanta</td>
<td></td>
</tr>
<tr>
<td></td>
<td>____________________________</td>
<td></td>
</tr>
<tr>
<td>Speaker of the House of Delegates</td>
<td>Edmund R. Donoghue, Savannah</td>
<td></td>
</tr>
<tr>
<td></td>
<td>____________________________</td>
<td></td>
</tr>
<tr>
<td>Vice Speaker of the House of Delegates</td>
<td>James W. Barber, Douglas</td>
<td></td>
</tr>
<tr>
<td></td>
<td>____________________________</td>
<td></td>
</tr>
<tr>
<td>AMA Delegate (terms to end 2018)</td>
<td>Joy A. Maxey</td>
<td></td>
</tr>
<tr>
<td>Seat currently held by</td>
<td>Joy A. Maxey</td>
<td></td>
</tr>
<tr>
<td>John S. Antalis</td>
<td>____________________________</td>
<td></td>
</tr>
<tr>
<td>Alternate Delegates (term to end 2018)</td>
<td>John S. Antalis</td>
<td></td>
</tr>
<tr>
<td>Seat currently held by</td>
<td>John S. Antalis</td>
<td></td>
</tr>
<tr>
<td>Jack M. Chapman, Jr.</td>
<td>____________________________</td>
<td></td>
</tr>
<tr>
<td>Seat currently held by</td>
<td>Jack M. Chapman, Jr.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Second District Medical Society
Barbara H. McCollum, M.D., Thomasville, 2018 (to fill the unexpired term of Sandra Reed, M.D.)

Eighth District Medical Society
Keith Russell Johnson, M.D., Waycross, 2017 (to fill the unexpired term of Jim Barber, M.D.)
Sudhakar Jonnalagadda, M.D., Douglas, 2017 (to fill the unexpired term of Keith Johnson, MD)

Bibb County Medical Society
William P. Brooks, M.D., Macon, Director, 2019
Madalyn Davidoff, M.D., Warner Robins, Alternate Director, 2019

Cobb County Medical Society
Despina D. Dalton, M.D., Austell, Director, 2017 (elected to fill the term left by Steven Huffman, M.D.)
Nydia Bladuell, M.D., Marietta, Alternate Director, 2018 (elected to fill the unexpired term of Despina D. Dalton, M.D.)

Georgia Medical Society
David S. Oliver, M.D., Savannah, Director, 2019
Kelly A. Erola, M.D., Savannah, Alternate Director, 2019

Gwinnett-Forsyth Medical Society
John Y. Shih, D.O., Suwanee, Director, 2019
James L. Smith, M.D., Lawrenceville, Alternate Director, 2019

Muscogee County Medical Society
Frederick C. Flandry, M.D., Columbus, Director, 2019
W. Frank Willett III, M.D., Columbus, Alternate Director, 2019

Richmond County Medical Society
John F. Salazar, M.D., Augusta, Director, 2019
Donnie P. Dunagan, M.D., Augusta, Alternate Director, 2019

Young Physician Section (elections are held annually)
Vinaya Puppala, M.D., Carrollton, Director (remains director until elections are held)
Edward Marchan, M.D., Atlanta, Alternate Director (remains alternate director until elections are held)

Medical Student Section (elections are held annually in conjunction with MAG HOD; the chair and vice chair serve as director and alternate director)
2016 MAG HOD REFERENCE COMMITTEES

REFERENCE COMMITTEE A – HEALTH CARE POLICY

Chair: Kelly Michelle DeGraffenreid, M.D. MAA
Vice Chair: Benjamin David Spitalnick, M.D. Pediatrics

Loy Dekle Cowart III, M.D. GAfp
Nikki Hughes, M.D. MAA
Carmen Michelle Kavali, M.D. MAA
Karl Daniel Schultz Jr., M.D. Hall
Joseph Sealy Wilson Jr., M.D. Cardiology

Staff: Susan Moore/Kimberly Ramseur

REFERENCE COMMITTEE C - LEGISLATION

Chair: Katarina Gabrielle Lequeux-Nalovic, M.D. Dermatology
Vice Chair: Patrick Leroy Blohm, M.D. Georgia

Kathryn Cynette Elmore, M.D. DeKalb
Welborn Cody McClatchey, M.D. MAA
Lionel Dain Meadows, M.D. Jackson-Banks
Ramana Puppala, M.D. Stephens-Rabun
Mitzi Beth Rubin, M.D. GAfp

Staff: Derek Norton/Trey Reese

REFERENCE COMMITTEE F – FINANCE AND ADMINISTRATION

Chair: Deborah Ann Martin, M.D. MAA
Vice Chair: Abhishek Gaur, M.D. Cardiology

Donnie P. Dunagan, M.D. Richmond
Noel Holtz, M.D. Cobb
James Robert Malcolm, M.D. Cobb
Donald Carl Siegel, M.D. DeKalb
William Frank Willett III, M.D. Muscogee

Staff: Sally Jacobs
REFERENCE COMMITTEE S – PRESCRIPTION DRUG ABUSE

Chair
Martha Mary Wilber, M.D. MAA
Vice Chair
Gurinder Jit Singh Doad, M.D. Dougherty

Robert Adair Blackwood, M.D. Richmond
William Robert Lane Jr., M.D. Bibb
Randy Frank Rizor, M.D. MAA
P. Tennent Slack, M.D. Hall
James Lofton Smith Jr., M.D. GCEP

Staff: Kate Boyenga/Bethany Sherrer

PARLIAMENTARIAN

Joy A. Maxey, M.D. DeKalb

CREDENTIALS COMMITTEE

Chair
Fonda Ann Mitchell, M.D. MAA
Nikki Hughes, M.D. MAA
Fred Lester Daniel, M.D. Georgia
Andrea Palmer Juliao, M.D. DeKalb

TELLERS

Masoumeh Ghaffari, M.D. Cobb
Henry Harris Barnard, M.D. Dougherty
Albert Farah Johary, M.D. MAA
RECOGNITION
### Medical Association of Georgia
#### 2016 House of Delegates

**Certificates of Appreciation**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>John S. Harvey, M.D.</td>
<td>President</td>
<td>2015-2016</td>
</tr>
<tr>
<td>Steven M. Walsh, M.D.</td>
<td>President-elect</td>
<td>2015-2016</td>
</tr>
<tr>
<td>Manoj H. Shah, M.D.</td>
<td>Immediate Past President</td>
<td>2015-2016</td>
</tr>
<tr>
<td>Madalyn N. Davidoff, M.D.</td>
<td>First Vice President</td>
<td>2015-2016</td>
</tr>
<tr>
<td>Steven M. Huffman, M.D.</td>
<td>Second Vice President</td>
<td>2015-2016</td>
</tr>
<tr>
<td>E. Frank McDonald Jr., M.D.</td>
<td>Speaker of the House of Delegates</td>
<td>2014-2016</td>
</tr>
<tr>
<td>Alan L. Plummer, M.D.</td>
<td>AMA Alternate Delegate</td>
<td>2005-2016</td>
</tr>
<tr>
<td>Steven M. Huffman, M.D.</td>
<td>Director, MAG Board of Directors</td>
<td>2014-2016</td>
</tr>
<tr>
<td>Despina D. Dalton, M.D.</td>
<td>Alternate Director, MAG Board of Directors</td>
<td>2014-2016</td>
</tr>
<tr>
<td>Robert C. Jones, M.D.</td>
<td>Alternate Director, MAG Board of Directors</td>
<td>2014-2016</td>
</tr>
<tr>
<td>James W. Barber, M.D.</td>
<td>Chair, GAMPAC Board of Directors</td>
<td>2013-2016</td>
</tr>
<tr>
<td>James W. Barber, M.D.</td>
<td>Member, GAMPAC Board of Directors</td>
<td>2010-2016</td>
</tr>
<tr>
<td>Matthew P. Mumber, M.D.</td>
<td>President, 7th District Medical Society</td>
<td>2006-2016</td>
</tr>
<tr>
<td>Donald C. Siegel, M.D.</td>
<td>Member, Judicial Council</td>
<td>2005-2016</td>
</tr>
<tr>
<td>Hillary R. Newland Jr., M.D.</td>
<td>Chair, MAG Committee on Continuing Medical Education</td>
<td>1990-2016</td>
</tr>
<tr>
<td>John S. Antalis, M.D.</td>
<td>Member, GPLA Steering Committee</td>
<td>2007-2016</td>
</tr>
<tr>
<td>Michael E. Greene, M.D.</td>
<td>Member, GPLA Steering Committee</td>
<td>2007-2016</td>
</tr>
<tr>
<td>James W. Barber, M.D.</td>
<td>Member, MAG Task Force on Workers’ Compensation</td>
<td>2016</td>
</tr>
<tr>
<td>Snehal C. Dalal, M.D.</td>
<td>Member, MAG Task Force on Workers’ Compensation</td>
<td>2016</td>
</tr>
</tbody>
</table>
Carlos J. Giron, M.D.  
Member, MAG Task Force on Workers’ Compensation  
2016

Robert L. Howell, M.D.  
Member, MAG Task Force on Workers’ Compensation  
2016

Lee A. Kelley, M.D.  
Member, MAG Task Force on Workers’ Compensation  
2016

D. Kay Kirkpatrick, M.D.  
Member, MAG Task Force on Workers’ Compensation  
2016

Stephen M. McCollam, M.D.  
Member, MAG Task Force on Workers’ Compensation  
2016

Randy F. Rizor, M.D.  
Member, MAG Task Force on Workers’ Compensation  
2016

Barry N. Straus, M.D.  
Member, MAG Task Force on Workers’ Compensation  
2016

Ammar Divan, M.D.  
Member, MAG Task Force on Prescription Drug Abuse  
2016

Sandra Fryhofer, M.D.  
Member, MAG Task Force on Prescription Drug Abuse  
2016

Ammar Divan, M.D.  
Member, MAG Task Force on Prescription Drug Abuse  
2016

D. Ray Gaskin, M.D.  
Member, MAG Task Force on Prescription Drug Abuse  
2016

Carlos J. Giron, M.D.  
Member, MAG Task Force on Prescription Drug Abuse  
2016

Brady R. Rumph, M.D.  
Member, MAG Task Force on Prescription Drug Abuse  
2016

Margaret D. Schaufler, M.D.  
Member, MAG Task Force on Prescription Drug Abuse  
2016

C. Alan Scott, M.D.  
Member, MAG Task Force on Prescription Drug Abuse  
2016

P. Tennent Slack, M.D.  
Member, MAG Task Force on Prescription Drug Abuse  
2016

Richard L. Elliott, M.D.  
Member, MAG Task Force on Prescription Drug Abuse  
2016

Richard A. Stappenbeck, M.D.  
Member, MAG Task Force on Prescription Drug Abuse  
2016
Peasha Houston, M.D.  
Member, MAG Task Force on Health Outcomes  
2016

James W. Barber, M.D.  
Member, MAG Task Force on Electronic Health Care  
2016

Mark A. Jester, M.D.  
Member, MAG Task Force on Health Outcomes  
2016

Gary R. Botstein, M.D.  
Member, MAG Task Force on Electronic Health Care  
2016

Barbara J. Jones, M.D.  
Member, MAG Task Force on Health Outcomes  
2016

Jack M. Chapman Jr., M.D.  
Member, MAG Task Force on Electronic Health Care  
2016

Daniel Lee Miller, M.D.  
Member, MAG Task Force on Health Outcomes  
2016

Madalyn N. Davidoff, M.D.  
Member, MAG Task Force on Electronic Health Care  
2016

Adrienne D. Mims, M.D.  
Member, MAG Task Force on Health Outcomes  
2016

Michael F. Doherty, M.D.  
Member, MAG Task Force on Electronic Health Care  
2016

Quentin R. Pirkle Jr., M.D.  
Member, MAG Task Force on Health Outcomes  
2016

Swati Gaur, M.D.  
Member, MAG Task Force on Electronic Health Care  
2016

Barry N. Straus, M.D.  
Member, MAG Task Force on Health Outcomes  
2016

Matthews W. Gwynn, M.D.  
Member, MAG Task Force on Electronic Health Care  
2016

Joseph W. Stubbs, M.D.  
Member, MAG Task Force on Health Outcomes  
2016

Dominic Mack, M.D.  
Member, MAG Task Force on Electronic Health Care  
2016

Steven M. Walsh, M.D.  
Member, MAG Task Force on Health Outcomes  
2016

Howard M. Maziar, M.D.  
Member, MAG Task Force on Electronic Health Care  
2016
<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Task Force</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Randy J. Ruark, M.D.</td>
<td>Member</td>
<td>MAG Task Force on Electronic Health Care</td>
<td>2016</td>
</tr>
<tr>
<td>Larry L. Sanders Jr., M.D.</td>
<td>Member</td>
<td>MAG Task Force on Electronic Health Care</td>
<td>2016</td>
</tr>
<tr>
<td>Thekkepat G. Sekhar, M.D.</td>
<td>Member</td>
<td>MAG Task Force on Electronic Health Care</td>
<td>2016</td>
</tr>
<tr>
<td>Lillian R. Schapiro, M.D.</td>
<td>Member</td>
<td>MAG Task Force on Electronic Health Care</td>
<td>2016</td>
</tr>
<tr>
<td>Stephen A. Sudler, M.D.</td>
<td>Member</td>
<td>MAG Task Force on Electronic Health Care</td>
<td>2016</td>
</tr>
<tr>
<td>W. Scott Bohlke, M.D.</td>
<td>Member</td>
<td>MAG Task Force on Tort Reform</td>
<td>2016</td>
</tr>
<tr>
<td>Jeffrey B. English, M.D.</td>
<td>Member</td>
<td>MAG Task Force on Tort Reform</td>
<td>2016</td>
</tr>
<tr>
<td>Brian E. Hill, M.D.</td>
<td>Member</td>
<td>MAG Task Force on Tort Reform</td>
<td>2016</td>
</tr>
<tr>
<td>Mark A. Jester, M.D.</td>
<td>Member</td>
<td>MAG Task Force on Tort Reform</td>
<td>2016</td>
</tr>
<tr>
<td>Lillian R. Schapiro, M.D.</td>
<td>Member</td>
<td>MAG Task Force on Tort Reform</td>
<td>2016</td>
</tr>
<tr>
<td>Barry N. Straus, M.D.</td>
<td>Member</td>
<td>MAG Task Force on Tort Reform</td>
<td>2016</td>
</tr>
<tr>
<td>David C. Bosshardt, M.D.</td>
<td>Member</td>
<td>MAG Task Force on Scope of Practice</td>
<td>2016</td>
</tr>
<tr>
<td>Amanda K. Brown, M.D.</td>
<td>Member</td>
<td>MAG Task Force on Scope of Practice</td>
<td>2016</td>
</tr>
<tr>
<td>Donald N. Cote, M.D.</td>
<td>Member</td>
<td>MAG Task Force on Scope of Practice</td>
<td>2016</td>
</tr>
<tr>
<td>Carolyn Meltzer, M.D.</td>
<td>Member</td>
<td>MAG Task Force on Scope of Practice</td>
<td>2016</td>
</tr>
<tr>
<td>Sid Moore, M.D.</td>
<td>Member</td>
<td>MAG Task Force on Scope of Practice</td>
<td>2016</td>
</tr>
<tr>
<td>John B. Neeld Jr., M.D.</td>
<td>Member</td>
<td>MAG Task Force on Scope of Practice</td>
<td>2016</td>
</tr>
<tr>
<td>Lillian R. Schapiro, M.D.</td>
<td>Member</td>
<td>MAG Task Force on Scope of Practice</td>
<td>2016</td>
</tr>
<tr>
<td>Manan B. Shah, M.D.</td>
<td>Member</td>
<td>MAG Task Force on Scope of Practice</td>
<td>2016</td>
</tr>
</tbody>
</table>
2016 Life Members

Oscar E. Aguero, Sr., M.D.
Alfredo Alarcon, M.D.
Marshall Bonner Allen, Jr., M.D.
Barbara J. Allen-Dalrymple, M.D.
Joseph M. Almand, Jr., M.D.
John H Angell, M.D.
Murray C Arkin, M.D.
Gerson Harvey Aronovitz, M.D.
Cirilo A. Aseron, Jr., M.D.
Harold Asher, M.D.
George Jeff Austin, Jr., M.D.
Henry Faver Ball, M.D.
Crawford F. Barnett, Jr., M.D.
William Lawrence Barnwell, M.D.
Albert Barrocas, M.D.
John Gilbert Bates, M.D.
William Ward Baxley, Jr., M.D.
Ernest W. Beasley, Jr., M.D.
James Louis Beeton, M.D.
James A. Bedingfield, M.D.
Fred M. Bell, Jr., M.D.
William H. Benson, Jr., M.D.
William Henry Biggers, M.D.
William F. Bloom, M.D.
Jerry Arvin Boatwright, M.D.
H. William Bondurant, M.D.
James Larry Boss, M.D.
Franklyn P Bousquet, Jr., M.D.
James Edward Boyett, M.D.
Robert L. Brand, III, M.D.
Donald L. Branyon, Jr., M.D.
Farrell Hobbs Braziel, M.D.
Carl H. Brennan, Jr., M.D.
Spencer S. Brewer, Jr., M.D.
Harry Harris Brill, Jr., M.D.
Avery B. Brinkley, M.D.
John B. Brinson, Jr., M.D.
William P. Brooks, M.D.
Juanita Annette Brooks-Warren, M.D.
Nelson H. Brown, M.D.
Leonard Brown, M.D.
John Knox Burns, III, M.D.
Charles George Burton, M.D.
Leon Hays Bush, M.D.
Dwana Marie Bush, M.D.
William H. Cabaniss, Jr., M.D.
Louis G. Cacchioli, M.D.
Gerald E. Caplan, M.D.
Daniel Bennett Caplan, M.D.
George C. Cauble, M.D.
Henry Rives Chalmers, M.D.
Rives Coleman Chalmers, M.D.
Arthur Bleakley Chandler, Sr., M.D.
Remer Y. Clark, II, M.D.
Howard Malin Coe, M.D.
Jay S. Coffsky, M.D.
Sheldon B. Cohen, M.D.
Marvyn Donald Cohen, M.D.
Paul Gary Cohen, M.D.
Richard William Cohen, M.D.
Terrence J. Cook, M.D.
Rawser Paul Crank, Jr., M.D.
Harry J. Crider, Jr., M.D.
Laurence Tarver Crimmins, M.D.
John M. Crymes, M.D.
Ernest F Daniel, Jr., M.D.
Waverly Berkley Dashiel, M.D.
John K Davidson, III, M.D.
Marion Bedford Davis, Jr., M.D.
Henry Gordon Davis, Jr., M.D.
Alfred L. Davis, Jr., M.D.
John Lorraine Davis, III, M.D.
Gaston De Lemos, M.D.
Jose Arturo Delgado, M.D.
Keith A. Dimond, M.D.
Pierce Kendal Dixon, M.D.
Robert S. Donner, M.D.
Roy Gordon Duncan, M.D.
William Robert Dunn, M.D.
Louis Dupont, M.D.
Thomas Earl Dupree, M.D.
Lawrence L. Durisch, Jr., M.D.
Harmer Orin Eason, Jr., M.D.
Mariano Miguel Echemendia, M.D.
2016 Life Members

Lois Taylor Ellison, M.D.
Bruce A. Elrod, M.D.
Eileen Frieda Elson, M.D.
Harold S. Engler, M.D.
David Allan Epstein, M.D.
William G. Erickson, M.D.
Richard C. Estes, M.D.
John G. Etheridge, M.D.
James Patrick Evans, M.D.
William B. Fackler, Jr., M.D.
Alva Humphrey Faulkner, M.D.
Elaine B. Feldman, M.D.
Elliott Ronald Finger, M.D.
Waldo Emerson Floyd, Jr., M.D.
Harry Robert Foster, Jr., M.D.
Julia Graydon Wood Foster, M.D.
Milton Frank, III, M.D.
Milton H. Freedman, M.D.
Thomas Rumph Freeman, M.D.
Charles Freeman, Jr., M.D.
Ronald A. Freeman, M.D.
William H Galloway, M.D.
Cyler D. Garner, M.D.
Glen Earl Garrison, M.D.
Brinton Bizzelle Gay, Jr., M.D.
William N. Gee, Jr., M.D.
Clyde Darrell Gilbert, M.D.
Charles Braselton Gillespie, M.D.
Joe I. Gillespie, M.D.
Bruce M. Gillett, M.D.
Martin Irving Goldstein, M.D.
William J. Gower, M.D.
Herbert S Greenwald, Jr., M.D.
David Howard Greenwald, M.D.
Joseph W. Griffin, Jr., M.D.
Albert Valdemar Gude, M.D.
Jerold Alan Haber, M.D.
Maxwell F Hall, Jr., M.D.
Newell M. Hamilton, M.D.
John H Harbour, M.D.
Billy Star Hardman, M.D.
William J. Hardman, M.D.
John Robert Harrison, M.D.
William Alton Hays, Jr., M.D.
John Phinazee Heard, M.D.
Edgar Randolph Hensley, M.D.
Pascual Herrera, M.D.
Eugene Van Landingham Herrin, M.D.
Theodore Hersh, M.D.
John Bunn Hill, Jr., M.D.
Joseph H. Hilsman, M.D.
Jack Walter Hirsch, M.D.
Frank Hoffman, M.D.
Bernard C. Holland, M.D.
Emory Willie Holloway, Jr., M.D.
Charles Milligan Holman, M.D.
Noel Holtz, M.D.
Henry Lee Howard, Jr., M.D.
Douglas Crawford Huber, M.D.
John L. Hughes, M.D.
Wayne Gary Hulsey, M.D.
Arthur Lee Humphries, Jr., M.D.
Marion W Hurt, M.D.
Dirk Erik Huttenbach, M.D.
Steve Kyousick Hwang, M.D.
Menard C Ihnen, M.D.
Ervine P. Inglis, Jr., M.D.
John S Inman, Jr., M.D.
Anthony Frank Isele, M.D.
Sidney Isenberg, M.D.
Bethanne Foley Jenks, M.D.
Thomas Devann Johnson, M.D.
Charles Garden Johnson, M.D.
Milton I. Johnson, Jr., M.D.
Jimpsey Burke Johnson, M.D.
C. Emory Johnson, Jr., M.D.
Henry B Jones, Jr., M.D.
George Richard Jones, M.D.
William Ellis Josey, M.D.
Julio Jove, M.D.
Zeynep Karasu, M.D.
Ferdinand Vogt Kay, M.D.
William R. King, Jr., M.D.
James Lon King, Jr., M.D.
James Leroy Kirkpatrick, M.D.
Luella V Klein, M.D.
William Jay Klopstock, M.D.
Milton Joseph Krainin, M.D.
Robert Anthony Kral, M.D.
Abraham J. Kravtin, M.D.
Constantine Peter Lampros, M.D.
Charles A Lanford, Sr., M.D.
James Franklin Langford, M.D.
Bob G. Lanier, M.D.
Walter Edward Lee, Jr., M.D.
Ted Flournoy Leigh, M.D.
Bernard Lerman, M.D.
Jesse Clarence Lester, M.D.
Michael K. Levine, M.D.
Craig Stodard Lichtenwalner, M.D.
Paul Harvey Liebman, M.D.
William D. Logan, Jr., M.D.
Kathryn S. Lovett, M.D.
William Trent Lucas, M.D.
Spencer Fleetwood Maddox, Jr., M.D.
Robert Mainor, M.D.
David S. Mann, M.D.
Frank Rambo Mann, Jr., M.D.
James Hunt Manning, M.D.
Thomas Windrow Marks, M.D.
Louie F Woodward Marshall, M.D.
Jose Ramon Martinez, M.D.
Alberto Carlos Martinez, M.D.
Stephen C. May, Jr., M.D.
Charles Bush May, M.D.
Alva L. Mayes, Jr., M.D.
Ray Harold McCord, M.D.
John Marshall McCoy, M.D.
Fayette M. McElhannon, Jr., M.D.
Joe Lewis McLendon, M.D.
John W. McLeod, M.D.
Noah D. Meadows, Jr., M.D.
Henry Getzen Mealing, Jr., M.D.
William Hugh Meeks, Sr., M.D.
Jack F. Menendez, M.D.
Harvey Ernest Merlin, M.D.
Roger Albert Meyer, M.D.
Charles Aloysius Meyer, Jr., M.D.
Carey A Mickel, Jr., M.D.
Jacqueline White Miller, M.D.
Byron D. Minor, M.D.
Victor Augustus Moore, Jr., M.D.
Russell Ray Moores, M.D.
Hugo A. Sanchez Moreno, M.D.
Harvey Vaughan Morgan, M.D.
Jacob Moshev, M.D.
Benjamin F Moss, Jr., M.D.
Steven A. Muller, M.D.
William Bernard Mullins, M.D.
Alexander T. Murphey, M.D.
Hamil Murray, M.D.
Darrell W. Murray, M.D.
E. Anthony Musarra, II, M.D.
Dearing A. Nash, M.D.
John Bruce Neeld, Jr., M.D.
Joe L. Nettles, M.D.
Maury C. Newton, Jr., M.D.
William Lanier Nicholson, M.D.
Benjamin Boyd Okel, M.D.
James Lawton O'Quinn, M.D.
William W. Orr, Sr., M.D.
William W. Osborne, M.D.
John Anthony Page, M.D.
Joseph L. Parker, M.D.
Prentiss E Parker, Jr., M.D.
Jesse Lyle Parrott, M.D.
Thomas Corley Paschal, M.D.
Robert Marion Patton, M.D.
Peter Michael Payne, M.D.
Jesse R Peel, M.D.
William Jefferson Pendergrast, Sr., M.D.
Henry Stone Pepin, Jr., M.D.
James Chandler Pope, M.D.
Edwin C. Pound, Jr., M.D.
Stuart Holmes Prather, Jr., M.D.
Carol Graham Pryor, M.D.
Dent W. Purcell, M.D.
Norman B Pursley, M.D.
2016 Life Members

James Leroy Rabb, M.D.
Harold Smith Ramos, M.D.
Alfred Henry Randall, Jr., M.D.
William Rawlings, M.D.
Otis Grey Rawls, M.D.
Albert A. Rayle, Jr., M.D.
Charles Joseph Rey, Jr., M.D.
Donald Wallace Rhome, M.D.
Sterling H Richardson, M.D.
Henry C. Ricks, Jr., M.D.
Wells Riley, M.D.
Robert Arthur Robbins, M.D.
Ralph Donald Roberts, M.D.
Phillip Lee Roberts, M.D.
Michael Frederick Roberts, Jr., M.D.
Harvey B. Roddenberry, M.D.
Howard Stephen Rosing, M.D.
Julius Thornton Rucker, Jr., M.D.
Edward Kinzel Russell, M.D.
Ferrol Aubrey Sams, Jr., M.D.
Helen F. Sams, M.D.
Gerald E. Sanders, M.D.
John Keith Schellack, M.D.
Philip Thomas Schley, M.D.
Elbert William Schmitt, Jr., M.D.
Carl C. Schuessler, M.D.
Robert Ira Schwartz, M.D.
George P. Sessions, M.D.
Narendra K. Shah, M.D.
Kailash B. Sharma, M.D.
Edwin C. Shepherd, M.D.
Eloise Baim Sherman, M.D.
Barry David Silverman, M.D.
Charles M. Silverstein, M.D.
Robert Webb Simmons, M.D.
William Crawford Simmons, M.D.
Howel William Slaughter, Jr., M.D.
Hugh F Smisson, Jr., M.D.
Luther J. Smith, II, M.D.
Samuel Raymond Smith, M.D.
Chester M. Smith, Jr., M.D.
Patton Paul Smith, M.D.

James Leon Smith, M.D.
William Hill Somers, M.D.
John Aziz Souma, M.D.
Stephen Danny Spain, M.D.
Jacob Aaron Spanier, M.D.
Raymond F Spanjer, M.D.
Oscar Smith Spivey, M.D.
Irving Teague Staley, M.D.
Franklin Julian Star, M.D.
Michael Stebler, M.D.
John Edward Steinhaus, M.D.
Dan Bryan Stephens, M.D.
Elma Mera Steves, M.D.
Robert L Stump, Jr., M.D.
Yung-Fong Sung, M.D.
Jonathan S. Swift, M.D.
Panagiotis N. Symbas, M.D.
David E. Tanner, M.D.
Robert Pierpont Taylor, M.D.
David C. Thibodeaux, M.D.
Dr. Donald Ray Thomas, M.D.
William Robert Thompson, M.D.
William A. Threlkeld, M.D.
John Nicholas Tiliacos, M.D.
Ralph A. Tillman, M.D.
William Clyde Tippins, Jr., M.D.
Robert P Tucker, M.D.
Mildred Virginia Tuggle, M.D.
William Darrell Tumlin, M.D.
David Allen Turner, M.D.
Carroll S Tuten, M.D.
Karl Henry Ullman, M.D.
Charles R. Underwood, M.D.
Charles Bell Upshaw, Jr., M.D.
Herbert E. Valentine, Jr., M.D.
Edgar Allen Vaughan, M.D.
Irving Victor, M.D.
John Seth Wade, M.D.
Edward Jones Waits, M.D.
Charles Osborne Walker, Jr., M.D.
Richard Storer Ward, M.D.
John D. Watson, Jr., M.D.
2016 Life Members

Paul Daniel Webster, III, M.D.
Claude M. Whidden, M.D.
Paul Austin Whitlock, Jr., M.D.
Stewart Earle Wiegand, M.D.
Christopher James Wilke, M.D.
Howard J. Williams, Jr., M.D.
William T. Williams, M.D.
Joseph Sealy Wilson, Sr., M.D.
John Page Wilson, M.D.
Henry H. Wilson, M.D.
Roy Witherington, M.D.
Homer Patrick Wood, M.D.
Robert Warner Wood, M.D.
Thomas Earl Wyatt, M.D.
Owen K. Youles, Jr., M.D.
Frank Yu, M.D.
Alex Z. Klopman, M.D.
Joseph Robert Zanga, M.D.
Arnold Zweig, M.D.
2016 Deceased Members

Harry B. Bechtel, M.D.
Sarah L. Clark, M.D.
Gary Jay Kaplan, M.D.
William Calvin Lavely, M.D.
James S. Reynolds, M.D.
Frank A. Wilson, III, M.D.
REPORTS OF OFFICERS AND DIRECTORS
FIRST DISTRICT MEDICAL SOCIETY

SUBJECT: Annual Report

SUBMITTED BY: Aaron H. Davidson, M.D., Director
Michelle R. Zeanah, M.D., Alternate Director

REFERRED TO: Not Referred

FIRST DISTRICT MEDICAL SOCIETY

<table>
<thead>
<tr>
<th>Secretary</th>
<th>2014 MAG Members</th>
<th>2015 MAG Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ogeechee River</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aaron Davidson, M.D.</td>
<td>81</td>
<td>91</td>
</tr>
<tr>
<td>Statesboro</td>
<td></td>
<td></td>
</tr>
<tr>
<td>East GA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>James B. Polhill, M.D.</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>Louisville</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laurens</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mal Hollander, M.D.</td>
<td>31</td>
<td>26</td>
</tr>
<tr>
<td>Dublin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Southeast GA</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>21</td>
<td>15</td>
</tr>
<tr>
<td>St. Johns Parish</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Michael J. Sharkey, M.D.</td>
<td>5</td>
<td>11</td>
</tr>
<tr>
<td>Hinesville</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>147</strong></td>
<td><strong>150</strong></td>
</tr>
</tbody>
</table>

1 The First District Medical Society met at the May 2016 meeting of the Ogeechee River Medical Society.
2 Officers were reaffirmed for a two-year term last year – Dr. Aaron H. Davidson, Director and Secretary and Dr. Michelle R. Zeanah, Alternate Director.
3 Our local medical society had regular meetings during the year – monthly except during the summer.
4 We had four delegates attend the 2015 House of Delegates. Dr. Zeanah served on Reference Committee A as Vice Chair. Dr. Davidson was elected to serve on the Physician’s Institute Board.
5 Dr. Zeanah is the Chair of the GAMPAC Board of Directors and serves on the Council on Legislation.
We had a dinner for our local legislators in July, which was attended by Sen. Jack Hill and Reps. Jan Tankersley, John Burns and Butch Parrish.

We sent a delegation to the Gold Dome in February and Drs. Zeanah, Davidson, and W. Scott Bohlke attended the legislative seminar at Jekyll Island in July.

Drs. Davidson and Bohlke also attended a legislative breakfast in April.

# # #
SECOND DISTRICT MEDICAL SOCIETY

SUBJECT: Annual Report

SUBMITTED BY: G. Ashley Register Jr., M.D., Director
Sandra B. Reed, M.D., Alternate Director

REFERRED TO: Not Referred

SECOND DISTRICT MEDICAL SOCIETY

<table>
<thead>
<tr>
<th>Secretary</th>
<th>2014 MAG Members</th>
<th>2015 MAG Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colquitt</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gary Lodge, M.D.</td>
<td>26</td>
<td>26</td>
</tr>
<tr>
<td>Moultrie</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decatur</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gordon C. Miller, M.D.</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Bainbridge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thomas Area</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waters Merrill Hicks Jr., M.D.</td>
<td>32</td>
<td>38</td>
</tr>
<tr>
<td>Thomasville</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tift</td>
<td>33</td>
<td>28</td>
</tr>
<tr>
<td>Member at Large</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>104</strong></td>
<td><strong>106</strong></td>
</tr>
</tbody>
</table>

The Second District Medical Society held a joint meeting with Thomas Area Medical Society (TAMS) on August 25, 2016. The following officers were elected: Ashley Register, M.D., Treasurer; Patty June, M.D., Director; and Barbara McCollum, M.D., Alternate Director. Dr. McCollum is scheduled to replace Sandra Reed, M.D., after the 2016 House of Delegates meeting. Dr. Reed will be relocating to the Atlanta area.

Moultrie will start a new family medicine residency and a new medical school is forthcoming, which will be affiliated with the Philadelphia College of Osteopathic Medicine (PCOM).

Membership: 210
THIRD DISTRICT MEDICAL SOCIETY

Director: 03.16

SUBJECT: Annual Report

SUBMITTED BY: Santanu Das, M.D., Director
W. Steven Wilson, M.D., Alternate Director

REFERRED TO: Not Referred

---

THIRD DISTRICT MEDICAL SOCIETY

<table>
<thead>
<tr>
<th>Secretary</th>
<th>2014 MAG Members</th>
<th>2015 MAG Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flint</td>
<td></td>
<td></td>
</tr>
<tr>
<td>William P. Pannell, M.D.</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Cordele</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sumter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thomas Gatewood Jr., M.D.</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>Member at Large</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>13</strong></td>
<td><strong>13</strong></td>
</tr>
</tbody>
</table>

# # #
FOURTH DISTRICT MEDICAL SOCIETY

SUBJECT: Annual Report

SUBMITTED BY: Stanley W. Sherman, M.D., Director
Andrea P. Juliao, M.D., Director
Brian A. Levitt, M.D., Alternate Director
Kathryn C. Elmore, M.D., Alternate Director

REFERRED TO: Not Referred

---

FOURTH DISTRICT MEDICAL SOCIETY

(See DeKalb Medical Society – Director 15.16)

# # #
FIFTH DISTRICT MEDICAL SOCIETY

SUBJECT: Annual Report

SUBMITTED BY: Rutledge Forney, M.D., Director
Michael C. Hilton, M.D., Director
Quentin R. Pirkle Jr., M.D., Director
Lisa Perry-Gilkes, M.D., Director
Thomas E. Bat, M.D., Alternate Director
Brian E. Hill, M.D., Alternate Director
Charles I. Wilmer, M.D., Alternate Director
Fonda Ann Mitchell, M.D., Alternate Director

REFERRED TO: Not Referred

FIFTH DISTRICT MEDICAL SOCIETY
(See Medical Association of Atlanta – Director 20.16)

# # #
SUBJECT: Annual Report

SUBMITTED BY: Leiv M. Takle Jr., M.D., Director
William D. Lazenby, M.D., Alternate Director

REFERRED TO: Not Referred

### SIXTH DISTRICT MEDICAL SOCIETY

<table>
<thead>
<tr>
<th>Secretary</th>
<th>2014 MAG Members</th>
<th>2015 MAG Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coweta</td>
<td>11</td>
<td>14</td>
</tr>
<tr>
<td>Spalding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Charles T. Hopkins Jr., M.D. Griffin</td>
<td>14</td>
<td>22</td>
</tr>
<tr>
<td>Troup</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thomas Gore, M.D. LaGrange</td>
<td>47</td>
<td>42</td>
</tr>
<tr>
<td>Upson</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Keith B. Huckaby, M.D. Thomaston</td>
<td>16</td>
<td>13</td>
</tr>
<tr>
<td>Member at Large</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>91</strong></td>
<td><strong>93</strong></td>
</tr>
</tbody>
</table>

# # #
The Seventh District Medical Society has begun to see a reinvigoration of its local societies. The Floyd-Polk-Chattooga Medical Society had one meeting in May with more than 75 physicians in attendance. There are plans to have a fall meeting. I would like to thank Dr. John Cowen for spearheading this effort in Rome.

Under the leadership of Dr. David Bosshardt, the Walker-Catoosa-Dade Medical Society still meets monthly. I have been able to visit them several times during the year to give updates from MAG and the Georgia Composite Medical Board. They are currently studying MACRA and scope of practice issues.
I again want to sincerely thank Ms. Joanne Thurston and the Cobb County Medical Society for inviting those physicians in the southern part of the Seventh District to their medical society meetings. They have had several very interesting medical topics of discussion.

Finally, I am optimistic that the Whitfield-Murray Medical Society will continue to work to have more meetings. It is becoming clear in today’s health care environment that physicians are finding it more difficult to find time to participate in many activities outside of the office or the hospital. MAG and its resources offer the knowledge and the collegiality that is needed more and more today.

# # #
SUBJECT: Annual Report

SUBMITTED BY: James W. Barber, M.D., Director
KEITH R. JOHNSON, M.D., ALTERNATE DIRECTOR

REFERRED TO: Not Referred

---

<table>
<thead>
<tr>
<th>MAG Area</th>
<th>2014 MAG Members</th>
<th>2015 MAG Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ben Hill Irwin</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>C. Morgan Smith Jr., M.D. FitzGerald</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coffee</td>
<td>17</td>
<td>14</td>
</tr>
<tr>
<td>Challori J. Reddy, M.D. Douglas</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glynn</td>
<td>42</td>
<td>46</td>
</tr>
<tr>
<td>Neil E. Goodman, M.D. Brunswick</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ocmulgee</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Todd Peacock, M.D. Eastman</td>
<td></td>
<td></td>
</tr>
<tr>
<td>South GA</td>
<td>64</td>
<td>56</td>
</tr>
<tr>
<td>Thomas E. Phillips, M.D. Valdosta</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Okefenokee</td>
<td>36</td>
<td>32</td>
</tr>
<tr>
<td>Pauline Bellecci, M.D. Waycross</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wayne</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Member at Large</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>175</strong></td>
<td><strong>164</strong></td>
</tr>
</tbody>
</table>
District 8 is composed of the southeast corner of Georgia, and includes the following component medical societies: Altamaha, Ben Hill-Irwin, Camden-Charlton, Coffee, Glynn, Wayne, Ocmulgee, Okefenokee, and South Georgia. Over the course of this last year, district meetings were held in most of the counties (in conjunction with hospital medical staff meetings). There, we were able to give a 2016 legislative update, promote MAG membership, and discuss the advantages of working together as an organized house of medicine. The work must go on, as we continue to face challenges of access, reimbursement, and administrative/regulatory burdens. We must not allow these challenges to impede access to high quality health care in southeastern Georgia.

At our annual meeting on September 27, we enjoyed great fellowship and elected a new Director, Dr. Keith Johnson (Waycross) and Alternate Director Dr. Sudhakar Jonnalagadda (Douglas).

# # #
REVISED
(10.07.16)

NINTH DISTRICT MEDICAL SOCIETY

Director: 09.16

SUBJECT: Annual Report

SUBMITTED BY: Richard A. Wherry, M.D., Director
Stephen Jarrard, M.D., Alternate Director

REFERRED TO: Not Referred

NINTH DISTRICT MEDICAL SOCIETY

<table>
<thead>
<tr>
<th>Secretary</th>
<th>2014 MAG Members</th>
<th>2015 MAG Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barrow</td>
<td></td>
<td></td>
</tr>
<tr>
<td>W. Dwight Austin, M.D.</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Winder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blue Ridge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Raymond E. Tidman, M.D.</td>
<td>17</td>
<td>13</td>
</tr>
<tr>
<td>Blue Ridge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elbert</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Cherokee-Pickens</td>
<td></td>
<td></td>
</tr>
<tr>
<td>William Marks, M.D.</td>
<td>27</td>
<td>37</td>
</tr>
<tr>
<td>Canton</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Habersham</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laurie H. Gillespie, M.D.</td>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td>Demorest</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jackson Banks</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>Stephens Rabun</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stephen Jarrard, M.D.</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>Lakemont</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Member at Large</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>108</strong></td>
<td><strong>122</strong></td>
</tr>
</tbody>
</table>

1 No meeting was held this year partly due to geographical issues and no one stated a need for one. Despite this fact, the district experienced an increase of 14 members - a growth rate of 13 percent.

# # #
TENTH DISTRICT MEDICAL SOCIETY

Director: 10.16

SUBJECT: Annual Report

SUBMITTED BY: Arthur J. Torsiglieri, M.D., Director
John O. Bowden, M.D., Alternate Director

REFERRED TO: Not Referred

---

TENTH DISTRICT MEDICAL SOCIETY

<table>
<thead>
<tr>
<th>Secretary</th>
<th>2014 MAG Members</th>
<th>2015 MAG Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baldwin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>George Martinez, M.D.</td>
<td>18</td>
<td>17</td>
</tr>
<tr>
<td>Milledgeville</td>
<td></td>
<td></td>
</tr>
<tr>
<td>East Metro</td>
<td></td>
<td></td>
</tr>
<tr>
<td>John O. Bowden, M.D.</td>
<td>61</td>
<td>65</td>
</tr>
<tr>
<td>Conyers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oconee Valley</td>
<td></td>
<td></td>
</tr>
<tr>
<td>William H. Rhodes Jr., M.D.</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Union Point</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Member at Large</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>89</td>
<td>88</td>
</tr>
</tbody>
</table>

# # #
BIBB COUNTY MEDICAL SOCIETY

SUBJECT: Annual Report

SUBMITTED BY: William P. Brooks, M.D., Director
Robert C. Jones, M.D., Alternate Director

REFERRED TO: Not Referred

BIBB COUNTY MEDICAL SOCIETY

<table>
<thead>
<tr>
<th>Secretary</th>
<th>2014 MAG Members</th>
<th>2015 MAG Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Robert Jonathan Dean, M.D. Macon</td>
<td>318</td>
<td>300</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>318</strong></td>
<td><strong>300</strong></td>
</tr>
</tbody>
</table>

From September 2015 through August 2016, Bibb County Medical Society (BCMS), Inc., held six meetings for its membership.

In September, we hosted our Annual Membership Picnic, inviting our local, state, and federal legislators and candidates as guests and welcoming new physicians and their families. Our event was a Sunday afternoon family picnic during which children played on a water slide and a combo climber.

At the Medical Association of Georgia House of Delegates, Bibb CMS had a total of 16 Delegates or Alternates in attendance. Dr. Michael E. Greene was re-elected as an AMA Delegate, and Dr. Billie L. Jackson was re-elected as an AMA Alternate Delegate. Dr. Malcolm S. Moore Jr. served as Chair of Reference Committee C (Legislation); Dr. John J. Rogers was Vice Chair of Reference Committee C&B; and Dr. Darl Rantz was a member of Reference Committee A (Health Care Policy).

At our Middle Georgia Educational Foundation lecture in November 2015, we presented a program entitled “Medical Cannabis.” Because the Georgia legislature legalized medical cannabis for treatment of specific diagnoses during the 2015 session, we provided three speakers and their perspectives: Dr. James L. Smith discussed the medical perspective; Tracy Field, Esq., discussed the legal perspective; and Dr. Mary Gregg with MagMutual Patient Safety Institute, discussed the risk management perspective. State Rep. Allen Peake and Dr. Alice House Chair of the Georgia Composite Medical Board, were invited guests.

Our December event was the annual President’s Party – with the installation of officers and presentation of awards. Dr. W. Robert Lane was installed as the President for 2016. Dr. Lynn Denny Medical Director of the Macon Volunteer Clinic from 2003 to 2015 was recognized with BCMS’ Distinguished Service Award. Dr. William F. Bina III was named 2015 Physician of the Year and his wife, Gayle Bina, M.S., was named the Citizen of the Year.
In January 2016, BCMS members participated in Physicians’ Day at the Capitol. Our members met with area legislators and discussed various issues with them.

On March 3, 2016, Mr. Steven Adams, MCS, CPC, InHealth Professional Services, presented “Value Modifier, PQRS, Risk Adjustment and ICD-10 – Oh My…” Office staff were allowed to accompany BCMS member physicians.

On March 20, 2016, BCMS arranged for our members and their children or grandchildren to have an afternoon of “Fun at the Museum.” Animal shows, The Sphere, and planetarium shows were highlights. The event was held at the Macon Museum of Arts & Sciences.

On April 21, BCMS members and spouses enjoyed “A Tasting of Appetizers and Craft Beers” at the Rocking Chair Ranch barn, the property of Dr. Rana Munna and Mr. Joseph Egloff. Several restaurants provided appetizers appropriate for the selection of craft beers. The event was well attended, and members and guests had a very enjoyable evening.

In August 2016, we held a daytime program for office staff. Dr. Gregg presented a risk management program entitled, “Reboot Your Risk Management Checklist.”

BCMS members held a number of key roles in MAG, including First Vice President (Dr. Madalyn Davidoff), Chair of the Council on Legislation (Dr. Michael E. Greene), AMA Delegate (Dr. Michael E. Greene), and AMA Alternate Delegate (Dr. Billie L. Jackson).

###
SUBJECT: Annual Report

SUBMITTED BY: (Vacant) Director
(Vacant) Alternate Director

REFERRED TO: Not Referred

<table>
<thead>
<tr>
<th>Secretary</th>
<th>2014 MAG Members</th>
<th>2015 MAG Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daniel T. McDevitt, M.D.</td>
<td>85</td>
<td>120</td>
</tr>
<tr>
<td>Stockbridge</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>85</strong></td>
<td><strong>120</strong></td>
</tr>
</tbody>
</table>

# # #
Cobb County Medical Society (CCMS) had a very successful and exciting year. President Nydia Bladuell, M.D. (2016) led the society in achieving its goals.

Drs. Jeffrey Stone and Mark Huffman are the CCMS participants to the Georgia Physicians Leadership Academy (GPLA) this year. Dr. Debi Dalton is a CCMS graduate from the GPLA. CCMS members also graduating from GPLA include, Drs. Mitzi Rubin, Kelly Weselman, Jennifer Tucker, and Robert Bashuk.

Our membership increased five percent during 2016. We have increased our membership by adding several specialty practices joining as a group. Scripts (the medical journal of CCMS) allowed the different specialties to contribute to the society as a whole.

CCMS held four meetings during 2016. The first was our Legislative meeting on January 20, 2016. Our guest included 10 members of the Georgia Legislature. Each legislator was given the opportunity to address the group about their committees and their thoughts on the upcoming session. Physicians were allowed to ask questions of the legislators.

Our spring meeting featured Candice Saunders, CEO from WellStar Health Systems. Ms. Saunders gave us an update on the addition of six hospital and 105 new physicians. The update included WellStar’s residency program that started in July.

Our fall meeting was a joint meeting with Medical Association of Atlanta. Our speaker was Salvatore Mangione, M.D., from Thomas Jefferson University. He spoke on “Group Thinking, Nazi Medicine and the Roots of Collective Evil.” Our last meeting of the year is our social meeting and election of officers.

Scripts, the journal of the Cobb County Medical Society, celebrated its fifth anniversary. Issues topics have included medical missions, cancer, history of medicine, and strokes.
The Board of Trustee expanded during 2016 with the inclusion of several new physicians.

Board members are:

Dr. Catherine Goodwin   Dr. Jeffrey Stone
Dr. Charles Hutchinson   Dr. Jeffrey Tharp
Dr. Dan Stephens   Dr. Elizabeth Street
Dr. Debi Dalton   Dr. Mehrnoosh Gaffari
Dr. Dirk Huttenbach   Dr. March Huffman
Dr. Stan Dysart   Dr. Mark Huffman
Dr. Stan Dysart   Dr. Marla Franks
Dr. Edward Lloyd   Dr. Tony Musarra
Dr. David Edwards   Dr. Noel Holtz
Dr. Elizabeth Whitaker   Dr. Nydia Bladuell
Dr. Tom Emerson   Dr. Gerry Parada
Dr. Jeffrey Proctor   Dr. Mary Pitcher
Dr. V. K. Puppala   Dr. Seth A. Yellin
Dr. Melissa Rhodes   Dr. Art Shearin
Dr. Royden Daniels   Dr. Mark Diehl

The committees have been working to enhance the physician cohesion and communication of our Board meetings and general membership meetings. We became a sponsor of the “Gobble Jog” to benefit MUST Ministry. CCMS organized a team to run the 5K. Several of our members were stationed around the course to facilitate any emergencies that might occur. To make sure we meet this goal, each November we have a social gathering at the Gardens of Kennesaw Mountain. This meeting allows members to get to know each other.

Advocating constructive health policies is another goal that CCMS has accomplished this year. The Cobb Healthcare Professionals PAC has created direct one-on-one contact with our legislators. Our legislative dinner on January 20, 2016, allowed us to meet, greet, and get to know 15 members of the Georgia General Assembly. The legislators were from Cobb, Bartow, Cherokee, and Fulton counties. Dr. Dalton attended MAG’s Summer Legislative meeting in July 2016.

# # #
CRAWFORD W. LONG MEDICAL SOCIETY

SUBJECT: Annual Report

SUBMITTED BY: Andrew H. Herrin, M.D., Director
Ryan M. Katz, M.D., Alternate Director

REFERRED TO: Not Referred

---

CRAWFORD W. LONG MEDICAL SOCIETY

<table>
<thead>
<tr>
<th>Secretary</th>
<th>2014 MAG Members</th>
<th>2015 MAG Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gary Walton, M.D. Athens</td>
<td>156</td>
<td>165</td>
</tr>
<tr>
<td>Total</td>
<td>156</td>
<td>168</td>
</tr>
</tbody>
</table>

# # #
The following is a brief summary of our programs and activities:

**Volunteer Leadership**

The following were elected to serve in 2016:

- President: Katherine Elmore, M.D.
- President-elect: Don Siegel, M.D.
- Vice President: Eric Erickson, M.D.
- Secretary/Treasurer: Qammar Rashid, M.D.
- Past President: Andrea P. Juliao, M.D.
- MAG Director: Stanley W. Sherman, M.D.
- MAG Director: Andrea P. Juliao, M.D.
- MAG Alternate Director: Katherine Elmore, M.D.
- MAG Alternate Director: Brian A. Levitt, M.D.
- Director-at-Large: Gulshan Harjee, M.D.
- Director-at-Large: Robin Dretler, M.D.
- Chair of the Commission on Advocacy: Roy W. Vandiver, M.D.
- Chair of the Commission on Community Service: Gary R. Boststein, M.D.
- Chair of the Commission on Legislative Activities: Joe Weissman, M.D.
- Chair of the Commission on Membership Services: William R. Hardcastle, M.D.
Community Service

The DeKalb Medical Society (DMS) continues to operate the highly successful Physicians’ Care Clinic (PCC), a community outreach program for the medically indigent in our county. This clinic is supported by part-time paid staff and a large cadre of health care professionals, including numerous DMS members who donate their time. The clinic is supported financially by corporate grants and individual donations. We have an annuity through the DeKalb Medical Hospital Foundation that supports the annual operating expenses of the clinic.

We continue to raise significant support through the physician community and other private foundations. Our goal is to increase the annuity to a level that the clinic will be self-supporting going forward. PCC operates as a charitable foundation by the society.

DeKalb members are also supporting a clinic in earthquake ravaged Nepal, the Taksindu medical camp, under the leadership of Dr. Gary Botstein. Physicians, nurses, pharmacists and other medical personnel will depart October 20 for Nepal and are expected to treat more than 300 patients during the trip. In addition to personnel, DMS has gathered medical supplies and equipment to support the team. This is the second year that DMS has supported this clinic.

Legislative Activities

We attempt to maintain a close relationship with our legislators through individual contacts as well as support of MAG’s legislative team. On December 6 will discuss “All Politics Are Local,” a gathering of legislative leaders in the county.

Communications

We have moved to an email communication system for urgent issues and meeting notices. We have a new website that is updated regularly and linked to PCC’s new site.

Programs

DMS kicked off the New Year with the Annual Meeting and Casino Night, celebrating community leaders Judy and Bob McMahan and the PCC, held on January 23 at the Ansley Golf Club. The society’s community service award was renamed the Judy and Bob McMahan Citizenship Award and they were the first recipients. In addition to honoring the McMahans, PCC named Dr. Michael Baron Volunteer of the Year.

Our fall calendar will be full with two more meetings: on October 5 DMS will hold a membership meeting with MAG Mutual Insurance Company, “Closing Gaps in the Continuum of Care: Best Practices in Care Transitions” and our legislative meeting noted above.

Membership and Finances

Our MAG membership increased this year and we were pleased that DeKalb Medical’s employed physicians joined the DeKalb Medical Society en masse, adding 104 new members.

It has been our pleasure to serve DMS as its Directors and Alternate Directors. We believe our county medical society remains a critical entity in the federation of medicine that allows us to maintain a grass roots presence and cultivate leaders for our state and national organizations.

# # #
DOUGHERTY COUNTY MEDICAL SOCIETY

Director: 16.16

SUBJECT: Annual Report

SUBMITTED BY: Timothy S. Trulock, M.D., Director
Michael D. Daugherty, M.D., Alternate Director

REFERRED TO: Not Referred

DOUGHERTY COUNTY MEDICAL SOCIETY

<table>
<thead>
<tr>
<th>Secretary</th>
<th>2014 MAG Members</th>
<th>2015 MAG Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>John B. Davis Jr., M.D. Albany</td>
<td>126</td>
<td>125</td>
</tr>
<tr>
<td>Total</td>
<td>126</td>
<td>125</td>
</tr>
</tbody>
</table>

# # #
The Georgia Medical Society (GMS) meets the second Tuesday in January, April, October and November at 6 p.m. for a social time, while dinner is served at 6:30 p.m. Following dinner, the meeting begins at 7 p.m. The meetings are held at Carey Hilliard’s Restaurant. Spouses are invited to join us for the evening.

On October 27, 2015, GMS sponsored the 15th Annual Health Care Heroes Awards. Nominations were accepted from individuals and/or organizations for individuals who deserved an award in any of the following categories: Health Care Innovation, Health Care Education, Community Outreach, Institution/Organization, Allied Health Professionals and Physician Lifetime Achievement. Sixteen awards were given.

At the November 10, 2015 meeting, the speaker was Dr. Murray Freedman. He spoke on “Sex, Hormones and Happiness.”

On January 12, 2016, the following officers were installed for 2016. President, Dr. Kelly A. Erola, Vice President, Dr. Luke J. Curtsinger, President-Elect, Dr. Joshua T. McKenzie, Secretary, Dr. William A. Darden, Treasurer, Dr. Fred L. Daniel. Delegates to the MAG House of Delegates include Drs. Vernon T. Bryant, Thomas E. Shook, Patrick L. Blohm, David S. Oliver, William A. Darden, Edmund R. Donoghue, Mark E. Murphy, and Joshua T. McKenzie. Alternate delegate is Dr. Carl B. Pearl. Also, Parliamentarian, Dr. Roland S. Summers, Historian, Dr. Leslie L. Wilkes, and Historian Emeritus, Dr. Thomas R. Freeman. The speaker for the evening was Dr. Rick Roth. He spoke on “The Mishandled Crisis Lessons Learned from the Ebola Epidemic.”

