WHEREAS, The American Medical Association’s commitment to improving physician  
professional satisfaction and practice sustainability is a cornerstone of AMA’s strategic plan and  
the AAM has developed policies supporting physician well-being; and

WHEREAS, Physicians are part of the ‘safety net’ of society as essential elements of the health care system of the United States. Loss of access to regular outpatient settings will lead to  
increased use of far more expensive emergency facilities. Insurers should fund MDs from  
savings garnered from reduction in outlays on care not delivered because of COVID-19, as they  
have shown exists by refunding policyholders¹ and

WHEREAS, Lessons of COVID-19 reveal the fragile condition of many medical practices and  
health care institutions operating under narrow economic margins. Smaller practices, in  
particular, are at great risk from disruption in revenue streams, including related to volume of  
service (not) rendered, risk withholds and other incentive payments. More frequent, regular  
basic payments for patient care and more frequent incentive payments than yearly may partly  
attenuate that risk²,³,⁴,⁵,⁶; and

WHEREAS, Loss of independent practices likely will lead to more physicians working for a  
system, risking reduced medical professional control over quality of care, reduced access to  
medical care in certain areas, as well as potentially the attenuation of the doctor-patient  
relationship⁷,⁸; and

WHEREAS, Prior authorization as currently, indiscriminately, practiced siphons off clinical care  
time and support staff resources, creating expense at the point of service level, while frequently

https://jamanetwork.com/journals/jama/fullarticle/2767633.  
delaying or denying necessary care. Eliminating routine prior authorization would relieve both issues; and

WHEREAS, Insufficient payment for episodes of care put further strain on both quality of care and survival of the individual medical practice; and

WHEREAS, A ‘real-time economic partnership’ of physicians and third party payers could be one concept to settle health care system fragility, especially if coupled with a smaller feedback loop between the parties; and

WHEREAS, Telehealth has been shown to be an effective means of delivering care to a large segment of the population, though for many others is not as effective, giving rise to a need for defining the appropriate use of telehealth going forward; and

WHEREAS, Resource allocation planning to meet crises (e.g., ventilators, personal protective equipment, vaccine distribution) would be more likely to be effective if it included physicians and other health care providers as core participants, who should also be indemnified for that service; and

WHEREAS, In an evolving health care system, inclusive of natural challenges and technological advances, the design of the medical office/clinic environment likely needs revision to remain efficient clinically and economically; and

WHEREAS, Time-sensitive, accurate testing for communicable disease is important in the medical as well as social environment, along with access to adequate personal protective equipment (PPE); and


11 ibid


WHEREAS, Political gridlock has truncated governmental support of health care with no assurance of adequate funding going forward; therefore be it

RESOLVED, That our American Medical Association promote national awareness of the loss of medical practices due to COVID-19, implications in terms of access to health care and the particular need for ongoing short term public support of all levels of health practices and institutions (Directive to Take Action); and be if further

RESOLVED, That our American Medical Association initiate a study on payment reform to devise a system that supports and sustains medical practices not only under routine circumstances but also in extended crises, with report back by I-21. (Directive to Take Action)

Fiscal Note: Not yet determined

Date received: Oct 2, 2020

RELEVANTAMA POLICY:

Pandemic Preparedness for Influenza H-440.847

In order to prepare for a potential influenza pandemic, our AMA: (1) urges the Department of Health and Human Services Emergency Care Coordination Center, in collaboration with the leadership of the Centers for Disease Control and Prevention (CDC), state and local health departments, and the national organizations representing them, to urgently assess the shortfall in funding, staffing, vaccine, drug, and data management capacity to prepare for and respond to an influenza pandemic or other serious public health emergency; (2) urges Congress and the Administration to work to ensure adequate funding and other resources: (a) for the CDC, the National Institutes of Health (NIH) and other appropriate federal agencies, to support implementation of an expanded capacity to produce the necessary vaccines and anti-viral drugs and to continue development of the nation's capacity to rapidly vaccinate the entire population and care for large numbers of seriously ill people; and (b) to bolster the infrastructure and capacity of state and local health department to effectively prepare for, respond to, and protect the population from illness and death in an influenza pandemic or other serious public health emergency; (3) urges the CDC to develop and disseminate electronic instructional resources on procedures to follow in an influenza epidemic, pandemic, or other serious public health emergency, which are tailored to the needs of physicians and medical office staff in ambulatory care settings; (4) supports the position that: (a) relevant national and state agencies (such as the CDC, NIH, and the state departments of health) take immediate action to assure that physicians, nurses, other health care professionals, and first responders having direct patient contact, receive any appropriate vaccination in a timely and efficient manner, in order to reassure them that they will have first priority in the event of such a pandemic; and (b) such agencies should publicize now, in advance of any such pandemic, what the plan will be to provide immunization to health care providers; (6) will monitor progress in developing a contingency plan that addresses future influenza vaccine production or distribution problems and in developing a plan to respond to an influenza pandemic in the United States.

