AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 117
(A-23)

Introduced by: Texas

Subject: Payment for Physicians Who Practice Street Medicine

Referred to: Reference Committee A

Whereas, A person experiencing homelessness is defined as someone who lacks a fixed, regular, and adequate nighttime residence; and

Whereas, The U.S. Department of Housing and Urban Development estimated that in 2022, nearly 600,000 Americans experienced homelessness, which is likely severely underreported; and

Whereas, Cities across the country report rising rates of evictions; and

Whereas, Street medicine's approach is to engage people experiencing homelessness exactly where they are by providing medical care to unsheltered populations experiencing homelessness in locations like encampments, parks, and under bridges versus mobile or stationary clinics focused on this population; and

Whereas, Homelessness reduces one's life expectancy by more years than do any of the major contributors to death in the U.S. (e.g., heart disease, smoking, diabetes, breast cancer), with people experiencing homelessness living 17.5 years less than the general population; and

Whereas, Many physical and mental health disparities exist between people experiencing homelessness and the general population as seen in, but not limited to, the prevalence of diabetes (18% vs. 9%), hypertension (50% vs. 29%), heart attack (35% vs. 17%), HIV (20% vs. 1%), substance use disorders (58% vs. 16%), depression (49% vs. 8%), and dual diagnosis of a mental health condition and a substance use disorder (30% to 70% vs. 2.5%); and

Whereas, People experiencing homelessness are five times more likely to be admitted as inpatients and have an average length of stay in the emergency department that is 2.32 times that of the general population due to untreated conditions escalating into life-threatening emergencies; and

Whereas, In terms of hospital admissions, it costs $2,559 more to treat patients experiencing homelessness than the general population, even after adjusting for age, gender, and hospital resource use; and

Whereas, Street medicine has been shown to decrease hospital admissions, hospital length of stay, and emergency department visits, and saved one health system $3.7 million in emergency department visits; and

Whereas, People experiencing homelessness are 11 times more likely to face incarceration, and formerly incarcerated individuals are approximately 10 times more likely to become homeless compared with the general population, thus perpetuating a "revolving prison door"; and

Whereas, The government spends an average of $35,578 per year for every person who must endure chronic homelessness toward publicly funded crisis services, including jails, hospitalizations, and emergency departments; and

Whereas, More than 95% of prisoners eventually return to the general population, along with their health conditions, and 80% are without health insurance upon reentry into the community; and

Whereas, Street medicine offers the opportunity to help former inmates who return to society to access continuous health care treatment for their mental and physical health conditions and find stable housing; and

Whereas, Grant-funded street medicine programs continue to expand across the country, including the nation's first emergency medicine street medicine fellowship in Fort Worth, Texas; and

Whereas, Even though the majority of street medicine programs are nonprofit programs, there are publicly funded pilot programs and resident-run clinics that demonstrate the efficacy of a standardized payment system; and

Whereas, In December 2022, California Medicaid published guidance for Medicaid managed care plans to follow regarding the use of street medicine to address the health needs of Medi-Cal members experiencing unsheltered homelessness; and

Whereas, Several American Medical Association policies (H-160.903, H-160.978, 11.1.4, and H-345.975) advocate for increasing access to care for underserved populations and eradicating homelessness but do not contain specific verbiage on compensation for physicians who practice street medicine; and

Whereas, There is no explicit AMA policy in support of Medicare and Medicaid payment for physicians who practice street medicine, and thus street medicine is an innovative program for the AMA to support to address a large problem for a long-term basis; therefore be it

RESOLVED, That our American Medical Association support the development of street medicine programs to increase access to care for populations experiencing homelessness and reduce long-term costs (New HOD Policy); and be it further

RESOLVED, That our AMA support the implementation of Medicare and Medicaid payment for street medicine initiatives by advocating for necessary legislative and/or regulatory changes, including submission of a recommendation to the Centers for Medicaid & Medicaid Services asking that it establish a new place-of-service code to support street medicine practices for people eligible for Medicare and/or Medicaid, with "street medicine" defined, in keeping with the Street Medicine Institute, as "the provision of health care directly to people where they are living and sleeping on the streets." (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 5/24/23