On February 28, the members enjoyed the annual GMS oyster and barbeque at the home of Dr. Kelly Erola and Rick Rebellato. The members had a great time and delicious food.

At the April 12 meeting, the speakers were Dr. Jacqueline Huntly who spoke on “How to live to be 100+” and Dr. Luke Curtsinger who spoke on “Let’s make Savannah a Blue Zone City.” Also at this meeting the
John B. Rabun Award was given to Dr. Carl L. Rosengart. This award is given to a member for his/her contributions to the community life outside the practice of medicine. Dr. Rosengart has contributed service to our community for the last 50 years.

On May 3, GMS sponsored the High School Preceptorship Program, which is a collaborative internship program between the Savannah-Chatham Public School System and the Georgia Medical Society. Eleven high school seniors from local public high schools were selected by the Board of Education to participate in the program. The students spent the day with physicians in their practice of medicine. The program began with an orientation breakfast at 6 a.m. and a closing banquet at 5 p.m. with discussion by the students on their activities for the day. Forty physicians participated. The program is chaired by Dr. Michael Zoller.

On May 17, the Retired and Life Members group enjoyed having a luncheon and sharing experiences in their practices. Dr. John Dekle chairs this group.

On June 22, 2016, Dr. Kelly Erola, President, addressed the new residents at Memorial University Medical Center and invited them to join. Thirty-five applications were submitted and GMS has welcomed these new members.

Dr. Erola addressed and welcomed the new medical students from the Medical College of Georgia on July 22 and handed out membership applications.

On August 17, Dr. Joshua McKenzie, President-elect, addressed and welcomed the new medical students at Mercer University Medical School – Savannah Campus. Thirty-five applications were completed and GMS welcomed these new members.

GMS will hold its Super Meeting at Alee Shriners Building on September 13, which is co-sponsored by St. Joseph’s/Candler, Memorial University Medical Center, and MAG Mutual Insurance Company. The speaker for the evening will be Tony Buettner, who is an author and the Vice President of Blue Zone Development. He will speak on “How to live to be 100” and “Making Savannah a Blue Zone City.”

Local legislators have been invited to speak on legislative issues at the October 11 meeting.

GMS has 614 members – of that 85 are residents and 161 are medical students.

###
GWINNETT-FORSYTH COUNTY MEDICAL SOCIETY

SUBJECT: Annual Report

SUBMITTED BY: John Y. Shih, D.O., Director
James L. Smith, M.D., Alternate Director

REFERRED TO: Not Referred

GWINNETT-FORSYTH COUNTY MEDICAL SOCIETY

<table>
<thead>
<tr>
<th>Secretary</th>
<th>2014 MAG Members</th>
<th>2015 MAG Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Julius Ajayi, M.D.</td>
<td>232</td>
<td>235</td>
</tr>
<tr>
<td>Lawrenceville</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>232</strong></td>
<td><strong>235</strong></td>
</tr>
</tbody>
</table>
The following is a brief summary of our 2016 program year:

Volunteer leadership

The following physicians are serving the Hall County Medical Society (HCMS):

President.......................... Karl Schultz, M.D.
Vice President.......................... Abhishek Gaur, M.D.
Secretary/Treasurer.................. Brett Krummert, M.D.
Past President........................ Dan Mullis, M.D.
Past President........................ Andrew Reisman, M.D.
MAG Director................................ Karl Schultz, M.D.
MAG Alternate Director................ Abhishek Gaur, M.D.

Community service

The society continues its involvement in the “Good News at Noon” medical clinic that serves the indigent of our community as well as the Health Access Initiative. We also continued to provide physicals to students at area high schools.

Legislative activities

We attempt to maintain a close relationship with our legislators and Congressmen through individual contacts as well as support MAG’s legislative team. We invite them to all our meetings.
Communications

We use an email/fax distribution system and frequent mailings in an effort to communicate with our members quickly and inexpensively. We also maintain close contact with the practice administrators, particularly those in the larger groups.

Programs

The society presents several programs to the membership each year focusing primarily on issues related to office management, legislation and politics.

Our spring program featured MAG Executive Director Donald J. Palmisano Jr. on “Navigating the Changing Environment of Healthcare.”

Gov. Nathan Deal was the featured speaker at HCMS’ September 15 meeting. MAG Mutual presented a risk management seminar following the Governor. New members of the hospital medical staff were honored.

As we prepare for the MAG House of Delegates meeting, we are pleased that Dr. Frank McDonald will be a candidate for President-Elect, as well as serve as Speaker of the House of Delegates. Also, Dr. Jack Chapman is a candidate for AMA Alternate Delegate – a position that he currently holds.

Membership and finances

Membership recruitment and retention and financial stability continue to be pressing issues and threaten the survival of our society. We are striving to add value to our organization through improved programming and involved leadership.

It has been a pleasure to serve as HCMS president this year.

# # #
MEDICAL ASSOCIATION OF ATLANTA

SUBJECT: Annual Report

SUBMITTED BY: Rutledge Forney, M.D., Director
Michael C. Hilton, M.D., Director
Quentin R. Pirkle Jr., M.D., Director
Lisa Perry-Gilkes, M.D., Director
Thomas E. Bat, M.D., Alternate Director
Brian E. Hill, M.D., Alternate Director
Charles I. Wilmer, M.D., Alternate Director
Fonda Ann Mitchell, M.D., Alternate Director

REFERRED TO: Not Referred

MEDICAL ASSOCIATION OF ATLANTA

<table>
<thead>
<tr>
<th>Secretary</th>
<th>2014 MAG Members</th>
<th>2015 MAG Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Association of Atlanta</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Charles Wilmer, M.D.</td>
<td>1,799</td>
<td>1,855</td>
</tr>
<tr>
<td>Atlanta</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1,799</td>
<td>1,855</td>
</tr>
</tbody>
</table>

The Medical Association of Atlanta (MAA) started the year with its July 28, 2015 board meeting followed by an offsite planning meeting August 14th-16th, 2015 at Callaway Gardens Resort. Other board meetings were held on the following dates in the 2015-2016 year: December 1, 2015, January 28, 2016, March 24, 2016, and May 19, 2016.

MAA began the year with a joint meeting with the Cobb Medical Society on September 24th with Richard Jadick, D.O. speaking on “Combat Trauma on the Front Lines of Fallujah.”

On November 12th we co-hosted a dinner meeting with the Medical Association of Georgia featuring a panel discussion with leaders from the American Medical Association.

On February 3, 2016, we had nationally known speaker Nate Kaufman speak on the future of medicine with the topic “Navigating the Minefields of Physician Practice.”

MAA hosted its annual social event and dinner at the Bobby Cox Suite on opening night of the Atlanta Braves baseball season on April 4th. This continues to be the most popular social event hosted each year.

And on May 12th we hosted a dinner meeting with our sponsor Privia Health Systems.
The following MAA members attended the April 2016 GAMPAC Fly-In in Washington, DC: Thomas Bat, M.D, Matthews Gwynn, M.D., John Harvey, M.D., Albert Johary, M.D., Fonda Mitchell, M.D., Quentin Pirkle, M.D., Randy Rizor, M.D., and Steve Walsh, M.D.

The year ended with our annual meeting held on June 16, 2016 at Maggiano’s with a presentation by MAG Executive Director/CEO Donald Palmisano Jr., speaking on “What are the top issues impacting Georgia physicians?”

The following officers were installed to serve for the 2016 – 2017 year:

**MAA Officers:** President, Thomas Bat, M.D.; President-elect, Charles Wilmer, M.D.; Treasurer, Martha Wilber, M.D.; Secretary, Deborah Martin, M.D.; Chairman of the Board, Quentin Pirkle, M.D.

The following members were installed to serve on the board of the MAA.

**MAA Board Members:** Robert J. Albin, M.D., Larry Bartel, M.D., Dimitri Cassimatis, M.D., Patrick Coleman, M.D., Lawrence E. Cooper, M.D., Rutledge Forney, M.D., Sandra Fryhofer, M.D., John A. Goldman, M.D., Matthews Gwynn, M.D., Magdi Hanafi, M.D., Brad Harper, M.D., John S. Harvey, M.D., Brian Hill, M.D., Michael C. Hilton, M.D., Albert F. Johary, M.D., John A. Johnson, M.D., Faria Khan, M.D., Welborn Cody McClatchey, M.D., Fonda Mitchell, M.D., Dorothy Mitchell-Leef, M.D., Elizabeth Morgan, M.D., Lisa Perry-Gilkes, M.D., Ali R. Rahimi, M.D., Alan R. Redding, M.D., Randy F. Rizor, M.D., William E. Silver, M.D., Earl Thurmond, M.D., Steven M. Walsh, M.D., W. Hayes Wilson, M.D.

###

# # #
MUSCOGEE COUNTY MEDICAL SOCIETY

SUBJECT: Annual Report

SUBMITTED BY: Frederick C. Flandry, M.D., Director
W. Frank Willett III, M.D., Alternate Director

REFERRED TO: Not Referred

The following officers were elected to serve the Muscogee County Medical Society (MCMS):

President.................................................. W. Frank Willett III, M.D.
President-elect............................... Timothy Villegas, M.D.
Secretary/Treasurer.......................... Bret Crumpton, D.O.

On January 18, 2016, more than 120 members and spouses attended MCMS’ wine tasting at Epic Restaurant. It was a unique and wonderful opportunity to network with colleagues and meet new members. Chef Jamie Keating provided wonderful food pairings. The event was sponsored by Hudson Financial Group and MAG Mutual Insurance Company.

On April 2, 2016, we hosted MCMS night at the Columbus Cottonmouth’s hockey game as they faced off against the Louisiana Ice Gators. More than 40 physicians, spouses and their children enjoyed a catered meal from Moe’s Southwest Grill in a private suite at the game.

On September 22, 2016, we enjoyed a special beer tasting event at the RiverMill Event Centre. It was a great opportunity to spend time with colleagues and members. The event was hosted by Columbus Bank and Trust and Columbus Diagnostic Center.

MCMS had a full delegation at MAG’s House of Delegates last year with 10 members and will have a full delegation of nine members at this year’s meeting.

# # #
PEACHBELT COUNTY MEDICAL SOCIETY

Director: 22.16

SUBJECT: Annual Report

SUBMITTED BY: Karunakar Sripathi, M.D., Director
T. G. Sekhar, M.D., Alternate Director

REFERRED TO: Not Referred

PEACHBELT COUNTY MEDICAL SOCIETY

<table>
<thead>
<tr>
<th>Secretary</th>
<th>2014 MAG Members</th>
<th>2015 MAG Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joseph Woods, M.D.</td>
<td>117</td>
<td>138</td>
</tr>
<tr>
<td>Warner Robins</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>117</td>
<td>130</td>
</tr>
</tbody>
</table>

# # #
RICHMOND COUNTY MEDICAL SOCIETY

SUBJECT: Annual Report

SUBMITTED BY: Michael J. Cohen, M.D., Director
                John F. Salazar, M.D., Director
                Jill P. Hauenstein, M.D., Alternate Director
                Donnie P. Dunagan, M.D., Alternate Director

REFERRED TO: Not Referred

RICHMOND COUNTY MEDICAL SOCIETY

<table>
<thead>
<tr>
<th>Secretary</th>
<th>2014 MAG Members</th>
<th>2015 MAG Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>James Rawson, M.D.</td>
<td>673</td>
<td>697</td>
</tr>
<tr>
<td>Waynesboro</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>673</td>
<td>697</td>
</tr>
</tbody>
</table>

1. **Officers**

   1. President…………………………………………………………..Craig Kerins, M.D.
   2. President-elect………………………………………………….Donnie Dunagan, M.D.
   3. Vice President ……………………………………………………Randy Hensley, M.D.
   4. Secretary …………………………………………………………..James Rawson, M.D.
   5. Treasurer …………………………………………………………Robert Kaminski, M.D.
   6. Director ……………………………………………………………Michael Cohen, M.D.
   7. Alternate Director ………………………………………………John Salazar, M.D.
   8. Alternate Director ………………………………………………Jill Hauenstein, M.D.
   9. Chairman…………………………………………………………Craig Kerins, M.D.
  10. Vice Chairman ……………………………………………………..Terry Cook, M.D.

2. **Membership**

<table>
<thead>
<tr>
<th></th>
<th>July 2014</th>
<th>July 2015</th>
<th>July 216</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active</td>
<td>554</td>
<td>537</td>
<td>525</td>
</tr>
<tr>
<td>Lifetime</td>
<td>50</td>
<td>51</td>
<td>55</td>
</tr>
<tr>
<td>Resident</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Retired</td>
<td>75</td>
<td>76</td>
<td>74</td>
</tr>
<tr>
<td>Student</td>
<td>192</td>
<td>186</td>
<td>184</td>
</tr>
</tbody>
</table>

The Richmond County Medical Society (RCMS) is alive and well. Meetings are held monthly from September through May with an average attendance of 58 physicians and guests. Our social hour often
features medical student research posters and our dinner programs are approved for continuing medical education (CME). In addition, we have instituted a July meeting and an August leadership institute.

We have formed a task force under the leadership of Dr. Adair Blackwood to look into the opioid addiction crisis in our area and are getting guidance from judges, law enforcement personnel and addiction specialists. The subject of our leadership conference was the opioid crisis in America, which was arranged by Drs. Rawson and Blackwood. We hope we will make a difference in our community.

Project Access continues to provide medical care and pharmaceutical assistance to the uninsured residents of Richmond County under the leadership of Dr. Terry Cook.

We are blessed with excellent staff including Dan Walton, Nancy Graham and Stacy McGahee.

Dr. Kerins continues to expand the reach of RCMS – whether it is in editorials in the local newspaper or in the RCMS newsletter or by just encouraging the board and the membership to take a more active role in the medical and general community.

**Programs 2015-2016**

- **September 2015**  Closed Claim Review – Joseph Griffin, M.D.
- **October 2015**  Thyroid Update – Edward Chin, M.D.
- **November 2015**  Sleep, Suicide and the Clock – Vaughn McCall, M.D.
- **Annual Legislative Meeting**
- **December 2015**  Christmas Party
- **January 2016**  Stroke and Dementia Prevention – David Hess, M.D.
- **February 2016**  New Developments in Lung Cancer – Zhonglin Hao, M.D.
- **March 2016**  Fountain of Youth – Achih Chen, M.D.
- **April 2016**  James Lyle Resident Research Awards
- **May 2016**  Electronic Medical Records and Medical Negligence – James Painter, J.D.
- **July 2016**  The Current State of the Economy – Sean Matthews, VP AIG
- **August 2016**  Leadership Seminar – Opioid crisis

###
SECTION REPORTS
IMG Section Purpose

International medical graduates (IMG) are defined as those physicians who received their undergraduate medical education outside of the U.S. and Canada. In 1963, IMGs represented slightly more than 10 percent of the physician workforce in the U.S. Today, they comprise 25 percent of the U.S. physician population, and more than one-quarter of the resident physician population.

The Medical Association of Georgia (MAG) is one of only 11 states in the country with an established IMG section. MAG formed the section to encourage the support and participation of IMGs in MAG and county medical societies. The section provides a forum for IMGs in organized medicine that promotes the purpose, objectives and goals of MAG and promotes the involvement of IMGs in shaping the future of organized medicine.

Activities of the IMG Section

The IMG section met several times throughout the year to address issues affecting IMGs in Georgia, as well as increase IMG membership and participation in MAG. The section plans to meet again this year on October 15 to elect officers and continue to discuss items of interest. Many physicians have difficulty in getting into residency program as the number of students graduating is increasing every year but the number of slots are not increasing as much. IMG section has worked with the MAG Board of Directors and a task force about the physician assistant program, but it has been put on hold as it has not worked well in other states that passed the law.

IMG Membership

Nationally, one in four practicing physicians are IMGs. Georgia ranks 13th in the top 20 U.S. states in which IMGs are practicing with approximately 4,438 or 19 percent of the entire physician workforce. At this point in the 2016 dues year, there are 376 IMG members in MAG. IMGs currently represent approximately seven percent of active MAG membership. IMG officers and section members will continue to make a concerted effort to recruit new MAG IMG members through various forms of peer-to-peer contact. Communication is key, and the IMG section will collect and disseminate information regarding important issues they face.

The IMG section would particularly like to thank MAG President John Harvey, M.D., for his continued outreach to the IMGs during his presidency.
I would also like to thank the following officers for their service to the IMG section this year:

Indran Krishnan, M.D., Vice Chairman
Dilip C. Patel, M.D., MAG HOD Delegate
Arvind Gupta, M.D., MAG HOD Alternate Delegate
Deepti Bhasin, M.D., Secretary

###
This past year has been a remarkable time of development for the Resident Physician Section (RPS). As you may know, a new governing council was elected during last year’s House of Delegates (HOD) meeting after a few years of inactivity. It is my pleasure to provide the following updates regarding the section’s activities since the 2015 HOD meeting. We are the future of MAG and believe that our participation and service will help improve the ability of this fantastic organization to serve the physicians and patients of Georgia for years to come. It is apparent that the policies passed by MAG have the potential to impact future physicians for years to come – more so than even practicing physicians thus necessitating our participation.

Section Reorganization

It has been some time since the RPS was active. Restarting the section was made possible by the interest by a few key residents in Atlanta, Columbus and Gwinnett and thanks to the mentorship and assistance of Drs. Harvey, Clark, Maxey and our invaluable Executive, Mr. Palmisano, and MAG staff members, including Kate Boyenga and Dayna Jackson. Without the support and contribution of these members we would not have been able to accomplish the challenging task of restarting the section!

We have submitted changes and updates to our internal bylaws, thereby providing a transparent and fair means of governance. We look forward to the consideration of these items of business at this year’s HOD. Every incremental improvement in our section will ultimately continue the pipeline of future health care leaders in Georgia.

AMA Participation

In 2015, the AMA held its Interim meeting in Atlanta, and we were fortunate to not only chair the Hospitality Committee but also represent the residents of Georgia in the Assembly of the Resident and Fellows Section. Furthermore, members of the governing council participated and contributed to the MAG AMA Delegation. We are very grateful to Dr. Clark and the Georgia delegation for their mentorship and inclusion in the business of the delegation. We look forward to working closely with the delegation for meetings to share and highlight those issues that directly impact Residents, Fellows and the future physicians of tomorrow. The RPS has had representation in the AMA Resident and Fellows Section for the past two national meetings. We hope to continue this participation as the Residents and Fellows of Georgia should continue to participate and shape the national dialogue on how medicine is practiced today and in the future.

Resident Dues Resolution

At the last MAG HOD meeting, the RPS presented a resolution to eliminate MAG dues for Residents, as many state societies have done in recent years. While ultimately, the Board decided to keep the current
dues structure, we have sought ways to off-set the cost of membership for one of the most vulnerable and under-represented constituent sections of MAG. Currently we still face the same challenges as in recent years; however, we are resolute in our willingness to work with MAG leadership to share the importance of participation and benefits of being affiliated with MAG. We welcome any suggestions or ideas on how we can reduce the barriers for participation and further empower Residents and Fellows to advocate for the issues related to post-graduate training and also the future practice of medicine in Georgia. It is our vision to create a pipeline of future physician leaders who plan on serving the citizens of Georgia, while influencing health policy on a national level.

Future Endeavors

As this Governing Council concludes its term, I hope that future Governing Councils continue to build on the work we have accomplished over the past year to continually increase the degree to which Residents and Fellows participate in the advocacy efforts of MAG. Many challenges lay in the road ahead; however, with the continued support of established MAG leaders, there is no doubt that the section will remain an active body within MAG. Without the participation of the future physicians of Georgia, MAG risks both its relevance but also esteemed influence on health policy and ultimately its ability to represent the physicians of Georgia.

We again wish to thank our colleagues for their support and encouragement throughout this tremendous year of growth.

###
SPECIAL REPORTS
EXECUTIVE COMMITTEE

SUBJECT: Annual Report – Strategic Plan

SUBMITTED BY: John S. Harvey, M.D., President

REFERRED TO: Not Referred

The Executive Committee is charged with developing and implementing the strategic direction of the association on an annual basis and submitting an annual report to the House of Delegates. I am pleased to provide this report on behalf of the Executive Committee.

Since 2007, the House of Delegates assigned the association’s strategic planning functions to the Executive Committee. This was done in recognition of the fact that successful organizations engage in an ongoing process of thinking strategically, which requires constant review of strategic goals and strategies. As a result, the Executive Committee and Board of Directors provide, on a continuous basis, a clear direction for the association, guide the allocation of resources and continuously focus and align our activities in light of a rapidly changing environment. In addition, it has been our practice to conduct a comprehensive review of core components of our strategic plan every five years since 2005. Last year, the Executive Committee presented to the House of Delegates the Strategic Plan 2020. This year completes the first year of our Strategic Plan 2020.

The Executive Committee provides the strategic direction of the association and the executive director is responsible for implementation. Prior to the beginning of the calendar year, the Executive Committee reviews the actions of the House of Delegates, surveys the health care environment on pressing issues and seeks the input of the senior staff. The Executive Committee then votes on that year’s strategic priorities and presents the plan to the Board of Directors.

The executive director provides frequent updates as to the status of the implementation of the strategic plan. To review any of the updates, please go to [www.mag.org/resources/executive-directors-message](http://www.mag.org/resources/executive-directors-message). We would like to draw your attention to the following key parts of the strategic plan that can be found at [www.mag.org/sites/default/files/downloads/2020-strategic-plan.pdf](http://www.mag.org/sites/default/files/downloads/2020-strategic-plan.pdf):

**Overarching Goals.** We have four strategic goals related to: Advocacy, MAG’s Value Proposition/Communication, Membership and Finances. They are as follows:

**Goal A.** The Medical Association of Georgia (MAG) will be Georgia’s premier physician advocacy organization in advancing a health care system that improves health outcomes and health care delivery at the patient, community and state levels while protecting the patient-physician relationship and ensuring physicians are free and able to exercise their independent medical judgment. (Advocacy)

**Goal B.** MAG will be an indispensable, value-added resource for its members in a number of key areas, including education, networking, information and services. (Value Proposition/Communication)
Goal C. MAG will build a membership that is committed to the profession, is representative of the diversity of physicians in Georgia, and reflects high ethical and professional standards. (Membership)

Goal D. MAG will secure sufficient financial and other resources that are needed to achieve and sustain its vision and strategic goals. (Finances)

Strategies: As part of the planning process, we developed strategies for achieving our four goals. We will continuously review these strategies as part of our ongoing process of thinking strategically. These strategies will change over time as we complete tasks and as circumstances change. The strategies are set forth under the goals to which they relate.

Executive Director Report: I have attached the report from our executive director as to the implementation of the Strategic Plan 2020.

Thank You: On behalf of the Executive Committee, I want to thank you for your review of the strategic plan and for your continued feedback. Keeping the association on course at a time of such rapid and fundamental change requires ongoing assessment, review and adjustment. Your input is a vital component to this process and to our future success.

# # #
2016 Strategic Plan of Work Summary

Please find the update on the 2016 Strategic Plan. For more on MAG’s activities, please go to www.mag.org/resources/executive-directors-message.

Advocacy (Goal A)

MAG will be Georgia’s premier physician advocacy organization in advancing a health care system that improves health outcomes and health care delivery at the patient, community and state levels while protecting the patient-physician relationship and ensuring physicians are free and able to exercise their independent medical judgment.

To achieve this goal, MAG will be an advocate for:

- Resolving public and private payer issues (commercial, Medicare, Medicaid, workers’ compensation) to ensure patients receive the care that they need
  - Address Prior Approval (Resolution 305C)
    - MAG and the Georgia Pharmacy Association agreed to form a Task Force on Prior Approval to be managed by the GPhA. The task force had its first meeting in June. The Georgia State University School of Law is now drafting legislation and regulatory remedies based upon recommendations from the joint task force.
  - Specialty Medications and Drug Formulary Transparency (Resolution 307C)
    - MAG supported H.B. 965 “The Honorable Jimmy Carter Cancer Treatment Access Act” that was signed by Gov. Nathan Deal.
Closing the Coverage Gap in Georgia (308C)
- MAG is working closely with the Georgia Chamber of Commerce to study potential solutions to drawing down federal money to address the uninsured. MAG has participated in the meetings and focus groups. The “Georgia Solution” will be addressed at the House of Delegates.

ID, document & communicate patterns of payer practices that have a negative impact on member practices and pursue actions with payers
- Please see the Department of Third Party Payer’s report that addresses a number of systemic issues with Blue Cross Blue Shield of Georgia.

Participate on public and private payer advisory committees to advocate for just treatment and payment.
- MAG and Blue Cross Blue Shield of Georgia have a quarterly meeting to address a number of payment issues.
- MAG meets quarterly with the Commissioner for the Department of Community Health on Medicaid issues.

Improving Electronic Health Records (Resolution 108A)
- MAG continues to work closely with the AMA on addressing issues with EHR. For example, MAG supports AMA successful efforts with CMS on removing the “meaningful use 3” program. Additionally, MAG supports AMA efforts with CMS to ensure interoperability with EHR systems.

Support recommendations in 2015 IOM Dying in America Report (Resolution 113A)
- MAG connected the sponsor of the resolution, Richard Cohen, M.D., with the American Medical Association. The AMA is working with Dr. Cohen on this resolution.

Limiting inappropriate scope of practice beyond that safely permitted by non-physician practitioner’s education, training and skills

Oppose scope of practice infringements that occur at the General Assembly
- H.B. 722, the medical marijuana bill, originally had language that expanded the scope of practice for pharmacists with a provision that allowed cultivation in Georgia. The language allowing for an expanded scope of practice for pharmacists has been removed. The bill failed to pass the General Assembly.
- S.B. 315 allows a physician assistant to prescribe hydrocodone combination products, which are a Schedule II. MAG was able to amend the language to be consistent with the MAG Board of Director’s directive. The bill failed to pass the General Assembly.
- S.B. 319 allows professional counselors the ability to “diagnose.” As in years past, we opposed this legislation. The bill was signed by Gov. Deal.
- MAG sent a letter to the U.S. Department of Veteran Affairs opposing a new rule that would allow nurse practitioners to have full and independent practice authority. An alert to the membership accompanied this letter. The request began with the Georgia Society of Anesthesiologists.
Truth in Advertising regarding board certification (Resolution 313C)
- MAG supported H.B. 826 and H.B. 1043, which is consistent with MAG Resolution 313C. H.B. 1043 was signed by Gov. Deal.

Protecting and promoting a fair civil justice system to ensure patients have access to the physicians they need
- Review those reform measures that remove the physician’s right to a jury trial
  - MAG has been actively engaged in the Patients’ for Fair Compensation model in Georgia and other states. MAG’s Executive Director spoke at a national PIAA conference on the problems associated with PFC’s plan.

Promoting good health habits that result in a healthier workforce and that saves Georgia tax dollars
- Supporting Expedited Partner Therapy (Resolution 111A)
  - MAG supported H.B. 813, which is consistent with MAG Resolution 111A. This bill failed to pass the General Assembly.

- Supporting the ABLE Act (Resolution 301C)
  - MAG supported H.B. 768, which is consistent with MAG Resolution 301C. This bill was signed by Gov. Deal.

- Preserving the Prescription Drug Monitoring Program (Resolution 306C)
  - MAG supported H.B. 900, which is consistent with MAG Resolution 306C. This bill was signed by Gov. Deal.

- Promoting the “Think About It” and Project DAN campaigns to reduce prescription drug abuse
  - MAG Foundation continues to push forward with its “Think About It” and Project DAN campaigns. The Toolkit is ready for distribution as well as the training videos. We are in the process of training law enforcement on how to administer Naloxone.
  - The MAG Foundation also conducted a strategic planning meeting in June with interested stakeholders as to the future of the program that will be presented at the MAG Foundation’s October board meeting.
  - MAG Foundation implemented a grant received from Kaiser Permanente to deliver drop boxes and educational materials in the higher education system areas where KP has a presence.

- Improve Colorectal Outcomes in Georgia (Resolution 110A)
  - MAG participated in the Georgia Colorectal Cancer Roundtable held in Atlanta.

- Improving Vaccine Availability in Small Practices (Resolution 105A)
  - The Board of Directors addressed this issue at the April meeting and promoted information on the website. Additionally, the Georgia Delegation brought a resolution to the AMA meeting.
Ensuring that physicians receive fair and adequate payment for the services they provide

- Report of the President on CON (Officer Report 1)
  - A survey was sent to the membership in March. The survey is consistent with Officer Report 1. The respondents favored MAG filing an amicus brief. The case is at the trial level and we have been in touch with physician’s counsel. MAG generally gets involved at the appellate level.

- Oppose the health insurance mergers of Aetna/Humana and Wellpoint/CIGNA (State Strategy)
  - MAG has met with the Commissioner of Insurance regarding our opposition to the health insurance mergers. A letter was also sent to the Commissioner of Insurance in March. MAG has also developed print and radio messaging through the Physicians Advocacy Institute. The hearing date set for June 24 for the Aetna-Humana merger was postponed due to the lawsuit filed by the Department of Justice to block the mergers. MAG and AMA were prepared to testify at the hearing and held a joint membership call in July. A big thanks to the Georgia Attorney General Sam Olens for joining the lawsuit.

- Assess the “Abusive Billing Practices” in the Georgia General Assembly
  - MAG has spent significant resources on Sen. Renee Unterman’s S.B. 382, which attempts to restrict a physician’s ability to balance bill. While we were successful in stopping the bill in the 2016 General Assembly, the Senate authorized a study committee to review the issue over the summer. MAG has had monthly meetings with interested stakeholders to find a solution. An in-person meeting was held with the interested specialty societies in Jekyll Island prior to the beginning of the Summer Legislative Conference. We continue to work with the specialty societies on this issue to find a solution.

- Educational and consultative advocate and resource to protect MAG members and practice staff from abusive payer behavior
  - Please see the Department of Third Party Payer’s report.

Increasing the number of physicians elected to the General Assembly

- Support physicians in their campaign for the Georgia House of Representatives
  - MAG worked diligently to have a fourth physician elected to the Georgia General Assembly in the House of Representatives District 123 – Mark Newton, M.D.

**Value Proposition/Communication (Goal B)**

MAG will be an indispensable, value-added resource for its members in a number of key areas, including education, networking, information and services.

To achieve this goal, MAG will:

- Enhance MAG/physicians’ brand and reputation with patients and other stakeholders
Utilize the “Top Docs Radio” program to promote issues of importance to the organization, physicians, patients and others

- MAG entered into an agreement with Top Docs to air two shows per month. Topics have included HealtheParadigm, health care fraud, out of network billing, MACRA, opioid abuse, TAI and DAN campaigns, GPLA, diabetes prevention, abusive payment practices, and the Philadelphia College of Osteopathic Medicine.

Ensuring the “Think About It” and Project DAN campaigns prominently reflect the MAG brand
- Please see the update above.

Continuing the work of the Medical Reserve Corps to promote MAG member participation in statewide emergency preparation and response activity
- MAG’s MRC presented an update to the Georgia Trauma Commission and received a subsequent grant. MAG has had numerous training programs to prepare the physicians in the event of a disaster. MAG’s MRC was prepared to activate when Hurricane Hermine was set to hit the Georgia coast.

Be a trusted resource for practice information (e.g., EHR, ICD-10, Affordable Care Act)

Online Prescription Resources (106A)
- MAG has updated its Medicare tab on the website to provide prescription resources.

Expand value-added services for physicians

Support the development and implementation of new programs, products and services that create value for MAG members and reposition MAG and its members to prosper in the value-based purchasing environment including consideration of offering a population health solution (health information exchange and analytics) to members and others
- MAG signed an agreement with KAMMCO Health Solutions for an analytic solution to physician practices. The new product is called HealtheParadigm.
- MAG studied a potential cloud based technology to assist physicians with credentialing.

Enhance the working relationship between MAG and AMA, specialty medical societies and county medical societies on issues affecting all physicians.

Oppose the health insurance mergers of Aetna/Humana and Wellpoint/CIGNA (National Strategy)
- MAG is one of 17 states chosen by AMA to receive resources to oppose the mergers. AMA has also committed additional resources to five states that would be most impacted by the mergers – Georgia, Connecticut, Colorado, California and Ohio.
- AMA committed to testifying at the hearing before the Georgia Commissioner of Insurance on July 24 that was eventually postponed.
o Assess the “Abusive Billing Practices” in the Georgia General Assembly (National Strategy)
  • MAG participates on an AMA Task Force that is addressing Abusive Billing Practices.
  • MAG has convened the impacted specialties to work towards finding a solution to Abusive Billing Practices.

  Membership (Goal C)

MAG will build a membership that is committed to the profession, is representative of the diversity of physicians in Georgia, and reflects high ethical and professional standards.

To achieve this goal, MAG will:

  ➢ Develop a value proposition that will resonate with the next generation of physicians and physician organizations

  o Discuss elimination of Dues for Residents and Reinvigorating the Resident Section (Resolution 401F)
    ▪ The MAG Board of Directors discussed this issue at the April Board meeting. The Board of Directors tabled the matter for an email vote to be accomplished within 90 days. An electronic survey was sent out within the 90-day period and the Board of Directors voted to keep the resident dues at the current level.

  Financial (Goal D)

MAG will secure sufficient financial and other resources that are needed to achieve and sustain its vision and strategic goals.

To achieve this goal, MAG will:

  ➢ Achieve at least a $200,000 surplus per year to protect the MAG brand

  o Develop a plan to secure the financial viability of the MAG Foundation and the Section 170 Annuity Plan
    ▪ The MAG Treasurer and MAG Foundation Treasurer met with MAG Executive Director and Foundation Director to discuss a plan to fully fund the Section 170 plan that will be presented at the Board of Director’s meeting in October.

  # # #
Your MAG Foundation is pleased to present its Annual Report for 2016. Over the past year, we have continued to strive on your behalf to lead philanthropic efforts to create a healthier Georgia.

THINK ABOUT IT CAMPAIGN

The Medical Association of Georgia Foundation (MAG Foundation) continues to partner with the most trusted and recognized health care system entities supporting its ‘Think About It’ campaign to reduce prescription drug abuse by distributing more than 1 million educational leaflets throughout the state since the beginning of the campaign in 2011. This includes CVS Health pharmacies, Walgreens pharmacies, Walmart pharmacies, Kaiser Permanente pharmacies, The Kroger Co., the Georgia of Department of Public Health, Children’s Healthcare of Atlanta, the Northeast Georgia Medical Center in Gainesville, the Phoebe Putney Health System (including Phoebe Physicians Group) in southwest Georgia, Northside Hospital – Forsyth, West Georgia Health System, the Mayo Clinic in Waycross, independent pharmacies, the Georgia Association of Community Service Boards, and the University of Georgia School of Pharmacy the Georgia Charitable Care Network – which includes about 100 independent non-profit clinics in the state. The “Help Prevent Prescription Drug Abuse in Georgia” leaflets encourage Georgians to 1) only take their medicine as prescribed and 2) not share their medicine and 3) store their medicine in a safe and secure place and 4) properly dispose of any unused medicine.

Project DAN Deaths Avoided by Naloxone

Last November, the ‘Think About It’ campaign’s subsidiary, ‘Project DAN’ began to develop and disseminate communications resources that address the use of Naloxone (which reverses the effects of an opioid overdose) and the Georgia 9-1-1 Medical Amnesty Law (which allows trained first responders to administer Naloxone; it provides limited immunity for people who call 911 in the event of a drug overdose). ‘Project DAN’ provides subsidies to purchase Naloxone for approved first responders and to provide training in overdose first aid the use of Naloxone and to pay for prescription drug disposal boxes in the community. Additionally, a media campaign launched in Northeast Georgia to include social media, billboards and print. Since September 2015, the social media campaign has boosted our brand and image with a 200% increase in followers (people that follow our page for posts and updates). We are working within the following counties: Union, Towns, Rabun, Lumpkin, White, Habersham, Dawson, Stephens, Hall, Banks, Forsyth, Jackson, Barrow, Clarke, Franklin, Gordon, Gilmer, Chatham, Whitfield and Murray counties. Physicians, local government and law enforcement officials and college campus police departments make up the majority of our stakeholders. Approximately, 1,400 kits have been distributed and we’ve had 10 recorded lives saved.

Once the LEO is approved for funding to receive Naloxone, each office undergoes training, which includes: application procedures for grant funds to receive Naloxone, a training video with a mock overdose and administration of Naloxone, visual instructions, overview of the Georgia 9-1-1 Medical Amnesty Law, and various media materials. The contents of the toolkit are provided on a
flash drive for future trainings. Thanks to ‘Think About It’ co-chair Dallas Gay, training coordinator Reuben Black and MAG member Dr. Rafael Pasqual for their time and dedication to the program. Ray Gaskin, M.D., David Gaskin, M.D. and Lori Cassity Murphy conducted the largest training in Chatham County. Our message now includes information on the rise in Fentanyl use and synthetic drugs coming from China and Mexico.

The campaign continues to donate materials and templates to groups, associations and individuals interested in starting a prescription drug abuse prevention campaign and the collateral has been translated in Spanish and other languages by The Center for Pan Asian Community Services.

Kaiser Permanente Community Benefit – Higher Education TAKE-BACK Initiative

Thanks to a $30,000 grant from the Kaiser Permanente (KP) Community Benefit, the ‘Think About It’ Higher Education TAKE-BACK Initiative began at the onset of Fall 2016 classes. A special note of gratitude to Foundation Board member, Ali Rahimi, M.D. for being the conduit to connect KP with MAGF. Thanks to Georgia Board of Regents member Tommy Hopkins, M.D., who introduced the program to the University System of Georgia. The TAKE-BACK Initiative includes several key components including:

- Funding prescription drug drop boxes that will be placed on Georgia State University campuses in Atlanta, Clarkston, Covington, Decatur and Dunwoody; Kennesaw State University in Marietta; Morehouse College in Atlanta. The University of West Georgia in Carrollton already had a drop box in place; promotional posters were provided. Students and other residents will be able to dispose of unused or expired prescription drugs on an anonymous, “no-questions-asked” basis.
- Providing colleges and universities in the state with posters that will address how students can safely dispose of unused and expired prescription drugs.
- Developing resources to raise awareness at colleges and universities in the state, including a website and a social media campaign.

‘Think About It’ Strategic Planning Task Force

In June 2016, several stakeholders representing entities throughout the state attended a ‘Think About It’ strategic planning session to determine the future of the program. In October 2016, the MAGF Board of Directors will be voting on the following priorities set by the task force, through 2020:

Partnerships
With over 7,800 physician members, the Association represents every physician - in every specialty - in every practice setting in the state. It has political clout and will support legislation that will curb or end this epidemic in Georgia. TAI will collaborate with new and existing partnerships among federal, state, regional and local agencies; private and not for profit organizations; academic medical training programs and others. As an example, the alliance of MAG and MAGF with the Georgia Pharmacy Association provides the opportunity to cross promote and educate members statewide about the PDMP. This will result in a more practical and efficient use of resources, while ensuring key stakeholders (physicians and pharmacists) agree and understand each person’s role in utilizing this integral prevention tool.

PDMP Engagement and Use
TAI will support workforce development around activities to reinforce the use of PDMP data and educate providers on the use and benefits of accessing the state’s database to determine if the patient is filling the order and/or seeking additional access avenues. In addition, MAG and MAGF will continuously strive to improve the state's PDMP, including root cause analyses on aspects related to PDMP operations and functionality, access, point of care drug monitoring, interoperability, integration and usage of the PDMP
data. An additional priority is to support a PDMP that is integrated into a physician’s practice’s workflow and to provide education related to HIPAA and the importance of establishing a compliance plan to prevent privacy breaches. Finally, MAGF will work in collaboration with vested key stakeholders and partners to establish an analytic road map for PDMP data usage and a strategy for the effective dissemination of audience-sensitive and actionable analytic and educational findings and reports.

**Physician Training and Education**

TAI will promote opportunities that facilitate appropriate, accessible, guideline based training, such as how to talk about substance disorders with patients, to help with community prevention and overdose response.

MAGF will utilize SAMHSA’s resources, including its Opioid Overdose Prevention Toolkit and will disseminate and promote the use of the CDC Policy Guidelines for Prescribing Opioids for Chronic Pain. MAG and MAGF will monitor the work of key national stakeholders such as the AMA and will promote and distribute additional resources, best practices and other support tools as they are released.

In an effort to establish educational guidelines within medical schools and residency programs, we will work to establish best practice protocols within the curriculum at the Medical College of Georgia and Georgia Regents University. The goal of our effort is to equip future physicians with the necessary knowledge and tools to ensure that they are prepared to manage this very complex clinical scenario. Other medical schools are beginning to implement similar programs and our products will represent the best of what is currently available.

By the HOD, we're likely to understand more on the following: funding from DBHDD; opioid prescribing guidelines (CDC, AMA, BCBS) and incorporating into CME; CME training and education through MCG and the Richmond County Medical Society; the PDMP law; over the counter Naloxone; communication with patients regarding pain; collaboration with DPH and QIO.

**Atlanta Heroin Working Group**

In the last year, through collaborative efforts of the GBI, Fulton County Medical Examiner’s office and other county medical examiners, a real-time data base to track statewide overdose deaths has been developed. Though not quite ready for primetime, this will become a useful tool to determine where and who is being touched by this epidemic. Lori Cassity Murphy serves on the training and education legislative committees. The training and education committee has developed a card with helpful resources for first responders to leave with overdose victims. The legislative committee remains vigilant on issues pertaining to the PDMP, over the counter Naloxone and the role of Harm Reduction Organizations. Murphy presented to the group in June with an update on ‘Project DAN’ and the TAKE-BACK Initiative. The group continues to follow closely the uptick in overdoses caused by Fentanyl. We look forward to partnering with key stakeholders to combat this problem, as seen as a direct correlation with prescription drug abuse.

**Memorial Golf Classic**

The Fourth Annual Jeffrey Gay Memorial Golf Classic on May 14, 2016 was a tremendous success. Special thanks to the volunteers and sponsors who helped raise over $20,000 for ‘Think About It.’

**“We’re Not Gonna Take It” High School Video Contest**

September 12 – October 28, 2016 Georgia Attorney General Sam Olens launched the 3rd Annual “We’re Not Gonna Take It” video contest for Georgia high school students to raise awareness to reduce prescription drug abuse. Georgia high school students are being challenged to create a 30-second video
explaining why they have chosen to live a healthy lifestyle and reject prescription drug abuse. MAG and MAGF sponsored the prizes awarded to the winner, runner-up and people’s choice winner. Lori Cassity Murphy represents the Foundation with other stakeholders from the GBI, GDNA and GPhA.

Please visit: law.ga.gov/videocontest for additional information. You can also find information on the ‘Think About It’ website.

**Presentations**

In May, campaign co-chair Dallas Gay and addiction medicine physician Shonali Saha, M.D. provided timely information on the prescription drug abuse epidemic and the campaign’s initiatives on ‘Top Docs’ Radio show. American Medical Association (AMA) Chair Patrice Harris, M.D. also conducted an interview on ‘Top Docs’ in June regarding the AMA’s Task Force to Reduce Opioid Abuse.

Campaign co-chair P. Tennent Slack, M.D. presented a CME at the Georgia Pharmacy Association Convention in June 2016.

Campaign co-chair Dallas Gay and Lori Cassity Murphy presented to stakeholders on ‘Think About It’ initiatives at The Council on Alcohol and Drugs in June.

In September, Fred Jones presented at a CME hosted by the National Association of Drug Diversion Investigators (NADDI) for law enforcement on our efforts to safely divert prescription drugs through ‘Project DAN’ and the TAKE-BACK Initiative.

The MAG Foundation has sponsored a number of ‘Think About It’ campaign presentations across the state in 2016. The events address important issues like non-opioid treatment options for chronic pain, screening and monitoring for opioid misuse, diversion and addiction, rules and laws that govern opioid prescribing, and the mechanics of prescribing and prescription monitoring in Georgia. Contact Lori Cassity Murphy at 678.303.9282 or lmurphy@mag.org to schedule a presentation, order printed materials for your office or with questions and for additional information. Go to ‘Think About It’ to make a donation to the campaign.

**GEORGIA PHYSICIANS LEADERSHIP ACADEMY**

The Georgia Physicians Leadership Academy (GPLA) continues to be a dynamic and enterprising program of the MAG Foundation. The update on GPLA is found in the report written by GPLA Steering Committee Chair, S. William Clark III, M.D. and is attached to this report. The 2016 fundraising campaign, “Inspire…Motivate…Lead,” is appropriately named in honor of chair and founder of GPLA, S. William Clark III, M.D. Dr. Clark will be honored at the House of Delegates for his years of service and dedication to the GPLA. Please consider a donation to the GPLA in honor of Dr. Clark. More than 80 GPLA graduates now serve in leadership roles at the Medical Association of Georgia (MAG) and other state and local medical societies – including MAG’s president-elect, Steven Walsh, M.D. The ninth – and largest – GPLA class is now underway.

**W.R. DANCY M.D. STUDENT LOAN FUND**

The MAG Foundation has supported and administered the W.R. Dancy, M.D. Student Loan Fund for medical students for 46 years. The Dancy Fund helps Georgia residents realize their dreams of attending medical school by granting them affordable loans. To date, the Foundation has supported 53 medical students in their pursuit of becoming a physician. Currently, the Fund assists three Georgia Residents in completing their medical education at an accredited medical school located in Georgia.
As of now, the Dancy Fund has two (3) outstanding loans in repayment phase, and total outstanding loans of $14,192.85. Total funds available for lending are $230,411.54.

DISTRESSED PHYSICIANS FUND

The Fund was created to assist physicians and their spouses who experience financial hardship caused by natural disasters or other circumstances beyond their control. Current funds available are $38,411.54.

CHARITABLE GIFT ANNUITY PLAN

The Foundation continues to work with PG Calc, an industry leader in administration of charitable gift annuity plans and with investment advisors Capital Group Private Client Services, to maximize earnings, within acceptable risk margins, on the plan’s assets.

FOUNDATION FUNDRAISING

The Georgia physician community has long been the leader in addressing the needs of our patients and our profession. As you can see, your MAG Foundation is working diligently on your behalf with programs to combat the epidemic of prescription drug abuse, train future leaders for our profession, and help aspiring physicians realize their dream. In order to maintain the momentum in our programs, MAGF needs your financial support. Many of you will be contacted by a colleague who is donating his or her time, as well as financial resources, to help support the great work that the MAG Foundation does on the behalf of each and every one of us. We ask that all of you join them in supporting your Foundation with a generous contribution. You can also visit www.mag.org/foundation.

Thank you for taking the time to read this report and learn about your Foundation, and for your continued support.

The Board of Trustees would like to especially thank our staff for their dedication and service:

Mr. Donald Palmisano Jr., MAG Executive Director and CEO and
MAG Foundation Executive Director and CEO
Mr. Fred Jones, MAG Foundation Director
Ms. Lori Cassity Murphy, MAG Foundation Program Development Director

MAG Foundation Board of Trustees:

Jack M. Chapman Jr. M.D., President
John S. Antalis, M.D., Vice President
Stephen M. Walsh, M.D., Secretary/Treasurer
W. Scott Bohlke, M.D.
E. Dan DeLoach, M.D.
Ali R. Rahimi, M.D.
M. Todd Williamson, M.D.

###
The Medical Association of Georgia Alliance (MAG Alliance) held its 2015 Annual Meeting and Luncheon in December with special guest and keynote speaker Representative Sharon Cooper. Representative Cooper, also a nurse and the spouse of a physician, shared with us her journey into politics, her concern for the health and healthcare of Georgians, and some of her recent successful legislative efforts.

The Alliance actively pursued two initiatives this year. Alliance members marketed the MAG Doctor of the Day service opportunity to community physicians. We secured the web address of www.docoftheday.org (which redirects users to the MAG webpage) and included that web address on a new informative brochure outlining the opportunity and benefits of service at the Capitol.

The Alliance also actively advocated for the passage of the Georgia Lactation Consultant Practice Act, legislation designed to improve access to clinical assistance for breastfeeding mothers and babies. The MAG House of Delegates voted to support this effort back in October of 2012. Representative Cooper was the lead sponsor of the legislation. Alliance members attended hearings at the Capitol, submitted written notes and letters of support to elected officials, met with Governor Deal to discuss the need for the law, and garnered the support of many other Georgians. We are pleased to report that the bill passed the General Assembly and was signed into law by Governor Deal on April 26.

For its advocacy efforts related to the Georgia Lactation Consultant Practice Act, the American Medical Association (AMA) Alliance recognized and awarded the MAG Alliance with its national LEAP (Legislation Education and Awareness Promotion) Award at the Chicago convention in June. Merrilee Gober, Eve Tidwell and Dave Street accepted the award on behalf of the MAG Alliance. It is believed that this is the first time the MAG Alliance has ever received a national AMA Alliance award.

Also at the AMA Alliance Convention, Dave Street (MAG Alliance President 2004-06) was elected by AMA Alliance membership to serve on the AMA Alliance Board Development Committee.

The 2016 MAG Alliance Annual Meeting and Luncheon is scheduled for September 26 with special guests and keynote speakers Senator Renee Unterman and Representative Andy Welch who will discuss Georgia’s sex trafficking issues and the initiative that will be on the statewide November ballot.

We continue to encourage all spouses of Georgia’s physicians and medical students to join our Alliance. At this time, membership is free. Persons interested can find information at www.magalliance.org (another web address we secured that redirects users to the MAG Alliance webpage).

# # #
Between January 1 and August 28, mag.org was viewed more than 79,000 times – or about 215 page views a day. The website had nearly 60,000 unique visitors during the first eight months of 2016, and more than 69 percent of those were considered “new” (i.e., first time) visitors. During the same eight-month period, the website’s “Find a Physician” feature was viewed more than 4,100 times by nearly 2,000 unique users. MAG also added a number of new website pages in 2016, including ones addressing the Zika virus, MACRA/MIPS, and medical innovation commercialization options.

MAG won a silver Davey Award for its website – its ninth award for mag.org.

MAG is now being followed by more than 3,700 accounts on Twitter, which includes a number of state and specialty medical societies. MAG has also increased its presence on Facebook – with 540 “likes.”
MAG Executive Director Donald J. Palmisano Jr. can be followed on Facebook, LinkedIn or on Twitter using the handle @DPalmisanoMAG.

MAG developed a mobile app that will include information on the 2016 HOD meeting. It features details on meeting times and locations, lodging and logistics, a list of exhibitors and sponsors, reports, and key staff and leader contacts. MAG members can download the app to their handheld device or tablet by going to the Apple or Google Play stores.

MAG’s weekly Georgia Pulse media highlights report has 6,235 subscribers.

MAG’s 1Q Journal focused on practice management, including a feature on the pending Aetna/Humana and Anthem/Cigna mergers and narrowing health insurance networks in Georgia. It also included articles on the Augusta health care market, MPFS, documentation, and compliance issues/marketing.

MAG’s 2Q Journal focused on health care policy, including a feature on where the health care market will be in five years for both physicians and patients. It also had articles on adult immunizations, the Georgia Composite Medical Board, and whistleblowers.

MAG’s 3Q Journal focused on technology and education. The feature article addressed MAG’s new health information/data analytics solution (HealthParadigm). The 3Q issue also had articles on MACRA, acute renal failure, CME and MAG’s CME accreditation program, the proposed CMS physician fee schedule for telemedicine, the Georgia Composite Medical Board (new ad rules), and physician/patient contact.

MAG HOD delegates are encouraged to contact Tom Kornegay at tkornegay@mag.org with advertising prospects for the Journal. MAG members can also submit case reports of 750 words or 1,500 words that are of interest to physicians across specialties to Kornegay.

MAG has produced its e-News from MAG newsletter once a month during 2016.
MAG produced its *e-News from the Capitol* report on a weekly basis during the legislative session in 2016.

MAG has hosted its ‘Top Docs Radio’ program on the Business Radio Network on the second and fourth Tuesday of every month in 2016. The program has now had more than 7,500 listeners from all 50 states and more than 80 countries. Topics have included insurers/payers, state legislation, chronic diseases, financial planning, fraud and abuse, MACRA/MIPS, regulatory compliance, physician’s manners, practice management, naloxone, opioid abuse, the Zika virus, PTNs, and diabetes.

MAG has distributed several press releases, including ones addressing the flu vaccine, the Aetna/Humana and Anthem/Cigna mergers, the MAG Alliance (applauding state lawmakers and Georgia Gov. Nathan Deal for passing and enacting the Georgia Lactation Consultant Practice Act), and the Medical Association of Georgia Foundation (celebrating the 100th graduate of its Georgia Physicians Leadership Academy).

MAG has distributed a number of alerts in 2016, including ones addressing the aforementioned ‘Top Docs Radio’ program; membership renewals/reminders, MAG’s annual legislative meeting, an interview that MAG CEO Donald J. Palmisano Jr. conducted on the ‘Health Matters’ radio show, a legal/compliance webinar, a Zika webinar, a revenue cycle management webinar, the Aetna/Humana merger, and the Physicians Foundation’s biennial survey.

MAG distributed a number of surveys in 2016, including ones on the effects of the Aetna 2013 acquisition of Coventry on physicians, the CON lawsuit survey, the workers’ compensation system in the state, physicians who prescribed opioids to patients, the pending insurer mergers (for AMA), and the Physicians Foundation (biennial survey).

Media inquiries have included CBS46 WGCL-TV Atlanta (ER billing), Bloomberg BNA (health insurance networks/silent PPOs), the Athens Banner Herald (the MAG Foundation’s ‘Think About It’ campaign and naloxone), the Atlanta Journal-Constitution (sexual misconduct by physicians against patients and medical marijuana), Modern Healthcare (Medicaid pay and a proposed CMS scope of practice rule), the New York Times (medical marijuana), Fox 28 Savannah (the Memorial Hospital/Novant deal), Reuters (the pending insurer mergers), MedPage Today (physicians attending political conventions), Medscape (false positives/medical malpractice), WABE 90.1 FM (sexual misconduct by physicians against patients), WSB-TV 2 Atlanta (Bobbi Kristina Brown autopsy), WSAV TV/Savannah (Chatham County/Corizon correctional medicine program), and the Valdosta Times (medical marijuana registry).

# # #
The Department of Membership and Marketing is responsible for providing direct support and services to Medical Association of Georgia (MAG) members, and developing recruitment and retention programs to attract physicians and medical students into the federation of organized medicine.

I am very pleased to present this report to the House of Delegates (HOD). As you will see, the department has been extremely active this year in promoting membership as a top priority of the Association.

2016 Activities of the Membership and Marketing Department

The 2016 membership year began October 13, 2015 with the first mailing of the dues statement. This mailing was sent to more than 14,000 member and non-member physicians in Georgia. Additional mailings were sent in December, January, March and June. Email reminders were sent frequently to all renewing physicians. A chart listing completed marketing tactics is below.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>October dues mailing</td>
<td>10/13/2015</td>
</tr>
<tr>
<td>October dues mailing #2</td>
<td>10/23/2015</td>
</tr>
<tr>
<td>Dues statements on the way email</td>
<td>10/26/2015</td>
</tr>
<tr>
<td>Dues reminder email</td>
<td>11/3/2015</td>
</tr>
<tr>
<td>December dues mailing</td>
<td>12/3/2015</td>
</tr>
<tr>
<td>Dues reminder email</td>
<td>12/7/2015</td>
</tr>
<tr>
<td>Membership card sent</td>
<td>12/11/2015</td>
</tr>
<tr>
<td>Dues reminder email</td>
<td>1/5/2016</td>
</tr>
<tr>
<td>Membership card sent</td>
<td>1/11/2016</td>
</tr>
<tr>
<td>January dues mailing</td>
<td>1/14/2016</td>
</tr>
<tr>
<td>Delinquent warning email</td>
<td>1/19/2016</td>
</tr>
<tr>
<td>Don’t forget to renew email</td>
<td>2/2/2016</td>
</tr>
<tr>
<td>Don’t expire email</td>
<td>2/22/2016</td>
</tr>
<tr>
<td>Membership card sent</td>
<td>2/24/2016</td>
</tr>
<tr>
<td>Your membership expired email</td>
<td>3/1/2016</td>
</tr>
<tr>
<td>March dues mailing</td>
<td>3/9/2016</td>
</tr>
<tr>
<td>Non-member email</td>
<td>3/29/2016</td>
</tr>
<tr>
<td>Journal mailing to non-members</td>
<td>4/1/2016</td>
</tr>
<tr>
<td>Exit survey</td>
<td>4/1/2016</td>
</tr>
<tr>
<td>Renewal call campaign</td>
<td>4/1/2016</td>
</tr>
<tr>
<td>Dues reminder</td>
<td>5/17/2016</td>
</tr>
<tr>
<td>Non-member email</td>
<td>5/17/2016</td>
</tr>
<tr>
<td>Membership card sent</td>
<td>5/18/2016</td>
</tr>
</tbody>
</table>
The membership department also utilized several different recruitment and retention methods including, but not limited to:

- **Staff phone calls:** Instead of using Comnet telemarketing service, MAG’s membership coordinator, Dawn Williams, made phone calls to 44 physicians’ offices reminding them that their memberships needed to be renewed. These phone calls were received well with 39 renewals as of August 31. She spoke directly with the office managers who were very appreciative of the reminder call. Several of the office managers explained that they had forgotten to pay or were planning on paying the dues soon. Some office managers requested group invoices versus individual invoices because they are easier to keep track of. Overall, this membership renewal phone call tactic was much more effective than using Comnet in years’ past.