Citation: CSAPH Rep. 5, I-12; Reaffirmed: A-15
Domestic Disaster Relief Funding D-130.966

1. Our American Medical Association lobby Congress to a) reassess its policy for expedited release of funding to disaster areas; b) define areas of disaster with disproportionate indirect and direct consequences of disaster as "public health emergencies"; and c) explore a separate, less bureaucratic process for providing funding and resources to these areas in an effort to reduce morbidity and mortality post-disaster.

2. Our AMA will lobby actively for the recommendations outlined in the AMA/APHA Linkages Leadership Summit including: a) appropriate funding and protection of public health and health care systems as critical infrastructures for responding to day-to-day emergencies and mass causality events; b) full integration and interoperable public health and health care disaster preparedness and response systems at all government levels; c) adequate legal protection in a disaster for public health and healthcare responders and d) incorporation of disaster preparedness and response competency-based education and training in undergraduate, graduate, post-graduate, and continuing education programs.

Citation: Res. 421, A-11; Reaffirmed: A-15

Emergency Preparedness D-130.974

Our AMA (1) encourages state and local public health jurisdictions to develop and periodically update, with public and professional input, a comprehensive Public Health Disaster Plan specific to their locations. The plan should: (a) provide for special populations such as children, the indigent, and the disabled; (b) provide for anticipated public health needs of the affected and stranded communities including disparate, hospitalized and institutionalized populations; (c) provide for appropriate coordination and assignment of volunteer physicians; and (d) be deposited in a timely manner with the Federal Emergency Management Agency, the Public Health Service, the Department of Health and Human Services, the Department of Homeland Security and other appropriate federal agencies; and (2) encourages the Federation of State Medical Boards to implement a clearinghouse for volunteer physicians (MDs and DOs) that would (a) validate licensure in any state, district or territory to provide medical services in another distressed jurisdiction where a federal emergency has been declared; and (b) support national legislation that gives qualified physician volunteers (MDs and DOs), automatic medical liability immunity in the event of a declared national disaster or federal emergency.

Citation: Sub Res. 803, I-05; Reaffirmed: A-06; Reaffirmed: BOT Rep. 2, A-07; Reaffirmed in lieu of Res. 938, I-11; Modified: BOT action in response to referred for decision Res. 415, A-12

Hospital Disaster Plans and Medical Staffs H-225.941

Our AMA encourages: (1) appropriate stakeholders to examine the barriers and facilitators that medical staffs will encounter following a natural or other disaster; and (2) hospitals to incorporate, within their hospital disaster plans, workplace and personal preparedness efforts
that reduce barriers to staff responses during a natural or other disaster, both within their institutions and across the community.

Citation: Res. 916, I-17
ONLINE FORUM TESTIMONY:

I feel this is a very well-worded resolution and I support it and its intent. I hope delegates will vote FOR it.

Lawrence Monahan, MD
Personal opinion

Let us get something positive from this Public Health crisis. I know Our AMA is up for the task.

David Welsh, MD
Personal opinion

Very well crafted resolution. Says a lot about what impact the pandemic has had on our fragile medical stem. Strongly support this resolution.

Jay Gregory, MD
Personal opinion

I support this resolution and urge its passage.

Kenneth Crabb, MD
Personal opinion

Strongly support this resolution. Perhaps there should be a special physician practice relief fund authorized through Congress to sustain physicians in the workforce during disasters and pandemics? Just as an aside, we in the practice of medicine have to decide how committed we are to support public health initiatives, including social determinants of health. Health Care Inequities involving vulnerable populations become tragically apparent during such crises...I would go along way with the legislature to show them we are "all in" in this regard.

Theodore Christopher, MD
Personal opinion

I support this resolution. We should pass it and send it on to the AMA HOD.

Lee Perrin, MD
Personal opinion

I strongly support the resolution. If not for some fortuitous value-based payments from last year, my practice would have no reserves and I would have had to use my own funds to stay open. The Payroll Protection Program was a band-aid and only helped to keep the staff employed. The second wave is upon us and most likely many small practices will have to close.

Edward Bush, MD
Personal opinion

FYI This resolution evolved from the webinar crafted by the OMSS Policy Committee to focus on a topic that could be expected to generate ideas for resolutions.

The speakers were very informative, and many of the Whereases were taken from their points.
The Governing Council, and our Policy Committee, welcome ideas for future webinars along the same lines, i.e., to facilitate resolution development from novel sources, especially the wider OMSS membership.

Join us for future webinars.

Matthew Gold, MD
Personal opinion

I strongly agree with all supportive comments, regarding this timely and well crafted resolution. Perhaps we might alter the title to "Applying the Lessons Learned". I would love to review the webinar, is there a link that I have missed?

Louise Andrew, MD
Personal opinion