RELEVANT AMA POLICY

Eradicating Homelessness H-160.903
Our AMA:
(1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;
(2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless;
(3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;
(4) supports the use of physician-led, team-based street medicine programs, which travel to individuals who are unhoused or unsheltered and provide healthcare and social services, as well as funds, including Medicaid and other public insurance reimbursement, for their maintenance;
(5) recognizes the need for an effective, evidence-based national plan to eradicate homelessness;
(6) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;
(7) will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs;
(8) encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;
(9) encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;
(10) (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; and
(11) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods;
(12) (a) supports training to understand the needs of housing insecure individuals for those who encounter this vulnerable population through their professional duties; (b) supports the establishment of multidisciplinary mobile homeless outreach teams trained in issues specific to housing insecure individuals; and (c) will make available existing educational resources from federal agencies and other stakeholders related to the needs of housing-insecure individuals.
(13) encourages medical schools to implement physician-led, team-based Street Medicine programs with student involvement.
Citation: Res. 401, A-15; Appended: Res. 416, A-18; Modified: BOT Rep. 11, A-18; Appended: BOT Rep. 16, A-19; Appended: BOT Rep. 28, A-19; Appended: Res. 414, A-22; Appended: Res. 931, I-22;

Housing Insecure Individuals with Mental Illness H-160.978
(1) The AMA believes that public policy initiatives directed to the homeless, including the homeless mentally ill population, should include the following components: (a) access to care (e.g., integrated, comprehensive services that permit flexible, individualized treatment; more humane commitment laws that ensure active inpatient treatment; and revisions in government funding laws to ensure eligibility for homeless persons); (b) clinical concerns (e.g., promoting diagnostic and treatment programs that address common health problems of the homeless population and promoting care that is sensitive to the overriding needs of this population for food, clothing, and residential facilities); (c) program development (e.g., advocating emergency shelters for the homeless; supporting a full range of supervised residential placements; developing specific programs for multiproblem patients, women, children, and adolescents; supporting the development of a clearinghouse; and promoting coalition development); (d) educational needs; (e) housing needs; and (f) research needs. (2) The AMA encourages medical schools and residency training programs to develop model curricula and to incorporate in teaching programs content on health problems of the homeless population, including experiential community-based learning

experiences. (3) The AMA urges specialty societies to design interdisciplinary continuing medical education training programs that include the special treatment needs of the homeless population. Citation: BOT Rep. LL, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: CMS Rep. 01, A-16; Reaffirmed: BOT Rep. 16, A-19; Reaffirmed: Res. 414, A-22;

11.1.4 Financial Barriers to Health Care Access
Health care is a fundamental human good because it affects our opportunity to pursue life goals, reduces our pain and suffering, helps prevent premature loss of life, and provides information needed to plan for our lives. As professionals, physicians individually and collectively have an ethical responsibility to ensure that all persons have access to needed care regardless of their economic means.
In view of this obligation,
(a) Individual physicians should:
(i) take steps to promote access to care for individual patients, such as providing pro bono care in their office or through freestanding facilities or government programs that provide health care for the poor, or, when permissible, waiving insurance copayments in individual cases of hardship. Physicians in the poorest communities should be able to turn for assistance to colleagues in more prosperous communities.
(ii) help patients obtain needed care through public or charitable programs when patients cannot do so themselves.
(b) Physicians, individually and collectively through their professional organizations and institutions, should participate in the political process as advocates for patients (or support those who do) so as to diminish financial obstacles to access health care.
(c) The medical profession must work to ensure that societal decisions about the distribution of health resources safeguard the interests of all patients and promote access to health services.
(d) All stakeholders in health care, including physicians, health facilities, health insurers, professional medical societies, and public policymakers must work together to ensure sufficient access to appropriate health care for all people.