- **Membership cards:** Part of MAG’s 2016 marketing campaign centers around newly developed membership cards. In previous years we developed a flyer explaining the benefits provided with membership, along with a tear out membership card. Printing of the card and postage costs quickly became prohibitive. Additionally, member interest in having a physical card diminished. This year we developed an online membership brochure that highlights MAG success stories, key areas of interest, upcoming events and an area where members may print a personalized membership card should they wish. If a physician would like a card mailed to them, membership staff will do so upon request.

- **Expansion of MAG’s group membership program:** Throughout the year, Donald J. Palmisano Jr. and membership staff visited several large groups across the state to promote MAG membership. In a recent survey by the Georgia Board of Physician Workforce, 77 percent of GME graduates reported their confirmed practice setting was in a group practice or hospital. Given the fact that Georgia’s new physicians are choosing group/employed settings for their practice at an increasing rate, we’ve found that offering MAG member group discounts serves as the top source for recruiting new members and retention of existing members while simultaneously increasing our market share.

- **Redevelopment of MAG’s Resident Section:** Over the last several years, the MAG section for residents and fellows has become inactive. Last year’s HOD meeting saw the first election of a Resident section. Since then, the section has met frequently. Continued support and sponsorship from residency programs has aided in an increase in resident members from 29 to 53, which is an increase of 83 percent. MAG staff has attended all section conference calls as well as six resident orientations, including the inaugural orientation at WellStar.

- **Redevelopment of MAG’s Young Physician Section (YPS):** Like the resident section, the YPS section had been inactive for the better part of a decade. During the January MAG Board of Director’s meeting, officers for the section were elected. The section has met a few times over the last year and has a seat on MAG’s BOD, as well as a delegate seat at MAG’s HOD meeting. It is our hope that the section will continue to expand over the next year.

### 2016 Membership Statistics

<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your membership expired email</td>
<td>6/1/2016</td>
</tr>
<tr>
<td>June dues mailing</td>
<td>6/9/2016</td>
</tr>
<tr>
<td>Membership card sent</td>
<td>6/28/2016</td>
</tr>
</tbody>
</table>

The membership department’s financial goal was to achieve $1,875,000 in dues revenue for the year. I am happy to report that we achieved our budget goal.
**Dues Revenue:** The membership department budgeted 2016 dues revenue at $1,875,000. To date, we have collected $1,986,530.50, which is $111,530.50 more than our goal.

![Dues Collected vs. Dues Budgeted](image1)

**Collected Dues Revenue:** Below is 2016 year-to-date dues revenue versus previous years. To date, MAG has collected $60,103.25 less than 2015.

![Dues Collected By Now 2012-2016](image2)

**New Members:** During 2009 and 2010 we experienced a significant decrease in the number of new members. Due to the fact that our core members are aging and often retiring at an earlier age, it became crucial that we find a way to increase the number of new members. We have been successful in changing this trend by adding 467 new members in the 2016 dues year.
**Second Year Members:** As we continue to increase the number of new members each year, the second year member category becomes an important one to watch. It is essential that once we get new members, that we retain them. For the 2016 dues year we have 453 second year members.

**Third Year and Plus Members:** This category is quite possibly the most important. We have found that by the time a physician has been a member for at least three years, they will most likely be a member for quite some time. This category is also pivotal as membership dues increase to $500. We currently have 4,185 third year or more members, which is an increase of 40 members over 2015.
Total Membership: While we often stress the importance of our Active membership base, MAG has several other categories of membership that are combined to form our total membership number. Our increased focus during 2016 on these other categories such as students, residents and “first year free” has paid off by bringing the 2016 total membership number to 7,602.
**Membership Figures:** Below is a chart comparing all aspects of MAG’s membership in 2016 versus previous years. Please note that the figures below are year-to-date membership comparisons through August 31.

### 2016 Membership Figures
As of August 31, 2016

<table>
<thead>
<tr>
<th>TOTAL ALL CATEGORIES</th>
<th>2012 YTD</th>
<th>2013 YTD</th>
<th>2014 YTD</th>
<th>2015 YTD</th>
<th>2016 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Members</td>
<td>193</td>
<td>637</td>
<td>858</td>
<td>884</td>
<td>763</td>
</tr>
<tr>
<td>2nd Year</td>
<td>257</td>
<td>222</td>
<td>667</td>
<td>794</td>
<td>736</td>
</tr>
<tr>
<td>Actives</td>
<td>3471</td>
<td>3408</td>
<td>3360</td>
<td>3624</td>
<td>3792</td>
</tr>
<tr>
<td>Total Active Dues Paying Members</td>
<td>3921</td>
<td>4267</td>
<td>4885</td>
<td>5302</td>
<td>5291</td>
</tr>
</tbody>
</table>

### ACTIVE MEMBERSHIP COMPARISON

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>New Members</td>
<td>858</td>
<td>884</td>
<td>763</td>
<td>499</td>
<td>467</td>
<td>-32</td>
</tr>
<tr>
<td>Other Actives</td>
<td>4027</td>
<td>4418</td>
<td>4528</td>
<td>4816</td>
<td>4638</td>
<td>-178</td>
</tr>
<tr>
<td>Total Dues Revenue (all categories)</td>
<td>$1,943,169</td>
<td>$2,052,957.50</td>
<td>$2,003,883.50</td>
<td>$2,046,633.75</td>
<td>$1,986,530.50</td>
<td>-$60,103.25</td>
</tr>
</tbody>
</table>
MEMBERSHIP CATEGORIES RETENTION RATES

<table>
<thead>
<tr>
<th></th>
<th>2015 Total</th>
<th>2016 YTD</th>
<th>% Retained</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016 A2s were 2015</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>new members</td>
<td>501</td>
<td>453</td>
<td>90.41</td>
</tr>
<tr>
<td>2016 ACT were 2015</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A2 and ACT</td>
<td>4824</td>
<td>4185</td>
<td>86.75</td>
</tr>
</tbody>
</table>

OTHER CATEGORIES OF MEMBERSHIP

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>First Free</td>
<td>1069</td>
<td>1350</td>
<td>1131</td>
<td>1060</td>
<td>664</td>
<td>1311</td>
<td>1499</td>
</tr>
<tr>
<td>Exempt</td>
<td>9</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Affiliate</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Int/Res</td>
<td>11</td>
<td>12</td>
<td>5</td>
<td>5</td>
<td>29</td>
<td>53</td>
<td></td>
</tr>
<tr>
<td>Associate</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Honorary</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Life</td>
<td>438</td>
<td>389</td>
<td>379</td>
<td>357</td>
<td>358</td>
<td>362</td>
<td>356</td>
</tr>
<tr>
<td>Retired**</td>
<td>151</td>
<td>151</td>
<td>149</td>
<td>141</td>
<td>140</td>
<td>77</td>
<td>109</td>
</tr>
<tr>
<td>Service</td>
<td>19</td>
<td>19</td>
<td>20</td>
<td>19</td>
<td>19</td>
<td>8</td>
<td>19</td>
</tr>
<tr>
<td>Students</td>
<td>178</td>
<td>310</td>
<td>470</td>
<td>454</td>
<td>393</td>
<td>453</td>
<td>458</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1879</td>
<td>2242</td>
<td>2162</td>
<td>2055</td>
<td>2335</td>
<td>1763</td>
<td>2497</td>
</tr>
</tbody>
</table>

Component Medical Society (CMS) Relations

The path to positive and effective relationships with components is paved with frequent communication and promotion of membership on a two-way level. In an effort to provide more detailed information on the activities of MAG headquarters to the component societies, the executive director holds conference calls with the CMS executives to share information between MAG and CMSs and to provide a forum for CMS executives to discuss issues among themselves.
We heard from several small CMSs over the previous years about the difficulties they have in maintaining a functioning CMS. With that in mind, MAG – with input from physician leaders from across the state – developed a list of services that it is making available to county medical societies in Georgia. These services include…

- Listing CMS dues on MAG’s billing statements and collecting those dues
- Producing monthly CMS and MAG member rosters and expired membership lists
- Providing CMS member/non-member demographic information
- Creating CMS-branded marketing resources (e.g., letterhead) and email accounts and membership applications
- Providing meeting planning assistance, including location selection, sponsorship acquisition, RSVP tracking, budgeting, and logistics (e.g., A/V, meals)
- Promoting CMS events and meetings with mailings
- Securing speakers for CMS meetings
- Assisting CMS with elections

We’ve also recently assisted two areas in reforming societies in their areas. We heard from physicians in both the Rome and North Georgia areas that their individual societies had become inactive and that they were looking to reform them with the inclusion of some of their adjacent component societies. Those societies have all met together with success and will reform in 2017. I look forward to reporting on their success next year.

For years, MAG staff has attended virtually every meeting to which they have been invited, and some to which they affirmatively sought an invitation. The department sends out a list of scheduled CMS and specialty society meetings monthly and asks MAG leaders to schedule attendance.

2017 Membership Year

The 2017 membership year will begin this October with the mailing of the first dues statement. Be on the lookout for your statement! To pay your 2017 MAG dues, contact Dawn Williams at 678.303.9261.

##
The Physicians’ Institute for Excellence in Medicine (Physicians’ Institute) is a 501(c) 3 subsidiary of the Medical Association of Georgia (MAG). The Physicians’ Institute focuses on outcomes-based education, performance improvement activities, and consulting to support physicians and their teams. The Physicians’ Institute has directed efforts toward meeting its mission of improving patient safety and achieving systems and clinical improvements for physicians and their patients.

Staff for the Physicians’ Institute includes Bob Addleton, Executive Vice President and Adele Cohen, Senior Vice President for Grants and Operations.

CME Collaborative Educational Grants

The Physicians’ Institute is a national leader in developing and managing collaborative educational projects that provide managed educational grants and projects to continuing medical education (CME) providers, with a focus on outcomes-based and performance improvement activities. To date, the Physicians’ Institute has developed and managed more than 45 initiatives and activities located in 25 states focusing on an array of clinical areas.

To support this national development, Bob Addleton continues to be involved in CME leadership activities at the national level. Addleton is currently president of the national organization, Alliance for Continuing Education in the Health Professions.

Many of the Physicians’ Institute initiatives utilize the Collaborative Grants Model™, which awards secondary grants to CME providers featuring integrated evaluation services, educational design consultation, project management, and aggregate outcome reports. Depending upon the project, standardized curriculum, monographs, video-based content including simulated patients, and audio-visual services may be provided. The Physicians’ Institute has a website that includes educational videos, related resources, and report summaries at www.physiciansinstitute.org.

During the past year, the Physicians’ Institute completed the following projects:

- **Opioid Education based on FDA Curriculum – Phase 2**
  The Physicians’ Institute is one of very few organizations that received support through an FDA educational initiative regarding long acting extended release opioids for prescribers. All pharmaceutical manufacturers of opioids have been required to contribute to a fund to support CME activities that follow a mandated FDA-approved curriculum. The Physicians’ Institute received continuation funding to support and manage educational activities for 10 state medical societies.
• **Georgia Physicians Leadership Academy – Class VIII**
  Served as lead faculty for the leadership portion of the curriculum. Administers and debriefs a 360 leadership feedback survey. Addleton serves as Dean of the GPLA.

• **Rheumatoid Arthritis**
  The Physicians’ Institute collaborated with Educational Concepts Group to support educational activities at 10 locations nationwide.

• **Patient Centered Medical Home – GAFP Phase 3, Emory Health System, and Universal American**
  The Physicians’ Institute provided consulting services to support the Georgia Academy of Family Physicians’ (GAFP) Patient Centered Medical Home University in support of physician practices in Georgia. Services included serving as faculty for educational collaborative and coaching individual practices.

Current projects of the Physicians’ Institute include the following:

• **Improving Pneumococcal Immunization Rates**
  Based on a request from Pfizer, the Physicians’ Institute is managing an immunization initiative in collaboration with the New Jersey Academy of Family Physicians (NJAFP) to improve pneumococcal immunization rates by replicating a successful model developed and managed by NJAFP.

• **Venous Thromboembolism Education**
  As a member of a national collaborative, the Physicians’ Institute is participating in venous thromboembolism (VTE) initiative targeting primary care physicians and their teams in collaboration with American College of Physicians (ACP) chapters.

• **Opioid Education based on FDA Curriculum – Phase 3 – State Medical Societies**
  The Physicians’ Institute is continuing with an additional grant to support and manage educational activities for six state medical societies.

• **Patient Centered Medical Home – PCMH- Stratus – South Georgia**
  See description from Patient Centered Medical Home completed activities above.

• **Georgia Physicians Leadership Academy – Class IX**
  See description from Georgia Physicians Leadership Academy Class VIII above.

• **Jump-Start Leadership**
  The Physicians Foundation awarded a grant to the Physicians’ Institute to provide leadership workshops to five medical societies nationwide that do not have leadership programs in place.

**CME Activities**

The Institute provides CME for physicians based on its own activities and through a joint providership program.
2016 CME Joint Providerships include:

- Crohn’s & Colitis Foundation
- MAG House of Delegates
- Georgia Physicians Leadership Academy
- Rheumatology Journal Club of Augusta, RSS
- The Intersection of PCMH, Pain Management and Performance Improvement CME – online activity
- comMIt – comprehensive motivational interviewing training for health care professionals – online activity
- ICD-10 Charts Training Academy – online activity

Thanks to the members of the Physicians’ Institute Board of Directors for their continuing involvement and support with this endeavor during the past year:

John S. Antalis, M.D.
William A. Bornstein, M.D.
Jack M. Chapman Jr., M.D., Secretary
Madalyn Davidoff, M.D
Aaron H. Davidson, MD.
Howard M. Maziar, M.D.
Alan L. Plummer, M.D., Vice President
Richard S. Simmons, M.D.
Donald Palmisano, MAG Executive Director, Treasurer

# # #
It gives us great pleasure and it is an honor for us to report to you that the Physicians Foundation (PF) has had yet another busy and successful year in its continuing efforts to empower physicians. To this end, and since our last formal report, the PF has supported and been actively involved in:

- Ongoing grant administration in the areas of cultivating physician leadership and workforce planning, as well as supporting resources that address the social and economic challenges that profoundly affect health care outcomes and costs.

- Comprehensive research initiatives, including policy papers centered on the effects of the MACRA legislation and changing payment models.

- The Physician Leadership Academy (now in its seventh year) and hosting the event in collaboration with Duke University. The academy is named the Karl Altenburger, M.D. Physician Leadership Academy in honor of the late physician leader who served on the PF Board, had been president of the Florida Medical Association and who was a tireless advocate for practicing physicians.

- The PF facilitated a conference in partnership with Brandeis University focused on building a physician leadership curriculum to help empower physicians to navigate today’s complex and ever changing health care system better.

- The PF also commissioned a 2016 National Patient Survey examining the status of the patient-physician relationship including factors that patients believe are contributing to increased health care costs, and patient perceptions of stakeholders impacting treatment options.

Some of the findings included in the overview of the survey included:

- Nine out of 10 patients are highly satisfied with their primary care physician

- 48 percent were not confident about being able to afford care should they become seriously ill

- 59 percent say that the cost of prescription drugs contributes to rising health care costs

- 83 percent of patients believe that health insurance companies have the most impact on available treatment options

The PF commissioned Richard (Buz) Cooper, M.D., to write a book exploring how poverty impacts health care and system costs. He focused on the need of the U.S. health care system to address the impact
of social determinants of health. All too often, physicians are blamed for the inordinate amount of costs to
treat those in poverty. In his last act before succumbing to pancreatic cancer, Dr. Cooper finished his
book: *Poverty and the Myth of Health Care Reform*. It has just recently been published by *Johns Hopkins
Press* and is a fascinating read from which, undoubtedly, we can learn.

The PF has also been very active on the grants front with Dr. Plummer leading the deliberations as Chair
of the Grants Committee. PF has approved 25 grants thus far in 2016 totaling $3.725 million. Of them,
one was made to the Medical Association of Georgia’s (MAG) Physician’s Institute for Excellence in
Medicine for nearly $150,000 to support its physician leadership project entitled *Jump Starting Physician
Leadership – A Catalyst to Start a Movement*.

Additional grants given last year since our 2015 report include:

- A grant given to the Cecil Sheps Center for Health Services Research at the University of North
  Carolina to develop a “Future Docs Forecasting Tool,” which is an interactive, user-friendly,
  web-based model that estimates the supply of physicians, use of physician services and the
  capacity of physician services, as well as the capacity of the physician workforce to meet future
  use of health care services at the sub-state, state and national levels.

- An ongoing grant given to Health Leads, an organization that works with leading health care
  organizations to tackle co-morbid health and social issues by connecting patients to community-
  based resources they need to be healthy – from food to transportation to health care services.

Dr. Ray, as Chair of the Research Committee, has been working to coordinate the 2016 National
Physician Survey with the survey firm, Merritt Hawkins. (This is in addition to overseeing the national
patient survey referenced earlier in the report). The response again this year from physicians has been
substantial – with 17,236 responses. Some 10,170 of them also took the time to send us additional
commentaries.

The PF has worked with Merritt Hawkins since 2008 and produced five biennial surveys since then. Of
note to MAG is that we will have a special break-out of all the physician responses by state, including
those from Georgia physicians.

Just some of the findings:

- 80 percent of physicians are overexerted or at capacity, with no time to see additional patients

- Only 20 percent are familiar with MACRA

- Only 6 percent indicate that ICD-10 coding has improved efficiency in their practices, while 42.5
  percent say it has detracted from efficiency

- Only 33 percent of physicians identify as independent practice owners or partners, down from
  48.5 percent in 2012

We are both pleased to represent MAG on the Board of the Physicians Foundation and we take our
responsibilities very seriously. The workload does tend to increase each year – although we believe it is
due to the number of significantly important contributions the PF is making to help physicians in their
practices. Although time consuming and, at times intensive, it is also very rewarding. We are also proud
to serve as president (Dr. Ray) and vice president (Dr. Plummer) of the Foundation where we comprise 40
percent of the Executive Committee, in addition to serving as chairs of two important PF committees.
Thank you for the opportunity to serve you, MAG members, and the Physicians Foundation

# # #
This report provides an update regarding department accomplishments and highlights in 2016 and since the 2015 October convening of the House of Delegates.

**MAG Helps Members Face Payer Challenges**

MAG members continue to contact the Third Party Payer Advocacy (TPP) Department for assistance and support in solving a multitude of issues related to audits, payment delays, underpayments and the like. The department typically finds itself investigating and facilitating the resolution of several issues at a time. MAG has been contacted by a number of small, medium and large groups as well as a county medical society and IPAs for assistance with persistent issues and patterns of poor customer service. MAG’s interventions have resulted in millions of dollars put back into the hands of the physician practices. These successes have been achieved for a number of reasons. MAG provides guidance in helping practices concisely describe the issue and its impact on the practice. These “stories” assist in making the case with the payer and is a very effective strategy. MAG also enjoys a positive and productive problem-solving relationship with the medical directors of each of the large payers. The rapport that MAG has with these clinicians results in issues being handled personally by these individuals. Over the course of 2016, MAG has met regularly with all of the payers, including Medicare and Medicaid. MAG had the opportunity to meet with CMS Acting Administrator Andy Slavitt and on another occasion with his chief of staff.

**Health eParadigm – A MAG-Sponsored, Physician-Led HIE and Data Analytics Solution**

After almost two years and three unanimous votes by the MAG BOD, MAG has entered into a partnership with KaMMCo Health Solutions to offer products and services to Georgia’s physician community and others. We know that there is a significant opportunity and a timing imperative to connect the independent physician community, who continue to be woefully under-represented in Georgia’s HIE environment. Making these connections is a pre-requisite to delivering analytics that support value-based purchasing payment models. While independent physicians will be the focus, this model will also be attractive to hospitals and other entities such as ACOs.

In addition to providing a much needed service and voice in this content area, it will solidify MAG’s brand as new models of health care reimbursement evolve that are dependent on data, measurement and process improvement.

Health eParadigm is the name selected. The EC approved members for the Health eParadigm Advisory Committee that meets monthly. Marketing materials, policies and procedures, and a website have been established and a series of introductory webinars are scheduled for the organizational infrastructure of MAG and Georgia’s House of Delegates (HOD). An exhibit is planned for the 2016 HOD.
MAG Medical Reserve Corps Preparing to Respond

MAG MRC leadership meets monthly as it develops its command and regional leadership structure. The MRC held its first training on April 30, which was very well attended. The drill focused on the assembly of a surge hospital. The next training was held in May at Dobbins Air Force Base where members convened with the Cobb-Douglas Health Department, its MRC and GDF units to learn how to transport patients. The MAG MRC staffed an exhibit and MAG MRC members were present in their uniforms at the July Legislative Session. The MAG MRC will be participating in a Radiation Treatment Network Full Scale Exercise in September at the Dobbins Air Force Base and will be visible at the 2016 HOD where it will be an exhibitor and sponsor.

MAG Represented in Statewide Programs and Initiatives

Whether the focus is quality improvement; care coordination; bringing practices together with hospitals around mutual interest; heart health; immunization advocacy; HIT/EHR/MU, MACRA, MIPS, etc., MAG has been present and engaged, participating in a meaningful way to represent its members. MAG continues to represent the voice of its membership by participating on a number of statewide programs and initiatives, including those related to MACRA and MIPS. MAG uses the ‘Top Docs Radio’ program to disseminate relevant information about these topics and associated programs. MAG has also endorsed the Compass Practice Transformation Network to assist practices in developing skills akin to the patient centered medical home model so that they can be prepared to succeed in a performance-based payment environment.

Hot Topic Forums and Learning Opportunities Offered to Members, Practice Managers and Others.

This member benefit is established to help MAG’s busy physicians meet their informational needs by offering the right information on the right topics via a convenient venue. We are extremely excited to have expanded MAG’s presence via talk radio in 2016, which would not have been possible without the generous funding by HCR, Alliant GMCF.

In 2016, MAG has partnered with ‘Top Docs Radio’ to offer a series of 24 talk radio interview segments on cutting edge trends and topics in health care. The ‘Top Docs Radio’ program has reached listeners in 80 countries and all 50 states in the U.S. More than 90 percent of listeners are from the U.S. and more than 75 percent are from Georgia, particularly metro Atlanta.

Finally, in support of practice administrators throughout Georgia, MAG has sponsored a series of three webinars to inform practices on revenue cycle, compliance and quality reporting matters.

Should you desire additional information or if you have questions, please contact me at 678.303.9275 or at smoore@mag.org.

###
GEORGIA MEDICAL POLITICAL ACTION COMMITTEE

SUBJECT: Annual Report

SUBMITTED BY: Michelle R. Zeanah, M.D., Chairman

REFERRED TO: Not Referred

Charge of the Committee

The Georgia Medical Political Action Committee (GAMPAC) is a voluntary, non-profit, unincorporated committee of individual physicians and others and is not affiliated with any political party. The committee is an independent, autonomous organization, and is not a branch or subsidiary of any national or other political action committee.

Purposes of GAMPAC:

- To promote the involvement of physicians and others to take a more active and effective part in governmental affairs;
- To educate physicians and others as to the understanding of how the three branches of government operate;
- To advise physicians and others as to the evaluation of support of public office holders and candidates for election to public office;
- To organize, promote, encourage and assist actions desirable for the purpose of effective political action;
- To receive and accept contributions from individuals and corporations to the extent authorized by law;
- To make contributions to candidates for public office as authorized by law; and
- To do any and all things necessary or desirable for the attainment of the purposes stated above.

GAMPAC Financial Report

As of August 15, 2016, GAMPAC has $66,956.91 cash on hand. Note that all of the general election planned contributions have already been deducted from this cash on hand balance.

GAMPAC Membership Report

As of September 15, 2016, GAMPAC has 334 members.

Chairman’s Circle Members 2016 ($2,500) 17 Members

- John S. Antalis, M.D.
- James William Barber, M.D.
- Thomas Edward Bat, M.D.
- W. Scott Bohlke, M.D.
- Spurgeon William Clark III, M.D.
- Rutledge Forney, M.D.
- Matthews Weber Gwynn, M.D.
With the new GAMPAC Board in place, elections were held for offices on the executive committee. The following Board members were elected as officers:

- Dr. Michelle Zeanah was elected Chair. She is a pediatrician who practices in Statesboro.
- Dr. James Smith was elected Vice Chair. He is an emergency room physician who practices in Buford.
- Dr. Randy Rizor was elected as Secretary/Treasurer. He is an anesthesiologist who practices in Atlanta.

These officers will now serve a two-year term until June 2018.

After the primary election in May, the General Assembly has added another physician in the legislature, MAG member Dr. Mark Newton. There will now be now four physicians serving in the legislature: Sen.
Dean Burke, an OB/GYN; Sen. Ben Watson, an internist; Rep. Betty Price, who practiced anesthesiology; and Dr. Mark Newton, an emergency physician. GAMPAC supported Dr. Newton’s candidacy at the maximum level.

GAMPAC held a board meeting via teleconference on Thursday, August 18. Items discussed included the 2016 General Election contribution plan and a new “contributor” GAMPAC membership category.

These discussions produced the following action items:

• Approval of the 2016 GAMPAC general election cycle contribution plan.
• Contributor GAMPAC member status at $95, and an opt-out provision on the MAG membership dues renewal form for this voluntary contribution.

The GAMPAC Board of Directors will hold another in-person board meeting at HOD after the MAG Board of Directors meeting in October.

###
REPORTS OF COMMITTEES
Committee on Council on Legislation

Committee: 04.16

SUBJECT: Annual Report

SUBMITTED BY: Michael E. Greene, M.D., Chairman

REFERRED TO: Not Referred

Charge of the Council

The Medical Association of Georgia’s (MAG) Council on Legislation (COL) was established to review legislation and to recommend policy positions to MAG’s policy-making bodies and to communicate MAG’s positions to legislators at the state and federal levels.

Summary of 2016 Regular General Assembly

The 2016 Legislative Session was very positive for physicians and patients. MAG tracked more than 300 bills during the 2016 legislative session, and MAG’s strong relationships with both leadership and rank and file legislators proved valuable to MAG members again in 2016. Not only did we work to pass several bills that benefitted MAG members, we were also able to stall or defeat several other bills that would have negatively affected physicians and patients.

Throughout the legislative process we continued to work with stakeholders and other interested parties, and thoroughly vetted all policy decisions through our COL to ensure that we maintained the most prudent posture for the good of medicine.

MAG successfully passed its priority legislation, including rental networks, provider directories, and the Prescription Drug Monitoring Program (PDMP). These three bills, along with several others, are described in detail in the legislative activities section below.

Additionally, MAG worked with budget writers and staff to provide input and recommendations on ways to continue the Medicaid Parity Payment for primary care physicians. As a result of our efforts and those of others, the legislature passed a 2017 appropriation bill that included $26.2 million to increase the reimbursement rate for select Medicaid primary care and OB-GYN codes, which is up from $23 million in FY 2016.

Legislative Activities

MAG Priority: Rental Networks

S.B. 158, a health insurance rental networks bill that will result in greater insurer disclosure and transparency and will ensure that physicians get paid their contracted rate in the event their network is leased. This measure will require insurers to register every rental network in the state with the Georgia Department of Insurance. S.B. 158 was the result of a measure (S.R. 561) that legislators passed in 2015 that led to the creation of a study committee. This was MAG’s top legislative priority for 2016.

MAG position: Supported. Outcome: Passed.
MAG Priority: Provider Directories
S.B. 302, which will require health insurance companies to maintain more accurate provider directories. This measure will require insurers to update their provider lists every 30 days and maintain those lists in both electronic and paper forms. It was the result of legislation that passed in 2015, including S.R. 561 and S.B. 158.
MAG position: Supported. Outcome: Passed.

MAG Priority: Prescription Drug Monitoring Program (PDMP)
H.B. 900, which will enhance the state’s Prescription Drug Monitoring Program (PDMP). This measure will 1) give physicians the authority to delegate the right to access the PDMP system to staff who are licensed, registered or board-certified health care professionals and 2) allow prescribers and dispensers to communicate with each other about potential abusers and 3) allow individuals who are authorized to access the PDMP system to report instances of misuse or abuse to the patient’s primary prescriber.
MAG position: Supported. Outcome: Passed.

PRESERVING PHYSICIAN AUTONOMY
H.B. 498 by Rep. Lee Hawkins (R-Gainesville) would have revised the definition of “professional counseling” by allowing clinical social workers, marriage and family therapists, and licensed counselors to use the term “diagnose” for billing and reimbursement purposes. MAG opposed this legislation because it believes that a diagnosis should be reserved for medical professionals for the sake of patient welfare. It is worth noting that Rep. Hawkins is a dentist.
MAG position: Opposed. Outcome: Did not pass.

H.B. 780 by Rep. Jodi Lott (R-Evans) would have changed the definition of the term ‘clinical laboratory’ in Georgia to exclude laboratories that aren’t diagnostic and/or are subject to the federal Clinical Laboratory Improvement Amendments (CLIA) provisions (i.e., the sole function is to examine human blood or blood components to manufacture of biological products). Sen. Dean Burke, M.D. (R-Bainbridge) introduced a companion bill in the Senate (S.B. 273), which did pass.
MAG position: Neutral. Outcome: Did not pass.

H.B. 775 by Rep. Earl Earhart (R-Powder Springs) will ban non-optometrists and non-ophthalmologists from writing prescriptions or dispensing “spectacles” – keeping in mind the state already has a prohibition on contact lenses.
MAG position: Supported. Outcome: Passed.

H.B. 944 by Rep. Sheri Gilligan (R-Cumming) would have allowed nurse practitioners and physician assistants to pronounce an organ donor’s death if they are under hospice care or in a nursing home.
MAG position: Neutral. Outcome: Did not pass.

S.B. 319 by Sen. Lester Jackson (D-Savannah) will allow professional counselors to “diagnose” a patient’s condition. MAG has consistently opposed this kind of change because it believes that diagnosing a patient’s condition should be reserved for medical professionals in order to safeguard patients.

MEDICAID
Lawmakers passed a 2017 FY budget (H.B. 751) that includes $26.2 million to increase the reimbursement rate for select Medicaid primary care and OB-GYN codes. This is up from a $23 million increase in FY 2016.
MAG position: Supported. Outcome: Passed.
H.B. 823 by Rep. Stacy Abrams (D-Atlanta) called for legislators to take steps to obtain the funds that are available under the Affordable Care Act to expand the Medicaid program in the state. MAG supports reform that 1) ensures the adequacy of payment and 2) reduces administrative burdens and 3) reinforces the physician-patient relationship and 4) promotes quality, including the Patient-Centered Medical Home. MAG will continue to call for the General Assembly to fund the Medicaid Parity Payment Program, it will encourage lawmakers to continue to fund every area of primary care, and it will work with legislators and regulators to develop funding options to provide care for Georgians who are uninsured. It is worth noting that in 2015 MAG’s House of Delegates (HOD) passed a resolution (308C.15) that calls for MAG to “explore options to provide health care insurance for Georgia citizens currently falling in the coverage gap.”

MAG position: Supported. Outcome: Did not pass.

HEALTH INSURANCE & INCREASING ACCESS TO CARE

H.B. 826 by Rep. Betty Price, M.D. (R-Roswell) would have established standards for physicians who state in advertisements that they are certified by any public or private board in any specialty or subspecialty. This bill would have required the ads to include the full name of the certifying board.

MAG Position: Supported. Outcome: Did not pass.

H.B. 684 by Rep. Chuck Martin (R-Alpharetta) would have allowed dental hygienists to clean patients’ teeth without a dentist present in certain “safety net” settings (e.g., free clinics) to increase the accessibility of care. Dentists would have maintained their supervisory role.

MAG position: Neutral. Outcome: Did not pass.

H.B. 952 (‘Professional Regulation Reform Act’) by Rep. Chad Nimmer (R-Blackshear) will give the governor the authority and duty to “actively supervise” the state’s professional licensing boards to ensure that their actions are consistent with state law. The governor will have the authority to review, write, approve or veto any rule before it is filed with the Secretary of State.


H.B. 509 by Rep. Jesse Petrea (R-Savannah) was designed to improve the quality of patient-centered and family-focused palliative care. It will establish a Palliative Care and Quality of Life Advisory Council, it will result in a statewide palliative care information and education program, and it will give physicians more palliative care options. MAG position: Supported. Outcome: Passed.

H.B. 555 (‘Right to Know Act’) by Rep. Joyce Chandler (R-Grayson) will establish a reporting requirement for minors who seek to get an abortion without parental consent. With input from the Georgia OB-GYN Society, lawmakers amended the bill so physicians would not be subject to the reporting requirement (i.e., the court system would).


H.B. 710 (‘ABLE Act’) by Rep. Scot Turner (R-Holly Springs) would have allowed eligible individuals with disabilities to make contributions to tax-exempt accounts to pay for certain qualified expenses like living expenses and housing. This measure would have also created an oversight commission. MAG position: Supported. Outcome: Did not pass. H.B. 710’s provisions were included in a bill (H.B. 768) by Rep. Lee Hawkins (R-Gainesville) that did pass. H.B. 768 will also allow eligible individuals who have disabilities to make contributions to tax-exempt accounts to pay for certain qualified expenses (e.g., living expenses and housing).

H.B. 853 (‘Coverdell-Murphy Act’) by Rep. Lee Hawkins (R-Gainesville) will provide additional resources for critical and comprehensive care facilities that provide care for patients who suffer a stroke.

MAG position: Supported. Outcome: Passed.

H.B. 810 by Rep. Spencer Frye (D-Athens) would have required a party who requests a patient’s medical record to pay for the copying and mailing costs. This bill would have also prohibited the entity that was providing the medical record from charging the patient for the service. The requesting party also wouldn’t have had to pay any additional cost to obtain the record in electronic form under this bill.

MAG position: Neutral. Outcome: Did not pass.

H.B. 776 by Rep. Sharon Beasley-Teague (D-Red Oak) would have required health insurers to pay for certain medical procedures that are related to peroral endoscopic myotonic surgical care that is deemed “experimental or investigational.”

MAG position: Neutral. Outcome: Did not pass.

A bill (H.B 882) by Rep. Darlene Talyor (R-Thomasville) was amended to include language that was originally included in S.B. 265 by Sen. Judson Hill (R-Marietta) that would have allowed physicians to have payment agreements with patients that would be exempt from state insurance laws.


H.B. 902 by Rep. Katie Dempsey (R-Rome) will require assisted living communities to provide educational information about influenza disease.

MAG position: Supported. Outcome: Passed.

H.B. 910 by Rep. Spencer Frye (D-Athens) will require the state regulations that govern the copying and mailing of medical records to be applied to psychiatric, psychological, and other mental health records. This bill will also make the third party that makes the request responsible for all copying and mailing costs.


H.B. 916 by Rep. Dustin Hightower (R-Carrollton) will give health care providers the opportunity to correct a clerical billing error before they are penalized by the Georgia Department of Community Health (DCH). Clerical or record-keeping errors will not constitute fraud or serve as the basis for the recoupment of full payment for the services that are provided. Providers will have 30 days to correct clerical or other errors upon notice, as well as have the opportunity to schedule a hearing to address attempts to withhold reimbursement or recoupment by DCH or its agents to address any or all of their concerns. Any state agency that provides recoupment or reimbursement to another entity will be prevented from establishing rules that will require full recoupment or withholding of reimbursement for clerical or record-keeping errors.

MAG position: Supported. Outcome: Passed.

H.B. 1043 by Trey Kelley (R-Cedartown) will exempt hospitals and health systems from having to follow the influenza vaccine protocol in the state. The Senate amended this bill to include language from Sen. Judson Hill’s S.B. 385, which calls for physicians to display the full name of their certifying board or complete a postgraduate training program in advertisements. This bill is consistent with a policy that MAG’s HOD passed in 2015.

MAG position: Supported. Outcome: Passed.

H.B. 1058 by Rep. Betty Price, M.D. (R-Marietta) will modify HIV/AIDS and STD testing protocols by 1) giving women the right to refuse to be tested and 2) allowing minors to consent to medical treatment if they are at risk of HIV/AIDS and 3) eliminating the requirement for the Georgia Department of Public Health to provide access to HIV/AIDS and STD testing for all residents of the state.
Health to develop HIV/AIDS counseling brochures and 4) providing that “disclosure to a parent or legal guardian of a minor’s AIDS confidential information is permissive rather than mandatory.”


S.R. 974 by Sen. Renee Unterman (R-Buford) will establish a study committee to examine the factors that lead to “surprise” billing – as well as develop ways to avoid the need for the practice.

MAG position: Supported. Outcome: Passed.

S.R. 1091 by Sen. Charlie Bethel (R-Dalton) will create a committee to study a wide range of issues that are related to adolescents who are hearing impaired. MAG position: Neutral. Outcome: Passed.

S.R. 1154 by Sen. Butch Miller (R-Gainesville) will establish a study committee to evaluate the effects of developing Emergency Cardiac Care Centers with certain scientifically validated protocols and procedures to increase the survivability of a cardiac event.


S.R. 1166 by Sen. Marty Harbin (R-Tyrone) will create a study committee to 1) examine the challenges that are faced by small businesses that need to obtain health insurance and 2) the potential for the state to develop and sponsor a self-insured group health insurance plan.

MAG position: Supported. Outcome: Passed.

S.B. 230 by Sen. Chuck Hufstetler (R-Rome) will allow volunteer health care professionals to render care during natural disasters in the state. In addition to MAG, the Georgia Chapter of the American College of Surgeons was a strong advocate for this bill. The measure does not give health care providers any additional privileges, and professionals are still subject to the rules that govern the Georgia Composite Medical Board. Volunteers will be covered under the state’s ‘Good Samaritan Act.’ Seventeen states have adopted this kind of legislation, including Tennessee.

MAG position: Supported. Outcome: Passed.

S.B. 265 (‘Physician Direct Pay Act’) by Sen. Judson Hill (R-Marietta) would have allowed physicians to enter into payment agreements with patients that would have been exempt from state insurance laws as long as the “direct financial relationship” did not exceed $6,000. The bill was consistent with MAG policy.

MAG position: Supported. Outcome: Did not pass.

S.B. 271 by Sen. Dean Burke, M.D. (R-Bainbridge) will reduce the involuntary commitment period in the state from 60 days to 40 days.


S.B. 291 (‘Georgia Affordable Free Market Health Care Act’) by Sen. Judson Hill (R-Marietta) was designed to “lower costs and improve access to care while assuring quality services are available.” This bill would have 1) established wellness rewards and incentives and 2) allowed direct patient/physician payment options and 3) addressed out-of-network coverage and 4) addressed ‘any willing provider’ contract issues. MAG position: Neutral. Outcome: Did not pass.

S.B. 302 by Sen. P.K. Martin (R-Lawrenceville) will require health insurance companies to maintain more accurate provider directories. It calls for 1) health carriers to post a current and accurate directory for every plan on their websites and 2) insurers to provide a printed and current copy of their directories upon an insured customer or prospective customer’s request and 3) insurers to provide their customers with accurate customer service contact information.

MAG position: Supported. Outcome: Passed.
S.B. 382 by Sen. Renee Unterman (R-Buford) was designed to address “surprise” billing, which occurs when a patient finds out that not all of the health care providers who provide their care at a given facility are included in their health insurance network and they consequently face higher, out-of-network charges. Sen. Unterman will form a committee to study this issue in greater detail, which is action that was endorsed by MAG.

MAG position: Opposed. Outcome: Did not pass.

S.B. 385 by Sen. Judson Hill (R-Marietta) will establish standards for physicians who run advertisements that state that they are certified by any public or private board in any specialty or subspecialty. The certifying board must be a member of the American Board of Medical Specialties, the American Board of Physician Specialties, or the American Osteopathic Association. This bill requires the ads to include the full name of the certifying board. This bill is consistent with a policy that MAG’s HOD passed in 2015.


H.B. 649 by Rep. Sharon Cooper (R-Marietta) will create a lactation consultant advisory committee and establish guidelines to license individuals who want to be lactation consultants. MAG’s House of Delegates voted to support this kind of legislation in 2014.

MAG position: Supported. Outcome: Passed.

PRESCRIPTION DRUGS

H.B. 34 by Rep. Mike Dugeon (R-Johns Creek) will give patients the freedom to use experimental drugs that have successfully completed FDA Phase I trials. The patient will be required to consult with their physician and sign a consent form to document that they understand the risks associated with taking the drugs. The patient will also have to exhaust every other option before they take this step. MAG worked with Rep. Dugeon to ensure that physicians will be immune from liability in the event a patient has a negative outcome.

MAG position: Supported. Outcome: Passed.

H.B. 588 by Rep. Valerie Clark (R-Lawrenceville) will establish a registry for ephedrine and pseudoephedrine products – which can be used to manufacture illegal drugs. The product manufacturers agreed to fund the program in hopes of decreasing drug abuse in the state.

MAG position: Supported. Outcome: Passed.

H.B. 722 by Rep. Allen Peake (R-Macon) would have expanded the list of patients who can use medical marijuana to include autism, epidermolysis, HIV/AIDS, peripheral neuropathy, Tourette’s syndrome, and terminal illness with a probable life expectancy of less than two years if the illness or its treatment produces one or more of the following: severe pain; nausea or severe vomiting; cachexia or severe wasting; post-traumatic stress disorder.

MAG position: Opposed. Outcome: Did not pass.

H.B. 783 by Rep. Bruce Broadrick (R-Dalton) is the annual “pharmacy clean-up” bill, which will ensure that Georgia’s code is in sync with the federal government pertaining to the scheduling of narcotics.


H.B. 813 by Rep. Rick Jasperse (R-Jasper) would have allowed a physician to write a prescription for an antibiotic for a patient’s partner when the physician has treated the patient for chlamydia, gonorrhea or trichomoniasis. This bill would have shielded physicians who act in good faith from civil or criminal liability. It included language that said that physicians who use this kind of therapy “shall not be deemed as having engaged in unprofessional conduct by their licensing board.”
H.B. 897 by Rep. Betty Price, M.D. (R-Roswell) will establish a voluntary drug repository program to accept and donate unused prescription medications – excluding controlled substances – for the indigent. Under this bill, “Any person, drug manufacturer, or health care facility [could donate a drug] to a participating pharmacy, hospital, or nonprofit clinic. Recipients of donated drugs may be assessed a handling fee. There is no liability to participants that donate, dispense, or manufacture drugs.” All drugs will have to be dispensed as a proper order from a licensed health care provider. It is also worth noting that in Georgia there is no tort or civil liability for donating, accepting, or dispensing drugs under the program if injury, death, or loss to person or property results unless an action or omission constitutes willful and wanton misconduct.

MAG position: Supported. Outcome: Did not pass.

H.B. 900 by Rep. Sharon Cooper (R-Marietta) will enhance the state’s Prescription Drug Monitoring Program (PDMP) by 1) allowing crime investigators to obtain a search warrant for the crime scene and 2) giving physicians the authority to delegate the right to access the PDMP system to staff who are licensed, registered or board certified health care professionals and 3) allowing prescribers and dispensers to communicate with each other about potential abusers and 4) allowing individuals who are authorized to access the PDMP system to report instances of misuse or abuse to the patient’s primary prescriber.

MAG position: Supported. Outcome: Passed.

The ‘Honorable Jimmy Carter Cancer Treatment Access Act’ (H.B. 965) by Rep. Mike Cheokas (R-Americus) will prevent insurance companies from limiting the coverage of drugs for Stage 4 cancer patients. This bill will allow physicians to prescribe a preferred drug(s) without having to prove to the insurer that other medications failed. In addition, any insurance company that offers health care plans in Georgia will not be able to force patients to respond to other treatments before trying more advanced treatment programs. The bill only applies to health plans that cover the treatment of advanced, metastatic cancer – which typically involves Stage 4 patients in which cancer has spread to other parts of the body. This legislation was inspired by the medical care that former President Jimmy Carter received for his cancer.

MAG position: Supported. Outcome: Passed.

S.B. 115 by Sen. Chuck Hufstetler (R-Rome) would have allowed physician assistants (PAs) to prescribe a 15-day supply – rather than the current 30-day supply – of Hydrocodone Combination Products (HCPs).

MAG position: Neutral. Outcome: Did not pass.

S.R. 1165 by Sen. Butch Miller (R-Gainesville) will create a study committee that will look at the causes and effects of opioid use and abuse in Georgia, as well as the actions that need to be taken to save lives.

MAG position: Supported. Outcome: Passed.

OTHER

H.B. 774 by Rep. Alex Atwood (R-St. Simons) would have prohibited the use of fireworks at certain times and in certain places. It would have also given counties and municipalities the authority to require a special permit to use consumer fireworks. MAG position: Neutral. Outcome: Did not pass.

Physicians’ Day at the Capitol - 2016

The annual Physicians’ Day at the Capitol on January 27 was largely successful. More than 40 physicians, representing several specialties and county medical societies, and 40 legislators participated in the day’s activities.
Physicians addressed a number of important issues, including narrowing health insurance networks and patient billing and prescription drug monitoring.

Legislators who spent time with the physicians included:

- Senate Majority Leader Bill Cowsert (R-Athens)
- Senate HHS Committee Chair Renee Unterman (R-Buford)
- Senate Insurance Committee Chair Charlie Bethel (R-Dalton)
- Senate Ethics Committee Chair Dean Burke, M.D. (R-Bainbridge)
- Sen. Ben Watson, M.D. (R-Savannah)
- Sen. Judson Hill (R-Marietta)
- Sen. Tyler Harper (R-Ocilla)
- Sen. P. K. Martin (R-Lawrenceville)
- Sen. Greg Kirk (R-Americus)
- Sen. John Kennedy (R-Macon)
- House HHS Committee Chair Sharon Cooper (R-Marietta)
- House HHS Committee Vice Chair Rick Jasperse (R-Jasper)
- Rep. Nikki Randall (D-Macon)
- Rep. Lee Hawkins (R-Gainesville)
- Rep. Buddy Harden (R-Cordele)
- Rep. Dustin Hightower (R-Carrollton)
- Rep. Jason Spencer (R-Woodbine)
- Rep. Paulette Braddock (R-Powder Springs)
- Rep. Demetrius Douglas (D-Stockbridge)
- Rep. Darlene Taylor (R-Thomasville)
- Rep. Bruce Williamson (R-Monroe)
- Rep. Tonya Anderson (D-Lithonia)
- Rep. Dominic LaRiccia (R-Douglas)
- Rep. B. J. Pak (R-Lilburn)
- Rep. Jeff Deffenbaugh (R-Lookout Mountain)
- Rep. Bert Reeves (R-Marietta)
- Rep. Trey Kelley (R-Cedartown)

In addition to MAG, the event was sponsored by the Georgia Society of the American College of Surgeons (lunch sponsor), Georgia State Medical Association, Georgia Society of Ophthalmology, Georgia Radiological Society, Georgia Society of Anesthesiologists, Georgia Society of Clinical Oncology, Georgia Orthopaedic Society, Georgia Society of Dermatology and Dermatologic Surgery, and Georgia Psychiatric Physicians Association.

**Physicians’ Day at the Capitol – 2017**

The 2017 Physicians’ Day at the Capitol is scheduled for January 25. All members are encouraged to participate and to stand in solidarity in their “white coat,” as this will serve as a reminder to legislators that doctors are attentive to the policies and proposals that affect their patients and practice environments.

**2016 Summer Legislative Education Seminar**

More than 50 physicians and 25 legislators attended the Medical Association of Georgia’s (MAG) ‘Summer Legislative Education Seminar’ at the Westin Jekyll Island on Friday, July 29 and Saturday, July 30.
The event involved legislators who serve on the key committees that are aligned with MAG’s legislative priorities, including Health and Human Services, Insurance, and Judiciary. It featured panel discussions that addressed a number of key issues, including out-of-network billing, how to address Georgia’s uninsured patient population, and the pending Aetna/Humana and Anthem/Cigna mergers. Attendees also received an update on developments at the federal level.

**MAG’s Proposed 2017 Legislative Priorities**

**Out-of-Network Billing and Network Adequacy**
The Medical Association of Georgia will support reforms that require appropriate network adequacy standards for insurers. We will advocate for transparency for insurers entering into contracts with physicians’ practices and work to determine an appropriate payment methodology.

**Medicaid Payment Parity**
The Medical Association of Georgia will advocate for the General Assembly to continue funding for the Medicaid Parity Payment Program. We will advocate that the legislature continue to fund all areas of primary care.

**Maintenance of Certification (MOC)**
The Medical Association of Georgia will work to ensure that Maintenance of Certification is not a condition for licensure. We will support efforts to alleviate the costly and burdensome aspects of MOC for physicians.

**Patient Safety Options**
The Medical Association of Georgia will advocate for measures that improve patient safety.

**Covering the Uninsured**
The Medical Association of Georgia will work with the legislature and state regulators on solutions for Georgia citizens who currently fall in the insurance coverage gap.

# # #
The objective of the Committee on Continuing Medical Education has been to make sure that the Medical Association of Georgia’s (MAG’s) accredited organizations offer quality, meaningful education to Georgia physicians and to ensure that physicians receive the AMA PRA Category 1 Credit™ they need to renew licenses, maintain Board certifications and to retain privileges at hospitals. The most important need continues to be for physicians to maintain and enhance the professional competencies they use for the care and well-being of their patients.

**Charge of the Committee on Continuing Medical Education**

The Committee on Continuing Medical Education is a Special Committee of MAG charged with the responsibility of accrediting organizations that desire to provide accredited continuing medical education (CME) activities to Georgia physicians. The Committee on Continuing Medical Education reviews and approves applications for accreditation and reaccreditation, establishes accreditation policies, provides supervision and guidance to surveyors and holds periodic training sessions for staff of accredited organizations. The Committee on Continuing Medical Education keeps all accredited organizations updated concerning MAG, Accreditation Council for Continuing Medical Education (ACCME) and American Medical Association (AMA) requirements and policies related to CME.

**Accomplishments**

During the past year MAG’s Department of Education has continued to build upon the accomplishments of the past.

Accomplishments throughout the year have included:

- Accreditation Services: There are nearly 40 MAG accredited CME providers. MAG continues to work with accredited CME providers to provide resources that will help them adhere to the ACCME’s Accreditation Criteria.
- CME accreditation surveys are managed by specially trained physician surveyors with the support of one MAG staff member. The primary duties of the Committee on Continuing Medical Education are to set policy, make accreditation and reaccreditation decisions and give input to our recognition from ACCME to accredit our state providers.

An extended thank you goes out to the members of the Committee on Continuing Medical Education. The Committee on Continuing Medical Education meets four times a year. This year the meetings were held on February 10, May 11 and August 24. The final meeting in 2016 is scheduled for November 2.
MAG’s physician surveyors spend a great amount of time reading the applications for accreditation and reaccreditation, reviewing CME activity files and attending the site survey visits of each provider. Our special thanks to them for all of their effort and time given to accomplish these tasks.

Committee on Continuing Medical Education members:

Darrell L. Dean, D.O., Chairman
Wayne S. Mathews, Jr., M.D.
James V. Rawson, M.D.
William E. Silver, M.D.

Physician surveyors:

Darrell L. Dean, D.O.
Wayne S. Mathews, Jr., M.D.

MAG staff:

Andrew J. Baumann, BA, Director of Education

# # #
During fiscal year 2016, the MAG Committee on Correctional Medicine under the leadership of Chairman Patton P. Smith, M.D., of Forsyth, met three times. Accreditation fees that were collected were used as the basis for paying consultants and as reimbursement for travel expenses to committee members who conduct site visits. All facilities in the accreditation program are on an annual billing cycle for renewal.

Site visits have been conducted at the following state prisons and county jails during this year: Lumpkin County Jail, Dahlonega; Augusta State Medical Prison, Augusta; Phillips State Prison, Buford; Walton County Jail, Monroe; Emmanuel Women’s Facility, Swainsboro; Whitworth Women’s Facility, Hartwell; Long State Prison, Ludowici; Helms Facility, Atlanta; Riverbend Correctional Facility, Milledgeville; Calhoun State Prison, Morgan; Washington State Prison, Davisboro; Jenkins Correctional Facility, Statesboro; Richmond County Jail, Augusta; Dodge State Prison, Chester; Smith State Prison, Glennville; Coffee Correctional Facility, Nichols; Dooly State Prison, Unidilla; Wilcox State Prison, Abbeville; and Chattooga County Jail, Summerville.

Georgia Department of Corrections continues a comprehensive intra-state agreement with Augusta University (AU) for the provision of health services with an organization specifically created for this purpose – the Georgia Correctional HealthCare, Inc. (GCHC). This agreement includes the responsibility for GCHC to pay the accreditation fees and has been in effect since July 1, 1997. Payments to MAG have been timely. Presently, all state prisons are accredited.

Members continue to be involved on each on-site visit to jails and prisons. They make recommendations to the committee regarding accreditation and needed improvements at facilities in the program. The MAG accreditation program is using several consultants regularly – both committee members and outside consultants – to conduct accreditation site visits. Since site visits are scheduled intermittently throughout the year, this arrangement continues to work very well and is cost effective.

Annual maintenance reporting has been in effect since January 1997 and allows for renewal of all facilities in the MAG program. This allows accredited facilities to renew by reporting and documentation only. On-site visits are scheduled at least every three years. Facilities are visited more frequently when they are experiencing significant changes or if we learn of problems or noncompliance of standards.

Thirty-two facilities were renewed by completing annual maintenance reports this fiscal year. These reports require documentation that often identifies problems, which are then monitored until a resolution is obtained.

The National Commission on Correctional Health Care (NCCHC) is publisher of the Standards for Health Services in Prisons, Jails and Juvenile Facilities. This committee endorses and uses the standards to measure compliance for accreditation purposes. Copies of the current standards are available for purchase directly from the NCCHC. If weaknesses in standards are observed, the MAG Correctional
Medicine committee makes recommendations that they believe will improve the quality of care. After great effort, the committee has published the *MAG Standards for Accreditation in Jails*, which is designed to be used primarily in jails with an average daily population of less than 200 people. It is anticipated that these standards, which are user friendly, will be adopted by many jails within the state of Georgia. It is hoped that these same jails will then seek to become accredited.

During this fiscal year, the *Bliven Award for Excellence* was presented to Coastal State Prison. The *Spivey Award*, which is presented only to jails for excellence in the provision of health care, was presented to Lumpkin County Jail and Lamar County Jail.

With the advent of the AU/GCHC program in prisons, significant changes have been introduced. The regionalization of correctional services has continued. Most infirmaries have been closed with only a few being designated as regional infirmaries. Only a few prisons are providing level III and IV mental health services. These few receive referrals from other prisons in their region. Dental services have been significantly reduced. X-ray services have been reduced by about 50 percent, mostly by reducing full-time x-ray technician’s positions to part-time and the use of mobile x-ray service vendors. Efforts to increase the use of telemedicine continue.

