AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Late Resolution 001
(November 2020)

Introduced by: Dhairya Shukla, Medical College of Georgia at Augusta University; Neha Siddiqui, Carle Illinois College of Medicine; Ramie Fathy, Perelman School of Medicine at the University of Pennsylvania

Sponsored by: N/A

Subject: Support for Universal Internet Access

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

I. Issues of internet access as a human right

Whereas, The United Nations has declared internet access as a human right[1]; and

Whereas, The 2019 Broadband Deployment Report found that 21.3 million Americans lack home internet access[2]; and

Whereas, Home internet access varies by socioeconomic status, with only 64.3% of households that make less than $25,000 of annual income having access to internet as opposed to 93.5% of households with over $50,000 of annual income[3,4]; and

Whereas, One in three families who earn less than $50,000 annually do not have high-speed home internet[5]; and

II. Broadband as a social determinant of health

Whereas, The United States congress defines broadband as a service that enables users to originate and receive high-quality voice, data, graphics, and video telecommunications[6]; and

Whereas, The 2020 FCC Broadband Deployment Report set the minimum service that qualifies as broadband at 25mbps upstream and 3mpbs downstream[7,8]; and

Whereas, Despite the FCC's Congressional mandate to "holistically evaluate progress in the deployment" of broadband, the FCC has declined to adopt benchmarks on affordability, data allowances, or latency for either fixed or mobile broadband services, because “[w]hile factors such as data allowances or pricing may affect consumers’ use of [broadband] or influence decisions concerning the purchase of these services in the first instance, such considerations do not affect the underlying determination of whether [broadband] has been deployed and made available to customers in a given area.”[7]; and

Whereas, Healthy People 2020 has identified internet access as a social determinant of health[9]; and

Whereas, Internet access is critical for receiving telehealth services, accessing childhood education, and applying for job opportunities, all of which contribute to health[10-13]; and

Whereas, During the current pandemic, telehealth and virtual education have become necessary to promote health and well-being[14]; and

Whereas, A majority of government applications for programs and benefits which affect health are available mostly or sometimes only online, especially during the COVID pandemic[12,13,15,16]; and

Whereas, The AMA has committed itself to health equity and improving social determinants of health, stating in H-65.960 that "optimizing the social determinants of health is an ethical obligation of a civil society"; and

III. Broadband use in healthcare delivery

Whereas, The COVID pandemic has increased reliance on telehealth and has furthered the divide between patients with and without internet access[17]; and

Whereas, A study comparing the demographics of patients with completed telemedicine encounters in the current COVID-19 era at a large academic health system found that those with completed telemedicine video visits, when compared to telephone-only visits, were more likely to be male (50% versus 42%; P=0.01), were less likely to be black (24% versus 34%; P<0.01), and had higher median household income (21% versus 32% with income <$50 000, 54% versus 49% with income of $50 000–$100 000, 24% versus 19% with income ≥$100 000)[18]; and

Whereas, A study commissioned by the US Chamber of Commerce found broadband has helped to further broaden the scope of healthcare and has led to dramatic cost savings by facilitating the fast and reliable transmission of critical health information, multimedia medical applications, and lifesaving services to many parts of the country[19]; and

Whereas, Telemedicine has been demonstrated to allow for increased access to care, higher show rates, shorter wait times, increased clinical efficiency, and higher convenience – all affecting quality of patient care[20,21]; and

Whereas, Telemedicine has been demonstrated to reduce patient and healthcare worker exposure to COVID-19 among other diseases, reduce use of Personal Protective Equipment (PPE), and reduce use of hospital beds and other limited resources[14,20]; and

IV. Broadband use in education

Whereas, The COVID-19 pandemic caused a near-total shutdown of the U.S. school system, forcing more than 55 million students to transition to home-based remote learning[5]; and

Whereas, One in five households with school-age children (ages 6-18), including 1.6 million immigrant families, do not have personal broadband internet access at home during the COVID-19 pandemic[20,22]; and

Whereas, There are 4.6 million households with school aged children that access internet at home solely through cell phones, and 1.5 million households with school aged children who have no internet access of any kind at all, including cell phones[22]; and

Whereas, One in three Black, Latino, and American Indian/Alaska Native families do not have home internet access sufficient to support online learning during the COVID-19 pandemic[23]; and

IV. COVID-19 pandemic has exacerbated disparities in internet access

Whereas, The United States internet usage has increased 34% between January 2020 and April 2020 during the COVID-19 pandemic[24]; and

Whereas, The FCC Lifeline program provides a choice between either discounted mobile internet access or discounted broadband access for qualifying low-income recipients[25]; and

Whereas, The FCC recognizes there is insufficient evidence to conclude that fixed and mobile broadband services are full substitutes in all cases[7]; and