Maintaining Mental Health Services by States H-345.975
Our AMA:
1. supports maintaining essential mental health services at the state level, to include maintaining state inpatient and outpatient mental hospitals, community mental health centers, addiction treatment centers, and other state-supported psychiatric services;
2. supports state responsibility to develop programs that rapidly identify and refer individuals with significant mental illness for treatment, to avoid repeated psychiatric hospitalizations and repeated interactions with the law, primarily as a result of untreated mental conditions;
3. supports increased funding for state Mobile Crisis Teams to locate and treat homeless individuals with mental illness;
4. supports enforcement of the Mental Health Parity Act at the federal and state level; and
5. will take these resolves into consideration when developing policy on essential benefit services.
Citation: Res. 116, A-12; Reaffirmation A-15; Reaffirmed: Res. 414, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 257
(A-23)

Introduced by: Texas, Florida, Pennsylvania, American Academy of Dermatology, American Contact Dermatitis Society, American Society for Dermatologic Surgery Association, Arizona, California, Indiana, Mississippi, New Jersey, New York, Oklahoma, South Carolina

Subject: AMA Efforts on Medicare Payment Reform

Referred to: Reference Committee B

Whereas, State and federal advocacy is one of the main reasons physicians join the American Medical Association and maintain membership in organized medicine; and

Whereas, Physicians have faced yearly reductions in the Medicare fee schedule while other health care entities get increases and cost-of-living updates; and

Whereas, Medicare rates influence Medicare Advantage rates and private insurers' fee schedules and profoundly affect payments to all modalities of medical practice; and

Whereas, Medicine's past efforts have failed to correct these chronic financing issues; and

Whereas, Our 2021 American Medical Association federal and state advocacy expenses were only 5.5% of our AMA's total expenses[1]; and

Whereas, Our AMA net operating margin increased 345% from 2017 to 2021, and our AMA reserves increased 52% to more than $1 billion, but expenses for federal and state advocacy decreased[1]; and

Whereas, The allocation and use of a greater percentage of AMA financial resources aimed at our legislative and regulatory advocacy efforts will increase our chance of correcting a flawed Medicare payment system; therefore be it

RESOLVED, That our American Medical Association declare Medicare physician payment reform as both an urgent and a top advocacy and legislative priority for our AMA (New HOD Policy); and be it further

RESOLVED, That our AMA prioritize significant increases in funding for federal and state advocacy budgets specifically to ensure Medicare physician payment reforms are achieved and updated annually according to the Medicare Economic Index (Directive to Take Action); and be it further

RESOLVED, That our AMA use the increased federal and state advocacy funding to:

1. Create and sustain a national media strategy and campaign promoting Medicare physician payment reform;
2. Fund Washington, D.C., fly-ins, with a white coat march promoting Medicare physician payment reform; and

3. Develop and implement any additional new strategies to accomplish this goal; (Directive to Take Action); and be it further

RESOLVED, That our AMA consider this policy the top advocacy priority until this goal is accomplished (New HOD Policy); and be it further

RESOLVED, That our AMA make the next National Advocacy Conference sharply focused upon reforming the Medicare payment system to create a more sustainable payment formula for physician practices with annual updates according to the Medicare Economic Index (Directive to Take Action); and be it further

RESOLVED, That our AMA report back to the House of Delegates at each annual and interim session on the progress of our AMA staff and physicians until this goal is accomplished. (Directive to Take Action)

Fiscal Note: $1 million to $8 million. AMA will implement the called for actions: Media and grassroots campaign, potential fly-in, providing reports, etc. Spend would be based on political opportunity and scaled appropriately, which is why a range is given for the fiscal note.

Received: 5/24/23

REFERENCES

1. 2021 Annual Report: www.ama-assn.org/system/files/2021-ama-annual-report.pdf

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 258
(A-23)

Introduced by: Texas

Subject: Adjustments to Hospice Dementia Enrollment Criteria

Referred to: Reference Committee B

Whereas, The enrollment criteria for hospice established in the early 1980s were based on a six-month life expectancy if the “underlying disease were to run its natural course,” and at the time of the development of six-month criteria, most hospice patients were cancer patients; and

Whereas, It has since been appreciated that the six-month life expectancy is more accurate in the cancer setting than for other medical conditions, namely dementia; and