This committee appreciates the continuing support given by MAG and respectfully submits this report as information on progress experienced this year.

# # #
SUMMARY OF HOUSE ACTIONS
<table>
<thead>
<tr>
<th>Title/Action</th>
<th>Referral</th>
<th>Status</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resolution 101A.15 – National Board of Physicians and Surgeons (NBPAS) Board Recertification</td>
<td>Administration</td>
<td>Policy Statement: MAG accepts the National Board of Physicians and Surgeons (NBPAS) as an alternative to ABMS for recertification for physicians in Georgia.</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Resolution was submitted to the American Medical Association for consideration at the AMA 115 meeting.</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td>AMA combined Resolution 924 (Alternative Pathways to Board Recertification and Georgia’s resolution 925 and referred both for a report back at A-16.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>AMA Delegation</td>
<td>In June 2016, the AMA HOD received a comprehensive report submitted by the Council on Medical Education. The AMA adopted CME Report 2 – Update on Maintenance of Certification and Osteopathic Continuous Certification. This will be addressed in the AMA Delegation Report that is submitted to the 2016 HOD.</td>
<td></td>
</tr>
<tr>
<td>Title/Action</td>
<td>Referral</td>
<td>Status</td>
<td>Completed</td>
</tr>
<tr>
<td>-------------</td>
<td>----------</td>
<td>--------</td>
<td>-----------</td>
</tr>
<tr>
<td>Resolution 102A.15 – Computer Electronic Health Record Cybersecurity</td>
<td>AMA Delegation</td>
<td>Resolution was submitted to the American Medical Association for consideration at the AMA i15 meeting. AMA adopted Resolution 221 – Indemnity for Breaches in Electronic Health Record Cybersecurity – as amended: That our American Medical Association advocate for indemnity or other liability protections for physicians whose electronic health record data and other electronic medical systems become the victim of security compromise.</td>
<td>✓</td>
</tr>
<tr>
<td>Resolution 103A.15 – Georgia Cancer Control Consortium (GC3)</td>
<td>Council on Legislation</td>
<td>Policy Statement: MAG supports all efforts including those of the Georgia Cancer Control Consortium and other health care organizations including legislation to create a palliative care network that offers access to palliative care for both in-patient and out-patient treatment in each region of the state.</td>
<td>✓</td>
</tr>
</tbody>
</table>

AMA Delegation
Resolution was submitted to the American Medical Association for consideration at the AMA i15 meeting.
AMA adopted Resolution 221 – Indemnity for Breaches in Electronic Health Record Cybersecurity – as amended: That our American Medical Association advocate for indemnity or other liability protections for physicians whose electronic health record data and other electronic medical systems become the victim of security compromise.

Council on Legislation
Policy Statement: MAG supports all efforts including those of the Georgia Cancer Control Consortium and other health care organizations including legislation to create a palliative care network that offers access to palliative care for both in-patient and out-patient treatment in each region of the state.
MAG attended the first Georgia Colorectal Roundtable in March. MAG also supported H.B. 965 preventing health insurance companies from limiting cancer drugs to patients, which was signed by the Governor.

Reference Committee A
MAG House of Delegates 2015
<table>
<thead>
<tr>
<th>Title/Action</th>
<th>Referral</th>
<th>Status</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resolution 104A.15 – Insurance Deductibles</td>
<td>No referral</td>
<td>No action is required</td>
<td>✓</td>
</tr>
<tr>
<td>DID NOT Adopt calling for the Medical Association of Georgia (MAG) delegates to the American Medical Association (AMA) to introduce a resolution asking the AMA support deductibles that run with the prime policyholder’s birthday month rather than calendar year and for the AMA to encourage state societies to pursue the same at the state level.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resolution 105A.15 – Vaccine Availability in Small Practices</td>
<td>AMA Delegation</td>
<td>A resolution was submitted to the AMA for its consideration at its 2016 annual meeting.</td>
<td>✓</td>
</tr>
<tr>
<td>Adopted resolve 1 that the Medical Association of Georgia (MAG) delegation to the American Medical Association (AMA) present a resolution asking the AMA to encourage vaccine manufacturers to make small quantities of vaccines available for purchase without financial penalty to help small practices maintain a comprehensive vaccine inventory.</td>
<td></td>
<td>In June 2016 the AMA adopted MAG’s resolution now numbered as Resolution 404 with a change in title to now read as Vaccine Available in Small Quantities.</td>
<td>✓</td>
</tr>
<tr>
<td>Adopted as amended resolve 2 that MAG investigate the feasibility to create a purchasing group or other means for MAG members to purchase vaccines</td>
<td>Finance Committee Legal Department</td>
<td>On April 16, 2016, the Board of Directors did not take an action to pursue becoming a purchasing group. The Board was informed that there are various resources online that members can access to obtain vaccines in smaller quantities through group purchasing arrangements.</td>
<td>✓</td>
</tr>
<tr>
<td>Title/Action</td>
<td>Referral</td>
<td>Status</td>
<td>Completed</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>----------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Resolution 106A.15 – Increasing the Grace-Period for Medicare Part D Recipients</td>
<td>Office of the President</td>
<td>A letter from the MAG President was sent to AMA’s President urging the AMA to work with CMS to resolve this situation with Medicare Part D.</td>
<td>✓</td>
</tr>
<tr>
<td>Adopted resolve 1 that the Medical Association of Georgia (MAG) urge the American Medical Association (AMA) to work with the Centers for Medicare &amp; Medicaid Services (CMS) to allow Medicare recipients to change their Medicare Part D plan within the first three months of the new year if the original plan they signed on for does not appear to be the most appropriate plan for their clinical problem after examination by their physicians.</td>
<td></td>
<td>The AMA explained its perspective on the issue as outlined in 106A.15. MAG spoke to the sponsor of the resolution who will seek further information before we move forward with additional discussions with AMA.</td>
<td>✓</td>
</tr>
<tr>
<td>Adopted new resolve 2 that MAG provide educational support to patients and physicians regarding online prescription resources such as the Medicare plan finder at medicare.gov.</td>
<td>Third Party Payer Advocacy</td>
<td>MAG provided some educational resources on the Medicare/Medicaid webpage of MAG’s website.</td>
<td>✓</td>
</tr>
<tr>
<td>Resolution 107A.15 – Waiver Not To Use Electronic Records</td>
<td>Third Party Payer Advocacy</td>
<td>MAG worked closely with Congressman Tom Price to pass the “Patient Access and Medicare Protection Act (S. 2425) which gives CMS the authority to expedite applications for exemptions from EHR MU Stage 2 requirements for 2015.</td>
<td>✓</td>
</tr>
<tr>
<td>Adopted Resolution 107A.15 that the Medical Association of Georgia (MAG) advocates for waivers to allow physicians who are not confident with the use of electronic health records (EHR) to not be financially punished or fined because of their decision to forego the use of electronic records.</td>
<td></td>
<td>Policy Statement MAG shall advocate for waivers to allow physicians who are not confident with the use of electronic health records to not be financially punished or fined for not using an electronic record program.</td>
<td>✓</td>
</tr>
<tr>
<td>Title/Action</td>
<td>Referral</td>
<td>Status</td>
<td>Completed</td>
</tr>
<tr>
<td>-------------</td>
<td>----------</td>
<td>--------</td>
<td>-----------</td>
</tr>
<tr>
<td>Resolution 108A.15 – Improving EHR</td>
<td>Administration</td>
<td>Policy Statement: MAG supports the American Medical Association in its advocacy with the U.S. Department of Health Human Services, IT experts, researchers and executives to reframe policy around the desired future capabilities of electronic health records (EHR) technology to enhance patient care, improve productivity and reduce administrative costs.</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Administration</td>
<td>Policy Statement: MAG supports the 2014 AMA position paper that outlines eight priorities to improve EHR usability for physicians and other stakeholders in the health care industry, including the following:</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. EHR systems should be designed to enhance physician-patient communication and engagement;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. EHR systems should support team-based care by maximizing each person’s productivity in accordance with state licensure laws and allow physicians to delegate tasks as appropriate;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. EHR systems should be designed to enhance care coordination across the continuum of care;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. EHR systems should offer product modularity and configurability to meet individual practice requirements;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. EHR systems should support medical decision</td>
<td></td>
</tr>
</tbody>
</table>

Reference Committee A
MAG House of Delegates 2015
<table>
<thead>
<tr>
<th>Title/Action</th>
<th>Referral</th>
<th>Status</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resolution 108A.15 -- Improving EHR (cont.)</td>
<td></td>
<td>4. EHR systems should offer product modularity and configurability to meet individual practice requirements;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. EHR systems should support medical decision making with concise, context sensitive and real-time data;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>6. EHR systems should facilitate connected health care across care settings and enable both exporting data and properly incorporating data from other systems;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>7. EHR systems should be interoperable with patient mobile technology to support patient engagement; and 8) EHR systems should be designed with end-user input and EHR technology should facilitate post-product implementation feedback.</td>
<td></td>
</tr>
<tr>
<td>Resolution 109A.15 – Meaningful Use Stage 3</td>
<td>Administration</td>
<td>Policy Statement: MAG supports AMA’s efforts to advocate for the U.S. Department of Health and Human Services (HHS) to pause the Meaningful Use (MU) Stage 3 regulation, and evaluate the MU program.</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MAG will continue to work closely with the AMA on this initiative.</td>
<td></td>
</tr>
</tbody>
</table>

Reference Committee A
MAG House of Delegates 2015
<table>
<thead>
<tr>
<th>Title/Action</th>
<th>Referral</th>
<th>Status</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resolution 110A.15 – Georgia Colorectal Cancer Roundtable</td>
<td>Administration</td>
<td>Policy Statement:&lt;br&gt;MAG supports increasing the colorectal cancer screening rate in Georgia from 67.8 percent to 80 percent by 2018 for adults over the age of 50.</td>
<td>✓</td>
</tr>
<tr>
<td>Adopted that the Medical Association of Georgia (MAG) and the physicians of Georgia endorse the efforts of the Georgia Colorectal Cancer Roundtable (GCCRT) to improve colorectal cancer outcomes in Georgia by increasing the colorectal cancer screening rate in Georgia from 67.8 percent to 80 percent by 2018 for adults over the age of 50.</td>
<td></td>
<td>MAG attended the first meeting of the Georgia Colorectal Cancer Roundtable in March.</td>
<td>✓</td>
</tr>
<tr>
<td>Resolution 111A.15 – Expedited Partner Therapy (EPT)</td>
<td>Administration</td>
<td>Policy Statement:&lt;br&gt;MAG supports expedited partner therapy (EPT) in Georgia to help combat the spread of sexually transmitted diseases.</td>
<td>✓</td>
</tr>
<tr>
<td>Adopted Resolution 111.15 that the Medical Association of Georgia (MAG) supports the adoption of expedited partner therapy (EPT) in Georgia as recommended by the Centers for Disease Control and Prevention (CDC) to help combat the spread of sexually transmitted diseases.</td>
<td></td>
<td>MAG worked with the sponsor of the bill in 2016 related to expedited partner therapy (EPT). Unfortunately, the bill did not pass.</td>
<td>✓</td>
</tr>
<tr>
<td>Title/Action</td>
<td>Referral</td>
<td>Status</td>
<td>Completed</td>
</tr>
<tr>
<td>-------------</td>
<td>----------</td>
<td>--------</td>
<td>-----------</td>
</tr>
<tr>
<td>Resolution 112A.15 – Drug Formularies</td>
<td>No Referral</td>
<td>No action is required</td>
<td>✓</td>
</tr>
<tr>
<td>DID NOT Adopt Resolution 112A.15 calling for the Medical Association of Georgia (MAG) to advocate that insurance companies should be required to specify a comparable pharmaceutical product that the insurance company will cover when a pharmaceutical denial is sent to the physician or patient.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resolution 113A.15 – IOM “Dying in America” Report</td>
<td>Administration</td>
<td>Policy Statement: MAG supports and promotes the recommendations of the Institute of Medicine (IOM) “Dying in America” report, which provides recommendations to improve the quality of end-of-life care received by all patients.</td>
<td>✓</td>
</tr>
<tr>
<td>Adopted resolve 1 that the Medical Association of Georgia (MAG) supports and promotes the recommendations of the Institute of Medicine (IOM) “Dying in America” report, which provides recommendations to improve the quality of end-of-life care received by all patients.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adopted resolve 2 that the Georgia Delegation to the American Medical Association (AMA) introduce a similar resolution to the AMA at its next House of Delegates calling for the AMA to support and promote the recommendations of the Institute of Medicine “Dying in America” report, which provides recommendations to improve the quality of end-of-life care received by all patients.</td>
<td>AMA Delegation</td>
<td>A resolution was submitted to the AMA for consideration at its AMA i15 meeting. AMA referred Resolution 006, IOM “Dying in America” Report for a report back at the A-16 meeting. The resolution sponsor, Dr. Richard Cohen, is working closely with the AMA on its position. A report from the AMA BOT in June called for additional time to vet the full IOM report and stated it would submit a final report at the 2016 Interim meeting.</td>
<td>✓</td>
</tr>
<tr>
<td>Title/Action</td>
<td>Referral</td>
<td>Status</td>
<td>Completed</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------</td>
<td>----------</td>
<td>------------------------------------------------------------------------------------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Resolution 114A.15 – Veterans Affairs</td>
<td>Administration</td>
<td>Policy Statement: MAG supports enhanced communications between patients’ Veterans Affairs (VA) physicians and their other non-VA treating physicians.</td>
<td>✓</td>
</tr>
<tr>
<td>Adopted that the Medical Association of Georgia (MAG) supports and advocates for an electronic and/or telephone electronic medical records (EMR) and communications system that will allow enhanced communications between patients’ Veterans Affairs (VA) physicians and their other non-VA treating physicians.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resolution 115A.15 – Pharmaceutical Company Co-Pay Cards</td>
<td>No referral</td>
<td>No action is necessary</td>
<td>✓</td>
</tr>
<tr>
<td>DID NOT Adopt for the Medical Association of Georgia delegation to the American Medical Association (AMA) House of Delegates present a resolution asking the Centers for Medicare &amp; Medicaid Services (CMS) to allow patients on government health programs to use pharmaceutical company co-pay cards to help control the cost of pharmaceutical products and medications.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resolution 116A.15 – Medicare Consultation Code</td>
<td>No referral</td>
<td>No action is necessary</td>
<td>✓</td>
</tr>
<tr>
<td>DID NOT Adopt for the Medical Association of Georgia (MAG) delegation to the American Medical Association present a resolution asking the Centers for Medicare &amp; Medicaid Services (CMS) to adequately pay physicians for the care of Medicare patients by reinstating consultation codes.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Title/Action</td>
<td>Referral</td>
<td>Status</td>
<td>Completed</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>-----------------------</td>
<td>------------------------------------------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Committee 02.15, Constitution and Bylaws, Item 6 – Life Membership</td>
<td>Administration</td>
<td>The Constitution and Bylaws shall be revised to reflect these changes.</td>
<td>✓</td>
</tr>
<tr>
<td>Adopted Committee 02.15 that amends MAG Bylaws Chapter II, Membership, Section 7 Life Members.</td>
<td></td>
<td>CHAPTER II – MEMBERSHIP SECTION 7. LIFE MEMBERS. A member in good standing who is 70 years of age (on or by January 1 of the current dues year) <strong>shall</strong> may be classified as a Life Member if the physician has been an active, dues paying member of any state medical society for at least 25 consecutive years and has been an active, dues paying member of this Association for at least two of those years and has notified the secretary of the Medical Association of Georgia his or her desire to be reclassified as such…</td>
<td>✓</td>
</tr>
<tr>
<td>Committee 02.15, Constitution and Bylaws, Item 7 – Alternate Delegates</td>
<td>Administration</td>
<td>The Constitution and Bylaws shall be revised to reflect this change.</td>
<td>✓</td>
</tr>
<tr>
<td>Adopted Committee 02.15 that amends MAG Bylaws Chapter V, House of Delegates, Section 5, Organization, (c) Committees.</td>
<td></td>
<td>CHAPTER V - HOUSE OF DELEGATES SECTION 5. ORGANIZATION (c) Committees. The Speaker of the House of Delegates shall appoint, from delegates and alternates of the House of Delegates, the Reference Committees, the Credentials Committee, and other committees considered necessary for the proceedings of the House of Delegates…</td>
<td>✓</td>
</tr>
<tr>
<td>Title/Action</td>
<td>Referral</td>
<td>Status</td>
<td>Completed</td>
</tr>
<tr>
<td>-------------</td>
<td>----------</td>
<td>--------</td>
<td>-----------</td>
</tr>
<tr>
<td>Committee 02.15, Constitution and Bylaws, Item 8 – Absence of the Vice Speaker</td>
<td>Administration</td>
<td>The Constitution and Bylaws shall be revised to reflect these changes.</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CHAPTER V - HOUSE OF DELEGATES SECTION 5. ORGANIZATION (a) Speaker of the House of Delegates and Vice Speaker of the House of Delegates. The House of Delegates shall be presided over by the Speaker, or in the absence of the Speaker, by the Vice Speaker. In the absence of the Vice Speaker, the Speaker may designate a delegate to serve in that capacity for the duration of the meeting. In the absence of both, the President shall nominate two delegates to serve as Speaker and Vice Speaker who the House of Delegates will confirm. Delegate agreeable to the House of Delegates may preside…</td>
<td></td>
</tr>
<tr>
<td>Committee 02.05, Constitution and Bylaws, Item 9 – Reports to HOD Requiring Listings of Physicians (Director Reports)</td>
<td>Administration</td>
<td>MAG Constitution and Bylaws shall be revised to reflect these changes.</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CHAPTER VI - BOARD OF DIRECTORS SECTION 4. ELECTIONS AND TERMS OF DIRECTORS (d) Duties of Directors and Alternate Directors…The director shall make submit an annual report at the Annual Session of the House of Delegates, listing all physicians in the respective district who are members of a component society, membership data of each component society within the respective district and describing the work and condition of the profession of each county in that district. The alternate director shall assist the director in the performance…</td>
<td></td>
</tr>
<tr>
<td>Title/Action</td>
<td>Referral</td>
<td>Status</td>
<td>Completed</td>
</tr>
<tr>
<td>-------------</td>
<td>----------</td>
<td>--------</td>
<td>-----------</td>
</tr>
<tr>
<td>Committee 02.15, Constitution and Bylaws, Item 10 – BOD Composition</td>
<td>Administration</td>
<td>MAG Constitution and Bylaws will be revised to reflect these changes: CHAPTER VI - BOARD OF DIRECTORS SECTION 2. COMPOSITION. (b) Directors and Alternate Directors are selected as follows: (vii) In the event of a membership surge that provides for a significant increase in representation on the Board of Directors by a component medical society, upon approval of the Board of Directors, the component medical society may seat the added representatives immediately prior to the election cycle and notification of such election results shall be forwarded to the House of Delegates at the next annual session. (viii) (vii) (ix) The Young Physician Section of the Association shall be entitled to a Director and an Alternate Director representative on the Board of Directors, said officers to be elected annually by the members of the Young Physician Section. (viii) (ix) (x) The Medical Student Section of the Association shall be entitled to a Director and an Alternate Director representative on the Board of Directors, said officers to be elected annually by the members of the Medical Student as the Chair and Vice Chair, respectively, of the Medical Student Section</td>
<td>✓</td>
</tr>
<tr>
<td>Title/Action</td>
<td>Referral</td>
<td>Status</td>
<td>Completed</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>----------</td>
<td>------------------------------------------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Committee 02.15, Constitution and Bylaws, Item 11 – Executive Committee Nominations</td>
<td>Administration</td>
<td>MAG Constitution and Bylaws will be revised to reflect these changes</td>
<td>✓</td>
</tr>
<tr>
<td>Adopted Committee 02.15 that amends MAG Bylaws Chapter, VII, Executive Committee, Section 1, Purpose and Meetings</td>
<td></td>
<td>CHAPTER VII   EXECUTIVE COMMITTEE SECTION 1. PURPOSE AND MEETINGS. (a) Duties. The Executive Committee shall: …(4) nominate members of all boards required by the law of the State of Georgia on recommendation of the district societies where applicable or not otherwise provided for, all such recommendations being subject to confirmation by the Board of Directors…</td>
<td></td>
</tr>
<tr>
<td>Committee 02.15, Constitution and Bylaws, Item 12 – Appointment of the MAG Journal Editor</td>
<td>Administration</td>
<td>MAG Constitution and Bylaws will be revised to reflect this change.</td>
<td>✓</td>
</tr>
<tr>
<td>Adopted Committee 02.15 that amends the MAG Bylaws , Chapter XII, Official Publication, Section 2, Journal.</td>
<td></td>
<td>CHAPTER XII - OFFICIAL PUBLICATION. SECTION 2. JOURNAL. The Board of Directors shall appoint an Editor of the Journal and define the powers and duties of the Editor and Editorial Board, and shall appoint an Editorial Board annually. The Executive Committee shall provide oversight for the Journal of the Medical Association of Georgia.</td>
<td></td>
</tr>
<tr>
<td>Committee 02.15, Constitution and Bylaws, Item 13 – Name of Parliamentary Procedure Manual</td>
<td>Administration</td>
<td>MAG Constitution and Bylaws will be revised to reflect these changes.</td>
<td>✓</td>
</tr>
<tr>
<td>Adopted Committee 02.15 that amends the MAG Bylaws Chapter V, House of Delegates, Section 6, Procedures, and Chapter VI, Board of Directors, Section 6, Procedures, and Chapter VII, Executive Committee, Section 5, Procedure as follows:</td>
<td></td>
<td>CHAPTER V - HOUSE OF DELEGATES SECTION 6. PROCEDURE. The deliberations of the Association shall be conducted in accordance with the current edition of Sturgis’ Rules of Order The American Institute of Parliamentarians Standard Code of Parliamentary Procedure unless contrary to the Association’s Constitution and Bylaws or procedures of the House of Delegates.</td>
<td></td>
</tr>
<tr>
<td>Title/Action</td>
<td>Referral</td>
<td>Status</td>
<td>Completed</td>
</tr>
<tr>
<td>-------------</td>
<td>----------</td>
<td>--------</td>
<td>-----------</td>
</tr>
<tr>
<td>Committee 02.15, Constitution and Bylaws, Item 13 – Name of Parliamentary Procedure Manual (Cont.)</td>
<td>Administration</td>
<td>CHAPTER VI - BOARD OF DIRECTORS SECTION 6. PROCEDURES. The deliberations of the Board shall be conducted in accordance with the current edition of <em>Sturgis’ Rules of Order</em>. The American Institute of Parliamentarians Standard Code of Parliamentary Procedure unless contrary to the Association’s Constitution and Bylaws or procedures of the House of Delegates.</td>
<td>✓</td>
</tr>
<tr>
<td>Committee 02.15, Constitution and Bylaws, Item 14 – CMS and District BOD</td>
<td>Administration</td>
<td>MAG Constitution and Bylaws will be revised to reflect these changes.</td>
<td>✓</td>
</tr>
</tbody>
</table>

**Committee 02.15, Constitution and Bylaws, Item 14 – CMS and District BOD**

Adopted Committee 02.15 that amended MAG Bylaws Chapter VI, Board of Directors, Section 2. Composite, (b) Directors and Alternate Directors.
(iv) If a district society has one component county medical society entitled to separate representation with less than 50 active members who are not also members of the component county medical society entitled to separate representation, then the component county medical society is entitled to one less Director and one less Alternate Director than the number provided above and the district society is entitled to one Director and one Alternate Director to be elected by all members of the district society including the members of the component county medical society which has separate representation. The Director and Alternate Director elected to represent the district society must be persons not affiliated with the component county medical societies entitled to separate representation. The component county medical society entitled to separate representation shall maintain at least one Director and one Alternate Director.

(v) If a district society has two or more component county medical societies entitled to separate representation with more than 50 active members who are not also members of component county medical societies entitled to separate representation, then the component county medical societies are entitled to the number of Director and Alternate Directors as provided above and the district society is entitled to one Director and one Alternate Director to be elected by the members of the district society who are not also members of any one of the component county medical societies which has separate representation if these members number more than five (5).

(vi) If a district society has two or more component county medical societies entitled to separate representation with less than 50 active members who are not also members of a component county medical society entitled to separate representation, then each component county medical society with the exception of the smallest component county medical society entitled to separate representation shall be entitled to the number of Directors.
<table>
<thead>
<tr>
<th>Title/Action</th>
<th>Referral</th>
<th>Status</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Committee 02.15, Constitution and Bylaws, Item 14 – CMS and District BOD (Cont.)</td>
<td></td>
<td>and Alternate Directors provided above. The smallest component county medical society entitled to separate representation is entitled to one less Director and one less Alternate Director than the number provided above and the district society is entitled to one Director and one Alternate Director to be elected by all members of the district society. The Director and Alternate Director elected to represent the district society must be persons not affiliated with the component county medical societies entitled to separate representation. All component county medical societies entitled to separate representation shall maintain at least one Director and one Alternate Director.</td>
<td></td>
</tr>
<tr>
<td>Committee 02.15, Constitution and Bylaws, Item 15 – CMS Delegate Selections</td>
<td>Administration</td>
<td>MAG Constitution and Bylaws will be revised to reflect these changes.</td>
<td>✓</td>
</tr>
<tr>
<td>Adopted Committee 02.15 that amends MAG Bylaws Chapter III, Component County Societies, Section 6, Duties.</td>
<td></td>
<td>CHAPTER III. COMPONENT COUNTY SOCIETIES SECTION 6. DUTIES. Each component county society shall meet the minimum standards set forth in this Section. Each society shall: (a) meet one or more times a year, elect officers and select its delegates annually at a meeting…</td>
<td></td>
</tr>
<tr>
<td>Resolution 504CB.15 – MAG Foundation Board of Trustees’ Term Limits</td>
<td>MAG Foundation Board of Trustees</td>
<td>Notification of this action was forwarded to the Board of Trustees of the MAG Foundation. The MAG Foundation updated its bylaws to reflect this action.</td>
<td>✓</td>
</tr>
<tr>
<td>Adopted as amended by the House of Delegates that the Medical Association of Georgia (MAG) adopts as policy that the trustees of the MAG Foundation be appointed for three years and serve no more than three consecutive terms.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Title/Action</td>
<td>Referral</td>
<td>Status</td>
<td>Completed</td>
</tr>
<tr>
<td>---------------------------------------------------------</td>
<td>-------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Resolution 505CB.15 – Physicians’ Institute Board of Directors’ Term Limits</td>
<td>Physicians’ Institute Board of Directors</td>
<td>Notification of this action was forwarded to the Physicians’ Institute for Excellence in Medicine. The Physicians’ Institute for Excellence in Medicine updated its bylaws to reflect this action.</td>
<td>✓</td>
</tr>
<tr>
<td>Adopted that the Medical Association of Georgia (MAG) adopts as policy that the Directors of the Physicians’ Institute for Excellence in Medicine be appointed for three years and serve no more than two consecutive terms.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resolution 506CB.15 – Physicians’ Institute Bylaws Deletion</td>
<td>Physicians’ Institute Board of Directors</td>
<td>Notification of this action was forwarded to the Physicians’ Institute for Excellence in Medicine. The Physicians’ Institute amended its bylaws to reflect this action.</td>
<td>✓</td>
</tr>
<tr>
<td>Adopted that the Medical Association of Georgia (MAG) adopts as policy that Section 6. Article IV of the Physicians’ Institution for Excellence in Medicine bylaws be amended by deleting this section from the bylaws. Article IV, Section 6. The Board of Directors may establish reasonable compensation for the officers of the corporation.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resolution 507CB.15 – Physicians’ Institute Bylaws Revisions</td>
<td>Physicians’ Institute Board of Directors</td>
<td>Notification of this action was forwarded to the Physicians’ Institute for Excellence in Medicine. The Physicians Institute for Excellence in Medicine updated its bylaws to reflect this action.</td>
<td>✓</td>
</tr>
<tr>
<td>Adopted that the Medical Association of Georgia (MAG) adopts as policy the Section 4, Article III of the Physicians’ Institute for Excellence in Medicine bylaws be revised to clarify that a majority of the Board is needed to constitute a quorum.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Title/Action</td>
<td>Referral</td>
<td>Status</td>
<td>Completed</td>
</tr>
<tr>
<td>-------------</td>
<td>----------</td>
<td>--------</td>
<td>-----------</td>
</tr>
</tbody>
</table>
| Article III, Section 4  
At all meetings of the Board of Directors, more than one half a majority of the Directors then in office shall be necessary to constitute a quorum for the transaction of business. If a quorum is present, the acts of a majority of the directors in attendance shall constitute the acts of the Board. | | | |
| Resolution 508CB15, Resolves 1-5 – Out-of-State Membership  
Committee 02.15, Constitution and Bylaws, Item 4, Out-of-State Membership  
Adopted resolve 1 that the MAG Bylaws be amended in Chapter II, with new Section 3 entitled Out-of-State Membership and the subsequent Sections of this Chapter be renumbered:  
Adopted resolve 2 that the new membership section on out-of-state membership will create a reduced dues membership category for physicians who are licensed to practice medicine in Georgia and meet the membership criteria of Chapter II, Section 1(a)(i) but who practice the majority of their professional time in another state.  
Adopted resolve 3 that out-of-state members of MAG may be solicited by GAMPAC for contributions but will not have the right to vote, | Finance Committee Membership Department | MAG Constitution and Bylaws will be revised to reflect this new Section 3 of Chapter II.  
CHAPTER II.  
SECTION 3. OUT-OF-STATE MEMBERSHIP. Out of State Members are defined as those physicians who are licensed in Georgia, who meet the membership criteria of Chapter II, Section 1(a)(i), but who practice the majority of their professional time in another State. The Board will set the amount of dues for Out of State Members. Out of State Members of MAG may be solicited by GAMPAC for contributions but will not have the right to vote, hold office or receive the Journal of the MAG or other benefits, unless accorded by the House of Delegates or the MAG Board of Directors. Out of State Members of MAG will have the right to join county medical societies and but not count towards their delegate allotment to the MAG House of Delegates  
A revised dues structure will be recorded and kept in the Department of Membership. | ✓ |
<table>
<thead>
<tr>
<th>Title/Action</th>
<th>Referral</th>
<th>Status</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>hold office or receive the Journal of the Medical Association of Georgia or</td>
<td>Board of Directors</td>
<td>At its meeting on January 30, 2016, the Board of Directors set dues for out-of-state members at $100.</td>
<td>✓</td>
</tr>
<tr>
<td>other benefits, unless accorded by the House of Delegates or the MAG Board</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>of Directors. Adopted as amended resolve 4 that out-of-state members of MAG</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>will have the right to join county medical societies but not count toward</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>their delegate allotment to the MAG House of Delegates. Adopted resolve 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>that the Board of Directors will set the amount of dues for out-of-state</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>members.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resolution 501CB.15, resolves 1-4 – AMA Delegation Elections Committee</td>
<td>No Referral</td>
<td>No action required.</td>
<td>✓</td>
</tr>
<tr>
<td>02.15, Constitution and Bylaws, Item 1 – AMA Delegation Elections DID NOT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adopt resolves 1-4 calling for MAG to amend its bylaws, Chapter VIII,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Election and Terms of Officers, Section 2, Procedure, (d) Delegates and</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alternate Delegates to the AMA, regarding the way in which elections are</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>held.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resolution 502CB.15 – AMA Delegation Term Limits Committee 02.15, Constitution and Bylaws, Item 2, AMA Delegation Term Limits</td>
<td>No Referral</td>
<td>No action required.</td>
<td>✓</td>
</tr>
<tr>
<td>DID NOT Adopt calling for MAG to amend its bylaws, Chapter VIII, Election</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and Terms of Officers, Section 2, Procedure, (d) Delegates and Alternate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delegates to the AMA, regarding the way in which elections are held.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Title/Action</td>
<td>Referral</td>
<td>Status</td>
<td>Completed</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>-------------------</td>
<td>------------------------------------------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Officers, Section 2 Procedure (d) Delegates and Alternate Delegates to the AMA, regarding term limits.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resolution 503CB.15 – Council on Legislation Chair Term Limits</td>
<td></td>
<td>The Constitution and Bylaws will be amended to reflect this change.</td>
<td>✓</td>
</tr>
<tr>
<td>Committee 02.15, Committee on Constitution and Bylaws, Item 3 – Council on Legislation Chair Term Limits.</td>
<td>Administration</td>
<td>CHAPTER IX - COMMITTEES SECTION 3. APPOINTMENTS AND TERMS OF COMMITTEE MEMBERS. All standing committee members will be recommended by the Executive Committee unless otherwise specified in the Bylaws. Standing committee members will be appointed for terms of 2 years and may not serve more than three terms, unless directed by specific action of the Executive Committee, or as otherwise specified by these Bylaws. Committee chairmen will not be subject to term limits, except the Council on Legislation chair, who shall be elected annually for no more than eight (8) consecutive years.</td>
<td></td>
</tr>
<tr>
<td>Adopted to amend MAG Bylaws, Section IX, Committees, Section 3, Appointments and Terms of Committee Members. (This is in keeping with a recommendation from the MAG Executive Committee)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## 2015 HOUSE OF DELEGATES

Updated: 9/21/2016

Sid Moore Jr., M.D., Chairman
Marcus Downs, Ryan Larosa, Elizabeth Bullock, Staff

<table>
<thead>
<tr>
<th>Title/Action</th>
<th>Referral</th>
<th>Status</th>
</tr>
</thead>
</table>
| Officer 01.15 – Report of the President | Office of the Executive Director  
Department of Communications  
Council on Legislation  
Legal Department | A survey was sent to the membership in March. We continue to follow the case. The CON educational piece was submitted on the survey. We will engage the case when it reaches the Georgia Court of Appeals. | ✓ |
| Resolution 301C.15 – Able Act | Council on Legislation | Policy Statement:  
MAG supports the implementation of the Achieving a Better Life Experience (ABLE) Act of 2014 at the state level so that Georgia’s disabled citizens may remain in the workforce and not lose disability benefits.  
MAG supported H.B. 710 and H.B. 768 in the 2016 General Assembly. H.B. 768 was signed by the Governor. | ✓ |
<table>
<thead>
<tr>
<th>Title/Action</th>
<th>Referral</th>
<th>Status</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resolution 302C.15 – Abuse-Deterrent Technology Opioids</td>
<td>Council on Legislation</td>
<td>Policy Statement: MAG believes that if insurance carriers provide coverage for certain extended-released opioid, they must also provide coverage for the same extended-release opioid with abuse-deterrent technology when available.</td>
<td>✓</td>
</tr>
<tr>
<td>Resolution 303C.15 – Direct Primary Care</td>
<td>Council on Legislation</td>
<td>Policy Statement: MAG supports state legislation that amends Georgia laws governing insurance regulations and physician licensure so as to ensure that such laws do not create unnecessary impediments to the offering of direct primary care arrangements. This would include legislation that permits physicians contracting as direct primary care providers to not be considered “risk bearing entities,” thus excluding them from insurance licensure and insurance regulation requirements.</td>
<td>✓</td>
</tr>
<tr>
<td>Title/Action</td>
<td>Referral</td>
<td>Status</td>
<td>Completed</td>
</tr>
<tr>
<td>-------------</td>
<td>----------</td>
<td>--------</td>
<td>-----------</td>
</tr>
<tr>
<td>Resolution 304C.15 – Lymphedema Treatment Act</td>
<td>AMA Delegation</td>
<td>A resolution was submitted to the AMA for consideration at its AMA i15 meeting. AMA adopted Substitute Resolution 822 which reads: Resolved, that our American Medical Association support Medicare coverage for appropriate and evidence-based treatment of lymphedema. New Title Medicare Coverage for Evidence-based Lymphedema Treatment</td>
<td>✓</td>
</tr>
<tr>
<td>Resolution 305C.15 – Prior Approval</td>
<td>Third Party Payer Advocacy</td>
<td>Policy Statement: Titled: Insurance Transparency MAG shall advocate for: 1) all prior approval procedures and forms to be clearly available on an insurance plan website; 2) forms to be transparent with all materials in clear, concise and literacy appropriate language for the calendar year; 3) all insurance companies to post current drug formularies clearly on an insurance plan website; and 4) provide the drug formulary when denied. MAG is working with the Georgia Pharmacy Association on a task force to push these recommendations.</td>
<td>✓</td>
</tr>
<tr>
<td>Title/Action</td>
<td>Referral</td>
<td>Status</td>
<td>Completed</td>
</tr>
<tr>
<td>-------------</td>
<td>----------</td>
<td>--------</td>
<td>-----------</td>
</tr>
<tr>
<td>Resolution 305C.15 – Prior Approval (cont.)</td>
<td>Third Party Payer Advocacy Legislative Advocacy</td>
<td>At the Board meeting on April 16, MAG President John Harvey, M.D., reported that the MAG/Georgia Pharmacy Association Task Force was established and charged to investigate clinical and operational challenges presented by payers’ prior authorization requirements, to engage payers in addressing common concerns, and to recommend statutory, regulatory and/or operational fixes that assure patients receive proper care while assuring reasonable costs controls.</td>
<td>✓</td>
</tr>
<tr>
<td>Resolution 306C.15 – Preserving the Georgia Prescription Drug Monitoring Program</td>
<td>Council on Legislation Legislative Advocacy</td>
<td>The Georgia General Assembly allocated money in the 2016 budget to continue funding the Prescription Drug Monitoring Program (PDMP). H.B. 900 contained provisions to allow greater law enforcement access. MAG supported H.B. 900 and it was signed by the Governor.</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Board of Directors</td>
<td>This item is addressed in the regulations that have been promulgated through the passage of H.B. 900. It is also being addressed by the MAG/GPhA task force.</td>
<td>✓</td>
</tr>
<tr>
<td>Title/Action</td>
<td>Referral</td>
<td>Status</td>
<td>Completed</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------</td>
<td>-----------------------------------</td>
<td>---------</td>
<td>-----------</td>
</tr>
<tr>
<td>Resolution 306C.15 – Preserving the Georgia Prescription Drug Monitoring Program (Cont.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>eminent danger to patient safety without a subpoena. The Georgia State Attorney General’s office would have oversight of this process.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resolution 307C.15 – Specialty Medications and Drug Formulary Transparency</td>
<td></td>
<td>Policy Statement: MAG believes that insurers and payers should eliminate complex barriers and reinstate physicians as the primary authority for patient treatment decisions – providing coverage transparency and protecting patient access to timely, affordable and medically appropriate care in Georgia.</td>
<td>✓</td>
</tr>
<tr>
<td>Adopted resolve 1 that the Medical Association of Georgia (MAG) advocates for insurers and payers to eliminate complex barriers, and reinstate physicians as the primary authorities for patient treatment decisions – providing coverage transparency and protecting patient access to timely, affordable and medically appropriate care in Georgia.</td>
<td>Council on Legislation Third Party Payer Advocacy</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Adopted resolve 2 that MAG sends a letter to the Georgia Insurance Commissioner supporting drug formulary transparency for patients to help improve the quality of care provided by physicians.</td>
<td>Office of the President</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Policy Statement: MAG supported H.B. 965, the Honorable Jimmy Carter Cancer Treatment Access, which prevents health insurers from limiting coverage of drugs for stage 4 cancer patients. The bill was signed by the Governor.</td>
<td>MAG supports drug formulary transparency for patients to help improve the quality of care provided by physicians.</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Policy Statement: MAG sent a letter to the Commissioner of Insurance supporting drug formulary transparency.</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Title/Action</td>
<td>Referral</td>
<td>Status</td>
<td>Completed</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>-------------------------------</td>
<td>-----------------------------------------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Resolution 308C.15 – Closing the Coverage Gap in Georgia</td>
<td>Third Party Payer Advocacy</td>
<td>MAG is currently working with the Georgia Chamber of Commerce and the Georgia Hospital Association to find Georgia-based solutions to fill the coverage gap.</td>
<td>✓</td>
</tr>
<tr>
<td>Adopted as amended that the Medical Association of Georgia (MAG) explores options to provide health care insurance for Georgia citizens currently falling in the coverage gap.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resolution 309C.15 – Food and Nutrition Services in Georgia</td>
<td>Administration</td>
<td>Policy Statement: MAG supports the Food and Nutrition Service (FNS) agencies that provide a vital service of high quality, low cost health interventions within a community.</td>
<td>✓</td>
</tr>
<tr>
<td>Adopted resolve 1 that the Medical Association of Georgia (MAG) supports the Food and Nutrition Service (FNS) agencies that provide a vital service in the community by providing high quality, low cost health intervention.</td>
<td>Administration</td>
<td>Policy Statement: MAG supports legislation that include medically tailored FNS for individuals living with severe illnesses for which there is disease-specific evidence that demonstrates the cost effectiveness and improved health outcomes that result from FNS as an intervention.</td>
<td>✓</td>
</tr>
<tr>
<td>Adopted resolve 2 that MAG supports legislation that include medically tailored FNS for individuals living with severe illnesses for which there is disease-specific evidence that the results of the FNS intervention demonstrates cost effectiveness and improved health outcomes.</td>
<td></td>
<td>The 2016 General Assembly did not have legislation to address this matter. MAG will support in future general assemblies.</td>
<td>✓</td>
</tr>
<tr>
<td>Title/Action</td>
<td>Referral</td>
<td>Status</td>
<td>Completed</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>------------------</td>
<td>------------------------------------------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Resolution 310C.15 – Tobacco Tax</td>
<td></td>
<td>Policy Statement: MAG supports legislation that will increase the state’s tobacco excise tax to an amount that will improve the health of Georgia residents. MAG continues to provide the tobacco excise tax as a funding solution to fund Medicaid.</td>
<td>✓</td>
</tr>
<tr>
<td>Adopted as amended from the floor that the Medical Association of Georgia (MAG supports legislation that increases the state’s tobacco excise tax to an amount that will improve the health of Georgia residents.</td>
<td>Council on Legislation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resolution 311C.15 – Amend H.R. 6, The 21st Century Cures Act</td>
<td></td>
<td>A resolution was submitted to the AMA House of Delegates for its consideration at its i15 meeting.</td>
<td>✓</td>
</tr>
<tr>
<td>Adopted by substitution that the MAG delegates to the AMA House of Delegates introduce a resolution asking that the AMA Board of Trustees lobby the U.S. Senate to amend H.R. 6 to prohibit all supplement (Medigap) insurance policies (Part B, Part C, and Part D) from denying coverage of the entire Medicare approved expenses for a FDA approved clinical trial that Medical Part A does not; and allow sponsors of clinical trials to cover what supplement insurance does not for those beneficiaries with supplement insurance, as well as what supplement insurance would have covered for those Medicare beneficiaries without Part B or Part C and/or Part D supplement insurance (Medigap); or, alternatively, that in cases of Medicare and FDA approved clinical trials, Medicare be required to pay 100 percent of all Medicare approved expenses.</td>
<td>AMA Delegation</td>
<td>AMA combined Resolution 813, Removing Financial Barriers To Participation in Clinical Trials for Medicare Beneficiaries and Georgia Resolution 823. Resolutions 813 and 823 were referred for decision with a request for an informational report back to the House of Delegates. The AMA in June modified Policy H-460-965. The modification ensures that while AMA is directed to engage in advocacy, the efforts are not limited to only the Medicare program and FDA related clinical trials. With passage of H.R. 6 in the U.S. House of Representatives, AMA sent letters to support innovation and participation in clinical trials by incorporating third-party payer coverage in federal health care programs of patient case costs.</td>
<td></td>
</tr>
</tbody>
</table>
Resolution 312C.15 – Licensed Physician’s Ability to Practice

Adopted that the Medical Association of Georgia (MAG) supports legislation asserting that medical centers should not be allowed to deny a licensed Georgia physician the ability to utilize the medical center’s facilities as this denial is limiting the physician’s ability to practice medicine and to provide the best medical care to their patients.

Policy Statement:
MAG supports legislation asserting that medical centers should not be allowed to deny a licensed Georgia physician the ability to utilize its facilities as this denial is limiting the physician’s ability to practice medicine and to provide the best medical care to their patients.

Resolution 313C.15 – Truth in Advertising

Adopted resolve 1 that our Medical Association of Georgia supports legislation that requires all health care professionals – physicians and non-physicians – to accurately and clearly disclose their training and qualifications to patients.

Adopted resolve 2 that our Medical Association of Georgia supports legislation that states that a medical doctor or doctor of osteopathic medicine may not hold oneself out to the public in any manner as being certified by a public or private board including but not limited to a multidisciplinary board or “board certified,” unless all of the following criteria are satisfied:

a) The advertisement states the full name of the certifying board.

Policy Statement:
MAG supports legislation that: 1) requires all health care professionals – physicians and non-physicians – to accurately and clearly disclose their training and qualifications to patients; and 2) states that a medical doctor or doctor of osteopathic medicine may not hold oneself out to the public in any manner as being certified by a public or private board including but not limited to a multidisciplinary board or “board certified,” unless all of the following criteria are satisfied: a) the advertisement states the full name of the certifying board; and b) the board is either a member of the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA); or requires successful completion of a postgraduate training program.
<table>
<thead>
<tr>
<th>Title/Action</th>
<th>Referral</th>
<th>Status</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resolution 313C.15 – Truth in Advertising (Cont.)</td>
<td></td>
<td>approved by the Accreditation Commission for Graduate Medical Education (ACGME) or the AOA that provides complete training in the specialty or subspecialty certified, followed by prerequisite certification by the ABMS or AOA board for the training field and further successful completion of examination in the specialty or subspecialty certified.</td>
<td>✓</td>
</tr>
<tr>
<td>b) The board either:</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>1. Is a member of the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA);</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>2. Requires successful completion of a postgraduate training program approved by the Accreditation Commission for Graduate Medical Education (ACGME) or the AOA that provides complete training in the specialty or subspecialty certified, followed by prerequisite certification by the ABMS or AOA board for the training field and further successful completion of examination in the specialty or subspecialty certified</td>
<td></td>
<td>MAG supported H.B. 1043 and S.B. 385 which awaits the Governor’s signature. The Governor signed H.B. 1043 into law.</td>
<td>✓</td>
</tr>
<tr>
<td>Title/Action</td>
<td>Referral</td>
<td>Status</td>
<td>Completed</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>------------</td>
<td>-----------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Resolution 314C.15 – ICD-10 Stop the Nonsense</td>
<td>No Referral</td>
<td>No action is necessary</td>
<td>✓</td>
</tr>
<tr>
<td>DID NOT Adopt Resolution 314C.15 calling for the MAG Delegates to the American Medical Association (AMA) House of Delegates present a resolution asking the Centers for Medicare &amp; Medicaid Services (CMS) to immediately cancel the ICD-10 program as a coding method and that it be used for population studies and mortality statistics, which is what it was originally developed for, and that those who wish to use the ICD-10 program shall be paid an extra $150 per patient visit as a stipend for the physician’s participation in data collection for research.</td>
<td>No Referral</td>
<td>No action is necessary</td>
<td>✓</td>
</tr>
</tbody>
</table>
### 2015 HOUSE OF DELEGATES

Reference Committee F

<table>
<thead>
<tr>
<th>Title/Action</th>
<th>Referral</th>
<th>Status</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Officer 04.15 – Office of the Treasurer</td>
<td>Administration</td>
<td>Treasurer’s Report will be filed in the historical records.</td>
<td>✓</td>
</tr>
<tr>
<td>Filed Officer 04.15 the report of the Treasurer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resolution 401F.15 – Elimination of Dues for Residents</td>
<td>Finance Committee</td>
<td>This action shall be vetted by the Finance Committee in consultation with the Department of Membership to determine the financial impact of eliminating dues for resident and fellows’ membership. A recommendation should be returned to the Board of Directors for final action.</td>
<td>✓</td>
</tr>
<tr>
<td>Referred to the Board of Directors/Executive Committee for decision resolve 1 that MAG eliminate dues for residents and fellows to improve recruitment, leadership development and ultimately encourage long-term membership.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referred to the Board of Directors/Executive Committee for decision resolve 2 that MAG commit the financial resources necessary to reactivate and maintain the residents and fellows section.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>On April 16, the issue became the focus of a lengthy debate on the recommendation of the Finance Committee and a recommendation from the Resident Physician and Fellow Section. The Board of Directors decided to table this issue for three months to ascertain the merits to suspend resident dues for a period of five years at which time an email vote would be taken by the Board of Directors to determine a final decision.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>The votes were tabulated and the results concluded that MAG shall continue the current $75 resident dues arrangement, and engage MAG resident members with introducing MAG leadership to the residency program directors with the opportunity to discuss sponsorship for their residents.</td>
<td></td>
</tr>
<tr>
<td>Title/Action</td>
<td>Referral</td>
<td>Status</td>
<td>Completed</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------------------</td>
<td>--------------</td>
<td>-------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Resolution 402F.15 – MAG House of Delegates</td>
<td>No referral</td>
<td>No action is required</td>
<td>✓</td>
</tr>
<tr>
<td>DID NOT Adopt Resolution 402F.15 calling for MAG’s House of Delegates to be held in venues within the southeast outside of Georgia that will accommodate the meeting and stimulate more interest in the attendance of HOD.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
COMMITTEE ON ANNUAL SESSION

SUBJECT: Policy Sunset and Reaffirmation Report

SUBMITTED BY: Frank McDonald Jr., M.D., Speaker of the House of Delegates

REFERRED TO: Consent Calendar

The House of Delegates (HOD) adopted policy that established a sunset mechanism for Medical Association of Georgia (MAG) policy. Under the sunset mechanism, policies adopted are systematically reviewed after adoption to assess their continuing timeliness and relevance. The MAG Board of Directors shall annually submit to the HOD, a list of MAG policy statements, which in the opinion of the Board no longer serve the best interests of the association.

At the October meeting, the Annual Session Committee will present a list of MAG policies that are five years old that were reviewed by relevant committees and recommendations made for: 1) retention and reaffirmation; 2) rescission and sunset; and 3) sunset with replacement by a new or revised policy.

The sunset mechanism for MAG policy was established to:

- Promote efficiency in HOD deliberations;
- Identify and rescind outmoded, duplicative, or inconsistent policies;
- Update and/or modify policies which are still pertinent but for which change has occurred; and
- Facilitate development and maintenance of a MAG policy information base and policy compendium.

A complete copy of the 2016 MAG Policy Compendium is posted on the MAG website. Of the 78 policies that were reviewed, 69 are being recommended for retention/reaffirmation, five are being recommended for sunset and four are being recommended for new language and replacement by a new or revised policy. Policies that have been recommended for sunset will be retained in MAG’s historical records.

The Annual Session Committee expresses its appreciation to the MAG Board, councils, committees and MAG staff for their continued assistance and cooperation in this activity, as well as the MAG office of the Executive Director, which is in charge of maintaining the MAG Policy Compendium and organizes the five-year reviews. The contributions and collective expertise of the councils and committees have ensured the continued success of this project.

RECOMMENDATIONS:

1. That the policies set forth in Appendix I, be reaffirmed.
2. That the policies set forth in Appendix II, be sunset.
3. That the policies set forth in Appendix III, be sunset and replaced with new policy.

# # #
15.993 Seat Belt Law – HD 5/1/1995
MAG supports supplementing the mandatory seat belt fines with educational and/or community service requirements to further deter violations of the mandatory seat belt law. (Reaffirmed 9/30/2006; 10/16/2011)
   Reviewed by the Council on Legislation. The Council determined that this policy statement is still relevant.

35.984 Scope of Practice – HD 5/19/2001
MAG, in the public interest, opposes enactment of legislation to authorize the independent practice of medicine by any individual who has not completed the state's requirements for licensure to engage in the practice of medicine and surgery in all of its branches. (Reaffirmed 9/30/2006; 10/16/2011)
   Reviewed by the Council on Legislation. The Council determined that this policy statement is still relevant.

35.994 Psychologists' Hospital Admitting Privileges – BD 1/1/1996
MAG opposes psychologists having hospital admitting privileges. (Reaffirmed 9/30/2006; 10/16/2011)
   Reviewed by the Council on Legislation. The Council determined that this policy statement is still relevant.

60.990 Hepatitis B Immunizations – HD 9/30/2006
MAG supports public health rules which require children to be immunized for Hepatitis B prior to enrollment in school or daycare centers. (Reaffirmed 10/16/2011)
   Reviewed by task force members who determined that this policy statement continues to be relevant.

60.991 Harassment in Schools – EC 9/16/2001
MAG opposes harassment, bullying or discrimination in schools based on race, religion, national origin, ethnicity, sex, age, sexual orientation, and physical disabilities. Such behavior can and does have a negative impact on the health and well-being of our school children and others. (Reaffirmed 9/30/2006; 10/16/2011)
   Reviewed by legal counsel who determined that this policy statement continues to be relevant.

60.992 Children's Immunization and Screening – HD 5/19/2001
MAG supports the immunization, visual testing and hearing screening standards currently in practice for public schools and recommends that they be expanded to include all private and home schooled school-age children. (Res: 312C-01, Res.1) (Reaffirmed 9/3/2006; 10/16/2011)
   Reviewed by the Council on Legislation. The Council determined that this policy statement is still relevant.

100.997 Narrow Therapeutic Index – HD 9/30/2006
MAG supports prohibition of any substitutions of a prescribed medication with a narrow therapeutic index with another manufacturer's form of the same medication with a narrow therapeutic index on a state or federal prescription drug plan chosen by the patient, without first submitting written or electronic
notifications of such change by the formulary to the patient and prescribing physicians. (Reaffirmed
10/16/2011)
Reviewed by the Council on Legislation. The Council determined that this policy statement is
still relevant.

120.980 Drug Formularies Transparency – HD 10/16/2011
MAG supports transparency in a patient’s formulary information allowing for medical decisions to be
made at the point of care including streamlining administrative process through electronic prior
authorizations with all costs of implementation being borne by health insurers and/or pharmaceutical
companies. (Res. 111A.11, Resolve 3)
Reviewed by task force members who determined that the policy statement continues to be
relevant.

120.981 Specialty Medication Financial Discriminations – HD 10/16/2011
MAG supports patient protections that prohibit health plans from financial discriminations to patients
based on diagnosis and need for specialty medications, and plans that allow for reasonable patient
costs. (Res. 111A.11, Resolve 2)
Reviewed by task force members who determined that the policy statement continues to be
relevant.

120.982 Specialty Medication Access – HD 10/16/2011
MAG supports eliminating complex barriers limiting access to specialty medications with physicians
as the primary authorities for patient treatment decisions. (Res. 111A.11, Resolve 1)
Reviewed by task force members who determined that the policy statement continues to be
relevant. The problem has only gotten worse over the years.

120.986 Dispensing Legally Valid Prescriptions – EC 2/26/2006
MAG supports legislation that requires pharmacists to fill legally valid prescriptions; however in the case
of a pharmacist who has issued a written objection to dispensing abortion drugs, such pharmacist shall
provide immediate referral to an appropriate alternative dispensing pharmacy, and immediately return the
prescription to the prescription holder, without interference. (Reaffirmed 10/16/2011)
Reviewed by the Council on Legislation. The Council determined that this policy statement is
still relevant.

120.991 Medication Step Care Therapy – HD 5/19/2001
MAG denounces, in principle, Medication Step Care Therapy programs when implemented as an
inflexible or administratively burdensome method to contain pharmacy costs as a part of a
Pharmacy Benefit Management Program or any pharmacy cost savings approach. (Reaffirmed
9/30/2006; 10/16/2011)
Reviewed by task force members who determined that the policy statement is still relevant and
should continue without revision.