Whereas, At least 21% of patients on Medicaid lack home internet access, accounting for approximately 15 of the estimated 21.3 million people that lack home internet access [26,27]; and

Whereas, The FCC Lifeline program is a discount program and not a free/fully subsidized program for which there is a significant backlog in applications and delay in application approvals, as well as a lack of an automatic application or automatic appeal process[25]; and

Whereas, During the COVID pandemic, after Lifeline expanded its capabilities, the program still only allows 1 stream of 25mbps per household, limiting access for households with more than one person working/attending school from home[28]; and

Whereas, In the 2020 legislative session as of October 2020, 43 states have considered legislation on broadband access[29]; and

Whereas, In 2020, multiple failed legislative efforts supported access to broadband internet in light of COVID pandemic, including the Emergency Broadband Benefit Program, which offered government subsidized free broadband service for COVID impacted people[30,31]; and

Whereas, It is probable that a stimulus package be proposed in the near future, which will likely include internet access as part of this package, between 2020 elections and the next meeting of the AMA House of Delegates[32,33]; and

Whereas, AMA policy H-478.980 Increasing Access to Broadband Internet to Reduce Health Disparities sets precedent for the AMA advocating for internet access, and acknowledges the health benefit of internet access, but only asks for expansion of internet infrastructure in rural/underserved communities to provide “connectivity” rather than pushing for universal access to internet for those with significant limitations in access or financial constraints; and

Whereas, Universal coverage of home internet access would increase accessibility to this tool that is critical for patient health; therefore be it

RESOLVED, That our AMA recognize that internet access is a social determinant of health; and be it further

RESOLVED, That our AMA support universal access to broadband home internet; and be it further

RESOLVED, That our AMA advocate for legislation to reduce barriers and increase access to broadband internet, including federal, state, and local funding of broadband internet to reduce price, the establishment of automatic applications for recipients of Medicaid or other assistance

programs, and increasing the number of devices and streams covered per household; and be it further

RESOLVED, That our AMA-MSS immediately forward this resolution to the AMA House of Delegates.

Fiscal Note: TBD

Date Received: 11/06/2020

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RELEVANT AMA AND AMA-MSS POLICY

Increasing Access to Broadband Internet to Reduce Health Disparities H-478.980
Our AMA will advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services. (Res. 208, I-18)

Health, In All Its Dimensions, Is a Basic Right H-65.960

Our AMA acknowledges: (1) that enjoyment of the highest attainable standard of health, in all its dimensions, including health care is a basic human right; and (2) that the provision of health care services as well as optimizing the social determinants of health is an ethical obligation of a civil society. (Res. 021, A-19)

Racial and Ethnic Disparities in Health Care H-350.974
1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care is an issue of highest priority for the American Medical Association.
2. The AMA emphasizes three approaches that it believes should be given high priority:

A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.

B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum,

in medical journals, at professional conferences, and as part of professional peer review activities.

C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities
3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.
4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations. (CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep. 1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19)

Expanding Access to Screening Tools for Social Determinants of Health/Social Determinants of Health in Payment Models H-160.896
Our AMA supports payment reform policy proposals that incentivize screening for social determinants of health and referral to community support systems. (BOT Rep. 39, A-18; Reaffirmed: CMS Rep. 10, A-19)

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 continued 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, with physician input, 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.
8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.
9. Our AMA will urge EHR vendors to adopt social determinants of health templates, created with input from our AMA, medical specialty societies, and other stakeholders with expertise in social determinants of health metrics and development, without adding further cost or documentation burden for physicians. (Res. 730, I-04; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation, A-10; Reaffirmed: BOT Rep. 16, A-11; Modified: BOT Rep. 16, A-11; Modified: BOT Rep. 17, A-12; Reaffirmed in lieu of Res. 714, A-12; Reaffirmed in lieu of Res. 715, A-12; Reaffirmed: BOT Rep. 24, A-13; Reaffirmed in lieu of Res. 724, A-13; Appended: Res. 720, A-13; Appended: Sub Res. 721, A-13; Reaffirmed: CMS Rep. 4, I-13; Reaffirmation I-13; Appended: BOT Rep. 18, A-14; Appended: BOT Rep. 20, A-14; Reaffirmation, A-14; Reaffirmed: BOT Rep. 17, A-15; Reaffirmed in lieu of Res. 208, A-15; Reaffirmed in lieu of Res. 223, A-15; Reaffirmation, I-15; Reaffirmed: CMS Rep. 07, I-16; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 227, A-17; Reaffirmed in lieu of: Res. 243, A-17; Modified: BOT Rep. 39, A-18; Reaffirmed: BOT Rep. 45, A-18; Reaffirmed: BOT Rep. 19, A-18; Reaffirmation: A-19; Reaffirmed: CMS Rep. 3, I-19)