Whereas, The admission criteria for hospice enrollment for dementia patients rely on the Functional Assessment Staging Test (FAST) scoring mechanism, which measures activities of daily living and rates appetite, nourishment, and mobility, based on the presumption of a linear progression (ordinal) of decline; and

Whereas, FAST Stage 7c is used as the cut-off point for acceptable, primary dementia criteria for hospice enrollment and provides accurate prognostication for dementia patients who follow ordinal degradation through FAST stages of decline; and

Whereas, A full 41% of dementia patients are either unable to be scored accurately using FAST or do not follow ordinal patterns of degradation, and of these patients who did not follow ordinal degradation or were unable to be accurately scored via FAST, 42% died within six months; and

Whereas, For patients who follow nonordinal decline, there is a three-fold difference in survival between those who did and did not receive medications for acute illness: 14.9 months for receivers and 5.2 months for nonreceivers; and

Whereas, This effect of treatment suggests that nonordinal patients with impaired mobility and better preserved language might be suitable for hospice if their palliative care plans were conservative but not suitable if more life-prolonging care was anticipated; therefore be it

RESOLVED, That our American Medical Association actively lobby the Centers for Medicare & Medicaid Services (CMS) to adjust the secondary hospice enrollment criteria for dementia. Specifically, CMS should incorporate dementia patients who are Functional Assessment Staging Test Stage 6e, who, or their families on their behalf, have chosen not to receive medications or interventions for acute illnesses. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 5/24/23

RELEVANT AMA POLICY

Alzheimer's Disease H-25.991
Our AMA:
(1) encourages physicians to make appropriate use of guidelines for clinical decision making in the diagnosis and treatment of Alzheimer's disease and other dementias;
(2) encourages physicians to make available information about community resources to facilitate appropriate and timely referral to supportive caregiver services;
(3) encourages studies to determine the comparative cost-effectiveness/cost-benefit of assisted in-home care versus nursing home care for patients with Alzheimer's disease and related disorders;
(4) encourages studies to determine how best to provide stable funding for the long-term care of patients with Alzheimer's disease and other dementing disorders;
(5) supports the use of evidence-based cost-effective technologies with prior consent of patients or designated healthcare power of attorney, as a solution to prevent, identify, and rescue missing patients with Alzheimer's disease and other related dementias with the help of appropriate allied specialty organizations;
(6) supports increased awareness of the sex and gender differences in incidence and etiology of Alzheimer's disease and related dementias; and
(7) encourages increased enrollment in clinical trials of appropriate patients with Alzheimer's disease and related dementias, and their families, to better identify sex-differences in incidence and progression and to advance a treatment and cure of Alzheimer's disease and related dementias.
Citation: CSA Rep. 6, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Appended: Res. 503, A-16; Appended: Res. 915, I-16;

Payment for Dementia Treatment in Hospitals and Other Psychiatric Facilities D-345.985
Our AMA will work with relevant specialty societies to promote appropriate payment for treatment for all types of dementias when patients are treated in an accredited facility, whether free-standing or part of a general medical facility, even when dementia is the primary diagnosis for admission.
Citation: Res. 824, I-17;

Physicians and Family Caregivers: Shared Responsibility H-210.980
Our AMA: (1) specifically encourages medical schools and residency programs to prepare physicians to assess and manage caregiver stress and burden;
(2) continues to support health policies that facilitate and encourage health care in the home;
(3) reaffirm support for reimbursement for physician time spent in educating and counseling caregivers and/or home care personnel involved in patient care;
(4) supports research that identifies the types of education, support services, and professional caregiver roles needed to enhance the activities and reduce the burdens of family caregivers, including caregivers of patients with dementia, addiction and other chronic mental disorders; and
(5) (a) encourages partner organizations to develop resources to better prepare and support lay caregivers; and (b) will identify and disseminate resources to promote physician understanding of lay caregiver burnout and develop strategies to support lay caregivers and their patients.
Citation: Res. 308, I-98; Reaffirmation A-02; Reaffirmed: CME Rep. 2, A-12; Appended: Res. 305, A-17;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 433
(A-23)

Introduced by: Texas

Subject: Upholding Scientifically and Medically Valid Practices for Blood Transfusions