130.967 Medical Response & Preparedness – HD 10/16/2011
MAG condemns terrorism in all its forms and believes that physicians have an obligation to provide
urgent medical care during disasters; it will take a primary role in coordinating physician efforts with
public health’s response to terrorism planning and other disasters as spelled out in Georgia’s
Emergency Operations Plan. MAG advocates for a functional medical component of the state
disaster plan and adequate funding for ongoing development of the state plan; it will work
collaboratively with the Georgia Department of Public Health Emergency Medical Services office,
the Georgia Emergency Management Agency, county medical societies, county health departments,
hospitals and others, on an ongoing basis: (a) in preparing for epidemics, terrorist attacks, and other
Appendix I

Special: 04.16

Disasters; physicians as a profession must provide medical expertise and work with others to develop public health policies that are designed to improve the effectiveness and availability of medical care during such events; (b) in the development, dissemination, and production of regional and statewide education and training initiatives to provide physicians, professionals, and other emergency responders with a fundamental understanding and working knowledge of their integrated roles and responsibilities in disaster management and response efforts; MAG strongly encourages medical schools to teach their students the principles of triage, chain of command teamwork, protecting themselves from becoming victims, and identifying and mobilizing resources; we also strongly encourage the Georgia residency programs to teach these principles of disaster medicine to their residents; (c) to develop a comprehensive strategy to assure surge capacity to address mass casualty care; (d) to implement communications strategies to inform professionals and the public about a terrorist attack or other major disaster; (e) to convene local and regional workshops to share "best practices" and "lessons learned" from disaster planning and response activities; (f) to urge individual physicians to take appropriate advance measures to ensure their ability to provide medical services at the time of disasters, including the acquisition and maintenance of relevant knowledge of disease surveillance and control, disease signs and symptoms, diagnosis, treatment, isolation precautions, decontamination protocols, and chemotherapy/prophylaxis against radioactive agents likely to be used in a terrorist attack, and (g) MAG supports utilizing the Division of Public Health's Physician/Health Professional Emergency Reserve Corps and the Georgia State Defense Reserve Corps, including qualified retired physicians, as volunteers to hospitals, local health departments, or other medical outpatient facilities in the event of a national disaster or any public health emergency situation. All emergency programs such as these must have a system to assure that those who are involved are legally certified and/or licensed and that the process can be implemented expeditiously. MAG supports state legislation and/or funding to the Georgia Division of Public Health for the development of a standardized identification program/badge or credentials for all emergency personnel, including physicians. (Special Report: 04.11, Attachment III)

Reviewed by task force members who determined that this policy statement is still relevant and is in line with the mission statement of the MAG Medical Reserve Corps.

130.968 Hospital Diversion – HD 10/16/2011

MAG: 1) supports hospital "diversion policies" which are developed by emergency room physicians, in coordination with nursing and/or administrative staff, national medical society expertise, (American College of Emergency Physician Guidelines) and with elected medical staff leadership; 2) recognizes that hospitals share the responsibility for emergency care coverage in a given geographic region and throughout the state. Consequently, MAG supports the establishment of local, multi-organizational task forces, with representation from hospital medical staffs, to devise local solutions to the problem of emergency department overcrowding, ambulance diversion, and physicians on-call coverage, and encourage the exchange of information among these groups. (Special Report: 04.11, Attachment III)

Reviewed by task force members who determined that this policy statement continues to be relevant.

155.978 Obesity Education – BD 4/16/2011

MAG supports comprehensive education on the epidemic of obesity and its impact on the future health and economics of the state; furthermore MAG supports appropriate compensated payments to physicians from third party payers in Georgia in the treatment of obesity in children.

Reviewed by task force members who determined that this policy statement continues to be relevant.
165.971 State Directed Health Care – HD 10/16/2011
MAG favors health care reform that is flexible and with specific implementation primarily determined by
the states on an individual basis. (Res. 304C.11)
Reviewed by the Council on Legislation. The Council determined that this policy statement is
still relevant.

165.972 Accountable Care Organizations – BD 1/29/2011
The following ACO principles shall be guiding principles for Georgia physicians when negotiating
ACO contracts for the medical practice.

1. Guiding Principle – The goal of an Accountable Care Organization (ACO) is to increase access to care,
improve the quality of care, and ensure the efficient delivery of care. Within an ACO, a physician’s primary
ethical and professional obligation is the well-being and safety of the patient; 2. ACO Governance – ACOs
must be physician-led and encourage an environment of collaboration among physicians. ACOs must be
physician-led to ensure that a physician’s medical decisions are not based on commercial interests, but
rather on professional medical judgment that puts patients’ interests first; a. Medical decisions should be
made by physicians. ACOs must be operationally structured and governed by an appropriate number of
physicians to ensure that medical decisions are made by physicians (rather than lay entities) and place
patients’ interests first. Physicians are the medical professionals best qualified by training, education, and
experience to provide diagnosis and treatment of patients. Clinical decisions must be made by the physician
or physician-controlled entity. MAG supports true collaborative efforts between physicians, hospitals, and
other qualified providers to form ACOs as long as the governance of those arrangements ensures that
physicians control medical issues; b. The ACO should be governed by a board of directors that is elected
by the ACO professionals. Any physician entity [e.g., Independent Physician Association (IPA), medical
group, etc.] that contracts with, or is otherwise part of, the ACO should be physician-controlled and
governed by an elected board of directors; c. The ACO’s physician leaders should be licensed in the state
in which the ACO operates and in the active practice of medicine in the ACO’s service area; d. Where a
hospital is part of an ACO, the governing board of the ACO should be separate and independent from the
hospital governing board; 3. Physician and patient participation in an ACO should be voluntary. Patient
participation in an ACO should be voluntary rather than a mandatory assignment to an ACO by Medicare.
Any physician organization (including an organization that bills on behalf of physicians under a single tax
identification number) or any other entity that creates an ACO must obtain the written, affirmative consent
of each physician to participate in the ACO. Physicians should not be required to join an ACO as a
condition of contracting with Medicare, Medicaid or a private payer, or being admitted to a hospital
medical staff; 4. The savings and revenues of an ACO should be retained for patient care services and
distributed to the ACO participants; 5. Flexibility in patient referral and antitrust laws — The federal and
state anti-kickback and self-referral laws and the federal Civil Monetary Penalties (CMP) statute (which
prohibits payments by hospitals to physicians to reduce or limit care) should be sufficiently flexible to allow
physicians to collaborate with hospitals in forming ACOs without being employed by the hospitals or ACOs.
This is particularly important for physicians in small and medium-sized practices who may want to remain
independent but otherwise integrate and collaborate with other physicians (i.e., so-called virtual
integration) for purposes of participating in the ACO. The ACA explicitly authorizes the Secretary to waive
requirements under the Civil Monetary Penalties statute, the Anti-Kickback statute, and the Ethics in
Patient Referrals (Stark) law. The Secretary should establish a full range of waivers and safe harbors that
will enable independent physicians to use existing or new organizational structures to participate as ACOs.
In addition, the Secretary should work with the Federal Trade Commission to provide explicit exceptions
to the antitrust laws for ACO participants. Physicians cannot completely transform their practices only for
their Medicare patients, and antitrust enforcement could prevent them from creating clinical integration
structures involving their privately insured patients. These waivers and safe harbors should be allowed
where appropriate to exist beyond the end of the initial agreement between the ACO and CMS, so that any
new organizational structures that are created to participate in the program do not suddenly become illegal
simply because the shared savings program does not continue; 6. Additional resources should be provided up front in order to encourage ACO development. The CMS Center for Medicare and Medicaid Innovation (CMI) should provide grants to physicians in order to finance up-front costs of creating an ACO. ACO incentives must be aligned with the physician or physician group’s risks (e.g., start-up costs, systems investments, culture changes, and financial uncertainty). Developing this capacity for physicians practicing in rural communities and solo-small group practices requires time and resources and the outcome is unknown. Providing additional resources for the up-front costs will encourage the development of ACOs since the “shared savings” model only provides for potential savings at the back end, which may discourage the creation of ACOs (particularly among independent physicians and in rural communities); 7. The ACO spending benchmark should be adjusted for differences in geographic practice costs and risk-adjusted for individual patient risk factors; a. The ACO spending benchmark, which will be based on historical spending patterns in the ACO’s service area and negotiated between Medicare and the ACO, must be risk-adjusted in order to incentivize physicians with sicker patients to participate in ACOs and incentivize ACOs to accept and treat sicker patients, such as the chronically ill; b. The ACO benchmark should be risk-adjusted for the socioeconomic and health status of the patients who are assigned to each ACO, such as income/poverty level, insurance status prior to Medicare enrollment, race and ethnicity, and health status. Studies show that patients with these factors have experienced barriers to care and are more costly and difficult to treat once they reach Medicare eligibility; c. The ACO benchmark must be adjusted for differences in geographic practice costs, such as physician office expenses related to rent, wages paid to office staff and nurses, hospital operating cost factors (i.e., hospital wage index), and physician HIT costs.

Reviewed by legal counsel who determined that the policy regarding ACOs is still relevant in today’s health care environment. These principles are still an important reference for physicians.

170.989 STD Education for Physicians – HD 10/16/2011
MAG supports improvements in training and education on STDs for physicians and urges medical schools to provide supervised training on STDs for all medical students and physicians in training. (Special Report 04.11, Attachment III)
Reviewed by task force members who determined that this continues to be problematic and, therefore, still quite relevant as MAG policy.

180.987 Medical Savings Accounts – HD 5/1/1995
MAG supports medical savings accounts combined with catastrophic insurance, as a cost efficient alternative to managed care. MAG supports a state tax code exemption for MSAs and exemption with the United States tax code to allow for MSA exemption. (Reaffirmed 9/30/2006; 10/16/2011)
Reviewed by the Council on Legislation. The Council determined that this policy statement is still relevant.

185.994 Chlamydia Screening – EC 12/1/1997
MAG supports insurance coverage for Chlamydia screening in Georgia. (Reaffirmed 9/30/2006; 10/16/2011)
Review by task force members who determined that this policy statement continues to be relevant.

185.987 Screening Coverage – HD 9/30/2006
MAG supports commercial and governmental health coverage of screening procedures, such as CBC, BMP, CMP, TSH, UA, Lipid Panel and yearly physical exams to provide for early detection and intervention for determining appropriate care. (Reaffirmed 10/16/2011)
Reviewed by task force members who determined that this policy statement continues to be relevant and is included in the Affordable Care Act as a necessary treatment for payment.
Appendix I
Special: 04.16

185.976 Clinical Care Counseling – HD 10-16-2011
MAG shall: 1) actively oppose government and/or third party payers’ interference in the content of communication in the delivery of clinical care between physicians and patients and a physician’s medical judgment as to the information or treatment that is in the best interest of a patient including the First Amendment right of physicians in their practice of the art and science of medicine to counsel patients on the dangers of firearms, and 2) support any litigation that may be necessary to block the implementation of newly enacted state laws restricting the privacy of the physician-patient family relationship. (Res. 101A.11)
Reviewed by task force members who determined that this policy statement continues to be relevant.

200.996 Physician Workforce – HD 10/16/2011
MAG will regularly monitor and review data from the Georgia Board for Physician Workforce and disseminate to the membership the results of such reviews. (Special Report 04.11, Attachment III)
Reviewed by task force members who determined that this policy statement continues to be relevant. The Physician Workforce released and posted its updated data in July 2016.

205.986 Paternal Responsibility – HD 10/16/2011
MAG encourages paternal responsibility in the birth and rearing of a child. (Res. 306C.11)
Reviewed by task force members who determined that this policy statement continues to be relevant. The original resolution was related to the importance of fathers of Medicaid children to be identified in order to receive the Medicaid benefits. It was modified to express a position that encouraged paternal involvement.

205.987 End of Life – HD 10/16/2011
MAG endorses and promotes patient-physician discussions on end-of-life issues. (Res. 107A.11)
Reviewed by task force members who determined that this policy statement continues to be relevant. End-of-life discussions are emotional and should be between a physician and patient.

215.992 Ancillary Services Payment – HD 5/19/2001
MAG supports legislation which would prohibit a hospital from entering into a contract with an insurer that prevents payment for ancillary services to anyone except those owned or contracted by the hospital. (Reaffirmed 9/30/2006; 10/16/2011)
Reviewed by the Council on Legislation. The Council determined that this policy statement is still relevant.

215.993 Hospital Exclusive Contracts - Forced Acceptance – HD 5/19/2001
MAG opposes any efforts which would require physicians to accept all insurance contracts accepted by the hospital in which they provide service. (Reaffirmed 9/30/2006; 10/16/2011)
Reviewed by task force members who determined that this policy statement continues to be relevant.

215.994 Hospital Purchases – HD 5/19/2001
MAG supports regulations and/or legislation which requires that a publicly owned hospital, with public or private administration, consult with its full medical staff sixty days prior to signing any contract containing a provision for administration of the hospital by an outside party. (Reaffirmed 9/30/2006; 10/16/2011)
Reviewed by the Council on Legislation. The Council determined that this policy statement is still relevant.
260.996 Pap Smear Guidelines – HD 10/16/2011
MAG endorses the College of American Pathologists Guidelines for the Review of Pap Tests in the
Context of Litigation or Potential Litigation. “The pap test is the most effective cancer screening test in
medical history and remains the most effective screening method for the identification of premalignant
cervicovaginal conditions. The Pap test has been associated with a 70 percent or greater decrease in the
United States death rate from cervical cancer. If the Pap test is to continue as an effective cancer
screening procedure, it must remain widely accessible and reasonably priced for all women, including
those economically disadvantaged and those at high risk for cervical cancer. There must also be an
understanding of the inherent limitations of this screening test. The Pap test is a screening test that
involves subjective interpretation by a cytotechnologist or pathologist of the thousands of cells that are
present on a typical gynecologic cytology specimen. Studies indicate an irreducible false negative rate of
approximately 5 percent. Although re-screening can reduce the false negative rate, zero-error performance
cannot currently be attained. Many factors, including the subjectivity involved in interpreting difficult
cases and sampling problems with specimen collection, prevent zero-error performance. In the context of
litigation and potential litigation, there should for these reasons be an unbiased and scientific method for
review of questioned cases that is fair to both the patient and the laboratory.” (additional guidelines
concerning courtroom use of test results are not included) (Special Report 04.11, Attachment III)
Reviewed by legal counsel who determined that preventative care for women, including the Pap
test, is still crucial to help ensure continued health and the early discovery of cancer. This policy
is still relevant and important.

260.998 Phlebotomists – HD 5/19/2001
MAG opposes legislation and regulations that would prohibit independent clinical laboratories from
placing lab employees or contractors in physicians' offices (consistent with the requirements of the federal
anti-kickback statute). (Reaffirmed 9/30/2006; 10/16/2011)
Reviewed by the Council on Legislation. The Council determined that this policy statement is
still relevant.

270.985 Health Care Costs – HD 9/30/2006
MAG supports legislation that allows the expenditures by individuals for health care services as well as
for health care insurance to receive the same favorable tax treatment as received by business entities for
the same expenditures. (Reaffirmed 10/16/2011)
Reviewed by the Council on Legislation. The Council determined that this policy statement is
still relevant.

The Medical Association of Georgia supports legislation that eliminates the financial threshold for Letters
of Non-Reviewability. (Reaffirmed 10/16/2011)
Reviewed by the Council on Legislation. The Council determined that this policy statement is
still relevant.

270.988 Prompt Pay and ERISA – HD 9/30/2006
MAG supports legislative and/or regulatory reform that requires equal enforcement of the "Georgia
Prompt Pay Act," closing the loopholes that allow ERISA plans and companies that are self-insured to
escape enforcement to the financial detriment of health care providers.
(Reaffirmed 10/16/2011)
Reviewed by the Council on Legislation. The Council determined that this policy statement is
still relevant.
275.990 Discrimination in Licensing – HD 10/16/2011
MAG opposes discrimination against physicians on the basis of being a graduate of a foreign medical school and supports state and territory responsibility for admitting physicians to practice, and urges licensing jurisdiction of medical licenses on an assessment of competence as determined by the state and territory issuing the license. (HOD 2011--policy review extraction)
Reviewed by legal counsel who recommends continuation of this policy statement. As Georgia attempts to fill a shortfall of physicians, especially primary care physicians, it becomes even more important for the state to not discriminate against IMGs.

275.991 State Medical Licensure Protection – HD 10/16/2011
MAG supports maintaining medical licensure at the state level without a requirement to tie participation in a third party payer plan to licensure. (Res. 301.11)
Reviewed by task force members who determined that this policy statement continues to be relevant.

275.992 National Licensure – HD 10/16/2011
MAG strongly opposes any implementation of a national licensure for physicians and rejects the Maintenance of Certification as a requirement to maintain state licensure. (Res. 102A.11)
Reviewed by task force members who determined that this policy statement continues to be relevant especially with continued MOC and compact discussions.

280.992 Medical Director Certification – HD 5/1/1997
MAG encourages medical directors of nursing homes to take advantage of the American Medical Directors Association certification training programs. (Reaffirmed 9/30/2006; 10/16/2011)
Reviewed by task force members who determined that this policy statement continues to be relevant. This continues to be highly encouraged by the nursing home administration.

290.972 Medical Fraud in Medicaid – HD 10/16/2011
MAG supports continued review of the eligibility process when applying for Medicaid, and supports a requirement documenting federal and state income tax returns to determine actual need and qualifications for public assistance in order to limit or eliminate fraudulent usage of Medicaid funds by state and federal governments. (Res. 103A.11)
Reviewed by task force members who determined that this policy statement continues to be relevant.

300.988 Mission Statement of Intra-State CME Accreditor – HD 10/16/2011
MAG recognizes that physicians’ professional responsibilities entail a commitment to a lifetime of learning. MAG has been recognized by the ACCME as the Accreditor of Intrastate providers of continuing medical education in Georgia. In this role, MAG strongly supports the development and accreditation of quality CME programs in state and metropolitan specialty societies, voluntary health organizations, and especially in local hospitals. For hospitals, the Joint Commission requires that every staff member's participation in hospital CME activities should be documented and reviewed at the time of reappointment. The Joint Commission requires that at hospital and health care organizations it accredits, physicians with clinical privileges document their CME. The Joint Commission will accept correctly completed AMA PRA applications stamped “approved” by the AMA as documented physician compliance with Joint Commission CME requirements. CME can play an essential role in supporting hospital accreditation requirements while improving practice and patient care; beyond this, MAG believes that each institution's medical staff should decide the types of CME activities that are appropriate for itself. In addition to the minimum amount of continuing medical education mandated by state law (i.e., as of 1992, physicians are required to complete 40 hours of Category 1 credits, or recognized credits, per every two years), all members of MAG are strongly encouraged to follow the recommendations of their
specialty societies, specialty boards, and local hospitals on the desirable level of participation in CME activities. We continue to believe that any system of mandatory CME should reflect the diversity of physicians' educational needs and individuals' pattern of learning. There is no CME requirement for membership in MAG. The physician's best motivation for participating in CME is the desire to maintain professional knowledge and ability through education. Voluntary achievement in CME is a major priority not only for the MAG's Continuing Medical Education Committee, but for the entire MAG. To accomplish this, MAG encourages all of its members to qualify for the AMA's Physician Recognition Award. (Special Report 04.11, Attachment III)

This policy was reviewed by the Continuing Medical Education Committee. The Committee determined that no changes were necessary to the current policy and recommended reaffirmation.

305.997 MCG Health, Inc. – HD 5/19/2001
MAG opposes the concept of MCG Health, Inc., which privatizes the state's only state-run teaching hospital. (Res 310C.01) (Reaffirmed 9/30/2006; 10/16/2011)

It is important to protect the only state-run teaching hospital in the state. MAG continues to advocate for the Medical College of Georgia at the state and local levels.

MAG supports the Georgia Department of Public Health’s Office of Health Equity and its efforts to reduce racial and ethnic health disparities in Georgia. (Special Report 04.11, Attachment III)

Reviewed by legal counsel who determined that this policy statement continues to be relevant as MAG continue our efforts to eliminate racial and ethnic health disparities in Georgia.

360.995 Nurses' Training – HD 5/1/1997
MAG recommends that the State Board of Nursing pursue the development of standardized training curriculums and standardized competency examinations for nursing assistants. (Reaffirmed 9/30/2006; 10/16/2011)

Reviewed by legal counsel who determined that this policy statement continues to be relevant and important.

375.999 Peer Review Protections – HD 5/19/2001
MAG supports the need for federal legislation that will afford enhanced protection of peer review information from disclosure. (Reaffirmed 9/30/2006; 10/16/2011)

Reviewed by the Council on Legislation. The Council determined that this policy statement is still relevant.

385.995 Bundled Payments – HD 10/16/2011
MAG opposes payment models that support reductions in physician payments based on cost not directly attributable to that physician unless the physician knowingly enters into an agreement to accept such a payment model. (Res. 110A.11)

Reviewed by task force members who determined that this policy statement continues to be relevant.

390.983 Payment Mechanism – HD 10/16/2011
MAG opposes Medicare’s new bundled payment models and initiatives which include 1) Centers for Medicare & Medicaid Services (CMS) and providers setting a target payment amount for a defined episode of care; 2) CMS to link payments for multiple services patients receive during an episode of care and 3) an entire team of physicians, and hospitals are compensated with a “bundled payment.” (Special Report 04.11, Attachment III)
MAG supports Medicare laws that allow private contracting between physicians and patients; MAG supports removing Medicare definitions of allowable charges; MAG supports a plan of differential reimbursement for Medicare recipients with the ability to pay. (Reaffirmed 9/30/2006; 10/16/2011)
Reviewed by the Council on Legislation. The Council determined that this policy statement is still relevant.

405.988 State Health in Georgia Government – HD 10/16/2011
MAG supports the position that only physicians should direct the state health department and its Board and that its office be maintained at a Departmental level immediately below the office of Governor. MAG supports having a close working relationship with the state and local public health departments in a way that complements each other’s efforts in improving the health of the community. (Special Report: 04.11, Attachment III)
Reviewed by the Council on Legislation. The Council determined that this policy statement is still relevant.

425.998 Early Intervention Programs – HD 10/16/2011
“MAG supports and promotes the development of early intervention and disease prevention programs at the national, state and local levels, including the mission, goals, and health indicators outlined in the U.S. Health and Human Services Department’s “Healthy People 2020 Plan,” Georgia’s Medicaid and Care Management Program initiatives, and the Georgia Department of Public Health’s 14 Health Promotion and Disease Prevention programs including: 1) the Adolescent Health and Youth Development program, 2) the Asthma Control program, 3) the Breast and Cervical Cancer program, 4) the Cancer State Aid program, 5) the Cardiovascular Health Initiative, 6) the Comprehensive Cancer Control program, 7) the Diabetes Prevention and Control program, 8) the Live Healthy Georgia program, 9) the Nutrition and Physical Activity Initiative program, 10) the Rape Prevention and Education program, 11) the Stroke and Heart Attack Prevention program, 12) the Tobacco Use Prevention program and 13) the Women’s Health Medicaid program and 14) Worksite Wellness program. (Special Report 04.11, Attachment III)
Reviewed by task force members who determined that this policy statement continues to be relevant.

430.997 Tobacco Use in Prisons – HD 5/1/1995
MAG supports the Georgia Department of Correction's commitment to cessation of the use of all tobacco products by staff and inmates in all of its facilities. (Reaffirmed 9/30/2006; 10/16/2011)
This policy is still relevant and should continue as MAG’s position statement related to tobacco use by staff and inmates within the Georgia Department of Corrections prisons and jails.

440.975 Coal-Fired Power Plants – HD 10/16/2011
MAG supports state government and utilities efforts to develop comprehensive energy efficiency standards of businesses, homes, appliances, and building construction prior to approving new coal burning power plants; MAG recommends that careful consideration and full public debate be given to the least polluting options. (Special Report 04.11, Attachment III)
Reviewed by the Council on Legislation. The Council determined that this policy statement is still relevant.
440.983 Health Department Funding – HD 5/19/2001
MAG supports the monitoring of the impact of "revenue maximization" in the state's Health Department funding on the local health departments and if "revenue maximization" proves to result in reduced funding for the local health departments, that MAG seek to secure funding of the local health departments to levels sustained prior to implementation of "revenue maximization". (Res. 311C.01; Reaffirmed 9/30/2006; 10/16/2011)
Reviewed by the Council on Legislation. The Council determined that this policy statement is still relevant.

530.882 CMS Registration Fees – HD 10/16/2011
MAG shall waive any registration fee required at MAG functions and/or events to county medical executives. (Special Report 04.11, Attachment III)
Reviewed by the Committee on Finance. Members recommended that MAG continue this policy statement to enhance its relationship with executives of our county medical societies.

530.883 Student Travel Reimbursement – HD 10/16/2011
MAG supports the funding of two medical students to attend the AMA Annual meeting. Funds will be charged to the MAG Medical Student Section. Medical students shall be identified to the AMA Delegation and shall participate as directed by the Chair of the AMA Delegation. (Special Report 04.11, Attachment III)
Reviewed by the Committee on Finance. Members recommended that MAG continue this policy statement to enhance its relationship with its Medical Student Section.

MAG shall coordinate trips to Washington, D.C., for the purpose of convening in a unified manner, our concerns about health care legislation to our Congressional Delegation. (Reaffirmed 10/16/2011)
Reviewed by the Council on Legislation. The Council determined that this policy statement is still relevant.

530.896 Membership List/Labels – HD 9/30/2006
MAG shall maintain a membership list and labels policy that defines its purpose, use, and composition and billing and purchasing rules. (Reaffirmed: 10/16/2011)
MAG has an active membership list and labels policy. Upon request, and after approval of use, MAG allows for certain physicians and organizations to purchase membership lists for a one-time use. At any time, any physician may opt out of having their name included.

530.897 Legislative Involvement – HD 9/30/2006
MAG will provide meaningful opportunities for physicians to participate in educating legislators, to improve their understanding of the practice of medicine, as government continues to impact all facets of the modern day practice of medicine; MAG urges all physicians to participate in such projects and programs conducted through MAG's legislative department. (Reaffirmed 10/16/2011)
Reviewed by the Council on Legislation. The Council determined that this policy statement is still relevant.

530.898 Employee Contracts – HD 9/30/2006
MAG shall maintain an employment policy that includes conducting annual reviews of all employees. (Reaffirmed 10/16/2011)
MAG has an employee manual and annual reviews are conducted annually. Employees have access to the employee manual through the HR Strategies Website.
Appendix I
Special: 04.16

530.909 Guest Attendance at MAG Events – BD 1/28/2006
Non-members and non-physicians (i.e., county medical society executives, MAG Mutual, Georgia Medical Care Foundation, Georgia Hospital Association) may be invited to attend events and/or functions of the Medical Association of Georgia at the discretion of the physician leader whose duties hold jurisdiction over the event and/or function. Information and materials related to the event and/or function will be provided to a guest only by order of the physician leader. All other matters pertaining to sharing information not referenced herein shall be left to the discretion of MAG President and/or Executive Director. (Reaffirmed 10/16/2011)
This policy statement is relevant as a mechanism to include friends of medicine at various events or functions and allows discretion when necessary to restrict access to MAG events.

530.936 Actions of AMA Meetings – HD 5/19/2001
MAG, at the conclusion of the AMA Annual and Interim meetings, will communicate to its members the actions taken by AMA. Reaffirmed 9/30/2006; 10/16/2011)
At the end of each meeting, MAG's Communication Director posts important actions passed by the AMA in MAG's publications to keep members informed. The Chairman of the AMA Delegation reports to the Board of Directors, and information is posted on MAG's website. This process continues to be relevant in communicating to members across the state.

530.959 AMA Nominations & Endorsements – EC 2/1/1997
MAG directs that all nominations to AMA first be addressed by the Georgia Delegation and then forwarded to the Executive Committee for association endorsement. In case of emergency, the President may authorize the association's endorsement. (Reaffirmed 9/30/2006; 10/16/2011)
This is a solid policy that is used by the association when Georgia physicians seek AMA office. At the direction of MAG, the AMA Delegation lends its support or not according to MAG’s position to candidates during the election process held at the AMA meetings.

The Council on Legislation shall be governed by a structure that will be attached to the MAG Master Committee Structure. (Reaffirmed 10/16/2011)
Reviewed by the Council on Legislation. The Council determined that this policy statement is still relevant.

545.946 AMA Collaborative Intent – HD 10/16/2011
MAG adopts the following AMA Statement of Collaborative Intent as follows: (1) The AMA House of Delegates endorses the following preamble of a Statement of Collaborative Intent: The Federation of Medicine is a collaborative partnership in medicine. This partnership is comprised of the independent and autonomous medical associations in the AMA House of Delegates and their component and related societies. As the assemblage of the Federation of Medicine, the AMA House of Delegates is the framework for this partnership. The goals of the Federation of Medicine are to: (a) achieve a unified voice for organized medicine; (b) work for the common good of all patients and physicians; (c) promote trust and cooperation among members of the Federation; and (d) advance the image of the medical profession; and (e) increase overall efficiency of organized medicine for the benefit of our member physicians and (2) The AMA House of Delegates endorses the following principles of a Statement of Collaborative Intent: (a) Organizations in the Federation will collaborate in the development of joint programs and services that benefit patients and member physicians. (b) Organizations in the Federation will be supportive of membership at all levels of the Federation. (c) Organizations in the Federation will seek ways to enhance communications among
Appendix I
Special: 04.16

physicians, between physicians and medical associations, and among organizations in the Federation. (d)
Each organization in the Federation of Medicine will actively participate in the policy development process
of the House of Delegates. (e) Organizations in the Federation have a right to express their policy positions.
(f) Organizations in the Federation will support, whenever possible, the policies, advocacy positions, and
strategies established by the Federation of Medicine. (g) Organizations in the Federation will support an
environment of mutual trust and respect. (h) Organizations in the Federation will inform other organizations
in the Federation in a timely manner whenever their major policies, positions, strategies, or public
statements may be in conflict. (i) Organizations in the Federation will support the development and use of
a mechanism to resolve disputes among member organizations. (j) Organizations in the Federation will
actively work toward identification of ways in which participation in the Federation could benefit them.
(Special Report 04.11, Attachment III)
Careful consideration was given to this policy. It is a policy that is still relevant today as MAG is
working closer with AMA.

All of the business of the MAG House of Delegates shall be conducted in two days. (Reaffirmed
9/30/2006; 10/16/2011)
The length of the House of Delegates has been consistent over the years. Several years ago MAG
changed its meeting from a Friday-Saturday to Saturday-Sunday meeting, which has worked
quite well in limiting the business portion of the HOD to two days and reducing the time out of
office for those attending meetings immediately prior to the HOD.

555.973 Recruitment – HD 10/16/2011
MAG encourages medical societies to begin grassroots projects aimed at increasing involvement in
organized medicine. (Special Report 04.11, Attachment III)
Over the past year, MAG has worked with several medical societies to revive their local areas
with much success. Increased involvement in organized medicine allows for physicians to see the
value of MAG and of joining their CMS.

555.982 Fiscal Year – HD 9/30/2006
MAG's fiscal year shall begin on January 1 of each year. (Reaffirmed 10/16/2011)
Reviewed by the Committee on Finance. This policy statement is in keeping with the MAG
Bylaws and association procedures.

555.985 Membership Diversity – BD 1/28/2006
The Medical Association of Georgia (MAG) recognizes the diversity of its membership with regards to
religion and culture, and discriminates against no members for their diversities. MAG shall direct its
Annual Session Committee to become cognizant of all religious holidays when scheduling MAG's annual
meetings. For all Executive Committee, Board of Directors, committees and educational meetings, MAG
shall make every effort to not hold such meetings on current or future nationally recognized religious
holidays. (Reaffirmed 10/16/2011)
MAG has worked hard to increase the diversity of its membership in regards to race, religion,
culture and practice environment. Our membership now truly represents all physicians in all areas
of the state.

555.989 Direct Membership – HD 5/19/2001
MAG shall maintain a category of direct membership, allowing physicians to join MAG without the
requirement of joining the county medical society. (Report of the Treasurer, Rec. 2) (Reaffirmed
9/30/2006; 10/16/2011)
MAG has seen a 35 percent increase in membership since 2010. Since 2001, when direct membership was enacted, we’ve seen an increase of 26.9 percent. We continue to work closely with our county medical societies (CMS) and have worked over the past year to revitalize many areas, however, the reality is that there are many areas of the state that do not have a functioning CMS. Direct membership allows physicians to join MAG without the added expense of also joining a non-functioning CMS.

555.992 Member Communication – HD 5/1/1997
MAG supports increasing visitation and communication by members of MAG leadership and staff to local, district, specialty societies, medical student and resident physician sections, similar professional societies i.e. Georgia Hospital Association, Georgia State Medical Association, Georgia Osteopathic Medical Association and other professional groups. It may be appropriate, and fruitful, to consider visibility of our Association at some hospital medical staff meetings around the state. (Reaffirmed 9/30/2006; 10/16/2011)
MAG has made tremendous strides to increase communication at the state and local level. MAG officers, especially the MAG president has made an assertive effort to increase MAG’s presence at district and county medical society meetings. Since becoming MAG executive director, Mr. Palmisano has frequently visited county medical and specialty societies, as well as other professional organizations to enhance MAG’s visibility throughout the state. There has been a renewed interest to revitalize MAG sections for greater input.

GAMPAC shall share with the Medical Association of Georgia a list of candidates for the Office of Governor, Lt. Governor, and Secretary of State and their stance on health care issues. (Reaffirmed 9/30/2006; 10/16/2011)
Reviewed by the Council on Legislation. The Council determined that this policy statement is still relevant.

###
Appendix II
MAG Policies for Sunset

280.993 Physicians and Long-Term Care Patients – HD 5/1/1995
MAG encourages physicians to continue treating their patients in long-term care facilities.
(Reaffirmed 9/30/2006; 10/16/2011)
Reviewed by task force members who determined this policy statement is no longer necessary. It has been confirmed by the nursing home association that typically a patient’s physician no longer follows the patient in the nursing home because care gets assumed by the medical director and team who is contracted by the facility to follow patients.

290.987 Physician Assistant Medicaid Billing – EC 5/1/1997
MAG strongly opposes the billing of Medicaid for physician assistant services using the two highest complex level physician office visit codes. (Reaffirmed 9/30/2006; 10/16/2011)
Reviewed by task force members who recommended that this policy be sunset.

450.999 GHA CARE Program Participation – HD 4/1/1993
MAG urges hospital medical staffs and county medical societies to actively participate in the evaluation of the Georgia Hospital Association CARE Program, including participating in the selection, measurement and use of quality indicators and outcome measures, particularly regarding economic credentialing. MAG affirms that the medical staff is an integral component of any medical quality of care activity, including Continuous Quality Improvement (CQI) and/or Total Quality Management (TQM) systems; MAG asks medical staffs to incorporate CQI/TQM activities into the peer review sections of their medical bylaws; MAG recognizes that serious concerns, including the validity of the data and confidentiality, remain about the implementation of CQI/TQM as it relates to medical practice; MAG works with county medical societies and medical staffs to facilitate physicians’ understanding and education in CQI/TQM activities; and MAG will continue to communicate to medical staffs involved in the GHA’s CARE pilot programs concerning their position and educational opportunities for physician-directed performance assessment monitoring systems. (Reaffirmed 05/2000; 05/2001; 09/30/2006; 10/16/2011)
Reviewed by task force members who recommend that this policy statement be sunset. The CARE program that was developed in 1993 no longer exists.

450.993 GHA Partnership for Health and Accountability(PHA) – EC 8/3/2001
MAG's participation in the Partnership for Health and Accountability does not constitute an endorsement of the partnership. (Reaffirmed 9/30/2006; 10/16/2011)
Reviewed by task force members who recommended that this policy statement be sunset. The nature of the PHA has changed since 2001. MAG has more recent policy that promotes collaborative opportunities with GHA related to patient safety, quality improvement, and population health initiatives.

530.884 Third Party Payer Services – EC 07/24/2011
MAG shall follow the following guidelines for MAG/Specialty Society Third Party Payer Services: 1) Each participating specialty society will pay MAG a fee of $2,500 per year; 2) MAG will charge a recovery fee of 10 percent for MAG/Specialty Society members and 25 percent for non-members; 3) If a practice that includes non-MAG/Specialty Society members submits claims for assistance, the individual physician’s claims will serve as the basis for the recovery fee (e.g., if Physician A is a
member and Physician B is a non-member, the recovery fee for Physician A would be 10 percent
while the recovery fee for Physician B would be 25 percent; 4) Practices must exhaust every
contractual remedy and appeal before submitting a claim to MAG; 5) Claims information submitted to
MAG must be in an electronic format and must include i) a record of every attempt to collect the
unpaid claims ii) a brief synopsis of the issue and iii) all supporting documentation; 6) Practices must
execute business associate agreements and other applicable legal documentation as required by the
state and federal government to ensure the privacy rights of patients; 7) MAG will not collect money
from patients. MAG will only collect money from public and private payers; 8) MAG does not offer
legal advice or practice management training; 9) MAG will provide members with up to one hour of
claims recovery staff support at no charge; MAG will refer practices to an outside attorney for
consultations that require more than one hour of staff time, and the practice will be responsible for any
fees that are required by the referral attorney. MAG will not collect a fee for this referral.

Careful consideration was given to this policy. While this was a good idea initially, the program
has been unsuccessful in attracting interest over the last few years as other streams of revenue
have taken precedence. MAG will continue to assist individual physician members when
problems arise with third party payer matters.

# # #
2016 Medical Association of Georgia

Appendix III

MAG Policies for Sunset with New Language

1. MAG adopts the AMA’s Ethical Principles of Managed Care and physician self-governance including disclosure provisions, selective contracting, financial incentives, case management, physician involvement, and utilization review and management. MAG opposes any de-selection of physicians from managed care plans based on physicians reporting of any managed care deviations from these ethical guidelines. MAG also adopts the following principles related to the effect of managed care (i.e., IPAs, PPOs, HMOs and ACOs) on the patient/physician relationship and advocates for governmental leaders to take appropriate actions to ensure that no entity inserts itself between the physician and his/her ability to treat and care for his/her patient: (1) that the physician/patient relationship is a covenant that is sacrosanct. This covenant includes concern for the patient, advocacy on behalf of the patient and a desire to assist in the healing of the patient; (2) that the profit motives and inappropriate cost containment strategies currently influencing the entire health care delivery system threatens to transform this covenant into a mere business contract; (3) that medicine and nursing must not be diverted from their primary tasks, which include the relief of suffering, the prevention and treatment of illness and the promotion of health; (4) that financial incentives that reward inappropriate care, whether through over utilization or under-utilization of health care services, should be prohibited; (5) that all patients should have the freedom to choose any physician they desire to see; (6) that all patients should have access to affordable health care coverage; (7) that health care decisions should be based on concern for the individual, and patients should be treated with dignity, compassion and respect; (8) in no way is this to be construed as support for a single payer national health care system; (9) MAG supports studies which address the impact and ethical implications of financial incentives, including discounted fee for service, withholds and capititated payments, on the quality of patient care delivered in managed care plans and on patient access to specialty care. (Special Report 04.11, Attachment III)

NEW LANGUAGE PROPOSED

MAG adopts the AMA’s Ethical Principles of Managed Care and physician self-governance including disclosure provisions, selective contracting, financial incentives, case management, physician involvement, and utilization review and management. MAG opposes any de-selection of physicians from managed care plans based on physicians reporting of any managed care deviations from these ethical guidelines. MAG also adopts the following principles related to the effect of managed care (i.e., IPAs, PPOs, HMOs and ACOs) on the patient/physician relationship and advocates for governmental leaders to take appropriate actions to ensure that no entity inserts itself between the physician and his/her ability to treat and care for his/her patient: (1) that the physician/patient relationship is a covenant that is sacrosanct. This covenant includes concern for the patient, advocacy on behalf of the patient and a desire to assist in the healing of the patient; (2) that the profit motives and inappropriate cost containment strategies currently influencing the entire health care delivery system threatens to transform this covenant into a mere business contract; (3) that medicine and nursing must not be diverted from their primary tasks, which include the relief of suffering, the prevention and treatment of illness and the promotion of health; (4) that financial incentives that reward inappropriate care, whether through over utilization or under-utilization of health care services, should be prohibited; (5) that all patients should have the freedom to choose any physician they desire to see; (6) that all patients should have access to affordable health care coverage; (7) that health care decisions should be based on concern for the individual, and patients should be treated with dignity, compassion and respect; (8) in no way is this to be construed as support for a single payer national health care system; (9) MAG supports...
studies which address the impact and ethical implications of financial incentives, including
discounted fee for service, withholds and capitated payments, on the quality of patient care
delivered in managed care plans and on patient access to specialty care.

Reviewed by task force members who determined that this policy should reflect the
position of the Medical Association of Georgia and therefore recommended that the first
sentence be removed from the policy.

185.977 Pay-for-Performance – HD 10/16/2011
MAG opposes pay-for-performance programs because they pose more risks than benefits for patients and
physicians. MAG encourages the use of physician data to benefit both patients and physicians and to
improve the quality of patient care and the efficient use of resources in the delivery of health care
services. While MAG respects innovations in assessing quality of care and cost efficiency, we do not
believe the claims-driven profiling methods that insurance companies use in their pay-for-performance
programs are accurate and effective in achieving this goal. (Special Report 04.11, Attachment III)

NEW LANGUAGE PROPOSED
MAG opposes pay-for-performance programs because they pose more risks than benefits for
patients and physicians. MAG encourages the use of physician data to benefit both patients and
physicians and to improve the quality of patient care and the efficient use of resources in
the delivery of health care services. While MAG respects innovations in assessing quality of
care and cost efficiency, we do not believe the claims-driven profiling methods that insurance
companies use in their pay-for-performance programs are accurate and effective in achieving this
goal.

Reviewed by task force members who recommended new language in light of value
performance expectations and considerations that are in the immediate future related to
the increasing access to clinical data.

540.950 Journal Directives
HD 10/16/2011
The following directives regarding the MAG Journal shall be used: 1) The JMAG Editorial Board will be
a strategic oversight group that meets at least four times a year or as needed to discuss editorial content
and other applicable issues; 2) JMAG should strive to remain budget neutral or better; and 3) JMAG
Journal should be published on a quarterly basis and include a recap of MAG’s House of Delegates
meeting each year that is supplemented by a detailed HOD meeting report which is printed as needed. The
detailed HOD report will also be posted on www.mag.org so that all members can access the information.
The Journal’s editorial content should address key issues that are pertinent to physicians, including
MAG’s advocacy efforts in the legislative (state and national) and legal areas; health policy;
education/CME; third party payer (e.g., Medicare/Medicaid); county/member/specialty news; medical
schools; and other case reports, etc. Standard Journal features will include messages from MAG’s
president, executive director and editor, and the MAG Alliance. (Special Report 04.11, Attachment III)

NEW LANGUAGE PROPOSED
The following directives regarding the MAG Journal shall be used: 1) The JMAG Editorial Board
will be a strategic oversight group that meets at least four times a year or as needed to discuss
editorial content and other applicable issues; 2) JMAG should strive to remain budget neutral or
better; and 3) JMAG Journal should be published on a quarterly basis and include a recap of
MAG’s House of Delegates meeting each year that is supplemented by a detailed HOD meeting
report which is printed as needed. The detailed HOD report will also be posted on www.mag.org
so that all members can access the information. The Journal’s editorial content should address
key issues that are pertinent to physicians, including MAG’s advocacy efforts in the legislative
(state and national) and legal areas; MAG’s subsidiaries; health policy; education/CME; third
party payer (e.g., Medicare/Medicaid); county/member/specialty/Alliance news; medical schools;
and other case reports, etc. Standard Journal features will include messages from MAG’s president and the executive director and editor, and the MAG Alliance.

Reviewed by the Editorial Board that recommended minor edits to reflect current procedures for JMAG.

545.957 Candidates for Office – HD 5/1/1995

Candidates for offices for MAG and AMA delegates and alternate delegates must explicitly state their stand on current issues affecting medical practice prior to the House of Delegates meeting, in their letter announcing their candidacy or any other campaign vehicle, so that MAG delegates can vote intelligently on the slate of candidates. (Reaffirmed 9/30/2006; 10/16/2011)

NEW LANGUAGE PROPOSED

Candidates for offices including AMA delegates and alternate delegates must, prior to the House of Delegates meeting, explicitly state their stand on current issues affecting the practice of medicine in their letter announcing their candidacy or any other campaign vehicle used in order for voting members to properly vet the candidates.

This policy was reviewed administratively. In the review process, it became apparent that slight edits were in order to reflect the intent of the policy.

# # #
REFERENCE COMMITTEE
A
RESOLUTION

Resolution: 101A.16

SUBJECT: Georgia Medical License for International Medical School Graduates

SUBMITTED BY: Georgia Academy of Family Physicians
Georgia Chapter, American Academy of Pediatrics

REFERRED TO: Reference Committee A

Whereas, Georgia currently faces a primary care physician shortage, especially in rural and inner city areas of the state as demonstrated by many studies; and

Whereas, the number of residency positions in primary care in Georgia is being increased; and

Whereas, it is important to retain as many of these residents trained in Georgia to remain in practice in Georgia to alleviate this shortage; and

Whereas, current statutes of the Georgia Composite Medical Board (GCMB) allow U.S. medical school graduates and international medical school graduates from a board-approved list of international medical schools to apply for an unrestricted license following completion of their first year of post graduate training; and

Whereas, international medical students who graduate from medical schools not recognized by the current statutes of the GCMB must wait until completion of their residency to apply for an unrestricted medical license to practice in Georgia; and

Whereas, third-year residents obtain experience in potential practice locations outside of their residency responsibilities, therefore these residents do not have these opportunities in Georgia; and

Whereas, this is an impediment to retaining these residents in Georgia and reducing the primary care physician shortage in Georgia; now therefore be it

RESOLVED, that the Medical Association of Georgia advocate to allow international medical school graduates not included in the current statutes of the Georgia Composite Medical Board to apply for an unrestricted medical license following completion of the second year of their residency program.

###

MAG Policy

**255.999 IMG Licensing Standards**

RESOLUTION
Resolution: 102A.16

SUBJECT: Improving Communications Among Health Care Clinicians
SUBMITTED BY: Whitfield-Murray Medical Society
REFERRED TO: Reference Committee A

Whereas, with the massive changes in the delivery of health care over the last few years, as electronic medical records (EMR), the advent of hospitalists being the PCP in the hospital, and the increasing amount of burdensome regulations that physicians and hospitals deal with daily, it is clear that the art of communication between all aspects of the health care spectrum has seen tremendous changes in the management of direct patient care; and

Whereas, though these changes are continuing, it is becoming that the art of communication between physicians-physicians, physicians-hospital staff, and physicians-patients appear to have only worsened resulting in higher health care costs, increased medical errors, and an increase in medical malpractice suits due to poor communications, also known as “systems” failure; and

Whereas, several studies have pointed out that direct communication between physicians on a particular patient during their hospitalization may be between three to 20 percent of the time. In one study, Bell et al. surveyed 1,772 PCPs for 1,078 hospitalized patients at six academic centers – only 77 percent were aware of the patient’s hospitalization, and of that only 23 percent received direct communication about their patient during their hospital care; and

Whereas, another study done by Roy et al. studied the communication between hospitalist teams who assumed care from a previous hospitalist team. They found that only 43.7 percent of the teams actually had a communication about the medical care of the same patients from the previous team;

Whereas, a later study again by Roy et al. looked into the barriers in communication between hospitalists and a patient’s PCP. They cited that hospitalists believed that they were too busy with multiple patients, did not believe it would help with in-patient care, or were unclear who the patient’s PCP actually was and did not have anyone find out. All these perceived barriers by hospitalists suggest that the concept of continuity of aftercare has not been a priority; and

Whereas, two years ago in Texas, poor communication resulted in a patient who had traveled to an Ebola-endemic region being sent home from the emergency room. The admitting nurse recorded this information, but none of the medical clinicians ever looked at it, which resulted in the patient exposing more people to Ebola; and

Whereas, the number of cases being sent to medical boards as well as cases involved in medical malpractice suits are increasing in number yearly and they are being labeled as “systems” failures; and

Whereas, in order to improve the quality of care in today’s health care environment, there must be a leader in the health care arena to change this increasing problem. Physicians must take the lead to improve communication between all the entities. State medical associations and the AMA must take a leadership role to decrease these kinds of unnecessary medical errors; now therefore be it

RESOLVED, that the Medical Association of Georgia (MAG) submits a resolution to the American Medical Association (AMA) that it, in association with the American Hospital Association, assess
the national impact of communication barriers and their negative impact on direct patient care in
the hospital and after discharge between physician-physician in the hospital, in-hospital and after
discharge care, and physician-patients and report to the AMA HOD by I-17; and be it further

RESOLVED, that MAG submits a resolution to the AMA to research and develop guidelines that
physicians can initiate in their communities to improve communication between physician-
physician in the hospital, hospital and after discharge care, and physician-patients and report to the
AMA HOD by I-17.

# # #
RESOLUTION

Resolution: 103A.16

SUBJECT: Signing of Death Certificates

SUBMITTED BY: Medical Association of Atlanta

REFERRED TO: Reference Committee A

Whereas, it is extremely important for population health data, accurate record keeping, etc. that death certificates be as accurate as possible in listing the cause of death and contributing factors; and

Whereas, for decades primary care physicians took care of their own patients when they were hospitalized, and therefore were very aware of the reason for hospitalization, the contributing factors leading to that hospitalization, and if the patient had an unfortunate turn of events leading to the patient’s demise, the primary care physician would be aware of the circumstances surrounding the cause of death; and

Whereas, times have changed with hospitalists today taking care of the vast majority of patients who are hospitalized, largely leaving primary care physicians no longer involved in their patient’s actual hospital stay; and

Whereas, despite primary care physicians no longer being involved in the hospitalization of their patients, they are still the ones responsible for filling out the death certificate despite not having first-hand knowledge of the cause of death and/or the immediate contributing factors leading to that death; and

Whereas, in order to do this, the primary care physician has to contact the hospital to obtain records and/or attempt to contact the hospitalist or emergency room physician who was involved in the patient’s care during that hospitalization. This second-hand data collection oftentimes leads to errors and inaccuracies on the death certificate; and

Whereas, the hospitalist or the emergency room physician who declares the patient deceased and is responsible for recording the time of death, has the most accurate, first-hand knowledge of cause of death and the contributing factors based on hospital records, discussion with immediate family members, etc.; now therefore be it

RESOLVED, that the Medical Association of Georgia’s (MAG) policy is the physician who declares a patient deceased be the physician responsible for signing the death certificate at the time of death.

# # #

References

TITLE 31 – HEALTH
CHAPTER 10 - VITAL RECORDS
§ 31-10-15 - Death certificate; filing; medical certification; forwarding death certificate to decedent’s county of residence; purging voter registration list.
c) (1) The medical certification as to the cause and circumstances of death shall be completed, signed, and returned to the funeral director or person acting as such within 72 hours after death by the physician in charge of the patient's care for the illness or condition which resulted in death, except when inquiry is required by Article 2 of Chapter 16 of Title 45, the "Georgia Death Investigation Act." In the absence of said physician or with that physician's approval the certificate may be completed and signed by an associate physician, the chief medical officer of the institution in which death occurred, or the physician who performed an autopsy upon the decedent, provided that such individual has access to the medical history of the case, views the deceased at or after death, and death is due to natural causes. If, 30 days after a death, the physician in charge of the patient's care for the illness or condition which resulted in death has failed to complete, sign, and return the medical certification as to the cause and circumstances of death to the funeral director or person acting as such, the funeral director or person acting as such shall be authorized to report such physician to the Georgia Composite Medical Board for discipline pursuant to Code Section 43-34-8.
RESOLUTION

SUBJECT: Physician Shortage

SUBMITTED BY: John A. Goldman, M.D., Delegate

REFERRED TO: Reference Committee A

Whereas, U.S. shortage of doctors by 2025: 61,700-94,700; and
Whereas, U.S. shortage of primary care physicians: 14,900-35,600; and
Whereas, U.S. shortage of surgeons and specialists: 37,400-60,300; and
Whereas, increase in the U.S. population by 2025: 27 million; and
Whereas, these shortages pose a real risk to patients. Because it takes between five and 10 years to train a doctor, projected shortages in 2025 need to be addressed now so that patients will have access to the care they need; and
Whereas, increase by 2025 in the number of Americans over age 65: 41 percent; and
Whereas, Georgia’s population increased by 18.3 percent from 2000 to 2010. The number of physicians in the state actually grew by 26 percent. But the increase in primary care doctors was only 14.5 percent, compared with nearly 37 percent for specialists. In addition, more than half of Georgia doctors are 50 or older; and
Whereas, “Legacy Physicians” are retiring earlier due to the increased regulatory burdens and unworkable electronic health records; and
Whereas, every county in Georgia has at least one doctor that practices primarily in that county. However:
• Six counties had no family medicine physician
• 31 counties had no internal medicine physician
• 63 counties had no pediatrician
• 79 counties had no OB/GYN
• 66 counties had no general surgeon; and
Whereas, the Association of American Medical Colleges (AAMC) feel we need additional federal support to train at least 3,000 more doctors a year by lifting the cap on federally funded residency training positions. Lawmakers have responded with proposals in the House and Senate to increase the number of residency positions. But they must act now in order to ensure that there are enough physicians for our growing and aging population. (But government programs are closing and/or consolidating hospitals.); and
Whereas, Cherri Tucker, executive director of the Board for Physician Workforce, said to solve the physician shortage, the state needs more initiatives to recruit doctors and get them to remain in Georgia. Such programs include school loan repayments; an increased number of medical residency
programs; and making the state a more attractive place for doctors to practice; now therefore be it

RESOLVED, that the Medical Association of Georgia (MAG) works with the American Medical Association (AMA) and the Georgia legislature to accomplish the following:

(1) Increase the physician workforce in Georgia; and
(2) Develop a legacy program allowing physicians who are 60 years and above to continue to practice.

###

**AMA Policy**

The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967

1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician
workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.

12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.

13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.

14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.

15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.

16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.

17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.

18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.

19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.

20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.

21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.

22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.

23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.
24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.

25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.

26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.

27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.

28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.

29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.

30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.

31. Our AMA will study the effect of medical school expansion that occurs without corresponding graduate medical education expansion.

**Long-Term Solutions to Medical Student Debt D-305.975**

Our AMA will: (1) encourage medical schools and state medical societies to consider the creation of self-managed, low-interest loan programs for medical students, and collect and disseminate information on such programs; (2) advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas; (3) work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment; (4) collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided; and (5) encourage the National Health Services Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.

**MAG Policy**

**200.995 Government Resources for Physicians**

HD 10/21/2012 MAG supports government efforts to increase financial resources and develop policies to improve the number of physicians practicing in Georgia. (Resolution 116A.12)

**310.995 Primary Care GME Graduates**

HD 10/20/2013 MAG support the efforts, including those of the Georgia Statewide Area Health Education Centers (AHEC), to retain more Georgia primary care GME graduates and to recruit more Georgia medical student graduates into Georgia primary care GME programs. (Res. 303C.13)
310.996 Residency Programs -- Funding
HD 10/20/2013 MAG supports state efforts to increase funding for all residency programs designed to train physicians to practice medicine in Georgia. (Res. 309C.13)

310.997 Physician Graduates
HD 10/21/2012 MAG supports development of a program for physician graduates seeking employment in Georgia and shall convey this support to the Georgia Board for Physician Workforce. (res. 303C.12)

310.998 Pediatric Residency Programs
HD 4/1/1991 MAG supports increased state support of General Pediatric Residency programs designed to provide primary pediatric physicians. (Reaffirmed 05/2000 10/5/2008; 10/20/2013)

310.999 Graduate Medical Education - Funding
RESOLUTION

SUBJECT: MACRA

SUBMITTED BY: Medical Association of Atlanta

REFERRED TO: Reference Committee A

Whereas, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) has been indicated by the Center for Medicare & Medicaid Services (CMS) as the next step for monitoring health care in the Medicare program; and

Whereas, MACRA is incomplete; and

Whereas, MACRA is extremely difficult to comprehend and it is based on assumptions that defy commonsense and research and it may raise costs; and

Whereas, MACRA has not been scrutinized thoroughly and therefore it is an investigative approach and is not evidence based; and

Whereas, the transcripts of the Medicare Payment Advisory Commission’s (MedPAC) October 8, 2015 and January 15, 2016 meetings indicate that members and staff perceive daunting impediments to the implementation of MACRA; and

Whereas, small, independent private practices are closing, increasing numbers of physicians are retiring, and fewer medical school graduates are choosing primary care; and

Whereas, this plan will penalize seven out of 10 small one- to two-physician practices in this country, because small practices will be overwhelmed complying with statistical reporting demands that do nothing to enhance the quality of care, instead of spending precious time seeing patients; and

Whereas, MACRA is the law but it is not ready for initiation; and

Whereas, a variety of medical organizations have proposed changes; and

Whereas, that MACRA needs revision, scientific scrutiny and evidence-based investigation into the best program to be developed; now therefore be it

RESOLVED, that the Medical Association of Georgia (MAG) submits a resolution to the American Medical Association (AMA) to continue to work with the Center for Medicare & Medicaid Services (CMS) to provide timely updates regarding MACRA.

###
AMA Policy

1. Our AMA will urge the Centers for Medicare and Medicaid Services to protect access to care by significantly increasing the low volume threshold to expand the MACRA MIPS exemptions for small practices (on a voluntary basis), and to further reduce the MACRA requirements for ALL physicians' practices to provide additional flexibility, reduce the reporting burdens and administrative hassles and costs.
2. Our AMA will advocate for additional exemptions or flexibilities for physicians who practice in health professional shortage areas.
3. Our AMA will determine if there are other fragile practices that are threatened by MACRA and seek additional exemptions or flexibilities for those practices.

Preserving a Period of Stability in Implementation of the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA) D-390.950
1. Our AMA will advocate that Centers for Medicare and Medicaid Services (CMS) implement the Merit-Based Payment Incentive Payment System (MIPS) and Alternative Payment Models (APMs) as is consistent with congressional intent when the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA) was enacted.
2. Our AMA will advocate that CMS provide for a stable transition period for the implementation of MACRA, which includes assurances that CMS has conducted appropriate testing, including physicians' ability to participate and validation of accuracy of scores or ratings, and has necessary resources to implement provisions regarding MIPS and APMs.
3. Our AMA will advocate that CMS provide for a stable transition period for the implementation of MACRA that includes a suitable reporting period.

MAG Policy

330.993 Payment Reform
HD 4/1/1991 MAG supports communicating ongoing federal legislative changes in Medicare payment reform to physicians in a timely manner. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013)

390.985 Payment Formula
HD 10/13/2007 MAG and the AMA will continue to work with the U.S. Department of Health and Human Services and Centers for Medicare and Medicaid Services to ensure the correctness of the formula calculations for Medicare payment. (Committee 01.07, Attachment III) (Reaffirmed 10/20/12)
RESOLUTION

SUBJECT: Distracted Driver Reduction

SUBMITTED BY: Medical Association of Atlanta

REFERRED TO: Reference Committee A

Whereas, a higher percentage of U.S. drivers text or use hand-held cell phones while driving compared to drivers in European countries; and

Whereas, road fatalities, which had been dropping in the past years, are up roughly eight percent in 2015 over the previous year; and

Whereas, one-fourth of all traffic accidents are associated with cell phone use; and

Whereas, eight deaths and 1,161 injuries are reported to involve a distracted driver each day in the U.S. per CDC estimates (i.e., a distracted driver is one driving while doing another activity that tends to take the driver’s attention away from driving); and

Whereas, 14 states and the District of Columbia have laws in place banning hand-held cell phone use and texting; now therefore be it

RESOLVED, that the Medical Association of Georgia (MAG) will support legislation that limits cell phone use to hands-free use only; and be it further

RESOLVED, that MAG will encourage the American Medical Association (AMA) to develop model legislation to limit cell phone use to hands-free use only across the country.

###

AMA Policy

The Dangers of Distraction While Operating Hand-Held Devices H-15.952

1. Our American Medical Association encourages physicians to educate their patients regarding the public health risks of text messaging while operating motor vehicles or machinery and will advocate for state legislation prohibiting the use of hand held communication devices to text message while operating motor vehicles or machinery.

2. Our AMA will endorse legislation that would ban the use of hand-held devices while driving.

3. Our AMA: (A) recognizes distracted walking as a preventable hazard and encourages awareness of the hazard by physicians and the public; and (B) encourages research into the severity of distracted walking as a public health hazard as well as ways in which to prevent it.

4. Our AMA supports public education efforts regarding the dangers of distracted driving, particularly activities that take drivers’ eyes off the road, and that the use of earbuds or headphones while driving is dangerous and illegal in some states.

5. Our AMA: (A) supports education on the use of earbuds or headphones in both ears during outdoor activities requiring auditory attention, including but not limited to biking, jogging, rollerblading, skateboarding and walking; and (B) supports the use of warning labels on the packaging of hand-held
devices utilized with earbuds or headphones, indicating the dangers of using earbuds or headphones in both ears during outdoor activities requiring auditory attention, including but not limited to biking, jogging, rollerblading, skateboarding and walking.

**MAG Policy**

**15.988 Cell Phone Use**
HD 10/13/2007 MAG supports legislation that prohibits the use of a cell phone while operating a vehicle for drivers 18 years old and younger and allow only hands free use by drivers over 18 years old. (Res. 318C.07) (Reaffirmed 10/20/2012)
RESOLUTION

SUBJECT: Control Cost of Brand and Generic Medications

SUBMITTED BY: Medical Association of Atlanta

REFERRED TO: Reference Committee A

Whereas, the cost of brand and generic medications are rapidly rising; and
Whereas, the average annual cost of cancer drugs increased from roughly $10,000 before 2000 to more than $100,000 by 2012, according to a recent study in Mayo Clinic Proceedings; and
Whereas, several breakthrough specialty medications and orphan drugs recently approved by the Food and Drug Administration (FDA) have subsequently entered the pharmaceutical market with hefty price tags. Consider Biogen Idec’s multiple sclerosis drug, Tecfidera, which costs $54,900 per patient per year; hepatitis C cures from Gilead Sciences, with a sticker price of $84,000 per patient; and Orkambi, a cystic fibrosis drug from Vertex Pharmaceuticals that was approved this month, which is priced at a whopping $259,000 per year; and
Whereas, for 222 generic drug groups prices increased by 100 percent or more between 2013 and 2014, according to Forbes. As generic drugs have long provided payers some respite from other more expensive products and services, rising prices in generics like Mylan NV’s albuterol sulfate – which increased about 4,000 percent from 2013 to 2014 – are well worth the concerns; and
Whereas, 73 percent of Americans find the cost of drugs to be unreasonable, and most blamed drug manufacturers for setting prices too high. Some particularly high-cost medications for hepatitis C have even forced insurers and Medicaid programs to limit usage of the drugs; and
Whereas, recent disclosure of the rapid increase in the cost of EpiPen indicates a concern for pricing of all medications; and
Whereas, private payers, doctors, and Accountable Care Organizations (ACOs) should collaborate with manufacturers on pharmacoeconomic studies in order to value the outcomes and financial benefits brought to the health system by a therapeutic drug; and
Whereas, if providers are facing greater accountability in the form of bundled reimbursement, pay-for-performance, and penalties for inadequate care, Big Pharma should not be off the hook. When a fairly priced product fails to yield the benefits quantified through joint pharmacoeconomic studies, the producer should reimburse payers for the drug price, or lead corrective measures – like an additional treatment regimen – at no further cost to other stakeholders; and
Whereas, generic drugs in theory operate in a free market where competition regulates prices. However, for certain drugs, the number of manufacturers may be small, thus putting this system at risk. In monopoly-like environments, regulators should set caps on price increases; and
Whereas, pharmaceutical firms in America enjoy a hands-off approach by government to pricing products, atypical by global standards. In fact, Medicare is barred from negotiating prices with
RESOLVED, that the Medical Association of Georgia (MAG) submits a resolution to the American Medical Association (AMA) that advocates for it:

(1) To investigate the purchasing of medications from outside the country with FDA guidance, on a temporary basis until availability in the U.S. improves;

(2) To advocate to permit temporary compounding with FDA’s guidance until medications are available;

(3) To advocate to allow increased competition in the marketing of medications;

(4) To advocate for participative pricing;

(5) To advocate for accountability for outcomes; and

(6) To advocate for increased regulation of the generic drug market.

AMA Policy

Cost of Prescription Drugs H-110.997
Our AMA:

(1) supports programs whose purpose is to contain the rising costs of prescription drugs, provided that the following criteria are satisfied: (a) physicians must have significant input into the development and maintenance of such programs; (b) such programs must encourage optimum prescribing practices and quality of care; (c) all patients must have access to all prescription drugs necessary to treat their illnesses; (d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and (e) such programs should promote an environment that will give pharmaceutical manufacturers the incentive for research and development of new and innovative prescription drugs;

(2) reaffirms the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourages physicians to supplement medical judgments with cost considerations in making these choices;

(3) encourages physicians to stay informed about the availability and therapeutic efficacy of generic drugs and will assist physicians in this regard by regularly publishing a summary list of the patient expiration dates of widely used brand name (innovator) drugs and a list of the availability of generic drug products;

(4) encourages expanded third party coverage of prescription pharmaceuticals as cost effective and necessary medical therapies;

(5) will monitor the ongoing study by Tufts University of the cost of drug development and its relationship to drug pricing as well as other major research efforts in this area and keep the AMA House
of Delegates informed about the findings of these studies;

(6) encourages physicians to consider prescribing the least expensive drug product (brand name or FDA
A-rated generic); and

(7) encourages all physicians to become familiar with the price in their community of the medications
they prescribe and to consider this along with the therapeutic benefits of the medications they select for
their patients.

Controlling the Skyrocketing Costs of Generic Prescription Drugs H-110.988
1. Our American Medical Association will work collaboratively with relevant federal and state agencies,
policymakers and key stakeholders (e.g., the U.S. Food and Drug Administration, the U.S. Federal Trade
Commission, and the Generic Pharmaceutical Association) to identify and promote adoption of policies to
address the already high and escalating costs of generic prescription drugs.

2. Our AMA will advocate with interested parties to support legislation to ensure fair and appropriate
pricing of generic medications, and educate Congress about the adverse impact of generic prescription
drug price increases on the health of our patients.

3. Our AMA encourages the development of methods that increase choice and competition in the
development and pricing of generic prescription drugs.

4. Our AMA supports measures that increase price transparency for generic prescription drugs.

MAG Policy

120.981 Specialty Medication Financial Discriminations
HD 10/16/2011 MAG supports patient protections that prohibit health plans from financial
discriminations to patients based on diagnosis and need for specialty medications, and plans that allow for
reasonable patient costs. (Res. 111A.11, Resolve 2)

120.982 Specialty Medication Access
HD 10/16/2011 MAG supports eliminating complex barriers limiting access to specialty medications with
physicians as the primary authorities for patient treatment decisions.(Res. 111A.11, Resolve 1)

125.993 Principles for Generic Substitution of Drugs
HD 10/4/2008 Principles for Generic Substitution of Drugs
1. MAG reaffirms its previous policy that all physicians be urged to supplement medical considerations
with cost considerations when selecting the drug of choice for an individual patient and to become well
informed about the quality of prescription drug products available from multiple sources.
2. Until the methodology for approval of bioequivalence and therapeutic equivalence of all drug products
is resolved, MAG reaffirms its previous policies:
a) that the dose of any medication continue to be titrated for optimum efficacy and safety, especially in
patients with chronic disorders who require prolonged therapy or patients in special population groups not
expected to respond to a drug in the normal manner;
b) when multiple refills of a drug product for chronic diseases are anticipated, physicians should avoid
substitution unless the products have been proven to be bioequivalent, and
c) when serious or unusual problems develop that may be related to drug substitution, the findings should
be documented. A short federal Food and Drug
Administration (FDA) reporting form is available on the last page of the FDA Drug Bulletin, which is sent quarterly to all practicing physicians. Physicians are urged to include the manufacturer and lot number of the drug product in the 1639 form.

3. MAG believes that the physician and pharmacist should take necessary steps to eliminate confusion to the patient when labels are changed as a result of any drug substitution, particularly when the color, shape, and taste of drug substitute vary from the originally prescribed product.

4. Pharmacists should not substitute any generic drug product that has a B bioequivalent rating (i.e., potential of documented bioinequivalent problem). All B-related drug products should be required to demonstrate bioequivalence, or their application should be withdrawn by the FDA.

5. Physicians should become familiar with specific laws governing generic drug substitution in their state and, where applicable, they should obtain a copy of the state's current generic substitution drug formulary.

6. The only text currently available for determining equivalence among drug products (i.e., Approved Drug Product With Therapeutic Equivalence Evaluations (the Orange Book or The List) should be revised as follows: Although the FDA is mandated to do so, single-source drugs should be eliminated. The manufacturing source for all multisource drug products should be included, even if it requires a rapid update system, possibly on-line, for the pharmacist. The inclusion of decisional criteria for determining bioequivalence and therapeutic equivalency of selected agents is recommended.

7. The FDA should proceed without undue delay to implement an imprint coding system for all solid oral dosage forms that allows identification of the manufacturing source of the product even if a nonmanufacturing distributor is involved. This will markedly aid the physician, the pharmacist, and the patient to know when drug substitution has occurred and will help to resolve causality if a drug product failure has occurred.

8. Selected post-marketing surveillance systems (other than spontaneous reporting) of adverse events should be explored by the FDA. Especially meaningful, might be studies that provide data on:
   a. A comparison of elderly patients with associated multiple diseases and/or on multiple drug therapy in whom the drug will be used, but who are not representative of the group in which the drug was tested for bioequivalency;
   b. Studies in patients compared with the group in whom the drug was tested when a number of active metabolites of a drug known to be present in different proportions than the test group; and
   c. Studies when the therapeutic index of a drug is quite narrow.

9. Congress should support the generic drug review and approval process with adequate personnel and financial resources for the FDA.

(Special Report 05.08, Attachment III) (Reaffirmed 10/20/2013)
RESOLUTION

SUBJECT: Access to Cosmetic Product Ingredients

SUBMITTED BY: Medical Association of Atlanta

REFERRED TO: Reference Committee A

Whereas, ingredients such as acrylates are often inactive ingredients in many products including cosmetics, skincare products, nail polish, and sunscreens; and

Whereas, acrylates and their copolymers are often used as film-forming agents, stabilizing agents, and waterproofing agents in hair styling products, cosmetics products, and sunscreens; and

Whereas, acrylates have long been known to have the potential to induce cutaneous hypersensitization; and

Whereas, acrylates were named the Contact Allergen of the Year in 2012 by the American Contact Dermatitis Society; and

Whereas, patients may be exposed to acrylates in occupational settings (painters, printers, dental personnel, orthopedic surgeons, beauticians) and in non-occupational settings (i.e. artificial nails, dental prostheses, hearing aids, cosmetics and skin products); and

Whereas, acrylates can penetrate most gloves (latex, nitrile, and vinyl), therefore gloves offer minimal protection for affected individuals; and

Whereas, skin patch testing is available that can help determine sensitivity to acrylates and other ingredients; and

Whereas, treatment of confirmed acrylate allergy requires removal of exposure to the causative agent; and

Whereas, some products including cosmetics, skincare products, and nail polish do not always make their ingredient list available on the bottle; and

Whereas, inactive ingredients in these products are not easily accessible by consumers; now therefore be it

RESOLVED, that the Medical Association of Georgia (MAG) submits a resolution to the American Medical Association (AMA) to encourage the Food and Drug Administration to mandate that all manufacturers of cosmetics, skincare products, nail polish, and sunscreens make their full ingredient lists available on the package and online to consumers; and be it further

RESOLVED, that MAG submits a resolution to the AMA to prepare a report to increase awareness of acrylate allergy, update potential sources of occupational and non-occupational exposure, and provide an update as to the best ways and barrier methods to avoid acrylate exposure by susceptible individuals, with a report back to the AMA HOD at A-2017.

###
RESOLUTION

SUBJECT: Electronic Health Records

SUBMITTED BY: John A. Goldman, M.D., Delegate

REFERRED TO: Reference Committee A

Whereas, physicians are burdened by unworkable electronic health records (EHR); and

Whereas, a “solution” electronic health record is supposed to be developed by “innovation” but the solution is not workable because the innovation is not ready; and

Whereas, even so the physician is still being required by law to use an “approved electronic health record;” and

Whereas, electronic health records take too long for accurate collection of data, cause a much longer office visit, foster less attention to the patient and more to the computer (sometimes with the physician’s back turned to the patient while data is recorded); and

Whereas, the AMA/RAND white paper has recognized and categorized the problems with electronic health records and yet the government continues to force physicians to use them or be penalized; and

Whereas, electronic health records – until fixed – are ruining good medical practice; and

Whereas, a recent article in the Annals Internal Medicine titled “Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties” (Ann Intern Med. Published online 6 September 2016 doi:10.7326(M16-0961) indicates: “For every office hour spent on direct clinical face time with patients, physicians in our sample spent nearly an additional two hours on EHR and desk work. Physicians spend nearly half of the total office day on EHR and desk work and less than one third on direct clinical face time with patients. They also spend 1 to 2 hours of personal time at home each night to “keep up;” and

Whereas, electronic health records are focused on regulatory issues and not on health care issues; and

Whereas, they need to be streamlined and the regulatory requirements that are not evidence based need to be severely limited and most eliminated; and

Whereas, despite AMA action, no relief from government regulation has occurred; now therefore be it

RESOLVED, that the Medical Association of Georgia (MAG) sends a resolution to the American Medical Association (AMA) encouraging a partnership with the Centers for Medicare & Medicaid Services (CMS) to develop workable “Certified Electronic Records;” and be it further

RESOLVED, that MAG submits a resolution to the AMA to work with the federal government to develop evidence-based, certified, workable, and streamlined electronic health records.

# # #
AMA Policy

EHR Interoperability D-478.972
Our AMA: (1) will enhance efforts to accelerate development and adoption of universal, enforceable electronic health record (EHR) interoperability standards for all vendors before the implementation of penalties associated with the Medicare Incentive Based Payment System; (2) supports and encourages Congress to introduce legislation to eliminate unjustified information blocking and excessive costs which prevent data exchange; (3) will develop model state legislation to eliminate pricing barriers to EHR interfaces and connections to Health Information Exchanges; (4) will continue efforts to promote interoperability of EHRs and clinical registries; (5) will seek ways to facilitate physician choice in selecting or migrating between EHR systems that are independent from hospital or health system mandates; and (6) will seek exemptions from Meaningful Use penalties due to the lack of interoperability or decertified EHRs and seek suspension of all Meaningful Use penalties by insurers, both public and private.

National Health Information Technology D-478.995
1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.

2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care.; and (D) advocates for more research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.

3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians? practices; and (B) develop minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.

4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.

5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.

6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.
7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.

**MAG Policy**

**315.994 Electronic Health Record - Usability**  
HD 10/18/2015 MAG supports the 2014 AMA position paper that outlines eight priorities to improve EHR usability for physicians and other stakeholders in the health care industry, including the following:  
1) EHR systems should be designed to enhance physician-patient communication and engagement;  
2) EHR systems should be support team-based care by maximizing each person's productivity in accordance with state licensure laws and allow physicians to delegate tasks as appropriate;  
3) EHR systems should be designed to enhance care coordination across the continuum of care;  
4) EHR systems should offer product modularity and configurability to meet individual practice requirements;  
5) EHR systems should support medical decision making with concise, context sensitive and realtime data;  
6) EHR systems should facilitate connected health care across care settings and enable both exporting data and properly incorporating data from other systems;  
7) EHR systems should be interoperable with patient mobile technology to support patient engagement; and  
8) EHR systems should be designed with end-user input and EHR technology should facilitate post-product implementation feedback. (Resolution 108A.15)

**315.995 Electronic Health Record -- Improving Technology**  
HD 10/18/2015 MAG supports the American Medical Association in its advocacy with the U.S. Department of Health and Human Services, IT experts, researchers and executives to reframe policy around the desired future capabilities of Electronic Health Records technology to enhance patient care, improve productivity and reduce administrative costs. (Resolution 108A.15)
RESOLUTION

SUBJECT: Physician Practice Bill of Rights

SUBMITTED BY: Medical Association of Atlanta

REFERRED TO: Reference Committee A

Whereas, a recent study from the Mayo Clinic showed that in 2011, 45.5 percent of doctors reported that they felt burned out, and that number rose to 54.4 percent in 2014.

Whereas, more than half of all doctors in this country feel that some aspect of their work as a doctor is making them feel burned out; and

Whereas, physicians are overregulated in their attempt to practice medicine and care for patients; and

Whereas, excessive regulations by the federal government and insurance companies, which are alleged to improve quality of care, are interfering with appropriate patient care; and

Whereas, excessive regulations by the federal government and insurance companies are interfering with research and new innovations in medicine; and

Whereas, excessive regulations by the federal government and insurance companies are leading to physician abuse, patient abuse, and physician burnout; and

Whereas, new proposed MACRA rules will further exacerbate the overregulation for physicians and increase further physician abuse; and

Whereas, excessive government intrusion is leading to increased physician abuse, the exiting of many physicians from private practice, and contributing to 400 physician suicides a year; and

Whereas, physician abuse leads to less quality patient care and a public health crisis; and

Whereas, insurance companies have overburdening prior approval process, which consumes valuable time and cost practices $64,274 per physicians, per year; and

Whereas, physician abuse is interfering with care adding continuous requirements for electronic health records (EHR) and regulatory requirements, which is supposed to improve quality of care, yet there is no data proving this to be true; now therefore be it

RESOLVED, that the Medical Association of Georgia (MAG) continue to work with the American Medical Association (AMA) to properly assist and educate physicians on rules and regulations effecting the practice of medicine to ensure compliance and the ability to provide quality service to patients.

# # #
RESOLUTION

Resolution: 111A.16

SUBJECT: Nonpayment for Unspecified Codes by Third Party Payers

SUBMITTED BY: Georgia Medical Society

REFERRED TO: Reference Committee A

Whereas, the Department of Health and Human Services’ (HHS) Centers for Medicare & Medicaid Services (CMS) required the use of ICD-10 diagnosis codes to replace ICD-9 codes as of October 1, 2015; and

Whereas, certain third party payers have stated their intent to deny payment for unspecified ICD-10 codes, with elimination of their grace period as of October 1, 2016; and

Whereas, it is impossible to avoid using unspecified codes if the practitioner wants to be accurate and truthful; and

Whereas, requiring specific codes in all circumstances requires the practitioner to code inaccurately and untruthfully in certain circumstances, contributing to inaccurate data collection, contrary to the purpose of ICD-10 code implementation; and

Whereas, the CMS website clearly states that unspecified codes are necessary in many situations (e.g., “In both ICD-9-CM and ICD-10-CM, sign/symptom and unspecified codes have acceptable, even necessary, uses”); and

Whereas, physicians should report specific diagnosis codes when they are supported by available medical record documentation and clinical knowledge of the patient’s health condition, but in some instances signs/symptoms or unspecified codes are the best choice to accurately reflect the health care encounter; and

Whereas, physicians should code each health care encounter to the level of certainty known for that encounter; and

Whereas, if a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis; and

Whereas, when sufficient clinical information is not known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate unspecified code (for example, a diagnosis of pneumonia has been determined but the specific type has not been determined); and

Whereas, in fact, you should report unspecified codes when such codes most accurately reflect what is known about the patient’s condition at the time of that particular encounter; and

Whereas, it is inappropriate to select a specific code that is not supported by the medical record documentation or to conduct medically unnecessary diagnostic testing to determine a more specific code; now therefore be it
RESOLVED, that the Medical Association of Georgia House of Delegates submits a resolution to the American Medical Association to push for insurance reform that would not penalize physicians and other health care practitioners financially or otherwise from using unspecified codes when appropriate.

# # #
RESOLUTION

SUBJECT: Electronic Medical Records Recovery Fees

SUBMITTED BY: Richmond County Medical Society

REFERRED TO: Reference Committee A

Whereas, the Merit-Based Incentive Payment Systems and Alternate Payment Models under the Medicare Access and CHIP Reauthorization Act are demanding access to quality measures in various domains in electronic medical records (EMR); and

Whereas, the EMR being used may not be able to provide this access; and

Whereas, with the many different EMR used by various hospitals and practices today not providing the transparency that was one of the major reasons for implementing the EMR system; and

Whereas, for these reasons stated above, as well as other reasons, a practice may wish to change its EMR that has been used in patient care for any length of time; and

Whereas, the practice incurs an expense for access to its own data (e.g., patients’ records) held hostage by the original EMR; and

Whereas, for this reason, the practice may elect to continue using an inferior EMR product; and

Whereas, this will negatively influence our ability to attain the original goals outlined for using an EMR; now therefore be it

RESOLVED, that the Medical Association of Georgia (MAG) submits a resolution to the American Medical Association (AMA) urging the proposal of legislation that would eliminate the costs associated with recovering patient health care records from a previous EMR vendor.

# # #

AMA Policy

EHR Interoperability D-478.972
Our AMA: (1) will enhance efforts to accelerate development and adoption of universal, enforceable electronic health record (EHR) interoperability standards for all vendors before the implementation of penalties associated with the Medicare Incentive Based Payment System; (2) supports and encourages Congress to introduce legislation to eliminate unjustified information blocking and excessive costs which prevent data exchange; (3) will develop model state legislation to eliminate pricing barriers to EHR interfaces and connections to Health Information Exchanges; (4) will continue efforts to promote interoperability of EHRs and clinical registries; (5) will seek ways to facilitate physician choice in selecting or migrating between EHR systems that are independent from hospital or health system mandates; and (6) will seek exemptions from Meaningful Use penalties due to the lack of interoperability or decertified EHRs and seek suspension of all Meaningful Use penalties by insurers, both public and private.
National Health Information Technology D-478.995
1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.

2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care.; and (D) advocates for more research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.

3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians’ practices; and (B) develop minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.

4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.

5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.

6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.

7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.

MAG Policy

315.994 Electronic Health Record - Usability
HD 10/18/2015 MAG supports the 2014 AMA position paper that outlines eight priorities to improve EHR usability for physicians and other stakeholders in the health care industry, including the following:
1) EHR systems should be designed to enhance physician-patient communication and engagement; 2) EHR systems should be support team-based care by maximizing each person’s productivity in accordance with state licensure laws and allow physicians to delegate tasks as appropriate; 3) EHR systems should be designed to enhance care coordination across the continuum of care; 4) EHR systems should offer product modularity and configurability to meet individual practice requirements; 5) EHR systems should support medical decision making with concise, context sensitive and realtime data; 6) EHR systems should facilitate connected health care across care settings and enable both
exporting data and properly incorporating data from other systems; 7) EHR systems should be interoperable with patient mobile technology to support patient engagement; and 8) EHR systems should be designed with end-user input and EHR technology should facilitate post-product implementation feedback. (Resolution 108A.15)

**315.995 Electronic Health Record -- Improving Technology**

HD 10/18/2015 MAG supports the American Medical Association in its advocacy with the U.S. Department of Health and Human Services, IT experts, researchers and executives to reframe policy around the desired future capabilities of Electronic Health Records technology to enhance patient care, improve productivity and reduce administrative costs. (Resolution 108A.15)
REFERENCE COMMITTEE

C
RESOLUTION

Resolution: 301C.16

SUBJECT: MAG Alignment with the Medical Practice Act

SUBMITTED BY: Walker-Catoosa-Dade Medical Society

REFERRED TO: Reference Committee C

Whereas, Resolution 309C.14 was adopted by the Board of Directors on October 16, 2015 which states:

1) APRNs cannot prescribe treatment for an unconfirmed medical diagnosis and this supersedes all other MAG policies; and
2) Practicing APRNs cannot enter an unconfirmed medical diagnosis; and

Whereas, the 2020 Strategic Plan Advocacy Goal was adopted October 16, 2015 by the Board of Directors stating MAG limit inappropriate scope of practice beyond that safely permitted by non-physician practitioners’ education training and skills; and

Whereas, MAG policy 360.984 references physician protocol; in practice it is actually a written clinical nurse protocol; and

Whereas, MAG policy 360.985 references agreement with APRNs; and

Whereas, MAG policy 360.987 recognizes advanced practice registered nurses (APRN) in practice under “supervision” and the actual statutory word is “delegation” or “delegation of medical acts”; now therefore

be it

RESOLVED, that the Medical Association of Georgia (MAG) adopt policy and correct all existing policies such that these policies will align with the Medical Practice Act and other laws and rules and regulations such that they include the following:

1) Only a physician may enter a medical diagnosis for a patient;
2) A physician licensed in the state of Georgia may delegate certain specific medical acts to an APRN, with whom the physician has entered into an agreement in accordance with state law;
3) Written clinical nurse protocols for the delegation of medical acts will contain at a minimum: a) recognizable signs and symptoms and other data supported by the APRN's observation, b) the delegating physician's medical diagnosis pertinent to the observations and c) treatments appropriate to the diagnosis; and
4) Treatments ordered, including prescriptions under protocol, will be limited to those contained in the written protocol for the certain medical act delegated.

# # #
MAG Policy

120.975 APRN Prescribing Under Protocol
BD 10/16/2015 MAG believes that APRNs: 1) should not prescribe drugs for a treatment of an unconfirmed medical diagnosis; 2) are trained only to enter a nursing diagnosis for a patient and should not enter an nonestablished medical diagnosis for a patient; and 3) should be governed by the Georgia Composite Medical Board.

360.983 APRN -- Radiographic Imaging
HD 10/20/2013 MAG oppose current legislation that would allow an APRN to order radiographic imaging pursuant to a physician protocol. (Officer 01.13, Rec. 4)

360.985 APRN Protocol Agreement
HD 10/20/2013 MAG opposes increasing the number of APRNs supervised by a physician greater than current law, which is four, pursuant to a protocol agreement. (Officer 01.13, Rec. 3)

360.986 APRN Prescriptive Authority
HD 10/20/2013 MAG opposes increasing an APRN's prescriptive authority to order Schedule II narcotics. (Officer 01.13, Rec. 2)

360.987 APRN Requirements
HD 10/20/2013 MAG supports the current requirement that APRNs work under "supervision" versus a "collaboration and consultation" agreement with physicians. (Officer 01.13, rec. 1)
RESOLUTION

Resolution: 302C.16

SUBJECT: Network Transparency and Network Management to Benefit Patients

SUBMITTED BY: Georgia Society of Anesthesiologists
Medical Association of Atlanta

REFERRED TO: Reference Committee C

Whereas, insurers and employers are imposing larger deductibles and co-insurance on consumers through creation of limited provider networks; and

Whereas, a growing source of patient’s dissatisfaction is patient inability to evaluate network adequacy and effectively navigate insurance networks; and

Whereas, patients are suffering increased out-of-network deductibles and co-insurance costs; and

Whereas, the most likely setting for these patient challenges is in a hospital setting where physician insurance contracts do not mirror all hospital insurance contracts; and

Whereas, most agree that patients who receive unintended or unplanned services from out-of-network providers at an in-network facility should not bear the full responsibility of out-of-network costs; and

Whereas, insurers’ narrow and limited physician networks place out-of-network physicians under pressure to collect payment for services adding increased clerical burdens; and

Whereas, A Consumer Reports patient survey shows:

• 30 percent received a “surprise bill” where their plan paid less than expected
• 23 percent received a bill from a doctor who performed services without the patient’s anticipation of that service/fee, and
• 14 percent were charged out-of-network charges, and

Whereas, insurance companies have failed to provide to their insureds accurate information about physician networks or to provide a means for the patient to evaluate network adequacy and navigate the network both effectively and timely within a hospital setting; and

Whereas, the inherent problem of insurance networks is they are impractical and impossible to utilize in current practice; insurance networks fail to recognize the role a medical community plays in real-time patient care; and physicians practice and their patients live in medical “communities”, not in “insurance networks”; and

Whereas, 28 states are considering patient protection for out-of-network bills and four states (Florida, New York, Illinois and Connecticut) have passed laws restricting provider payment; and

Whereas, these laws either include or propose elements of mandated participation in insurance contracts, a ban on physician balance billing, and implementation of arbitration systems; and
Whereas, these policies interfere with the principles of competition, undermine the ability of the patient to act as a prudent consumer, and block the value competition brings to the patient over time; and

Whereas, physicians and policy holders agree that patients who receive services from out-of-network providers at an in-network facility should not bear the full responsibility of out-of-network costs and that effective policy changes need to be implemented to help the consumer; now therefore be it

RESOLVED, the Medical Association of Georgia (MAG) supports legislation that would have insurers do the following:

(1) Provide information that allows patients to evaluate network adequacy within their hospitals, which includes publishing provider in-network rates and a list of in-network physicians by medical specialty and medical group within the hospital; and

(2) In cases involving non-emergency care (a) patients will be given statements that services may be provided by out-of-network providers, (b) hospitals will have to post names and links of all contracted insurers for the benefit of both consumers and medical staff, and (c) insurers must create and support a system for network navigation to provide in-network consumer protection and to inform consumers as to whether a physician is in network and the consequences of using an out-of-network provider.

###

**AMA Policy**

**Network Adequacy H-285.908**

1. Our AMA supports state regulators as the primary enforcer of network adequacy requirements.
2. Our AMA supports requiring that provider terminations without cause be done prior to the enrollment period, thereby allowing enrollees to have continued access throughout the coverage year to the network they reasonably relied upon when purchasing the product. Physicians may be added to the network at any time.
3. Our AMA supports requiring health insurers to submit and make publicly available, at least quarterly, reports to state regulators that provide data on several measures of network adequacy, including the number and type of providers that have joined or left the network; the number and type of specialists and subspecialists that have left or joined the network; the number and types of providers who have filed an in-network claim within the calendar year; total number of claims by provider type made on an out-of-network basis; data that indicate the provision of Essential Health Benefits; and consumer complaints received.
4. Our AMA supports requiring health insurers to indemnify patients for any covered medical expenses provided by out-of-network providers incurred over the co-payments and deductibles that would apply to in-network providers, in the case that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities.
5. Our AMA advocates for regulation and legislation to require that out-of-network expenses count toward a participant’s annual deductibles and out-of-pocket maximums when a patient is enrolled in a plan with out-of-network benefits, or forced to go out-of-network due to network inadequacies.
6. Our AMA supports fair and equitable compensation to out-of-network providers in the event that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities.
7. Our AMA supports health insurers paying out-of-network physicians fairly and equitably for emergency and out-of-network bills in a hospital. AMA policy is that any legislation which addresses this
issue should assure that insurer payment for such care be based upon a number of factors, including the physicians' usual charge, the usual and customary charge for such service, the circumstances of the care and the expertise of the particular physician.

8. Our AMA provides assistance upon request to state medical associations in support of state legislative and regulatory efforts, and disseminate relevant model state legislation, to ensure physicians and patients have access to adequate and fair appeals processes in the event that they are harmed by inadequate networks.

9. Our AMA supports the development of a mechanism by which health insurance enrollees are able to file formal complaints about network adequacy with appropriate regulatory authorities.

10. Our AMA advocates for legislation that prohibits health insurers from falsely advertising that enrollees in their plans have access to physicians of their choosing if the health insurer's network is limited.

11. Our AMA advocates that health plans should be required to document to regulators that they have met requisite standards of network adequacy including hospital-based physician specialties (i.e. radiology, pathology, emergency medicine, anesthesiologists and hospitalists) at in-network facilities, and ensure in-network adequacy is both timely and geographically accessible.

**MAG Policy**

**185.970 Insurance Networks**

HD 10/19/2014 MAG supports requirements that all health insurance plans are regulated to ensure network adequacy by requiring insurers to provide transparency regarding the methodology for physician selection in health insurance networks and sufficient quality patient access to all physician specialties. (Resolve 1, Res. 311C.14)
RESOLUTION

SUBJECT: Maintenance of Certification (MOC)

Submitted by: Cherokee-Pickens County Medical Society

Referred to: Reference Committee C

Whereas, MAG Policy 230.992 (10.19.14) opposes any efforts to require Maintenance of Certification (MOC) as a condition of medical licensure, or as a prerequisite for hospital/staff privileges, employment in Georgia medical facilities, reimbursement from third parties, or issuance of malpractice insurance; and

Whereas, MAG Policy 230.991 (10.18.15) accepts the National Board of Physicians and Surgeons (NBPAS) as an alternative to the American Board of Medical Specialties (ABMS) for recertification of physicians in Georgia (the former requiring only CME while the latter requires MOC); and

Whereas, AMA Resolution 309 from summer 2016 calls for the immediate end of any mandatory recertifying examination by the ABMS and rather calls for a recertification process based on high quality, appropriate CME material; and

Whereas, the governor of Oklahoma, on April 12, 2016, signed S.B. 1148 into law declaring “Nothing in the Oklahoma Allopathic Medical and Surgical Licensure and Supervision Act shall be construed as to require a physician to secure a Maintenance of Certification (MOC) as a condition of licensure, reimbursement, employment or admitting privileges at a hospital in this state. For the purposes of this subsection, ‘Maintenance of Certification (MOC)’ shall mean a continuing education program measuring core competencies in the practice of medicine and surgery and approved by a nationally recognized accrediting organization;” and

Whereas, the above-mentioned S.B. 1148 had been unanimously approved by the Oklahoma House and Senate; now therefore be it

RESOLVED, that the Medical Association of Georgia supports the adoption of legislation that prohibits the use of Maintenance of Certification (MOC) as a condition of medical licensure or as a prerequisite for hospital or staff privileges, employment in state medical facilities, reimbursement from third parties or issuance of malpractice insurance.

# # #

AMA Policy

An Update on Maintenance of Licensure D-275.957

Our American Medical Association will: 1. Continue to monitor the evolution of Maintenance of Licensure (MOL), continue its active engagement in discussions regarding MOL implementation, and report back to the House of Delegates on this issue.

2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review MOL issues.
3. Work with the Federation of State Medical Boards (FSMB) to study whether the principles of MOL are important factors in a physician's decision to retire or have a direct impact on the U.S. physician workforce.

4. Work with interested state medical societies and support collaboration with state specialty medical societies and state medical boards on establishing criteria and regulations for the implementation of MOL that reflect AMA guidelines for implementation of state MOL programs and the FSMB's Guiding Principles for MOL.

5. Explore the feasibility of developing, in collaboration with other stakeholders, AMA products and services that may help shape and support MOL for physicians.

6. Encourage the FSMB to continue to work with state medical boards to accept physician participation in the American Board of Medical Specialties maintenance of certification (MOC) and the American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) osteopathic continuous certification (OCC) as meeting the requirements for MOL and to develop alternatives for physicians who are not certified/recertified, and advocate that MOC or OCC not be the only pathway to MOL for physicians.

7. Continue to work with the FSMB to establish and assess MOL principles, with the AMA to assess the impact of MOL on the practicing physician and the FSMB to study its impact on state medical boards.

8. Encourage rigorous evaluation of the impact on physicians of any future proposed changes to MOL processes, including cost, staffing, and time.

An Update on Maintenance of Licensure H-275.917

AMA Principles on Maintenance of Licensure (MOL):

1. Our American Medical Association (AMA) established the following guidelines for implementation of state MOL programs:
   A. Any MOL activity should be able to be integrated into the existing infrastructure of the health care environment.
   B. Any MOL educational activity under consideration should be developed in collaboration with physicians, should be evidence-based and should be practice-specific. Accountability for physicians should be led by physicians.
   C. Any proposed MOL activity should undergo an in-depth analysis of the direct and indirect costs, including physicians' time and the impact on patient access to care, as well as a risk/benefit analysis, with particular attention to unintended consequences.
   D. Any MOL activity should be flexible and offer a variety of compliance options for all physicians, practicing or non-practicing, which may vary depending on their roles (e.g., clinical care, research, administration, education).
   E. Any MOL activity should be designed for quality improvement and lifelong learning.
   F. Participation in quality improvement activities, such as chart review, should be an option as an MOL activity.

2. Our AMA supports the Federation of State Medical Boards Guiding Principles for MOL (current as of June 2015), which state that:
   A. Maintenance of licensure should support physicians' commitment to lifelong learning and facilitate improvement in physician practice.
   B. Maintenance of licensure systems should be administratively feasible and should be developed in collaboration with other stakeholders. The authority for establishing MOL requirements should remain within the purview of state medical boards.
   C. Maintenance of licensure should not compromise patient care or create barriers to physician practice.
   D. The infrastructure to support physician compliance with MOL requirements must be flexible and offer a choice of options for meeting requirements.
   E. Maintenance of licensure processes should balance transparency with privacy protections (e.g., should capture what most physicians are already doing, not be onerous, etc.).
3. Our AMA will:
A. Continue to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major CME credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format, and continue to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies, and other entities requiring evidence of physician CME as part of the process for MOL.
B. Advocate that if state medical boards move forward with a more intense or rigorous MOL program, each state medical board be required to accept evidence of successful ongoing participation in the ABMS MOC and AOA-Bureau of Osteopathic Specialists Osteopathic Continuous Certification to have fulfilled all three components of the MOL, if performed,
C. Advocate that state medical boards accept programs created by specialty societies as evidence that the physician is participating in continuous lifelong learning and allow physicians to choose which programs they participate in to fulfill their MOL criteria.
D. Oppose any MOL initiative that creates barriers to practice, is administratively unfeasible, is inflexible with regard to how physicians practice (clinically or not), does not protect physician privacy, or is used to promote policy initiatives about physician competence

MAG Policy

230.992 Maintenance of Certification
HD 10/19/2014 MAG opposes any efforts to require Maintenance of Certification (MOC) as a condition of medical licensure, or as a pre-requisite for hospital/staff privileges, employment in State of Georgia medical facilities, reimbursement from third parties, or issuance of malpractice insurance. (Res. 1, Res. 113A.14)

Resolution 101A.15 -- National Board of Physicians and Surgeons (NBPAS) Board Recertification
Adopted as amended resolves 1 and 2 of Resolution 101A.15 that 1) the Medical Association of Georgia creates policy that accepts the National Board of Physicians and Surgeons (NBPAS) as an alternative to ABMS for recertification for physicians in Georgia and that 2) the MAG delegation to the American Medical Association (AMA) submit a resolution supporting the AMA recognizing NBPAS as an alternative to ABMS for recertification for physicians nationally
RESOLUTION

SUBJECT: Advertisement of Board Certification in Georgia

SUBMITTED BY: Georgia Chapter, American College of Physicians
Medical Association of Atlanta

REFERRED TO: Reference Committee C

Whereas, the 2016 Georgia General Assembly passed H.B. 1043 restricting advertisement of board certification to the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA); and

Whereas, physicians can earn board certification from other boards; and

Whereas, the requirements for earning ABMS Maintenance of Certification (MOC) are not fully relevant to all clinical practice settings; now therefore be it

RESOLVED, that the Medical Association of Georgia (MAG) update its Policy Compendium to state that a licensed physician in Georgia may lawfully declare certification by a medical board if such physician meets the stated qualifications of such board, and earned certification by an ABMS or AOA board of the same or related specialty at least once; and be it further

RESOLVED, that MAG introduce a bill in the Georgia General Assembly that substitutes language in H.B. 1043, which would provide that a licensed physician in Georgia may lawfully declare certification by a medical board if such physician meets the stated qualifications of such board, and earned certification by an ABMS or AOA board of the same or related specialty at least once.

# # #

MAG Policy

Resolution 313C.15 – Truth in Advertising

Adopted resolve 1 of Resolution 313C.15 that our Medical Association of Georgia supports legislation that requires all health care professionals – physicians and nonphysicians– to accurately and clearly disclose their training and qualifications to patients. Adopted resolve 2 of Resolution 313C.15 that our Medical Association of Georgia supports legislation that states that a medical doctor or doctor of osteopathic medicine may not hold oneself out to the public in any manner as being certified by a public or private board including but not limited to a multidisciplinary board or “board certified,”unless all of the following criteria are satisfied:

a) The advertisement states the full name of the certifying board.
b) The board either: 1. Is a member of the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA); 2. Requires successful completion of a postgraduate training program approved by the Accreditation Commission for Graduate Medical Education (ACGME) or the AOA that provides complete training in the specialty or subspecialty certified, followed by prerequisite certification by the ABMS or AOA board for the training field and further successful completion of examination in the specialty or subspecialty certified.
RESOLUTION

SUBJECT: Protection for Visiting Athletes and Team Physicians

SUBMITTED BY: Georgia Orthopaedic Society

REFERRED TO: Reference Committee C

Whereas, athletes, coaches, and support staff for many different sports frequently visit the state of Georgia to participate in athletic competition; and

Whereas, a visiting team physician will often travel with the team to provide sports medicine services; and

Whereas, a visiting team physician is typically not licensed in Georgia to treat athletes, coaches, and support staff; and

Whereas, the visiting team physician who provides medical care without a Georgia license currently does so at great professional risk; and

Whereas, visiting athletes receive high-quality care from a visiting team physician who knows them and is aware of their medical history; and

Whereas, 22 other states have passed legislation that protects visiting team members by enabling visiting team physicians to provide care for the visiting athletes, coaches, and staff; now therefore be it

RESOLVED, that the Medical Association of Georgia supports the passage of legislation that will protect visiting athletes by providing for limited exemption of licensure for visiting team physicians who are licensed in their home state, to care for athletes, coaches, and support staff while participating in sporting events within the state of Georgia.

###
RESOLUTION

SUBJECT: Nurse Protocol Agreement

SUBMITTED BY: Walker-Catoosa-Dade Medical Society

REFERRED TO: Reference Committee C

Whereas, the 12 or more nursing schools in Georgia that grant advanced practice nursing degrees are not using common clinical nurse protocols in their teaching of advanced practice nursing students; now therefore be it

RESOLVED, that the Medical Association of Georgia (MAG) encourages the degree granting advance practice registered nurse (APRN) programs in Georgia to teach by commonly accepted protocols similar to those that may be used in practice under their delegating physician who may delegate certain selected medical acts to the APRN (OCGA 43-34-23 and 25); and be it further

RESOLVED, that MAG reports to the Georgia Composite Medical Board the discrepancy in education and illegal nursing practice by performance of physician delegated medical acts under the laws of Georgia that may be easily corrected by this modification of using selected common clinical nurse protocols for delegation of certain medical acts; and be it further

RESOLVED, that MAG advises the Georgia Board of Nursing that such a state of disparity exists where the mechanism of delegation of medical acts, that is the written clinical nurse protocol from delegating physician to the agreement bound APRN, is not being commonly used, thereby putting the delegating physician at risk of discipline for failure to comply with these provisions of the Medical Practice Act.

# # #

MAG Policy

360.987 APRN Requirements
HD 10/20/2013 MAG supports the current requirement that APRNs work under "supervision" versus a "collaboration and consultation" agreement with physicians. (Officer 01.13, rec. 1)
RESOLUTION

SUBJECT: Review of Delegated Medical Acts

SUBMITTED BY: Walker-Catoosa-Dade Medical Society

REFERRED TO: Reference Committee C

Whereas, the Georgia Composite Medical Board (GCMB) is responsible for setting the standard of medical care in the state of Georgia; and

Whereas, Resolution 309C.14, resolve four adopted a policy of support for APRNs performing medical acts under delegation by the physician be under the oversight of the GCMB; now therefore be it

RESOLVED, that the Medical Association of Georgia (MAG) supports the Georgia Composite Medical Board's (GCMB) monitoring of the delegation of medical acts by periodic assessment of the use of the following:

1. Written protocols with acknowledgment of updates;
2. Annual Nurse Protocol Agreement review and renewal;
3. Pharmacological training by the delegating physician for the APRN; and
4. Chart review/patient examination by the delegating physician sufficient to ensure compliance with the law; and be it further

RESOLVED, that MAG supports a process that may be performed by a simple check-off on a license renewal form like other questions to the physician acknowledging compliance with the law by use of written protocols, education and oversight of APRN performance of physician delegated medical acts; and be it further

RESOLVED, that MAG supports legislative funding sufficient for periodic assessment of compliance with the law governing the delegation of medical acts for the assurance of patient safety and the standard of practice.

# # #

MAG Policy

360.999 Supervision of Nurses Definition
N/A 4/1/1980 Physician supervision of a nurse means that the physician is responsible for the medical acts performed by the nurse, acting in accordance with his prescription or instruction. The supervising physician or his physician designee must be available daily to examine his patient and must regularly and systematically review the medical care. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013)

360.987 APRN Requirements
HD 10/20/2013 MAG supports the current requirement that APRNs work under "supervision" versus a "collaboration and consultation" agreement with physicians. (Officer 01.13, rec. 1)
RESOLUTION

SUBJECT: Health Care Insurer Contracts

SUBMITTED BY: Medical Association of Atlanta

REFERRED TO: Reference Committee C

Whereas, health insurers generally fail to agree on terms that would allow patients to continue longstanding relationships with their current health care providers; and

Whereas, patients often must choose a different provider or face larger fees to see the same provider out of network; and

Whereas, contract negotiations involving health care systems and health care insurers influence the health, well-being, safety and finances of the people and patients involved; now therefore be it

RESOLVED, that the Medical Association of Georgia supports providers having the opportunity to discuss insurance contracts during the time of year that grants patients sufficient notice prior to open enrollment and only end coverage for the patient at the end of a calendar year.

###

AMA Policy

**Amendments to Managed Care Contracts H-285.952**

It is policy of the AMA that: (1) participating physicians be allowed a minimum of 60 days to review amendments to managed care contracts;

(2) patients should have the opportunity for continued transitional care from physicians and hospitals whose contracts with health plans have terminated for reasons other than loss of/restrictions on their license/certification or fraud. Patients eligible for transitional care should specifically include, but not be limited to those who are: undergoing a course of treatment for a serious or complex condition, undergoing a course of institutional or inpatient care, undergoing non-elective surgery, pregnant, or are terminally ill at the time that they receive notice of the termination. Transitional care should be provided at the physicians' and hospitals' discretion, and should continue for an appropriate length of time. Physicians and hospitals also should continue to receive payment for the services provided during this transitional period.

(3) when a participating physician leaves a managed care plan, patients of the physician be informed, in a timely manner, of the departure by the physician and/or the managed care plan, and, if applicable, of their right to elect continued transitional care from that physician;

(4) when a participating physician voluntarily leaves a managed care plan, patients of the physician be informed of the departure by the physician and/or the managed care plan;

(5) the AMA opposes managed care plan mandating that physician to notify all his/her patients;
(6) the AMA opposes the preapproval of physician-developed notification letters by managed care plans required if a participating physician who is voluntarily leaving the plan chooses to inform his/her patient of the departure; and

(7) managed care contracts not hold participating physicians financially liable for medical services delivered to a patient who electively chooses or mistakenly receives medical services from a "non-plan" physician.

MAG Policy

**285.989 Financial Incentives**
HD 4/1/1996 MAG opposes the use of managed care techniques which adversely impact patient care and the physician/patient relationship through the use of financial incentives designed to limit a patient's choice of physician or patient's choice of services and recommends the continuation of fee for service and a doctor/patient relationship. (Reaffirmed 05/02; 10/13/07; 10/20/12)
RESOLUTION

Resolution: 309C.16

SUBJECT: Step Therapy Protocols with First Fail Protocols

SUBMITTED BY: Medical Association of Atlanta

REFERRED TO: Reference Committee C

Whereas, insurance companies employ step protocols and first fail protocols to limit initiation and continuation of specialty medications; and

Whereas, decisions on specialty medications therapy are made by the physician; and

Whereas, physicians are required to make evidence-based medical decisions; and

Whereas, insurance companies are making medication decisions without medically caring for the patient; and

Whereas, insurance companies are making medical decisions without examining patient; and

Whereas, insurance companies are practicing medicine without a license; and

Whereas, physicians are required to make evidence-based medical decisions while insurance companies are unable to make evidence-based medical decisions and should not be allowed to; now therefore be it

RESOLVED, that the Medical Association of Georgia (MAG) works in concert with the Specialty Tiers Coalition of Georgia (STCGA) to develop Step Therapy Legislation in Georgia that accomplishes the following:

(1) Permits a prescriber to override the step therapy when patients are stable on a prescribed medication;

(2) Permits a physician to override the step therapy if the physician expects the treatment to be ineffective based on the known relevant physical characteristics of the patient and the known characteristics of the drug regimen; will cause or will likely cause an adverse reaction by or physical harm to the patient; or is not in the best interest of the patient, based on medical necessity;

(3) Requires health insurance plans to incorporate step therapy approval and override processes in their preauthorization applications;

(4) Prohibits insurers from requiring insured patients from having to fail a prescription medication more than once;

(5) Limits any single step therapy protocol to a maximum of 60 days;

(6) Prohibits a previously insured patient from having to repeat step therapy for a condition they are undergoing treatment for when they are in the process of changing insurers;
(7) Prohibits plans from limiting or excluding coverage for a drug, if it has been previously approved when plans make formulary design changes; and

(8) Supports a single standardized prior authorization form, in paper or electronic format, on all insurance formulary websites to be utilized by patients during the provision of medical services.

###

**AMA Policy**

**Prior Authorization Simplification and Standardization D-120.938**
Our AMA will address the negative impact of medication step therapy programs on patient access to needed treatment by supporting state legislation that places limitations and restrictions around the use of such programs and their interference with a physician's best clinical judgement.

**MAG Policy**

**120.984 Step Therapy**
HD 10/13/2007 MAG opposes any contractual requirement that requires the use of step therapy from any public or private third party payer. (Appendix III - Committee 01.07) (Reaffirmed 10/20/2012)

**120.988 Physician Prescribing data**
HD 5/4/2002 MAG opposes access to individual physician's prescribing data by pharmaceutical manufacturers and their representatives. (Res. 305C-02) (Reaffirmed 10/13/07; 10/20/2012)

HD 5/19/2001 MAG denounces, in principle, Medication Step Care Therapy programs when implemented as an inflexible or administratively burdensome method to contain pharmacy costs as a part of a Pharmacy Benefit Management Program or any pharmacy cost savings approach. (Reaffirmed 9/30/2006; 10/16/2011)
RESOLUTION

SUBJECT: Protect Physician Practices from MOC

SUBMITTED BY: Muscogee County Medical Society

REFERRED TO: Reference Committee C

Whereas, the Maintenance of Certification (MOC) system in place from the ABMS/AOA and their constituent specialty organizations has not improved the care of patients or the health of the nation as proposed; and

Whereas, it has proven to be unacceptably time consuming and cost ineffective for physicians and their practices; and

Whereas, Oklahoma recently passed legislation prohibiting use of the MOC process/designation in state licensing, hospital, insurance, or other professional credentialing; and

Whereas, several other states have enacted similar legislation; and

Whereas, two years ago the MAG HOD passed a resolution placing MAG on record as opposing any attempt in Georgia to mandate MOC participation by physicians; and

Whereas, entities in Georgia have already begun to require MOC participation for credentialing; now therefore be it

RESOLVED, that the Medical Association of Georgia supports the adoption of legislation comparable to that enacted in Oklahoma or more comprehensive, if possible, to protect Georgia physicians and their practices.

# # #

AMA Policy

An Update on Maintenance of Licensure D-275.957

Our American Medical Association will:
1. Continue to monitor the evolution of Maintenance of Licensure (MOL), continue its active engagement in discussions regarding MOL implementation, and report back to the House of Delegates on this issue.
2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review MOL issues.
3. Work with the Federation of State Medical Boards (FSMB) to study whether the principles of MOL are important factors in a physician's decision to retire or have a direct impact on the U.S. physician workforce.
4. Work with interested state medical societies and support collaboration with state specialty medical societies and state medical boards on establishing criteria and regulations for the implementation of MOL that reflect AMA guidelines for implementation of state MOL programs and the FSMB's Guiding...
Principles for MOL.
5. Explore the feasibility of developing, in collaboration with other stakeholders, AMA products and services that may help shape and support MOL for physicians.
6. Encourage the FSMB to continue to work with state medical boards to accept physician participation in the American Board of Medical Specialties maintenance of certification (MOC) and the American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) osteopathic continuous certification (OCC) as meeting the requirements for MOL and to develop alternatives for physicians who are not certified/recertified, and advocate that MOC or OCC not be the only pathway to MOL for physicians.
7. Continue to work with the FSMB to establish and assess MOL principles, with the AMA to assess the impact of MOL on the practicing physician and the FSMB to study its impact on state medical boards.
8. Encourage rigorous evaluation of the impact on physicians of any future proposed changes to MOL processes, including cost, staffing, and time.