Referred to: Reference Committee D

Whereas, Current authorized and emergency-use vaccinations for prevention of SARS-CoV-2 (COVID-19) infection in the U.S. have been well studied and shown to have no risk for the community blood supply; and

Whereas, 79% of the U.S. population has received at least one dose of a COVID-19 vaccine; and

Whereas, In 2019, there were 10,852,000 red blood cell transfusions, 2,243,000 platelet transfusions, and 2,185,000 plasma transfusions in the U.S.; and

Whereas, Blood components are not labeled with health or demographic information about donors to protect their privacy; and

Whereas, Regulation of blood component labeling is regulated by the U.S. Food and Drug Administration, not state or local authorities; and

Whereas, Recently, a growing number of individuals have requested hospitals and blood centers to provide blood for transfusion for their personal use from donors who have not received a COVID-19 vaccination because of incorrect information that the vaccine will harm them through the transfusion; and

Whereas, Providing blood for transfusion from donors who have not received a COVID-19 vaccination is not medically indicated, and there is no scientific evidence that demonstrates adverse outcomes from the transfusions of blood products collected from vaccinated donors; and

Whereas, Some state legislatures are now considering laws mandating medical facilities to provide blood from donors who have not received a COVID-19 vaccination; and

Whereas, Allowing broad and unscientific requests for exclusion of certain blood products will place a substantial burden on blood banks, impacting the timely delivery of those products to patients; therefore be it

RESOLVED, That our American Medical Association support scientifically and medically supported transfusion best practices (New HOD Policy); and be it further

RESOLVED, That our AMA discourage patient requests for blood products and components beyond current federal regulations or best-practice guidelines, including requests to exclude products from individuals who have received COVID-19 vaccines New HOD Policy); and be it further

RESOLVED, That our AMA oppose all legislation or policy mandating patient requests for blood products from specific donors. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 5/24/23

REFERENCES

1. Association for the Advancement of Blood & Biotherapies, America's Blood Centers, American Red Cross. Joint Statement: Blood Community Reiterates the Safety of America's Blood Supply for Patients. Jan. 27, 2023. https://americasblood.org/wp-content/uploads/2023/01/Joint-Statement-Blood-Community-Reiterates-the-Safety-of-Americas-Blood-Supply-for-Patients.pdf

RELEVANT AMA POLICY

Blood for Medical Use H-50.996

(1) Blood transfusions and the use of other bodily tissues or substances or biological substances in rendering medical care to patients are often essential to save the life of a patient or to protect his health. Protecting the welfare of patients requires that blood for transfusions and bodily tissues or substances and biological substances be available and that use when needed be encouraged and not burdened with unreasonable restrictions and increased costs.

(2) When liability for damages in the absence of negligence is imposed following injury resulting from the administration of blood transfusions, bodily tissues or substances or biological substances, the cost of medical care is increased and inevitably the availability of medical care is adversely affected.

(3) The public interest requires and the state medical associations are urged to seek the enactment of appropriate state legislation which will provide that any person or organization involved in the collection, processing, distribution, or administration of blood or other bodily tissues or substances or biological substances for medical use shall be liable for any injury suffered by a patient only if the injury was proximately caused by the negligence of such person or organization.
Citation: BOT Rep. M, I-70; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 610
(A-23)

Introduced by: American College of Rheumatology, American Academy of Allergy, Asthma and Immunology, American Academy of Neurology, American College of Physicians, American Society of Anesthesiologists, American Society of Hematology, American Society for Radiation Oncology, American Thoracic Society, American Urological Association, Association for Clinical Oncology Endocrine Society

Subject: NIH Public Access Plan

Referred to: Reference Committee F

Whereas, In 2022 the White House Office of Science and Technology Policy (OSTP) issued a memo on Ensuring Free, Immediate, and Equitable Access to Federally Funded Research, which established new guidance for improving public access to scholarly publications and data resulting from federally supported research; and

Whereas, The OSTP memo directed federal agencies to update policies to allow public access to federally funded research without an embargo, and the National Institutes of Health (NIH) subsequently issued its proposed NIH Plan to Enhance Public Access to the Results of NIH Supported Research; and