An Update on Maintenance of Licensure H-275.917
AMA Principles on Maintenance of Licensure (MOL):
1. Our American Medical Association (AMA) established the following guidelines for implementation of state MOL programs:
   A. Any MOL activity should be able to be integrated into the existing infrastructure of the health care environment.
   B. Any MOL educational activity under consideration should be developed in collaboration with physicians, should be evidence-based and should be practice-specific. Accountability for physicians should be led by physicians.
   C. Any proposed MOL activity should undergo an in-depth analysis of the direct and indirect costs, including physicians' time and the impact on patient access to care, as well as a risk/benefit analysis, with particular attention to unintended consequences.
   D. Any MOL activity should be flexible and offer a variety of compliance options for all physicians, practicing or non-practicing, which may vary depending on their roles (e.g., clinical care, research, administration, education).
   E. Any MOL activity should be designed for quality improvement and lifelong learning.
   F. Participation in quality improvement activities, such as chart review, should be an option as an MOL activity.

2. Our AMA supports the Federation of State Medical Boards Guiding Principles for MOL (current as of June 2015), which state that:
   A. Maintenance of licensure should support physicians' commitment to lifelong learning and facilitate improvement in physician practice.
   B. Maintenance of licensure systems should be administratively feasible and should be developed in collaboration with other stakeholders. The authority for establishing MOL requirements should remain within the purview of state medical boards.
   C. Maintenance of licensure should not compromise patient care or create barriers to physician practice.
   D. The infrastructure to support physician compliance with MOL requirements must be flexible and offer a choice of options for meeting requirements.
   E. Maintenance of licensure processes should balance transparency with privacy protections (e.g., should capture what most physicians are already doing, not be onerous, etc.).

3. Our AMA will:
   A. Continue to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major CME credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format, and continue to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty
boards, hospital credentialing bodies, and other entities requiring evidence of physician CME as part of the process for MOL.
B. Advocate that if state medical boards move forward with a more intense or rigorous MOL program, each state medical board be required to accept evidence of successful ongoing participation in the ABMS MOC and AOA-Bureau of Osteopathic Specialists Osteopathic Continuous Certification to have fulfilled all three components of the MOL, if performed,
C. Advocate that state medical boards accept programs created by specialty societies as evidence that the physician is participating in continuous lifelong learning and allow physicians to choose which programs they participate in to fulfill their MOL criteria.
D. Oppose any MOL initiative that creates barriers to practice, is administratively unfeasible, is inflexible with regard to how physicians practice (clinically or not), does not protect physician privacy, or is used to promote policy initiatives about physician competence

MAG Policy

230.992 Maintenance of Certification
HD 10/19/2014 MAG opposes any efforts to require Maintenance of Certification (MOC) as a condition of medical licensure, or as a pre-requisite for hospital/staff privileges, employment in State of Georgia medical facilities, reimbursement from third parties, or issuance of malpractice insurance. (Res. 1, Res. 113A.14)

Resolution 101A.15 -- National Board of Physicians and Surgeons (NBPAS) Board Recertification
Adopted as amended resolves 1 and 2 of Resolution 101A.15 that 1) the Medical Association of Georgia creates policy that accepts the National Board of Physicians and Surgeons (NBPAS) as an alternative to ABMS for recertification for physicians in Georgia and that 2) the MAG delegation to the American Medical Association (AMA) submit a resolution supporting the AMA recognizing NBPAS as an alternative to ABMS for recertification for physicians nationally.
RESOLUTION

Resolution: 311C.16

SUBJECT: Physician Control of Admissions to Hospital

SUBMITTED BY: Medical Association of Atlanta

REFERRED TO: Reference Committee C

Whereas, evidence-based clinical practice guidelines – such as those listed by the Department of Health and Human Services’ Agency for Healthcare Research and Quality, the Chest guidelines for anticoagulation, and Choosing Wisely – often are broadly worded and do not distinguish between diseases and conditions considered and not considered when issued; and

Whereas, these treatment guidelines are held as standards of care by some and embraced by insurance companies when making reimbursement policy and decisions; and

Whereas, due to the unknown financial liability that they will incur, patients more likely than not will refuse admission to hospital if their insurance carrier denies pre-authorization for payment of a hospital admission; and

Whereas, in January 2016, the revised Chest guidelines for the management of deep venous thrombosis and pulmonary embolization was released; and

Whereas, for hemodynamically stable pulmonary emboli and non-limb threatening deep venous thrombosis, outpatient management is advocated without hospitalization; and

Whereas, no exception for post-surgical patients is made in the guidelines; and

Whereas, this is an unfortunate oversight and insurance companies will be adopting these guidelines for reimbursement purposes since it will save them up to $10 billion each year in hospital costs; and

Whereas, treatment guidelines, in general, frequently do not distinguish post-operative patients from medical patients despite post-operative patients often requiring in-patient hospital observation while initially being treated for a complication of surgery: such as, the most recent Chest Guideline failing to consider the need for hospitalization while being fully anti-coagulated for a post-operative thrombotic event; now therefore be it

RESOLVED, that the Medical Association of Georgia (MAG) updates its policy compendium to state that the surgeon, and not the insurance company, shall determine the need for hospitalization for a post-surgical complication, for the first three weeks after surgery for non-neurosurgical patients and for the first six weeks for neurosurgical patients; and be it further

RESOLVED, that MAG supports legislation requiring insurance companies to defer to the surgeon regarding the need for hospitalization for post-operative complications for the first three weeks after surgery for non-neurosurgical patients and for the first six weeks for neurosurgical patients.

# # #
AMA Policy

AMA policy states: (1) That certain professional decisions critical to high quality patient care should always be the ultimate responsibility of the physician regardless of the practice setting, whether it be a health care plan, group practice, integrated or non-integrated delivery system or hospital closed department, whether in primary care or another specialty, either unilaterally or with consultation from the plan, group, delivery system or hospital. Such decisions include, but are not limited to, the following: (a) What diagnostic tests are appropriate. (b) When and to whom physician referral is indicated. (c) When and with whom consultation is indicated. (d) When non-emergency hospitalization is indicated. (e) When hospitalization from the emergency department is indicated. (f) Choice of service sites for specific services (office, outpatient department, home care, etc.). (g) Hospital length of stay. (h) Frequency/length of office/outpatient visits or care. (i) Use of out-of-formulary medications. (j) When and what surgery is indicated. (k) When termination of extraordinary/heroic care is indicated. (l) Recommendations to patients for other treatment options, including non-covered care. (m) Scheduling on-call coverage. (n) Terminating a patient-physician relationship. (o) Whether to work with, and what responsibilities should be delegated to, a mid-level practitioner. (p) Determination of the most appropriate treatment methodology. (2) The AMA encourages state medical associations to consider development and wide dissemination of guidelines for the extent of practicing physician involvement in plan, group, system or hospital department medical decisions and policies. Such guidelines should be relevant to their jurisdiction, allow for variation in plan, group, system or hospital department sponsorship and structure, and optimize patient care. (3) The AMA encourages organizations and entities that accredit or develop and apply performance measures for health plans, groups, systems or hospital departments to consider inclusion of plan, group, system or hospital department compliance with any applicable state medical association or medical staff-developed decision-making guidelines in their evaluation criteria. (4) The AMA encourages physicians in integrated health plans and systems to have a functioning medical staff structure in place.
RESOLUTION

Resolution: 312C.16

SUBJECT: Improving Access to Health Care in Georgia

SUBMITTED BY: Georgia Academy of Family Physicians
Georgia Chapter, American College of Physicians

REFERRED TO: Reference Committee C

Whereas, the Patient Protection and Affordable Care Act (ACA) expanded Medicaid eligibility to all working individuals with incomes up to 138 percent of the federal poverty level (FPL), which was $16,242 for a single adult and $33,465 for a family of four in 2015; and

Whereas, the ACA directs the U.S. federal government to pay for 90 percent of the cost of newly eligible Medicaid beneficiaries in Georgia with federal dollars indefinitely; and

Whereas, Georgia ranks 49th in state tax collections per capita ($1,680), 50th in total Medicaid spending per patient; and 45th for access and affordability and prevention and treatment; and

Whereas, current Georgia Medicaid eligibility levels for aged, blind, or disabled adults is 76 percent of FPL, 38 percent of FPL for parents of minors, and 0 percent for childless adults, making Georgia have one of the highest coverage gaps in the country (around 300,000 working citizens); and

Whereas, Georgia State University, using a standard economic impact IMPLAN model in 2013, estimated the 10-year effect of Medicaid expansion in Georgia (2014-23) that included $40.5 billion in new federal dollars the state would receive, generating 70,000 jobs statewide, creating an $8.2 billion positive impact on the state economy, and yielding $276 million annually in increased state and local tax revenue; and

Whereas, many physicians in Georgia do not accept patients covered by Medicaid due to the Medicaid fee schedule not covering the cost of providing care; and

Whereas, there is an inadequate supply of physicians in rural Georgia; and

Whereas, the Georgia Chamber of Commerce brought together all stakeholders to form the Georgia Health Care Access Taskforce to create a unique Georgia solution in the form of a 1115 Medicaid waiver to bring down the billions of federal dollars to expand health care to the uninsured population in Georgia currently falling in the insurance coverage gap with incomes below 138 percent of FPL; now therefore be it

RESOLVED, that the Medical Association of Georgia supports a Medicaid waiver to close the coverage gap in Georgia in a fiscally responsible and sustainable way that meets the needs of patients and providers which includes, but is not limited to the following:

(1) That patients receive proven, cost-effective care that is not impeded by unnecessary barriers to enrollment or unaffordable cost-sharing; and

(2) That such a waiver eliminates regulatory barriers to providing proven, cost-effective care; and seek parity for all physician services with the Medicare fee schedule.
MAG Policy

290.968 Medicaid Expansion -- Waiver
HD 10/20/2013 MAG supports Georgia seeking a waiver from the U.S. Department of Health & Human Services (HHS) Secretary to allow Georgia to use the Medicaid expansion funds to buy private insurance in the state health insurance exchange for eligible Georgia citizens at or below 138 percent of the federal poverty level. (Res. 305c.13)

290.969 Primary Care Pay Parity
HD 10/19/2014 MAG supports legislation that extends the Medicaid Primary Care Pay Parity Program; and supports including in the program obstetrician/gynecologists. (Res. 306C)

290.971 Medicaid Expansion
HD 10/21/2012 MAG support innovations and modifications of the Georgia Medicaid program balancing the needs of Georgia’s uninsured patients with the need to achieve a sustainable solution to the budget shortfalls and expected future financial challenges. (Res. 601HC.12, 605HC.12 and 611HC.12)
REFERENCE COMMITTEE
F
The Finance Committee continues to be active in overseeing MAG’s budget and financial resources. The committee met twice since the last meeting of the House of Delegates. The committee reviews MAG’s financials and investments at each meeting.

In 2011, the Finance Committee diligently went through a selection process and appointed Mauldin & Jenkins, CPA, as MAG’s new auditors. FY 2015 was the fifth year that Mauldin and Jenkins, CPA, performed the audit and the Finance Committee is very pleased with their services. The Finance Committee reviewed and approved the audit of the FY 2015 financial statements, which were found to be accurate in all material respects.

In 2009, following the significant downturn of the economy, as well as declining membership, the Finance Committee recommended to the Board of Directors that it approve the five-year strategic goal to build $1 million in reserves. In 2012, we surpassed this goal and 2014 was the fifth year of this plan. The Finance Committee is pleased to report that 2015 continues with this strategic goal to build MAG’s reserves and strengthen our Association. Our next goal was to strengthen MAG’s balance sheet by eliminating our long-term debt. In February 2014, MAG paid off the mortgage on the building at 1849 The Exchange, Atlanta, GA 30339. The building was purchased in 2006, and at that time, we had a 20-year mortgage at 6.15 percent. The payoff included a $310,000 prepayment penalty, but even with taking this into account, the early payoff of the building saved MAG more than $400,000 in interest and cash flow over the remaining life of the loan, which was 12 years. We are now working on our next goal to build a reserve of 12 months operating expenses. Management is to be commended for its successful growth in membership and continued discipline with management of expenses.

In 2015, the Board of Directors approved the Operating Budget for FY 2016, where revenues exceed expenses by $200,000, and we are pleased to report that MAG is again on target to exceed the budgeted surplus of $200,000.

This report provides delegates with a summary of MAG’s audited financial performance for FY 2015 and our projections on how MAG will end FY 2016.

MAG’s Financial Performance in FY 2015

This section on MAG’s financial performance in 2015 is divided into two parts. The first part compares our performance in 2015 with 2014 using Combined MAG Figures. We refer to these figures as “combined” because, in addition to the operating revenues and expenditures, which are approved by the Board of Directors, they include the revenues and expenditures of our related entities such as the MAG Foundation, the Physicians’ Institute for Excellence in Medicine, GAMPAC and the MAG Alliance, as well as those that are “restricted” to specific purposes other than general operations.
Examples of “restricted” activities include the Tort Reform Fund, the PR Media Fund, the Partnership with Medicine Fund and the Medical Reserve Corps (MRC) Fund. In contrast, the budget approved by the Board of Directors is an operating budget that does not include revenues and expenditures for these “restricted” activities.

Because we do not formally budget for these restricted activities, the Combined MAG Figures (both revenues and expenditures) are greater than those found in the 2015 Operating Budget. The financial audit performed each year examines all of MAG’s financial activity, and therefore, includes both restricted and unrestricted revenues and expenditures. These figures are included in the Audit Report presented to the Board of Directors each year and are the ones used in this part of the report.

The second part of this section is designed to provide delegates with a more focused, strategic picture of our operating performance by using the operating budget figures only. The operating budget figures, which do not include revenue or expenditures for “restricted” activities or the revenues and expenses of related entities, allow us to compare our operating performance in 2015 with the operating performance of 2014 as well as compare our actual performance in 2015 with the 2015 budget targets approved by the Board of Directors. This part, therefore, provides delegates with a true comparison of how well we managed to the budget adopted by the Board of Directors.


Financial Highlights

<table>
<thead>
<tr>
<th>(Dollars in thousands)</th>
<th>2015</th>
<th>2014</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenues – Dues</td>
<td>$2,174</td>
<td>$2,170</td>
<td>0.2%</td>
</tr>
<tr>
<td>Revenues – Non dues</td>
<td>2,751</td>
<td>3,208</td>
<td>-14.2%</td>
</tr>
<tr>
<td>Total Revenues</td>
<td>4,925</td>
<td>5,378</td>
<td>-8.4%</td>
</tr>
<tr>
<td>Personnel expenses</td>
<td>2,546</td>
<td>2,471</td>
<td>3.0%</td>
</tr>
<tr>
<td>Other general and administrative expenses</td>
<td>2,111</td>
<td>2,734</td>
<td>-22.8%</td>
</tr>
<tr>
<td>Total Operating expenses</td>
<td>4,657</td>
<td>5,205</td>
<td>-10.5%</td>
</tr>
<tr>
<td>Operating results</td>
<td>268</td>
<td>173</td>
<td>54.9%</td>
</tr>
<tr>
<td>Non-operating and non-recurring items</td>
<td>116</td>
<td>(261)</td>
<td>-144.4%</td>
</tr>
</tbody>
</table>

Change in Equity

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in unrestricted equity</td>
<td>256</td>
<td>(90)</td>
<td>-384.4%</td>
</tr>
<tr>
<td>Change in restricted equity</td>
<td>128</td>
<td>2</td>
<td>6300.0%</td>
</tr>
<tr>
<td>Change in association equity</td>
<td>$384</td>
<td>$(88)</td>
<td>-536.4%</td>
</tr>
</tbody>
</table>

Association equity at year end   $4,264 $3,881 9.9%

Employees at year end            23   22   4.5%
Financial Analysis

Revenue: MAG and its related entities generated Total Revenues of $4,925,010 in 2015 or $453,122 (8.4%) less than 2014. This was primarily due to:

1) A decrease in Grants of $475,909 (53.1%), primarily Physicians’ Institute for Excellence in Medicine (PIEM) of $346,240 (49.8%) and MAG of $109,330 (69.4%).
2) A decrease in Other Revenues of $230,399 (53.8%), primarily Physicians’ Institute for Excellence in Medicine (PIEM) of $237,004 (60.9%).
3) An increase in Contributions of $260,306 (139.8%), primarily MAG Foundation, of $251,806 (164.9%).

Membership Dues Revenue for 2015 was $2,173,885 or $3,576 (0.2%) more than 2014. We produced Non-Dues Revenue of $2,751,125, which is $456,698 (14.2%) less than in 2014.

Expenses: MAG and its related entities spent $4,657,159 in 2015 or $547,372 (10.5%) less than in 2014 ($5,204,531). This was primarily due to:

1) An increase in Personnel costs of $75,076 (3.0%). In 2015, MAG increased its personnel count by one FTE and payment for staff bonus was also a factor.
2) A decrease in Building expenses of $316,592 (63.6%). In February 2014 MAG paid off the mortgage on the building at 1849 The Exchange, Atlanta, GA 30339. The building was purchased in 2006 and at that time we had a 20-year mortgage at 6.15 percent. The payoff included a $310,000 prepayment penalty, but even with taking this into account, the early payoff of the building saved MAG more than $400,000 in interest and cash flow over the remaining life of the building.
loan, which was 12 years.

3) A decrease in Other Administration costs of $254,215 (46.0%). The Physicians’ Institute for Excellence in Medicine (PIEM) expended $34,336 or $266,564 (88.6%) less than 2014 for Other Administration costs in performing their duties required under their grant agreements.

4) A decrease in Education of $43,427 (7.9%). The Physicians’ Institute for Excellence in Medicine (PIEM) expended $387,076 or $90,757 (19.0%) less than 2014 for education purposes in performing their duties required under their grant agreements.

Non-Operating and Non-Recurring Items:

- **Net Unrealized Gain on Life Insurance Policies and Annuity Contracts.** The MAG Foundation recognized $54,159 in net revenue from increases in the surrender values of Universal Life Insurance policies due to interest earned, reductions in surrender charges, changes in market value adjustments and annuity payment received.

- **Net Unrealized Gain on Life Insurance Policies and Annuity Contract Surrenders.** The MAG Foundation recognized $540,475 in net gains on the surrenders of commercial annuity investments.

- **Change in Value of Accrued Annuity Liabilities.** The MAG Foundation recognized an increase in Accrued Annuity Liabilities, which resulted in an expense of $375,715 in 2015.

- **Net Realized and Unrealized Loss on Investments.** The MAG Foundation recognized a $103,273 net loss on Investments.

### Assets:

<table>
<thead>
<tr>
<th>(Dollars in thousands)</th>
<th>2015</th>
<th>2014</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total cash and investments</td>
<td>$ 8,566</td>
<td>$ 5,529</td>
<td>54.9%</td>
</tr>
<tr>
<td>Operating assets</td>
<td>286</td>
<td>354</td>
<td>-19.2%</td>
</tr>
<tr>
<td>Property and equipment</td>
<td>2,942</td>
<td>3,024</td>
<td>-2.7%</td>
</tr>
<tr>
<td>Cash surrender value of annuity and life insurance policies</td>
<td>460</td>
<td>2,747</td>
<td>-83.3%</td>
</tr>
<tr>
<td>Grants and Pledges receivable</td>
<td>15</td>
<td>21</td>
<td>-28.6%</td>
</tr>
<tr>
<td>Student loans receivable</td>
<td>19</td>
<td>23</td>
<td>-17.4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>12,288</td>
<td>11,698</td>
<td>5.0%</td>
</tr>
</tbody>
</table>

MAG and its related entities’ Total Assets increased $589,879 (5.0%) in 2015. This was due to:

1) An increase of $3,037,136 (54.9%) in Cash and Investments. This increase was primarily due to the MAG Foundation increase in Investments of $2,808,424 from the surrender of commercial annuity contracts.

2) A decrease of $67,923 (19.2%) in Operating Assets. Changes in operating assets from year to year are largely due to timing of cash receipts and payments.

3) A decrease in Fixed Assets of $81,671 (2.7%), primarily due to aging of Fixed Assets.

4) A decrease of $2,286,788 (83.3%) in the MAG Foundations’ Cash Surrender Value of Annuity and Life Insurance Policies.

5) A decrease of $6,752 (31.6%) in PIEM Grants and MAG Foundation Pledges Receivable.

6) A decrease of $4,123 (18.2%) in Student Loans Receivable.
Liabilities and equity:

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating liabilities</td>
<td>483</td>
<td>464</td>
<td>4.1%</td>
</tr>
<tr>
<td>Deferred revenue</td>
<td>1,499</td>
<td>1,422</td>
<td>5.4%</td>
</tr>
<tr>
<td>Accrued annuity liabilities</td>
<td>6,041</td>
<td>5,931</td>
<td>1.9%</td>
</tr>
<tr>
<td>Association Net Assets</td>
<td>4,265</td>
<td>3,881</td>
<td>9.9%</td>
</tr>
<tr>
<td>Total</td>
<td>12,288</td>
<td>11,698</td>
<td>5.0%</td>
</tr>
</tbody>
</table>

MAG and its related entities’ Liabilities increased $206,382 (2.6%) in 2015. This was due to:

1) Operating liabilities increased $19,480 (4.2%) in 2015. Changes in operating liabilities from year to year are largely due to timing of cash receipts and payments.

2) Deferred Revenue increased $77,517 (5.5%) in 2015. Changes in deferred revenue from year to year are largely due to timing of cash receipts and payments.

3) The MAG Foundation Section 170 Plan Accrued Annuity Liabilities increased $109,385 (1.8%).

Part II: FY 2015 Management of the Operating Budget

Managing to the Operating Budget: 2015 is the fifth year since 2010 in which we have surpassed our budget of $200,000 in surplus. In 2012 we surpassed our goal of $1 million in surplus and combining our surplus for 2010 ($239,436), 2011 (484,084), 2012 ($528,857), 2013 ($429,726), 2014 ($167,298) and 2015 ($275,163), we reached a cumulative surplus of $2,124,564. With these successes, we have achieved our first goal, to match current year income with current year revenues (2012), and our second goal to eliminate Long-Term Debt (2014). We are working toward our third goal to build a reserve of 12 months operating expenses. We are continuing to build the financial strength of the association.

Operating Revenues: Total Operating Revenues in 2015 were $3,853,426. This represents a decrease of $28,459 (0.7%) over 2014 and $243,118 (6.7%) above the budget target of $3,610,308. The excess primarily resulted from increased revenues from Membership Dues Revenue of $198,536 (10.7%), increased revenues from Other Revenues of $23,447 (93.8%) and increased revenues in Correctional Medicine of $20,081 (12.4%).

Dues revenue in 2015 was $2,048,536, up $39,737 (2.0%) from $2,008,799 in 2014, and above budgeted dues revenues by $198,536 (10.7%).

Non-dues revenue was $1,804,890, down $68,196 (3.6%) from $1,873,086 in 2013 and $44,582 (2.5%) above the budget the budget target of $1,760,308. This was primarily the result of:

1) Overhead Allocation from GAMPAC and MAG Foundation down $67,450 (34.9%).

2) Other Revenues up $42,000

3) Special Meetings up $23,447 (93.8%)

4) Correctional Medicine Revenue up $20,081 (12.4%).

Operating Expenses: Total Operating Expenses in 2015 were $3,578,263, representing a decrease of $136,324 (3.7%) from 2014. Total Operating Expenses were $167,955 (4.9%) more than the budget. Personnel Expenses, which account for approximately 63.4% of all expenses, were $2,270,013 up $94,218 (4.3%) from $2,175,795 in 2014 and higher than the budget by $154,577 (7.3%). Non Personnel Expenses were $1,308,250, down $230,542 (15.0%) in 2014 ($1,538,792) and up $13,378 (1.0%) from the budget ($1,294,872).
Net Operating Income: Net Operating Income is the net of Total Operating Revenues minus Total Operating Expenses resulting in a Net Operating Surplus or Net Operating Deficit. We ended FY 2015 with a Net Operating Surplus of $275,163, which is $107,865 (64.5%) higher than 2014 and is $75,163 (37.6%) higher than the surplus of $200,000 approved by the Board of Directors.

Projected Results for FY 2016

(Based on month-end July 2016)

Our fiscal year-end projections are derived by extrapolating operating performance figures from July 2016 to the end of the year. These extrapolated figures suggest that we will come in above target, well ahead of the $200,000 operating budget surplus as adopted by the Board of Directors in 2015. It is the intent of the Board of Directors to use this surplus to continue to build reserves.

Total Revenues are projected to be $3,748,417, a decrease of $105,009 (2.7%) from 2015 and $149,945 (4.2%) higher than budget. As we near the end of our dues collection cycle, we estimate that Dues Revenues will be $2,000,000, a $48,536 (2.4%) decrease from 2015 and a $125,000 (6.7%) increase against the budget target of $1,875,000. Non-dues revenue is estimated to be $1,748,417, down $56,473 (3.1%) from 2015 and up $24,945 (1.4%) against the budget.

Total expenses are projected to be $3,380,531, a decrease of $197,732 (5.5%) from 2015 and $17,941 (0.5%) below budget. Personnel costs, which are projected to be $2,075,900, is a decrease of $194,113 (8.6%) from 2015 and $51,130 (2.4%) lower than budget. Non-personnel costs are projected to be $1,304,631, which is a $3,619 (0.3%) decrease over 2015 and $33,189 (2.6%) higher than budget.

A surplus of $367,886 is projected, which is $92,723 (33.7%) higher than 2015 and $167,886 (83.9%) higher than budget. Achieving this surplus will allow us to continue to build our reserves.
MAG’s Investment Policy

A copy of MAG’s Investment Policy is attached hereto for information. (Attachment 1).

Thank You

As Treasurer, I am grateful for the opportunity to have worked with the dedicated members of the Finance Committee this year.

William P. Brooks, M.D., Macon
Kelly A. Erola, M.D., Savannah
Rutledge Forney, M.D., Atlanta
Lisa Perry-Gilkes, M.D., Atlanta
William E. Silver, M.D., Atlanta
James L. Smith, M.D., Lawrenceville
Arthur Torsiglieri, M.D., Conyers
Michelle R. Zeanah, M.D., Statesboro

MAG Staff:

Sally-Anne Jacobs

###
MEDICAL ASSOCIATION OF GEORGIA

INVESTMENT POLICY

INTRODUCTION

The finances of the Medical Association of Georgia (MAG) are separated into two categories: “Operating Funds” and “Long Term Investments.” This document represents the Investment Policy for operating funds that are invested and for long-term investments.

Operating Funds: Operating Funds are generated from two sources: Dues Revenue and Non-Dues Revenue. These funds are used to finance the day-to-day operations of the association and are maintained in a “Commercial Paper Account” similar to a money market account so that they are available on a day-to-day basis. A majority, but not all, of the funds in the Commercial Paper Account are “swept” into an investment account at the end of the business day and returned to the Commercial Paper Account before the beginning of the next business day. This allows MAG to earn additional interest on these funds. Funds that are generated early in the membership year that are not needed for the day-to-day operation of the association are often invested in other instruments for use later in the year to meet cash flow needs. When cash on hand exceeds anticipated cash flow needs, the Finance Committee shall assess whether such excess funds should be invested in longer term securities to enhance return on investment.

Long Term Investments: Long Term Investments are those funds that are typically invested for the long-term growth of the association. Funds that comprise MAG’s Long Term Investments were generated by the sale of our PPO known as Georgia Health Network. These funds are maintained in a separate account referred to as managed care funds.

Purpose

The purpose of this Investment Policy is to set forth the investment objectives and investment guidelines for the association’s Invested Operating Funds and Long-Term Investments.

Investment objectives have been formulated with attention to:

- Assuring that the association has sufficient cash flow to allow its uninterrupted operation;
- Maximizing return on investment relative to the risk tolerance of the Medical Association of Georgia;
• The need to achieve prudent diversification of assets; and
• The strategic financial goals of the association.

Duties of the Board of Directors

The Board of Directors has the fiduciary obligation to ensure that the assets of the association are invested in a prudent manner. The Board of Directors will receive a report from the Treasurer at each of its meetings and approve (or disapprove) the financial statements of the association. The Board of Directors approves the budget and submits a report on the budget and management of the association’s finances to the House of Delegates.

Duties of the Treasurer and Finance Committee

The Treasurer is elected by the HOD and serves a term of two years. The Treasurer chairs the Committee on Finance, which is comprised of at least seven (7) members of the Board of Directors appointed by the Chairman of the Board.

The Committee on Finance shall cause to be audited at least annually all accounts of the association. The Committee shall propose an annual budget for the fiscal year beginning on January 1 and submit that budget to the Board of Directors at its last meeting in the last quarter of the fiscal year for Board approval.

Objectives

(a) All investments shall fall within the legal requirements and regulations governing the association’s legal status as a 501 (c) 6 corporation.

(b) Investments of current budget year’s revenue should be structured to conserve principal and earn the highest return available on short-term liquid investments.

(c) Monies in excess of amounts needed for short-term obligations should be invested to earn the highest return available on long-term investments within the risk tolerance as set in allowable ranges for asset categories.

Types of Investment and Quality Ratings

The following is a list of investment type and quality ratings:

Cash Equivalents

• Treasury Bills (T-Bills): That are guaranteed by full faith and credit of the U.S. government.

• Banker’s Acceptances (BAs): May be purchased from banks or trust companies, subject to approved FDIC guaranteed insurance limitations, organized under the
laws of Canada or the United States of America or any province or state thereof, which have combined capital and surplus of at least $1,000,000,000 in U.S. dollars.

- **Repurchase Agreement (Repos):** May be purchased from banks for trust companies, organized under the laws of Canada or the United States of or any province or state thereof, which have combined capital and surplus of at least $1,000,000,000 in U.S. dollars.

- **Commercial Paper** rated “prime” or its equivalent by either the National Credit Office, Inc. or Standard & Poor’s Corporations, or their successors, and unrated commercial paper of similar quality in which the bank is also investing funds held by it in a trust or trusts subject to the jurisdiction of the Probate Courts of the State of Georgia (including any investment in pools or mutual funds of such commercial paper owned by the bank).

- **Cash** because of their liquidity and short-term to maturity for purposes of this investment policy, treasury bills, repos, commercial paper, and many money market funds are considered cash equivalents.

**Fixed Income**

- **Certificate of Deposit (CD’s):** May be purchased from banks or trust companies, subject to approved FDIC guaranteed insurance limitations, organized under the laws of Canada or the United States of America or any province or state thereof, which have combined capital and surplus of at least $1,000,000,000 in U.S. dollars.

- **Government Bonds** or other obligations of the United States government the principal and interest of which constitute direct obligations of the United States of America.

- **Federal agency bonds,** which include obligations of the Federal National Mortgage Association, Federal Intermediate Credit Banks, Federal Farm Credit Banks and Federal Home Loan Banks, Federal Home Loan Mortgage Corporation.

- **Corporate Bonds** with a quality rating of no less than A. If downgraded after purchase, then the investment manager and treasurer will monitor until it returns to A.

**Equities**

- **Stocks** or equivalent investments in mutual funds upon the advice of MAG’s investment advisor.
INVESTMENT OF OPERATING FUNDS

Purpose of Operating Funds

Operating funds are used for the day-to-day operations of the association. The primary source of operating funds is Dues Revenue. Because dues are collected in the fall of the year for the next membership year, MAG often has more funds on hand than required for operations early in the year. Surplus membership dues and Non-Dues Revenue should be invested for the primary purpose of assuring that sufficient funds are available later in the year to meet cash flow needs. Operating Funds in excess of those needed for cash flow purposes may be invested for longer terms.

Time Horizon for Investment of Operating Funds

Typically, operating funds are needed for cash flow purposes and are invested for one year or less.

Risk Aversion

Since Operating Funds are used to finance the day-to-day operations of the association and preserve cash flow, the association has a low tolerance for risk of loss in value of invested Operating Funds.

Asset Allocation

The portfolio for the invested Operating Funds should be conservative reflecting the primary need for asset preservation and a low tolerance for risk.

Asset allocation guidelines for investment of operating funds will be as follows:

<table>
<thead>
<tr>
<th>ASSET CATEGORY</th>
<th>ALLOWABLE RANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equities</td>
<td>0% - 30%</td>
</tr>
<tr>
<td>Fixed Income</td>
<td>0% - 50%</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>50% - 100%</td>
</tr>
</tbody>
</table>
INVESTMENT OF LONG-TERM FUNDS

Purpose of Long-Term Investments

Long-Term Investments are not usually needed to fund the day-to-day operations of the association. Rather, these funds are available to pursue strategic goals of the association such as the purchase of a building or financing a new project. They may also be needed to pay an unexpected debt.

Time Horizon for Investment of Operating Funds

Long-term funds are invested for three (3) to five (5) years or longer.

Risk Aversion

We are willing to bear some short-term decline in value of Long Term Investments in an effort to achieve higher long-term returns.

Asset Allocation

The portfolio for the Long-Term Investments should be consistent with the goal of accumulation of capital and the preservation of its value for the economic betterment of MAG.

Asset allocation guidelines for investment of long-term funds will be as follows:

<table>
<thead>
<tr>
<th>ASSET CATEGORY</th>
<th>ALLOWABLE RANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equity</td>
<td>0% - 25%</td>
</tr>
<tr>
<td>Fixed</td>
<td>0% - 50%</td>
</tr>
<tr>
<td>Cash</td>
<td>10% - 100%</td>
</tr>
</tbody>
</table>

INVESTMENT GUIDELINES

Investment Authority

The Treasurer shall have authority to make/approve investment decisions based upon the Investment Policy developed by the Finance Committee and approved by Board of Directors. This authority may be delegated to the Executive Director.

Investment Manager

MAG expects any investment manager to review the specific investments at a frequency that will ensure the highest available return on its investments reflecting changes in the
economy, interest rates and other market factors and recommend changes to the Investment Portfolio if such change is indicated by these factors.

The investment manager shall meet quarterly with the Treasurer and/or Executive Director to discuss strategies and review quarterly performance and assess the overall risk of the portfolio relative to the market as a whole. The investment manager must receive approval from the Treasurer prior to making or changing investments.

The Treasurer shall be responsible for the following activities, but may delegate such authority to the Executive Director:

- Making or changing investments recommended by the investment manager;
- Opening accounts with brokers and dealers;
- Setting up safekeeping for securities;
- Signing specific documents.

The Executive Director shall report to the Treasurer any actions taken on delegated activities within 3 business days of taking such action.

**Policy Amendments**

Any change to this policy shall be given to the fund/investment managers in writing and such amendments shall be signed by at least two MAG officers. The Finance Committee shall review the investment policy annually.
AMA DELEGATION

SUBJECT: Annual Report

SUBMITTED BY: S. William Clark III, M.D., Chairman of the AMA Delegation

REFERRED TO: Reference Committee F

The American Medical Association (AMA) House of Delegates (HOD) meets twice a year. The June meeting is in Chicago every year and lasts for six days. The November meeting rotates among states where it is less likely that snow will impede transportation and lasts five days. Georgia was honored to be the host state for the AMA 2015 Interim House of Delegates Meeting. At the meeting, 517 voting delegates were credentialed. The Medical Association of Georgia’s (MAG) perspective was represented by five delegates (<1% of the AMA House) and alternates and other MAG members who serve in national specialty society delegations. As in MAG, delegates are apportioned to organizations based on the number of AMA members within their boundaries. When there are more Georgia physicians who are members of the AMA, the MAG HOD will elect more AMA delegates to advocate for MAG perspectives. We missed the cutoff for an additional delegate and alternate delegate last year by less than 50 new AMA members.

To accomplish MAG priorities at each meeting, the delegation divides the massive AMA HOD Handbook by reference committees and each member is assigned a reference committee. Then they study each report and resolution and suggest actions and strategies for the delegation to pursue that are then voted upon. The week before the meeting, every member of the delegation submits a detailed analysis with recommendations on his/her assigned committee, which is then discussed during a teleconference. At the teleconference – which is also attended by national medical specialty society delegates who are members of MAG – we determine our caucus position, prioritize our efforts and strategize for adoption of our priorities.

At the HOD meeting, the delegates and alternates work closely together. We caucus every morning, participate actively in reference committees and floor debate, collaborate in between sessions and behind the scenes to build consensus to pass our issues. And there are many other forums, caucuses and working receptions that our members attend to advance our issues and participate in the general debate.

In addition to representing MAG in 2016, the members of our delegation are concerned that the pipeline for future Georgia physician leadership at the national level needs to be replenished. Twenty to 30 years ago, many members of our current delegation were active in the medical student, resident/fellows, young physicians and organized medical staff sections – both in Georgia and at the AMA. We believe it is in MAG’s best future interests to revitalize these sections to become more active and relevant as soon as possible. MAG staff and interested leaders at each of these sections (except the OMSS, at this point) are actively attempting to rejuvenate the sections to increase involvement and membership. The Georgia AMA delegation supports these efforts.

The annual report this year is different from those of the past. I have pulled out into an appendix all the activities and outcomes of the different resolutions we have sent to the AMA and are following. Also submitted (as promised at last year’s MAG HOD) is the AMA Delegation Service Record, which documents individual participation in each of the agreed upon activities and meetings. Absences and their reasons are documented on Sheet 2 of the spreadsheet.
Conclusion

As you will see after reading the appendix, there is much activity at the AMA semiannual meetings. Your AMA Delegation has been disproportionately successful at accomplishing adoption of the issues sent to us by the MAG HOD. If you are not currently a member of the AMA, please join/rejoin today to allow for even more powerful representation of your interests at the national medical policy development level in the future.

We are currently in the process of planning for the AMA Interim Meeting to be held Saturday-Tuesday, November 12-15, 2016 in Orlando, Florida. We look forward to advocating on behalf of the MAG resolutions and positions that will be established at the 2016 MAG HOD. A preliminary schedule of the Interim Meeting activities is posted on our AMA page. Please take a look at it and connect to the AMA website by going to www.mag.org/affiliates/american-medical-association.

We encourage you to talk to your friends and colleagues who serve as AMA Delegates and Alternate Delegates, should you have specific questions or are interested in learning more about the AMA meetings.

I want to thank the members of the Georgia Delegation who serve on behalf of our association. They are: Sandra B. Reed, M.D., (Vice Chair), Michael E. Greene, M.D., Delegate, Joy A. Maxey, M.D., Delegate, Thomas E. Price, M.D., Delegate, John S. Antalis, M.D., Alternate Delegate, Jack M. Chapman Jr., M.D., Alternate Delegate, C. Gary Richter, M.D., Alternate Delegate, Billie Luke Jackson, M.D., Alternate Delegate, and John A. Goldman, M.D., Alternate Delegate.

We are pleased to recognize the service that our CEO Donald J. Palmisano Jr. provides and to applaud him for his leadership at the AMA level in many of the national staff and litigation forums. Of course, none of what we accomplish would be logistically possible without the able assistance of Donna Glass, the finest Executive Secretary in the House of Medicine.

I am truly honored to serve as your chairman and with the great team you send to each AMA meeting. We will continue to bring your voice and our policies to the AMA House of Delegates.

Recommendation:

1. That the MAG House of Delegates (HOD) approves the actions of the MAG AMA Delegation, as submitted in Appendix 1 of this report.

###
2016 MAG AMA Delegation Annual Report Appendix 1

The MAG AMA Delegation participated in many activities and debates at the 2015 Interim and 2016 Annual AMA House of Delegates. Our actions and the outcomes of MAG issues are detailed in this appendix to our annual report.

AMA INTERIM MEETING – NOVEMBER 13-18, 2015

The AMA Board of Trustees arrived in Atlanta a few days earlier to hold a Board meeting prior to I-15. MAA and MAG cohosted a dinner and meeting with AMA leaders at the Georgia Tech Hotel and Conference Center on Thursday, November 12. It was well attended and members were afforded the opportunity to get to know AMA leadership, ask questions and give opinions and concerns.

On Friday, the MAG past presidents on the delegation, the MAG president and president-elect attended the annual meeting of the Organization of State Medical Society Presidents (OSMAP). OSMAP participants heard a presentation from MAG Past President Walker Ray, M.D., and current President of the Physicians Foundation on the positive and promising initiatives of the Foundation. His topics included an overview of the foundation, summarizing intriguing surveys and informational documentation on issues including managing the transition to IDC-10. He briefed the participants on the various grants that have been awarded for many worthwhile patient care and leadership initiatives including significant financial support for statewide (e.g., Georgia Physicians Leadership Academy) and national physician leadership programming. He encouraged participants to view the Forbes Channel to see several stories highlighting the voice of physicians through the Physicians Foundation.

At the opening session on Saturday, AMA president Steven J. Stack, M.D., presented Joseph P. Bailey Jr., M.D., with the 2015 AMA Distinguished Service Award. This award is presented for meritorious service in the science and art of medicine. At the close of the house, MAG sponsored a Welcome to Georgia Reception – recognizing Dr. Bailey and allowing our delegates a unique opportunity to network with their colleagues and advance MAG priorities. Dr. Bailey was surrounded later that evening by family, friends and colleagues who honored him at the Georgia delegation dinner.

The Georgia AMA Delegation met several times during the Interim meeting to review reports and resolutions submitted to the AMA for action. Mornings began approximately at 6:30 a.m. when the delegation and other Georgia physicians representing national specialty societies or sections would gather to discuss the merits of each report and resolution and using MAG polices as the reference guide determining whether the delegation would or would not support. First and foremost were the resolutions submitted to the AMA from MAG of which the delegation took the lead to address in reference committees and the AMA House of Delegates.

The following is a summary report of those resolutions:

Resolution 101A, National Board of Physicians and Surgeons (NBPAS) Recertification, as adopted by MAG HOD

“that the AMA delegation to the American Medical Association (AMA) submit a resolution supporting the AMA recognizing NBPAS as an alternative to ABMS for recertification for physicians nationally.”

AMA Georgia Resolution 925 combined with Resolution 924, Alternative Pathways to Board Recertification and was referred to Reference Committee K. Reference Committee K recommended adopting as amended Resolution 924 in lieu of Resolution 925. Because of the complexity of the issues
presented in both resolutions, the members of the House decided to refer both resolutions for a report back at A-16. It is the AMA Council on Medical Education that monitors the development and implementation of maintenance of certification standards. The AMA Delegation committed to review this report at the AMA Annual meeting in 2016 and report back on its outcome. This was a positive outcome for this MAG resolution at this point of consideration and the results of the study would be scrutinized in June.

Resolution 102A.15, Computer Electronic Health Record Cybersecurity as adopted by the MAG HOD

“that the Medical Association of Georgia (MAG) present a resolution to the AMA to investigate indemnity for physicians and other health care providers whose Electronic Health Records (EHR) data and other electronic medical systems become the victim of security compromises.

AMA Georgia Resolution 221, Indemnity for Breaches in Electronic Health Record Cybersecurity was referred to Reference Committee B. Members of the reference committee heard testimony in support of the intent of Resolution 221 that highlighted the growing concern with security and privacy breaches as more patient information is being stored electronically. Reference Committee B recommended the following amended Resolution 221, which was adopted by the HOD:

“RESOLVED, that our American Medical Association advocate for indemnity or other liability protections for physicians whose electronic health record data and other electronic medical systems become the victim of security compromises. (Directive to Take Action)

This is a successful outcome for this MAG resolution.

Resolution 113A.15, IOM “Dying in America” Report as adopted by the MAG HOD

“that the Georgia Delegation to the American Medical Association (AMA) introduce a similar resolution to the AMA at its next House of Delegates [calling for the AMA to support and promote the recommendations of the Institute of Medicine “Dying in America” report, which provides recommendations to improve the quality of end-of-life care received by all patients.”

AMA Georgia Resolution 006 was referred to the Reference Committee on Amendments to the Constitution and Bylaws. Testimony for the resolution was predominately in favor of referral. While many who testified spoke in favor of the spirit of the report given the incredible amount of work that needs to be done around end-of-life decision making in the medical field, there was palpable skepticism about the content and recommendations of the IOM report. Testimony noted that the report had not been fully vetted by the AMA, and that there were incongruences between the different versions of the report as well as the report’s summary. There were concerns raised with some of the items in the IOM report relating to physician’s licensure. Because of all that was heard from members in the reference committee hearings, the reference committee recommended referral for decision. Members of the House of Delegates referred Resolution 006 for report back at A-16. The Georgia Delegation committed to review this report and actively advocate for the adoption of the spirit of the resolution. This was a positive outcome for this MAG resolution to date.

Resolution 304C.15, Lymphedema Treatment Act as adopted by the MAG HOD

“that the Medical Association of Georgia (MAG) delegation to the American Medical Association (AMA) submit a resolution for the AMA to support H.R. 1608 as written in current form as of October 17, 2015,”

AMA referred this Georgia resolution 304C.15 to Reference Committee J. There was unanimous testimony in support of Resolution 822. Testimony given requested amendments clarifying that compression garments are not items of durable medical equipment and the inclusion of coverage for specific treatment options. Reference Committee J proposed substitute language and recommended the HOD adopt Substitute Resolution 822. The AMA HOD adopted Substitute Resolution 822 as follows:

MEDICARE COVERAGE FOR EVIDENCE-BASED LYMPHEDEMA TREATMENT

RESOLVED, that our American Medical Association support Medicare coverage for appropriate and evidence-based treatment of lymphedema. (New HOD Policy)
This is a successful outcome for this MAG resolution.

Resolution 311C.15, Amend H.R. 6, The 21st Century Cures Act

that the MAG delegates to the AMA House of Delegates introduce a resolution asking that the
AMA Board of Trustees lobby the United States Senate to amend H.R. 6 to prohibit all
supplement (Medigap) insurance policies (Part B, Part C, and Part D) from denying coverage of
the entire Medicare approved expenses for a FDA-approved clinical trial that Medicare Part A
does not; and allow sponsors of clinical trials to cover what supplement insurance does not for
those beneficiaries with supplement insurance, as well as what supplement insurance would have
covered for those Medicare beneficiaries without Part B or Part C and/or Part D supplement
insurance (Medigap); or, alternatively, that in cases of Medicare and FDA-approved clinical
trials, Medicare be required to pay 100 percent of all Medicare approved expenses.”

The AMA combined Georgia Resolution 823 and Resolution 813, Removing Financial Barriers to
Participation in Clinical Trials for Medicare Beneficiaries and referred them together to Reference
Committee J. Resolution 813 called for AMA to advocate for legislation providing Medicare beneficiaries
with coverage for the full amount of Medicare approved expenses incurred through participation in
approved clinical trials. Resolution 823 called for AMA to advocate for the U.S. Senate to amend H.R. 6,
21st Century Cures Act to prohibit all supplement (Medigap) insurance policies from denying coverage of
the entire Medicare approved expenses for a FDA-approved clinical trial that Medicare Part A does not
cover. Testimony was mixed on Resolutions 813 and 823. Significant testimony stated that the issue of
clinical trial insurance coverage was multi-pronged and complex. Many of those testifying raised
potential concerns. Therefore, because the issue is both complex and time-sensitive, Reference
Committee J recommended referral. Members of the AMA HOD agreed with Reference Committee J and
referred for decision Resolutions 813 and 823 with a request for an informational report back to the
House of Delegates.

This was a positive outcome for this MAG resolution at this point, but the results of the study would be
scrutinized.

Other AMA actions included a new policy in opposition to the insurance mergers that, according to AMA
members, would erode competition, causing patients and employers to pay higher premiums and forcing
physicians to accept terms that will degrade their ability to provide patients with high-quality health care.
Building on its work with the National Association of Attorneys General, the AMA will present to a
majority of state attorneys general later in November. AMA’s testimony will highlight findings from the
AMA’s competition study and emphasize the importance of blocking mergers such as those between the
four major national insurers that are in the works.

AMA adopted a report written by the Council on Medical Education. The report notes that “given the
scrutiny Medicare funding of graduate medical education (GME) has received of late, there may now be a
greater prospect of developing a new payment system that could fund and shape a more appropriate
physician workforce.” The report suggestions included research state funding possibilities, turn to
philanthropic organizations, consider partnering with employers, work with location hospitals. In looking
ahead, policy adopted along with the report includes a number of actions that would help advance funding
for CME: 1) AMA will explore various models of all payer funding for GME; 2) organizations with
successful existing models should publicize and share their strategies, outcomes and costs; and 3) the
AMA will encourage insurance payers and foundations to enter into partnerships with state and local
agencies, academic medical centers and community hospitals to expand GME.

In response to increasing drug costs impacting patient access to needed medications, physicians voted to
convene a task force and launch an advocacy campaign to drive solutions and help make prescription
drugs more affordable. Physicians also are calling for greater competition in the pharmaceutical industry
and transparency in prescription drug prices and costs.
Policy was adopted concerning shortcomings in electronic health records (EHR) interoperability. The meaningful use program offers powerful financial incentives and disincentives for physicians but does not do so for EHR vendors. Meanwhile, most EHR systems fail to satisfy physician users. Physicians called for the Office of National Coordinator for Health IT (ONC) to prioritize EHR interoperability, data portability and health IT data exchange testing. The AMA will work with EHR vendors to promote transparency of actual costs of EHR implementation, and CME and ONC to identify barriers and solutions to data blocking so that physicians and hospitals have more options for purchasing, donating, subsiding or migrating to new EHRs.

The House referred CEJA Report 3 (Modernized Code of Medical Ethics). In 2008, the Council on Ethical and Judicial Affairs (CEJA) began the project to comprehensively review the AMA’s foundational document, the Code of Medical Ethics, and update the Opinions and interpret AMA Principles of Medical Ethics. The Council’s goal was to ensure that the Code’s ethical guidance keeps pace with the demands of a changing world of medical practice. This project represents the first such thoroughgoing review in more than 50 years. With assistance from the Federation of Medicine and AMA Councils and Sections, the Council reviewed each individual Opinion for clarity, timeliness and ongoing relevance in today’s health care environment, and consistency within the Code. However, reference committee testimony sparked questions and concerns regarding specific chapters of the Code. The final action of the House of Delegates was to agree with the reference committee recommendation to refer the Code of Medical Ethics and Judicial Affairs to clarify the confusion about the scope of code modernization.

The Georgia delegation agreed to participate with the Southeastern Delegation to study and make physician-friendly improvements to the proposed CEJA revisions to come to a meaningful agreement in the near future.

These are just a few of the many actions taken by the AMA House of Delegates last November. To obtain final AMA actions on all reports and resolutions introduced this past November, please go to www.mag.org/organizations/american-medical-association.

The Georgia delegation then began to prepare for the next AMA meeting. The AMA Annual meeting was held on June 11-15, 2016 at the Hyatt Regency Chicago. We will continue to serve the membership at the AMA meetings and in between the two major meetings we will work to promote and advocate for MAG policies through involvement in other AMA activities.

AMA ANNUAL MEETING – JUNE 11-15, 2016

The AMA Annual meeting was held at the Hyatt Regency in Chicago. The full delegation attended as well as our MAG President John S. Harvey, M.D., and MAG President-elect Steven M. Walsh, M.D. Staff support was MAG Executive Director Donald Palmisano Jr., and MAG Executive Assistant Donna Glass.

On Friday, many of our delegation members attended the Organization of State Medical Association Presidents (OSMAP) meeting. A significant portion of the June 10 OSMAP meeting was devoted to a discussion of the performance of state exchanges. Brian Blase, Ph.D., Senior Research Fellow, Mercatus Center, George Mason University, presented “An Analysis of Insurer Performance Selling Exchange Plans and the Future of the ACA.” Immediately following Dr. Blase, leadership from the medical societies of the states of California, North Carolina and Tennessee shared their various experiences. A lively Q&A Session followed.

OSMAP attendees also received an update on AMA Priorities, with special emphasis on narrow network
advocacy, from Steven J. Stack, M.D., then-president of AMA. The Physicians Foundation also presented its semi-annual report to OSMAP on their many ongoing activities and grant opportunities for physician leadership programs.

A compelling presentation was made on the activities and lavish expenditures of the American Board of Internal Medicine, presumably made possible by the high cost to recertifying physicians.

MAG secures a suite at AMA meetings to provide delegates and alternates a place to meet and wind down during the several days away from home and patients. The first caucus was held prior to the meeting by telephone conferencing at which time a workbook of all reports and resolutions was discussed and recommendations from each delegate and alternate were recorded. At the meeting, the delegation caucused each day in the suite and attended many more meetings of the federation throughout the week.

On Sunday, November 13, the delegation reviewed all reports and resolutions that were not listed in the handbook. Monday and Tuesday were devoted to reference committee reports and final actions taken.

The following is a summary of actions that occurred at the AMA Annual meeting on MAG resolutions and reports from resolutions submitted by MAG prior to 2016:

**MAG Resolution 105A.15**

MAG submitted to the AMA Annual Meeting, Resolution 105A.15 asking the AMA to encourage vaccine manufacturers to make small quantities of vaccines available for purchase without financial penalty to help small practices maintain a comprehensive vaccine inventory.

Now AMA Resolution 404 (A-16) was forwarded to Reference Committee D. Reference Committee D heard testimony that was largely supportive. One individual suggested referral to study other vaccine universal purchasing mechanisms in place in some jurisdictions. However, given the widespread agreement that the inability of physician practices to purchase small quantities of vaccines is a barrier to immunizations, Reference Committee D supported adoption.

Final Action: Resolution 404 was adopted with the following change in title: Vaccine Availability in Small Quantities.

This is a positive outcome for this MAG resolution.

**BOT Report 8-A-16**

A few years ago, the AMA House of Delegates, at Georgia’s insistence called for the Board of Trustees to submit a report at the AMA Annual Meeting each year summarizing AMA performance, activities and status for the prior year. A detailed report may be obtained online on the AMA website at www.ama-assn.org (under meeting archives, AMA June 2016 official proceedings).

**BOT 16-A-16**

In 2014, the Georgia Delegation introduced Resolution 606-I-14, which called for AMA to create and provide significant initial and ongoing funding for an AMA “super” political action committee (super PAC) to make independent expenditures for or against candidates for federal office based on recommendations from state medical society PACs and support from the American Medical Association Political Action Committee (AMPAC). The Board of Trustees Report 18-A-15 provided general background information on the growth of a funding sources for federal super PACs, common characteristics of these organizations, and identified benefits and risk associated with the creation of a super PAC for the AMA. The report noted on the positive side that organized medicine needs more champions in Congress and a super PAC would be an extra advocacy tool to potentially help elect our preferred candidates in federal elections. However, a substantial 35 percent federal excise tax would be imposed on expenditures of AMA corporate funds used to fund an AMA super PAC, and there was no
evidence that AMA would be able to raise sufficient funds from outside sources, including physicians
who are not members of AMA. The report concluded that AMA corporate funds should not be used for
this purpose and that the Board of Trustees would continue to study the feasibility of creating a super
PAC, with emphasis on exploring sources of sufficient outside funding and assuring that AMPAC’s
ongoing activities and fundraising would not be negatively affected. The AMA HOD disagreed and the
report was referred back to the Board of Trustees for further study.
This was a positive outcome for this MAG resolution to this point and the ensuing report would be
scrutinized.

BOT 16-A-16 again recommended against adoption of the creation of an AMA Fund for Physician
Candidates. After extensive debate in an evolving environment of Super PACs and other corporate
election activities, the AMA HOD again referred the concept back to the Board for further study.
This was again a positive outcome for this MAG resolution and demonstrates the importance of persistent
efforts to change large policy statements at the national level. The referral at this meeting occurred due to
the fact that the entire Southeastern Delegation adopted this as a caucus position, as the result of MAG
Delegation advocacy activities.

BOT Report 23-A-16
At its 2015 Interim Meeting, the AMA referred Resolutions 813-I-15 and 823-I-15, Removing
Financial Barriers to Participation in Clinical Trials for Medicare Beneficiaries and H.R. 6, 21st Century
Cures Act, to the AMA Board of Trustees. In June, the Board of Trustees returned with a report and the
following recommendations:

In lieu of adopting Resolutions 813-I-15 and 823-I-15, the Board modified policy H-460.965,
Viability of Clinical Research Coverages and Reimbursement, to read as follows:

Our AMA believes that: (1) legislation and regulatory reform should be pursued to mandate
third party payers should coverage of patient care costs (including co-pays/co-
insurance/deductibles) of nationally approved (e.g., NIH, VA, ADAMHA, FDA), scientifically
based research protocols or those scientifically based protocols approved by nationally recognized
peer review mechanisms; (2) third party payers should formally integrate the concept of
risk/benefit analysis and the criterion of availability of effective alternative therapies into their
decision-making processes; (3) third party payers should be particularly sensitive to the difficulty
and complexity of treatment decisions regarding the seriously ill and provide flexible, informed
and expeditious care management when indicated; (4) its efforts to identify and evaluate
promising new technologies and potentially obsolete technologies should be enhanced;…(9)
funding of biomedical research by the federal government should reflect the present opportunities
and the proven benefits of such research to the health and economic well-being of the American
people; and (10) the practicing medical community, the clinical research community, patient
advocacy groups and third party payers should continue their ongoing dialogue regarding issues in
payment for technologies that benefit seriously ill patients and evaluative efforts that will enhance
the effectiveness and efficiency of our nation’s healthcare system; and (11) legislation and
regulatory reform should be supported that establish program integrity/fraud and abuse safe
harbors that permit sponsors to cover co-pays/co-insurance/deductibles and otherwise not covered
clinical care in the context of nationally approved clinical trials.

This is a positive outcome for this MAG resolution.
At its 2015 Interim Meeting, the AMA referred to the Board of Trustees Resolution 6-1-15, “IOM ‘Dying in America’ Report,” introduced by MAG. The Georgia Resolution asked our AMA to support and advocate for the recommendations of the Institute of Medicine. Testimony for the resolution supported the spirit of the IOM report in light of the recognized need to improve quality of care at the end of life. However, testimony noted that AMA had not had an opportunity to vet the report thoroughly in light of existing AMA policies on relevant issues noted that endorsing the report in its entirety could have unintended consequences for AMA. The HOD requested that a report be presented to the HOD at the 2016 Annual meeting. In June 2016, the Board of Trustees, to ensure sufficient opportunity to carefully review the recommendations of the Institute of Medicine, reported that it will submit its final report at the 2016 Interim Meeting.

This is a positive outcome for this MAG resolution to date and the report will be scrutinized at I-16.

Council on Medical Education Report 2 – Update on Maintenance of Certification and Osteopathic Continuous Certification

The CME Report 2-A-16 addressed several earlier resolutions regarding Maintenance of Certification including Resolution 925-I-15 submitted by the Georgia Delegation on behalf of the Medical Association of Georgia. The Council on Continuing Medical Education submitted an extensive report on the subject and submitted the following four recommendations:


1. That our American Medical Association (AMA) 1) examine the activities that medical specialty organizations have underway to review alternative pathways for board recertification, and 2) determine if there is a need to establish criteria and construct a tool to evaluate if alternative methods for board recertification are equivalent to established pathways. (Directive to Take Action)

2. That our AMA reaffirm Policy D-275.954 (9), Maintenance of Certification and Osteopathic Continuous Certification, which asks the American Board of Medical Specialties (ABMS) to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting maintenance of certification (MOC) and certifying examinations. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy D-275.954 (4), which encourages the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and MOC. (Reaffirm HOD Policy)

4. That our AMA ask the ABMS to encourage its member boards to review their MOC policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on MOC activities relevant to their practice. (Directive to Take Action)

Reference Committee C heard overwhelming support for the comprehensive report, which provided an update on the Council on Medical Education’s efforts with the ABMS during the last year to improve the Maintenance of Certification (MOC) program. During testimony, it was noted that efforts to improve the MOC process are a work in progress. Therefore, Reference Committee C recommended adoption of
Council on Medical Education Report 2. Final HOD action concurred with Reference Committee C and the Council on Medical Education Report 2 was adopted. The detailed report may be obtained online at www.ama-assn.org under House of Delegates meeting archives, 2016 proceedings.

This is not a completely positive outcome for this MAG Resolution, which recommended that focused CME activities should be allowed for recertification in lieu of expensive board mandated recertification efforts. However, the current situation was far from “rubber stamped” and the issue continues to be studied. The new recommendations to review alternate pathways to recertification will provide opportunities for MAG advocacy in the coming meetings.

The following are other items of interest adopted by the AMA HOD:

- Modernized “Code of Medical Ethics” adopted by the House. Designed to 1) become more relevant (i.e., apply to contemporary medical practice) and 2) provide greater clarity (i.e., a better structure and format to ensure that the “foundational ethical principles and specific physician responsibilities are easy to find, read and apply”) and 3) improve consistency (i.e., “harmonized guidelines that consolidates related issues into a single, comprehensive statement”).

- Adopted a policy to support efforts to ensure that there are sufficient funds for medical residency positions. This measure also calls for “transparency in the actual costs of residency programs and how Graduate Medical Education (GME) funding is distributed to address physician shortages in undersupplied specialties.”

- Called for the pharmaceutical industry to fund a program to dispose of unwanted medications as hazardous waste – keeping in mind that an estimated 30 percent to 80 percent of patients do not finish prescriptions for common medication, including pain medications.

- Addressed the opioid overdose epidemic. The physician’s role in reducing opioid medication misuse, overdose and death is an important one. Several new policies were put into place addressing factors that are critical in reversing the epidemic, including prescription drug monitoring programs (PDMP), access to naloxone and addiction medicine as a sub-specialty.

- Adopted policy that recommends pursuing the following goals as part of an APM:
  - Provide resources to support the services physician practices need to deliver to patients, including mechanisms for regular updates to the amounts of payment to ensure they continue to be adequate to support the costs of high-quality care
  - Reduce burdens of health IT usage in medical practice
  - Promote physician-led team based care coordination that is collaborative and patient centered
  - Designed by physicians and provide the flexibility so that physicians can deliver the care their patients need.
  - Limit physician accountability to aspects of spending and quality that they can reasonably influence
  - Avoid placing physician practices at substantial financial risk and minimize administrative burdens
  - Be feasible for physicians in every specialty and all practice sizes to participate in.

- Also adopted new policy to support many types of technical assistance for practices that are working to implement successful APMs including:
  - Designing and employing a team approach
  - Obtaining the data and analysis needed to monitor and improve performance
Officer: 06.16
Attachment 1

- Forming partnerships and alliances to share tools, resources and data
- Obtaining the financial resources needed to make the transition to new payment models.

- Adopted new policy that outlines ethical ground rules for physicians using telemedicine to treat patients. (Two years ago AMA adopted policy on telemedicine related to the patient-physician relationship.) According to the new policy, any physician engaging in telemedicine must:
  - Disclose any financial or other interests in particular telemedicine applications or services
  - Protect patient privacy and confidentiality
  
  The policy outlines guidelines for physicians who either respond to individual health queries electronically or provide clinical services through telemedicine. Broadly some of the guidelines include:
  - Inform the patient about the limitations of the relationship and services provided
  - Encourage telemedicine patients who have a primary care physician to inform them about their online health consultation and ensure the information from the encounter can be accessed for future episodes of care
  - Ensure patients have a basic understanding of how telemedicine technologies are used in their care, the limitations of the technologies and ways the information will be used after the patient encounter

These and so many more reports and resolutions were considered at the AMA A-16 meeting. For more details on these and other items please go to [www.ama-assn.org/ama/pub/about-ama/our-people/house-delegates/meeting-archives.page](http://www.ama-assn.org/ama/pub/about-ama/our-people/house-delegates/meeting-archives.page).

**Election Results**

In a day-long series of runoff and special elections, delegates on June 14 voted for officer positions, including President-elect, members of the AMA Board of Trustees, Speaker and Vice Speaker of the House of Delegates, and six seats on four councils.

- David O. Barbe, M.D., was elected President-elect
- Susan R. Bailey, M.D., was re-elected Speaker of the House of Delegates
- Bruce A. Scott, M.D., was re-elected Vice Speaker of the House of Delegates
- William E. Kobler, M.D., was re-elected to the Board of Trustees
- Willarda V. Edwards, M.D. was elected to the Board of Trustees
- William A. McDade, M.D., was elected to the Board of Trustees

Also appointed to the Executive Committee of the AMA Board of Trustees:
  - Chair: Patrice A. Harris, M.D.
  - Chair-elect: Gerald E. Harmon, M.D.
  - Secretary: Jack Resneck Jr., M.D.

**Council seat elections:**
- Council on Constitution and Bylaws: Pino Colone, M.D.
- Council on Medical Services: Alan Harmon, M.D., and Lynn Jeffers, M.D.
- Council on Medical Services Resident and Fellow seats: Laura Fay Gephart, M.D.
- Council on Science and Public Health: Alex Ding, M.D., and David J. Walsh, M.D.
- Council on Medical Education: Cynthia Jumper, M.D.
MAG Delegation Endorsements for Future Elections

MAG member Patrice Harris, M.D., was interviewed by the Delegation and endorsed by secret ballot to run for President-elect of the AMA at the 2018 Annual Meeting. Her candidacy will be forwarded to the Southeastern Delegation for interview and possible endorsement at the 2016 Interim Meeting.

MAG member Sandra Fryhofer, M.D., was interviewed by the Delegation and endorsed by secret ballot to run for the AMA Board of Trustees at the 2018 Annual Meeting. Her candidacy will be forwarded to the Southeastern Delegation for interview and possible endorsement at the 2016 Interim Meeting.

Conclusion

This concludes the report of the activities of the Georgia Delegation between the 2015 and 2016 MAG HOD meetings. We hope you approve our actions.

###

- MAG Delegation Endorsements for Future Elections
- Conclusion
- This concludes the report of the activities of the Georgia Delegation between the 2015 and 2016 MAG HOD meetings. We hope you approve our actions.
- ###
## Delegation Service Record

### Key
- **P** (Present)
- **A** (Absent)
- **Y** (Yes)
- **N** (No)

*Reasons for absence are on Sheet 2*

<table>
<thead>
<tr>
<th></th>
<th>BC</th>
<th>SR</th>
<th>JM</th>
<th>TP</th>
<th>MG</th>
<th>BLJ</th>
<th>JA</th>
<th>JC</th>
<th>GR</th>
<th>JG</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2016 MAG BOD</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>January meeting</td>
<td>P</td>
<td>P</td>
<td>A</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
</tr>
<tr>
<td>April meeting</td>
<td>P</td>
<td>P</td>
<td>A</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>A</td>
</tr>
</tbody>
</table>

#### AMA Delegation business

<table>
<thead>
<tr>
<th>Event</th>
<th>Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>A-16 HOD Attendance</td>
<td>P P P P P P P P P P</td>
</tr>
<tr>
<td>A-16 HOD Worksheet submission</td>
<td>Y Y N Y Y Y Y Y Y Y</td>
</tr>
<tr>
<td>A-16 Pre-meeting Teleconference</td>
<td>P P P P P P P P P P</td>
</tr>
<tr>
<td>A-16 Saturday caucus</td>
<td>P P P P P P P P P P</td>
</tr>
<tr>
<td>A-16 AMA HOD 1</td>
<td>P P P P P P P P P P</td>
</tr>
<tr>
<td>A-16 Sunday caucus</td>
<td>P P P P P P P P P P</td>
</tr>
<tr>
<td>A-16 HOD 2</td>
<td>P P P P P P P P P P</td>
</tr>
<tr>
<td>A-16 Reference Committees</td>
<td>P P P P P P P A P P P</td>
</tr>
<tr>
<td>A-16 Sunday Receptions</td>
<td>P P P P P P A P P P</td>
</tr>
<tr>
<td>A-16 SED Monday breakfast</td>
<td>P P P P P P A P P P</td>
</tr>
<tr>
<td>A-16 Monday caucus</td>
<td>P P P A P P P P P P</td>
</tr>
<tr>
<td>A-16 HOD 3</td>
<td>P P P P A P P P P P</td>
</tr>
<tr>
<td>A-16 Monday receptions</td>
<td>P P P A P P P P P P</td>
</tr>
<tr>
<td>A-16 SED Reception</td>
<td>P P P A P P P P P P</td>
</tr>
<tr>
<td>A-16 Tuesday caucus</td>
<td>P P P A P P P P P P</td>
</tr>
<tr>
<td>A-16 HOD 4</td>
<td>P P P A P P P P P P</td>
</tr>
<tr>
<td>A-16 Inauguration Dinner</td>
<td>P P P A P P P P P P</td>
</tr>
<tr>
<td>A-16 Wednesday caucus</td>
<td>N/A N/A N/A N/A N/A N/A N/A N/A N/A N/A</td>
</tr>
<tr>
<td>A-16 HOD 5</td>
<td>P P P A P P P P P P</td>
</tr>
<tr>
<td>A-16 Meal with a delegate/alternate</td>
<td>34 8 5 16 4 5 22 24 8</td>
</tr>
</tbody>
</table>

(Number, Non-GA)

### I-16

<table>
<thead>
<tr>
<th>Event</th>
<th>Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>I-16 HOD Attendance</td>
<td></td>
</tr>
<tr>
<td>I-16 HOD Worksheet submission</td>
<td></td>
</tr>
<tr>
<td>I-16 Teleconference</td>
<td></td>
</tr>
<tr>
<td>I-16 Saturday caucus</td>
<td></td>
</tr>
<tr>
<td>I-16 AMA HOD 1</td>
<td></td>
</tr>
<tr>
<td>I-16 Sunday caucus</td>
<td></td>
</tr>
<tr>
<td>I-16 HOD 2</td>
<td></td>
</tr>
<tr>
<td>I-16 Reference Committees</td>
<td></td>
</tr>
<tr>
<td>I-16 SED Reception</td>
<td></td>
</tr>
<tr>
<td>I-16 SED Monday breakfast</td>
<td></td>
</tr>
<tr>
<td>I-16 Monday caucus</td>
<td></td>
</tr>
<tr>
<td>Event Description</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------</td>
<td></td>
</tr>
<tr>
<td>I-16 HOD 3</td>
<td></td>
</tr>
<tr>
<td>I-16 Tuesday caucus</td>
<td></td>
</tr>
<tr>
<td>I-16 HOD 4</td>
<td></td>
</tr>
<tr>
<td>I-16 Meal with a delegate/alternate</td>
<td></td>
</tr>
<tr>
<td>(Number, Non-GA)</td>
<td></td>
</tr>
<tr>
<td>2016 Recruited a new AMA member</td>
<td></td>
</tr>
<tr>
<td>2016 MAG HOD Attendance</td>
<td></td>
</tr>
<tr>
<td>Testified in Refcom</td>
<td></td>
</tr>
<tr>
<td>MAG Inauguration</td>
<td></td>
</tr>
<tr>
<td>MAG Delegation Caucus</td>
<td></td>
</tr>
<tr>
<td>Updated 9/4/16</td>
<td></td>
</tr>
</tbody>
</table>
2016 MAG AMA Delegation Reasons for Absence or Non-participation

Bill Clark

Sandra Reed
34C  Unreported

Joy Maxey
16D  Could not log on; Material reviewed and presented at teleconference

Tom Price
10E  Presented to Youth Leadership Institute
11E  Presented to 6th District GOP Convention
25E and thereafter  Departed AMA Convention to participate in US Congress

Mike Greene

Billie Luke Jackson

John Antalis
23A  Served on Refcom B, was preparing report
24A  Still preparing final Refcom B report

Jack Chapman

Gary Richter
34J  Unreported

John Goldman
11K  Attended his 50th reunion, University of Cincinnati Medical School
2016 Report to the MAG House of Delegates

This will be my final report to you as Chair of the Georgia Physicians Leadership Academy (GPLA) Steering Committee. Before the induction of our 10th class at the April Board meeting, I will stand down and become past chair of the Academy and am pleased to report that your GPLA has evolved into an effective and strategic program to train our future physician leaders.

At our recent Steering Committee meeting, Johnny Sy D.O. (Class VI) was elected to be the next Chair and Santanu Das M.D. (Class III) will follow him after one year. In order for the Academy to move forward, all members of the Steering Committee have committed to participate even more fully and alumni are also encouraged to become more involved.

Our transition plan will also include the retirement of Susan Reichman, our inaugural program coordinator. Dean Robert L. Addleton, EdD will continue as lead faculty and the 2016 GPLA curriculum was approved for 28.5 CME credits with joint sponsorship of the Physicians’ Institute for Excellence in Medicine. The curriculum continues to grow and evolve and presentations by alumni are welcomed.

As you know, the GPLA is a vigorous program of the MAG Foundation, funded by ongoing charitable contributions from alumni, MAG leaders, nominating society tuition and a generous grant from the Physicians Foundation—with institutional support from MAG, the MAG Foundation and the Physicians’ Institute for Excellence in Medicine.

Our mission is to provide emerging physician association leaders with enhanced leadership skills. Our curriculum focuses on: 1) mastering communication skills, 2) improving advocacy expertise and 3) developing strategies for negotiating conflict resolution, especially between specialty societies. An important element of the Academy is fostering personal relationships with other colleagues who will lead Georgia medical organizations in the future.

The GPLA’s ninth class first met in conjunction with the MAG BOD in April 2016. With its graduation next spring, the Academy will have trained over 120 MAG physician members from across our state.

Nominations for each class are accepted in November. Candidates must be MAG members who are nominated by their specialty or county medical society. The nominating organization is asked to pay the $1000 tuition fee that is used to partially underwrite lodging, meals, speakers, and class materials. Transportation costs are the responsibility of attendees.

In January 2013, the GPLA was awarded a $75,000 leadership grant from the Physicians Foundation Medical Practice Support Needs grants program. Those funds were used to support Classes 6 and 7, to enhance the curriculum and to develop a fundraising campaign to ensure the future of the Academy. We
applied for another grant from the Physicians Foundation in 2015 and were awarded almost $150,000 to
be used to help support Classes 8, 9 and part of 10.

The GPLA initially was dependent upon and is grateful for continuing financial support from our alumni
and MAG leadership. While the grant funds will mostly support immediate Academy needs, the Steering
Committee approved the launch of an ongoing endowment campaign which was initiated at the 2014
MAG HOD. Under the leadership of MAG Past Presidents Manoj Shah and Scott Bohlke (both GPLA 1),
the initial endowment launch has raised over $30,000.

What a contrast from the earliest days! As the Academy’s financial situation becomes more secure
through continuing alumni and other contributions or endowment support, it is poised to offer an even
more enriched Jedi curriculum.

I am honored that the MAG Foundation has asked me to lend my name to the 2016 endowment effort and
hope that you all can find some tax-deductible funds to ensure the success of the GPLA.

This in-depth, interactive, year-long program stretches over six sessions. The Class IX curriculum is
outlined below:

- Session 1. April 16-17, 2016: "Orientation, Self-Assessment and Leadership Strategies"
- Session 2. August 6-7, 2016: "Session 101: Media, Communication & Collaboration in the
  Medical Environment," followed by the Alumni Supper on the Roof. “Session 201: Inaugural
  Georgia Elected Physician Leaders Summit” St. Simons Island, GA
- Alumni GPLA Reception and Dinner: October 14, 2016: at MAG House of Delegates
- Session 3. November 5-6, 2016: "Decision Making and Conflict Resolution."
- Session 5. March 6-7, 2017: "Advocacy Day" at the Capitol
- Session 6. April 22, 2017: Presentation of Leadership Projects, Jedi Graduation Ceremony
  (concurrent to BOD) and new class orientation

Leadership Project

After completing a leadership assessment, class members commit to completing a personal leadership
project to improve identified leadership skills. The project may benefit their patients, communities,
and/or sponsoring medical societies during their class year. Project examples include: planning a
membership drive, presenting a health awareness and/or patient education program for the local
community. As they progress, physicians may request support from mentors and GPLA faculty and staff
as needed.

GPLA Inaugural Class

Scott Bohlke, M.D., Family Physician, Brooklet
Jacqueline Fincher, M.D., Internal Medicine, Thomson
Pam Gallup, M.D., OB/GYN, Savannah
Jeffrey Grossman, M.D., PM & R, Pain Management, Atlanta
Mark Hanly, M.D., Pathologist, Brunswick
Joel Higgins, M.D., OB/Gyn, Wyoming
Craig Kubik, DO, Gastroenterology, Waycross
Howard Maziar, M.D., Psychiatry, Atlanta
Howard McMahan, M.D., Family Physician, Ocilla
David Oliver, M.D., Otolaryngology, Savannah
<table>
<thead>
<tr>
<th></th>
<th>Name</th>
<th>Specialty</th>
<th>City</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Andrew Reisman, M.D.</td>
<td>Family Physician</td>
<td>Oakwood</td>
</tr>
<tr>
<td>2</td>
<td>Manoj Shah, M.D.</td>
<td>OBGyn</td>
<td>Warner Robins</td>
</tr>
<tr>
<td>3</td>
<td>Marc Wetherington, M.D.</td>
<td>Plastic Surgery</td>
<td>Rome</td>
</tr>
<tr>
<td></td>
<td><strong>GPLA Class II</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>James Barber, M.D.</td>
<td>Orthopaedics</td>
<td>Douglas</td>
</tr>
<tr>
<td>5</td>
<td>Florence Barnett, M.D.</td>
<td>Neurosurgery</td>
<td>Johns Creek</td>
</tr>
<tr>
<td>6</td>
<td>Gloria Campbell-D'Hue, M.D.</td>
<td>Dermatology</td>
<td>Atlanta</td>
</tr>
<tr>
<td>7</td>
<td>Bob Jones, M.D.</td>
<td>Family Physician</td>
<td>Macon</td>
</tr>
<tr>
<td>8</td>
<td>Sudhakar Jonnalagadda, M.D.</td>
<td>Gastroenterology</td>
<td>Douglas</td>
</tr>
<tr>
<td>9</td>
<td>Howard Odom, M.D.</td>
<td>Anesthesiology</td>
<td>Canton</td>
</tr>
<tr>
<td>10</td>
<td>Lisa Perry-Gilkes, M.D.</td>
<td>Otolaryngology</td>
<td>East Point</td>
</tr>
<tr>
<td>11</td>
<td>John Rogers, M.D.</td>
<td>Emergency Medicine</td>
<td>Macon</td>
</tr>
<tr>
<td>12</td>
<td>Angela Shannon, M.D.</td>
<td>Psychiatry</td>
<td>Stockbridge</td>
</tr>
<tr>
<td>13</td>
<td>Jules Toraya, M.D.</td>
<td>OBGyn</td>
<td>Savannah</td>
</tr>
<tr>
<td>14</td>
<td>Clyde Watkins, M.D.</td>
<td>Internal Medicine</td>
<td>Atlanta</td>
</tr>
<tr>
<td></td>
<td><strong>GPLA Class III</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Gregorio Abad, M.D.</td>
<td>PM&amp;R</td>
<td>Dublin</td>
</tr>
<tr>
<td>16</td>
<td>Santanu Das, M.D.</td>
<td>Pediatrics</td>
<td>Warner Robins</td>
</tr>
<tr>
<td>17</td>
<td>Paula Gregory, D.O.</td>
<td>Family Physician</td>
<td>Atlanta</td>
</tr>
<tr>
<td>18</td>
<td>Anuj Gupta, M.D.</td>
<td>Orthopaedics</td>
<td>Atlanta</td>
</tr>
<tr>
<td>19</td>
<td>Albert Johary, M.D.</td>
<td>Internal Medicine</td>
<td>Atlanta</td>
</tr>
<tr>
<td>20</td>
<td>Indran Krishnan, M.D.</td>
<td>Gastroenterology</td>
<td>McDonough</td>
</tr>
<tr>
<td>21</td>
<td>Bob Lane, M.D.</td>
<td>Anesthesiology</td>
<td>Macon</td>
</tr>
<tr>
<td>22</td>
<td>Cody McClatchey, M.D.</td>
<td>Internal Medicine</td>
<td>Atlanta</td>
</tr>
<tr>
<td>23</td>
<td>Charles Moore, M.D.</td>
<td>Otolaryngology</td>
<td>Atlanta</td>
</tr>
<tr>
<td>24</td>
<td>Pravinchandra Patel, M.D.</td>
<td>Gastroenterology</td>
<td>Columbus</td>
</tr>
<tr>
<td>25</td>
<td>Geoffrey Simon, M.D.</td>
<td>Pediatrics</td>
<td>Delaware</td>
</tr>
<tr>
<td>26</td>
<td>Harry Strothers, M.D.</td>
<td>Family Physician</td>
<td>Atlanta</td>
</tr>
<tr>
<td>27</td>
<td>Matthew Watson, M.D.</td>
<td>Emergency Medicine</td>
<td>Atlanta</td>
</tr>
<tr>
<td>28</td>
<td>Edward Young, M.D.</td>
<td>Hospitalist</td>
<td>Macon</td>
</tr>
<tr>
<td></td>
<td><strong>GPLA Class IV</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>David Bogorad, M.D.</td>
<td>Ophthalmology</td>
<td>Augusta</td>
</tr>
<tr>
<td>30</td>
<td>Snehal Dalal, M.D.</td>
<td>Orthopaedics</td>
<td>Lawrenceville</td>
</tr>
<tr>
<td>31</td>
<td>Madalyn Davidoff, M.D.</td>
<td>Cardiology</td>
<td>Warner Robins</td>
</tr>
<tr>
<td>32</td>
<td>Joyce Doyle, M.D.</td>
<td>Internal Medicine</td>
<td>Atlanta</td>
</tr>
<tr>
<td>33</td>
<td>Sreeni Gangasani, M.D.</td>
<td>Cardiology</td>
<td>Lawrenceville</td>
</tr>
<tr>
<td>34</td>
<td>Beullette Hooks, M.D.</td>
<td>Family Physician</td>
<td>Midland</td>
</tr>
<tr>
<td>35</td>
<td>Karen Lovett, M.D.</td>
<td>Radiology</td>
<td>Albany</td>
</tr>
<tr>
<td>36</td>
<td>Angela Mattke, M.D.</td>
<td>Emergency Medicine</td>
<td>Atlanta</td>
</tr>
<tr>
<td>37</td>
<td>Frank McDonald, M.D.</td>
<td>Neurology</td>
<td>Gainesville</td>
</tr>
<tr>
<td>38</td>
<td>Margaret Schaufler, M.D.</td>
<td>OBGyn</td>
<td>LaGrange</td>
</tr>
<tr>
<td>39</td>
<td>Sumayah Taliaferro, M.D.</td>
<td>Dermatology</td>
<td>Atlanta</td>
</tr>
</tbody>
</table>
GPLA Class V

Victoria Clements, D.O., Pediatrician, North Carolina
Mitch Cook, DO, Family Medicine, Athens
Edmund Donoghue, M.D., Forensic Pathology, Savannah
Sreeni Gangasani, M.D., Cardiology, Lawrenceville
Michael Groves, M.D., Otolaryngology, Augusta
Stephen Jarrard, M.D., General Surgery, Lakemont
Robert “Bo” Lewis, M.D., Orthopaedics, Columbus
Natraj Puthugramam, M.D., Reproductive Endocrinology, Augusta
Danny Newman, M.D., Internal Medicine, Augusta
James Velimesis, M.D., Anesthesiology, Milton
Michelle Zeanah, M.D., Pediatrics, Statesboro

GPLA Class VI

Abhishek Gaur, M.D., Cardiology, Gainesville
Keith Johnson, M.D., Anesthesiology, Waycross
Aysha Khoury, M.D., Internal Medicine, Atlanta
McGregor Lott, M.D., Ophthalmology, Waycross
Elizabeth Morgan, M.D., Plastic Surgery, Atlanta
Brian Nadolne, M.D., Family Medicine, Roswell
Henry Patton, M.D., Internal Medicine, Covington
Carla Roberts, M.D., OB/Gyn, Atlanta
Randy Ruark, M.D., Orthopaedics, Augusta
Rob Schreiner, M.D., Critical Care, Atlanta
Thekkepat Sekhar, M.D., OB/Gyn, Warner Robins
John Sy, D.O., Emergency Medicine, Savannah
Charles Wilmer, M.D., Cardiology, Atlanta

GPLA Class VII

Eric Awad, M.D., Neurology, Atlanta
Amanda Brown, M.D., Anesthesiology, Macon
Thomas Emerson, M.D., Urology, Marietta
Rutledge Forney, M.D., Dermatology, Atlanta
Wayne Hoffman, M.D., Family Medicine, Atlanta
Matt Lyon, M.D., Emergency Medicine, Augusta
Adrienne Mims, M.D., Family Medicine, Atlanta
Walt Moore, M.D., Rheumatology, Augusta
Piyush Patel, M.D., Family Medicine, Columbus
Purnima Patel, M.D., Ophthalmology, Atlanta
Ali Rahimi, M.D., Cardiology, Marietta
J Smith M.D., Emergency Medicine, Atlanta
Vijaya Vella, M.D., OB/Gyn, Warner Robins
Steven Walsh, M.D., Anesthesiology, Atlanta
<table>
<thead>
<tr>
<th>Class</th>
<th>Name</th>
<th>Specialty</th>
<th>City</th>
</tr>
</thead>
<tbody>
<tr>
<td>VIII</td>
<td>Jovan Adams, D.O.</td>
<td>Family Medicine</td>
<td>Warner Robins</td>
</tr>
<tr>
<td></td>
<td>Robert Bashuk, M.D.</td>
<td>Neurology</td>
<td>Marietta</td>
</tr>
<tr>
<td></td>
<td>Margaret Boltja, M.D.</td>
<td>Neurology</td>
<td>Macon</td>
</tr>
<tr>
<td></td>
<td>Janis Coffin, D.O.</td>
<td>Family Medicine</td>
<td>Augusta</td>
</tr>
<tr>
<td></td>
<td>Debi Dalton, M.D.</td>
<td>Pediatric Emergency Medicine</td>
<td>Powder Springs</td>
</tr>
<tr>
<td></td>
<td>Amy Eubanks, M.D.</td>
<td>Internal Medicine</td>
<td>Bremen</td>
</tr>
<tr>
<td></td>
<td>Tim Grant, M.D.</td>
<td>Anesthesia</td>
<td>Macon</td>
</tr>
<tr>
<td></td>
<td>Mark Griffiths, M.D.</td>
<td>Pediatric Emergency Medicine</td>
<td>Atlanta</td>
</tr>
<tr>
<td></td>
<td>Charles Miller, M.D.</td>
<td>General Practice</td>
<td>Douglas</td>
</tr>
<tr>
<td></td>
<td>Dilipkumar Patel, M.D.</td>
<td>Psychiatry</td>
<td>Lilburn</td>
</tr>
<tr>
<td></td>
<td>Rani Reddy, M.D.</td>
<td>Internal Medicine</td>
<td>Statesboro</td>
</tr>
<tr>
<td></td>
<td>Mitzi Rubin, M.D.</td>
<td>Family Medicine</td>
<td>Atlanta</td>
</tr>
<tr>
<td></td>
<td>Tucker Jennifer Tucker, M.D.</td>
<td>Orthopaedics</td>
<td>Atlanta</td>
</tr>
<tr>
<td></td>
<td>Kelly Weselman, M.D.</td>
<td>Rheumatology</td>
<td>Smyrna</td>
</tr>
<tr>
<td></td>
<td>Cliff Willimon, M.D.</td>
<td>Orthopaedics</td>
<td>Atlanta</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Class</th>
<th>Name</th>
<th>Specialty</th>
<th>City</th>
</tr>
</thead>
<tbody>
<tr>
<td>IX</td>
<td>Matt Astin, M.D.</td>
<td>Emergency Medicine</td>
<td>Macon</td>
</tr>
<tr>
<td></td>
<td>Deepti Bhasin, M.D.</td>
<td>Psychiatry</td>
<td>Warner Robins</td>
</tr>
<tr>
<td></td>
<td>Brad Bushnell, M.D.</td>
<td>Orthopaedics</td>
<td>Rome</td>
</tr>
<tr>
<td></td>
<td>Ann Contrucci, M.D.</td>
<td>Pediatrician</td>
<td>Atlanta</td>
</tr>
<tr>
<td></td>
<td>Kelly Erola, M.D.</td>
<td>Palliative Medicine</td>
<td>Savannah</td>
</tr>
<tr>
<td></td>
<td>Fred Flandry, M.D.</td>
<td>Orthopaedics</td>
<td>Columbus</td>
</tr>
<tr>
<td></td>
<td>Sandra Fryhofer, M.D.</td>
<td>Internal Medicine</td>
<td>Atlanta</td>
</tr>
<tr>
<td></td>
<td>Yolanda Graham, M.D.</td>
<td>Psychiatry</td>
<td>Atlanta</td>
</tr>
<tr>
<td></td>
<td>Brian Hill, M.D.</td>
<td>Urology</td>
<td>Atlanta</td>
</tr>
<tr>
<td></td>
<td>Sandra Hollander, M.D.</td>
<td>Hematology Oncology</td>
<td>Dublin</td>
</tr>
<tr>
<td></td>
<td>Mark Huffman, M.D.</td>
<td>Anesthesiology</td>
<td>Marietta</td>
</tr>
<tr>
<td></td>
<td>Jeremy Jones, M.D.</td>
<td>Ophthalmology</td>
<td>Atlanta</td>
</tr>
<tr>
<td></td>
<td>Matthew Keadey, M.D.</td>
<td>Emergency Medicine</td>
<td>Atlanta</td>
</tr>
<tr>
<td></td>
<td>Faria Khan, M.D.</td>
<td>Allergy</td>
<td>Suwanee</td>
</tr>
<tr>
<td></td>
<td>Fonda Mitchell, M.D.</td>
<td>OBGyn</td>
<td>Atlanta</td>
</tr>
<tr>
<td></td>
<td>Alyce Oliver, M.D.</td>
<td>Rheumatology</td>
<td>Augusta</td>
</tr>
<tr>
<td></td>
<td>Brian Ribeiro, M.D.</td>
<td>Internal Medicine</td>
<td>Ft. Benning</td>
</tr>
<tr>
<td></td>
<td>Eddie Richardson, Jr., M.D.</td>
<td>Family Medicine</td>
<td>Eatonton</td>
</tr>
<tr>
<td></td>
<td>Al Scott, M.D.</td>
<td>OBGyn</td>
<td>Decatur</td>
</tr>
<tr>
<td></td>
<td>Jeffrey Stone, M.D.</td>
<td>Family Medicine</td>
<td>Dallas</td>
</tr>
</tbody>
</table>
The graph below shows the specialty distribution of participants from all GPLA Classes. Please help us accomplish the Academy’s mission by making nominations for the missing county medical and specialty societies.
Although several county medical and medical specialty societies have validated the GPLA as a valuable asset in training future leaders, the MAG HOD has not yet officially endorsed the GPLA curriculum.

Therefore, the GPLA Steering Committee recommends that:

**Recommendation 1:** MAG will endorse the GPLA as an integral program in training future and emerging leaders of medical societies in GA, and

**Recommendation 2:** When MAG members who are not alumni of the GPLA are elected to the MAG Executive Committee, they will be encouraged to join the upcoming class if at all possible, and

**Recommendation 3:** All MAG members who are considering future physician leadership positions within any of our county medical or state medical specialty societies should be encouraged to seek nominations from their societies to undergo GPLA training.

The GPLA Steering Committee expresses particular appreciation to our faculty and staff:

Bob Addleton, EdD, Dean and Lead Faculty
Susan Reichman, BSN, GPLA Administrator
Fred Jones, MAG Foundation Director
Lori Cassity Murphy, Program and Development Director, MAG Foundation
Donald Palmisano Jr., MAG Executive Director/CEO; MAG Foundation CEO

**2016 GPLA Steering Committee Members**

Jacqueline Fincher, M.D., Class 1 representative
Jim Barber, M.D., Class 2 representative
Santanu Das, M.D., Class 3 representative, incoming Chair-Elect
Madalyn Davidoff, M.D., Class 4 representative
Stephen Jarrard, M.D., Class 5 representative
Johnny Sy, DO, Class 6 representative, incoming Chair
James “J” Smith, M.D., Class 7 representative
Jovan Adams, DO, Class 8 representative
Jack Chapman, M.D., MAG Foundation Board Chair
John Harvey, M.D., MAG President
Steve Walsh, M.D., MAG President-elect
Scott Bohlke, M.D., MAG Incoming Chair, MAG Council on Legislation
Joy Maxey, M.D., MAG Past President
Manoj Shah, M.D., MAG Past-President
Donald Palmisano, Jr., MAG Executive Director and CEO
Bob Addleton, EdD, Dean and Lead Faculty

# # #
RESOLUTION

Resolution: 401F.16

SUBJECT: Charter Rome Area Medical Society

SUBMITTED BY: Floyd-Polk-Chattanooga County Medical Society

REFERRED TO: Reference Committee F

Whereas, the counties of Floyd, Polk, Chattooga, Gordon, and Bartow are adjacent to each other in the Medical Association of Georgia’s (MAG) Seventh District Medical Society; and

Whereas, physicians in the counties of Floyd, Polk, Chattooga, Gordon, and Bartow have met and agreed to expand the county medical society; and

Whereas, MAG Bylaws Chapter III, Component County Societies, Section 1, provides that the House of Delegates may, in sparsely populated areas, organize the physicians of two or more counties into societies to be designated so as to distinguish them from district societies; and

Whereas, physician leaders in these counties believe that a new and active county medical society will attract non-member physicians practicing in the area to become involved and to join the county and state medical association; now therefore be it

RESOLVED, that the Medical Association of Georgia House of Delegates grant a charter to the combined counties of Floyd, Polk, Chattooga, Gordon, and Bartow for a new multi-county medical society to be titled the Rome Area Medical Society.

###
RESOLUTION

SUBJECT: Charter North Georgia Mountains Medical Society

SUBMITTED BY: Stephens-Rabun County Medical Society

REFERRED TO: Reference Committee F

Whereas, the counties of Stephens and Rabun and Habersham are adjacent to each other in the Medical Association of Georgia’s (MAG) Ninth District Medical Society; and

Whereas, physicians in the counties of Stephen, Rabun, Habersham and Towns have met and agreed to expand the county society of Stephens-Rabun to include members of Habersham CMS and to include physicians in Towns County, which has no county society representation; and

Whereas, MAG Bylaws. Chapter III, Component County Societies, Section 1, provides that the House of Delegates may, in sparsely populated areas, organize the physicians of two or more counties into societies to be designated so as to distinguish them from district societies; and

Whereas, physician leaders in these counties believe that a new and active county medical society will attract non-member physicians practicing in the area to become involved and to join the county and state medical association; now therefore be it

RESOLVED, that the Medical Association of Georgia House of Delegates grant a charter to the combined counties of Stephens, Rabun, Habersham and Towns for a new multi-county medical society to be titled the North Georgia Mountains Medical Society.

# # #
REFERENCE COMMITTEES
RESOLUTION
Resolution: 601S.16

SUBJECT: Controlled Drug Disposal for Pharmacies

SUBMITTED BY: Richmond County Medical Society

REFERRED TO: Reference Committee S

Whereas, there are great reservoirs of unused drugs in medicine cabinets in the community; and

Whereas, the most common gateway drug of our most vulnerable are legal drugs sitting in these medicine cabinets; and

Whereas, greater than 96 percent of opioid addicts take their first opioid before 21 years of age; and

Whereas, pharmacies would be the obvious convenient, safe location to dispose of these dangerous drugs; now therefore be it

RESOLVED, that the Medical Association of Georgia will work with the Georgia Board of Pharmacy to reduce barriers for placing drug collection boxes for unwanted/unused medications in retail pharmacies.

# # #

AMA Policy

Medications Return Program H-135.925
1. Our AMA supports access to safe, convenient, and environmentally sound medication return for unwanted prescription medications
2. Our AMA supports such a medication disposal program be fully funded by the pharmaceutical industry, including costs for collection, transport and disposal of these materials as hazardous waste.
3. Our AMA supports changes in federal law or regulation that would allow a program for medication recycling and disposal to occur.

Proper Disposal of Unused Prescription and Over-the-Counter (OTC) Drugs H-135.936
1. Our AMA supports initiatives designed to promote and facilitate the safe and appropriate disposal of unused medications.

2. Our AMA will work with other national organizations and associations to inform, encourage, support and guide hospitals, clinics, retail pharmacies, and narcotic treatment programs in modifying their US Drug Enforcement Administration registrations to become authorized medication collectors and operate collection receptacles at their registered locations.

3. Our AMA will work with other appropriate organizations to develop a voluntary mechanism to accept non-controlled medication for appropriate disposal or recycling.
RESOLUTION

SUBJECT: Substance Abuse Curriculum and CME Opportunities

SUBMITTED BY: Richmond County Medical Society

REFERRED TO: Reference Committee S

Whereas, there is a lack of medical training regarding the diagnosis of substance abuse in medical school curriculum; and
Whereas, a substance abuse history is seldom included by practicing physicians in the patient’s medical history; and
Whereas, tobacco, alcohol, opioid and other forms of legal and illegal drugs continue to damage lives and cost society enormous amounts of money; now therefore be it

RESOLVED, that the Medical Association of Georgia (MAG) policy is to make continuing substance abuse education material readily available to its membership; and be it further

RESOLVED, that MAG policy is to support the inclusion of Screening, Brief Intervention, and Referral to Treatment (SBIRT) diagnostic criteria into medical histories.

###

AMA Policy

Establishing Essential Requirements for Medical Education in Substance Abuse H-295.922

AMA policy states that alcohol and other drug abuse education needs to be an integral part of medical education; and that the AMA supports the development of programs to train medical students in the identification, treatment, and prevention of alcoholism and other chemical dependencies. Our AMA: (1) asks all residency review committees to review their training requirements in the treatment and management of substance abuse and addiction and to make recommendations for strengthening this provision as needed; and (2) encourages the development of specialty-specific needs assessment to determine whether targeted educational activities in substance abuse would be useful in their overall program of continuing medical education.

Improving Medical Practice and Patient/Family Education to Reverse the Epidemic of Nonmedical Prescription Drug Use and Addiction D-95.981

1. Our AMA:
   a. will collaborate with relevant medical specialty societies to develop continuing medical education curricula aimed at reducing the epidemic of misuse of and addiction to prescription controlled substances, especially by youth;
   b. encourages medical specialty societies to develop practice guidelines and performance measures that would increase the likelihood of safe and effective clinical use of prescription controlled substances, especially psychostimulants, benzodiazepines and benzodiazepines receptor agonists, and opioid analgesics;
c. encourages physicians to become aware of resources on the nonmedical use of prescription controlled substances that can assist in actively engaging patients, and especially parents, on the benefits and risks of such treatment, and the need to safeguard and monitor prescriptions for controlled substances, with the intent of reducing access and diversion by family members and friends;
d. will consult with relevant agencies on potential strategies to actively involve physicians in being? a part of the solution? to the epidemic of unauthorized/nonmedical use of prescription controlled substances; and
e. supports research on: (i) firmly identifying sources of diverted prescription controlled substances so that solutions can be advanced; and (ii) issues relevant to the long-term use of prescription controlled substances.

2. Our AMA, in conjunction with other Federation members, key public and private stakeholders, and pharmaceutical manufacturers, will pursue and intensify collaborative efforts involving a public health approach in order to:
a. reduce harm from the inappropriate use, misuse and diversion of controlled substances, including opioid analgesics and other potentially addictive medications;
b. increase awareness that substance use disorders are chronic diseases and must be treated accordingly; and
c. reduce the stigma associated with patients suffering from persistent pain and/or substance use disorders, including addiction.

Alcohol and Substance Abuse Education of Medical Students and Residents H-295.988
In cooperation with other organizations, the AMA supports the education of medical students and residents in the prevention and treatment of alcoholism and substance abuse in our nation's youth.

The Status of Education in Substance Use Disorders in America's Medical Schools and Residency Programs D-295.946
Our AMA will:
(1) advocate for in-depth qualitative studies to facilitate the preparation of physicians to care for patients with substance use disorders;
(2) facilitate the identification, dissemination, and implementation of successful substance use disorder educational programs across the educational continuum;
(3) encourage the Accreditation Council for Graduate Medical Education (ACGME) to include education about substance use disorders in their program accreditation requirements;
(4) encourage the American Board of Medical Specialties (ABMS) to encourage its member boards to include substance use disorder questions in their certification process; and
RESOLUTION

Resolution: 603S.16

SUBJECT: Expansion of Project DAN (Deaths Avoided by Naloxone)

SUBMITTED BY: Richmond County Medical Society

REFERRED TO: Reference Committee S

Whereas, Project DAN (Deaths Avoided by Naloxone) is an integral part of the MAG Foundation’s ‘Think About It’ campaign; and

Whereas, Project DAN is designed to reduce incidents of overdose by equipping law enforcement officers with the prescription drug Naloxone/Narcan and provide training for its use; and

Whereas, Project DAN is currently only available to the following 13 counties in northeast Georgia: Banks, Barrow, Dawson, Forsyth, Habersham, Hall, Jackson, Lumpkin, Rabun, Stephens, Towns, Union and White; now therefore be it

RESOLVED, that the Medical Association of Georgia (MAG) will expand the scope of Project DAN to make Naloxone/Narcan available to all remaining counties in Georgia; and be it further

RESOLVED, that MAG will seek funding to help agencies obtain this life-saving medication; and be it further

RESOLVED, that MAG will facilitate the training of first responders in the use of this medication.

###

AMA Policy

Increasing Availability of Naloxone H-95.932

1. Our AMA supports legislative and regulatory efforts that increase access to naloxone, including collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery.

2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone.

3. Our AMA encourages physicians to co-prescribe naloxone to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients.

4. Our AMA encourages private and public payers to include all forms of naloxone on their preferred drug lists and formularies with minimal or no cost sharing.

5. Our AMA supports liability protections for physicians and other health care professionals and others who are authorized to prescribe, dispense and/or administer naloxone pursuant to state law.

6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone to receive appropriate education to enable them to do so effectively.
Prevention of Opioid Overdose D-95.987

1. Our AMA: (A) recognizes the great burden that opioid addiction and prescription drug abuse places on patients and society alike and reaffirms its support for the compassionate treatment of such patients; (B) urges that community-based programs offering naloxone and other opioid overdose prevention services continue to be implemented in order to further develop best practices in this area; and (C) encourages the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities; and (D) will continue to monitor the progress of such initiatives and respond as appropriate.

2. Our AMA will: (A) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of opioid overdose; and (B) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for opioid overdose.
RESOLUTION

Resolution: 604S.16

SUBJECT: Prescription Drug Abuse Education in Medical School

SUBMITTED BY: Hall County Medical Society

REFERRED TO: Reference Committee S

Whereas, opioid pain medications are commonly used in clinical practice and there continues to be much debate about how to best prescribe and regulate these substances; and

Whereas, prescription drug abuse is an ongoing problem and methods of prevention are becoming more prevalent in clinical practice, yet overdose deaths are still at an unacceptable level; and

Whereas, physician organizations believe mandatory continuing medical education (CME) for all practicing physicians is unnecessary, but are making other efforts to address the issue; and

Whereas, multiple voluntary CME activities currently exist, including the University of Washington’s COPE-REMS, sponsored by the FDA; and

Whereas, the state of Massachusetts, in conjunction with all four of its medical schools, has set precedent by establishing Medical Education Core Competencies for the Prevention and Management of Prescription Drug Misuse; now therefore be it

RESOLVED, that the Medical Association of Georgia (MAG) supports the incorporation of Prescription Drug Misuse education into medical school curriculums.

# # #

References

CDC Guidelines:
a) https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

AAFP:
a) http://www.aafp.org/news/opinion/20110824opioidsvoices.html

University of Washington:

Massachusetts Curriculum:
AMA Policy

Establishing Essential Requirements for Medical Education in Substance Abuse H-295.922
AMA policy states that alcohol and other drug abuse education needs to be an integral part of medical education; and that the AMA supports the development of programs to train medical students in the identification, treatment, and prevention of alcoholism and other chemical dependencies. Our AMA: (1) asks all residency review committees to review their training requirements in the treatment and management of substance abuse and addiction and to make recommendations for strengthening this provision as needed; and (2) encourages the development of specialty-specific needs assessment to determine whether targeted educational activities in substance abuse would be useful in their overall program of continuing medical education.

The Status of Education in Substance Use Disorders in America’s Medical Schools and Residency Programs D-295.946
Our AMA will:
(1) advocate for in-depth qualitative studies to facilitate the preparation of physicians to care for patients with substance use disorders;
(2) facilitate the identification, dissemination, and implementation of successful substance use disorder educational programs across the educational continuum;
(3) encourage the Accreditation Council for Graduate Medical Education (ACGME) to include education about substance use disorders in their program accreditation requirements;
(4) encourage the American Board of Medical Specialties (ABMS) to encourage its member boards to include substance use disorder questions in their certification process; and
RESOLUTION

SUBJECT: Position on CDC Opioid Prescription Guidelines

SUBMITTED BY: P. Tennent Slack, M.D., Delegate

REFERRED TO: Reference Committee S

Whereas, deaths related to prescription opioids have become a major national problem; and
Whereas, said deaths are considered by many to be a physician-driven problem; and
Whereas, the Centers for Disease Control and Prevention (CDC) in March 2016 released guidelines pertaining to the prescribing of opioid pain medications for patients 18 years and older in the primary care setting; and
Whereas, said recommendations focus on the use of opioids to treat non-malignant, non-terminal, non-palliative pain greater than three months in duration; and
Whereas, certain third-party payers are citing said CDC guidelines as a basis for restricting and/or obstructing access to opioid therapy in non-terminal, non-palliative settings by multiple mechanisms including a reduction in the number of days’ supply per prescription and prior authorization requirements for all long-acting opioid preparations; and
Whereas, the prescribing of opioids is fundamentally the practice of medicine; now therefore be it
RESOLVED, that the Medical Association of Georgia (MAG) supports the current version of the Centers for Disease Control and Prevention (CDC) Opioid Prescription Guidelines but, with the following exception:

1. Primary care physicians may act outside of said guidelines if the physician deems it medically appropriate; and be it further
RESOLVED, that MAG does not support the application of the CDC Opioid Prescription Guidelines to specialties, which include, but are not limited to surgery and all its subspecialties, pain medicine, oncology, and rheumatology, which deploy opioid therapy as part of their standard daily medical practice; and be it further
RESOLVED, that MAG does not support the use of the CDC Opioid Prescription Guidelines by third party payers as a basis for restricting or obstructing access to opioid therapy.

###
RESOLUTION

Resolution: 606S.16

SUBJECT: Mandatory Opioid Prescribing CME

SUBMITTED BY: P. Tennent Slack, M.D., Delegate

REFERRED TO: Reference Committee S

Whereas, the annual number of prescription opioid-related overdose deaths has been labeled an epidemic by the Centers for Disease Control and Prevention (CDC); and

Whereas, the number of annual prescription opioid overdose deaths have a strong correlation with the annual number of opioid pills prescribed and dispensed; and

Whereas, physicians have a responsibility to prescribe opioids in a discriminating fashion; and

Whereas, legislation at both the national and state level is being considered that mandates continuing medical education (CME) training for all physicians as it relates to the prescribing of opioids; now therefore be it

RESOLVED, that the Medical Association of Georgia (MAG) supports mandatory continuing medical education (CME) training for all physicians as it pertains to the prescribing of opioids for therapeutic purposes, provided said-CME training program is approved by MAG.

# # #

AMA Policy

Improving Medical Practice and Patient/Family Education to Reverse the Epidemic of Nonmedical Prescription Drug Use and Addiction D-95.981

1. Our AMA:
   a. will collaborate with relevant medical specialty societies to develop continuing medical education curricula aimed at reducing the epidemic of misuse of and addiction to prescription controlled substances, especially by youth;
   b. encourages medical specialty societies to develop practice guidelines and performance measures that would increase the likelihood of safe and effective clinical use of prescription controlled substances, especially psychostimulants, benzodiazepines and benzodiazepines receptor agonists, and opioid analgesics;
   c. encourages physicians to become aware of resources on the nonmedical use of prescription controlled substances that can assist in actively engaging patients, and especially parents, on the benefits and risks of such treatment, and the need to safeguard and monitor prescriptions for controlled substances, with the intent of reducing access and diversion by family members and friends;
d. will consult with relevant agencies on potential strategies to actively involve physicians in being a part of the solution to the epidemic of unauthorized/nonmedical use of prescription controlled substances; and
e. supports research on: (i) firmly identifying sources of diverted prescription controlled substances so that solutions can be advanced; and (ii) issues relevant to the long-term use of prescription controlled substances.

2. Our AMA, in conjunction with other Federation members, key public and private stakeholders, and pharmaceutical manufacturers, will pursue and intensify collaborative efforts involving a public health approach in order to:

a. reduce harm from the inappropriate use, misuse and diversion of controlled substances, including opioid analgesics and other potentially addictive medications;

b. increase awareness that substance use disorders are chronic diseases and must be treated accordingly; and

c. reduce the stigma associated with patients suffering from persistent pain and/or substance use disorders, including addiction.
RESOLUTION

SUBJECT: Over-the-Counter Naloxone

SUBMITTED BY: Hall County Medical Society

REFERRED TO: Reference Committee S

Whereas, Georgia continues to experience high rates of prescription and non-prescription opioid overdose deaths; and
Whereas, the administration of intranasal naloxone by non-medical personnel is now allowed under Georgia law to reverse opioid overdose; and
Whereas, said administration has been shown to be safe and highly effective in numerous cases in Georgia and across the U.S.; and
Whereas, there are increasing calls from various advocacy groups and medical organizations to routinely co-prescribe naloxone when opioids are prescribed; and
Whereas, many physicians in Georgia are unaware that current state law allows for the use of intranasal naloxone; and
Whereas, the state pharmacy association is in support of making intranasal naloxone available over-the-counter at pharmacies; now therefore be it

RESOLVED, that the Medical Association of Georgia supports over-the-counter dispensing of intranasal naloxone for use in a manner consistent with state law.

# # #

AMA Policy

Increasing Availability of Naloxone H-95.932
1. Our AMA supports legislative and regulatory efforts that increase access to naloxone, including collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery.
2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone.
3. Our AMA encourages physicians to co-prescribe naloxone to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients.
4. Our AMA encourages private and public payers to include all forms of naloxone on their preferred drug lists and formularies with minimal or no cost sharing.
5. Our AMA supports liability protections for physicians and other health care professionals and others who are authorized to prescribe, dispense and/or administer naloxone pursuant to state law.
6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone to receive appropriate education to enable them to do so effectively.
RESOLUTION

SUBJECT: Hepatitis C Reduction

SUBMITTED BY: Whitfield-Murray Medical Society

REFERRED TO: Reference Committee S

Whereas, there were 11,229 reported cases of Hepatitis C Virus (HCV) in 2014; and
Whereas, there were 13,970 reported HCV cases in 2015; and
Whereas, there were 1,250 reported HCV cases of individuals ages 30 years and younger in 2015; and
Whereas, Georgia has had a 123 percent increase in HCV cases in children ages 36 months and younger; now therefore be it

RESOLVED, that the Medical Association of Georgia (MAG) encourages policymakers to take the following actions:

(1) Pursue an approach to the drug abuse problem, which would focus on preventing the initiation of drug use, aiding those who wish to cease drug use, and diminishing the adverse consequences of drug use;

(2) Recognize the importance of screening for alcohol and other drug use in a variety of settings, and broaden the concept of addiction treatment to embrace a continuum of modalities and goals, including appropriate measures of harm reduction, which can be made available and accessible to enhance positive treatment outcomes for patients and society;

(3) Encourage the expansion of opioid maintenance programs so that opioid maintenance therapy can be available for any individual who applies and for whom the treatment is suitable, allowing for training to be available so that an adequate number of physicians are prepared to provide treatment;

(4) Encourage the extensive application of needle and syringe exchange and distribution programs and the modification of restrictive laws and regulations concerning the sale and possession of needles and syringes to maximize the availability of sterile syringes and needles, while ensuring continued reimbursement for medically necessary needles and syringes; and be it further

RESOLVED, that MAG strongly supports the ability of physicians to prescribe syringes and needles to patients with injection drug addiction in conjunction with addiction counseling in order to help prevent the transmission of contagious diseases.

# # #