Whereas, The directive requires that peer-reviewed scholarly publications containing any content derived from federal funding, including data on which a study is based are made immediately available, at no cost, by the end of 2025; and

Whereas, The rapid implementation of the NIH plan, and specifically the elimination of the 12-month embargo, is extremely disruptive and may negatively impact the financial underpinnings of scholarly publishing and dissemination, and result in multiple unintended consequences; and

Whereas, This reverses a 2013 policy permitting such manuscripts to remain behind a subscription paywall for a one-year period before being accessible for free. The current compromise “12-month embargo” acknowledges the cost of assessing and publishing scientific content and takes into account interests of publishers, researchers, and public funders of research, and reflecting Congress’ guidance that the Administration take into consideration the role scientific publishers play in the peer review process in ensuring the integrity of the record of scientific research, including the investments and added value they make; and

Whereas, Our American Medical Association has longstanding policy that it will continue to work with publishing and professional organizations, and continue to work with Congress to prevent any changes to the current policy that requires public release of NIH research articles within 12 months of publication; and

Whereas, While there are undoubtedly advantages to these policies in that new knowledge described in published scientific manuscripts will become immediately available to researchers, scientists, and the lay public without a subscription – in theory allowing efforts to replicate

results and the application of new scientific and clinical knowledge faster – the NIH plan as proposed may not achieve these goals due to several likely unintended consequences; and

Whereas, The NIH plan as proposed is likely to have unintended negative consequences for equity, quality, peer review, scientific record oversight, financial sustainability, and the future of scientific research, resulting from the need for journals to substantially modify their business models; and

Whereas, Publications from medical and scientific societies provide an important platform to disseminate the most significant advances in specific medical and scientific fields. Historically, some of the most impactful and paradigm-shifting work has been published in society journals, where external, rigorous, scientific peer review is critical. Unfortunately, the NIH will encourage a pay-to-publish model that puts society journals and medical societies at substantial financial risk while jeopardizing scientific excellence in biomedical research; and

Whereas, As scientists are forced into a pay-to-publish model, the NIH Public Access Plan may create substantial inequity in those able to contribute to the body of peer-reviewed published scientific research, because necessary changes to business models will likely shift financial responsibility from subscribers to the researchers seeking to have their research published, creating substantial additional barriers for those seeking publication. Many researchers including junior scientists who often have limited funds will find these fees prohibitive. When funds are unavailable, publishing completed work will be delayed or abandoned, hindering the dissemination of new knowledge – precisely the opposite of the desired policy goals; and

Whereas, Clinical journals focus on expedient but thorough review and publication of research that affects patient care—not in a matter of years, but sometimes hours. Societies use journals to disseminate clinical practice guidelines that impact research practice or clinical decisions, rules of hospitals and clinics, spending by government and insurers, and ultimately public health. The guidelines are developed at great expense and with a significant resource burden. Utmost care is taken that they are current on the research, provide appropriate guidance based on proper methods and analysis of evidence, and bar any industry influence. Vigilance in publication research integrity and conflict of interest management gives confidence to clinicians and researchers that published information has been verified and is reliable; and

Whereas, Maintaining this trusted role in society, at a time when disinformation is rampant, requires a significant investment. However, in the absence of significant revenue from subscriptions, publishers will lack resources to maintain meaningful peer review. Diligent peer review, management and public disclosures of conflicts, and data and figure integrity checks are vital parts of the process. Threats such as plagiarism, “paper mills,” and fraudulent data are increasingly present and require steady attention; and

Whereas, These developments have the potential to cause significant harm to the viability of the U.S. biomedical research enterprise, and the OSTP and federal funding agencies may not fully appreciate the extent to which zero embargo public access policies will disrupt the entire ecosystem of the research enterprise; and

Whereas, A careful examination of the updated policy and more extended time to hear concerns from medical societies and the public is warranted, along with consideration of alternatives to increase access to scientific publications while maintaining quality; and

Whereas, Given these serious concerns, it is critical that any plan that may disrupt the existing business model for scientific journals is implemented in a way that minimizes adverse

consequences and ensures continued equitable access to quality clinical research; therefore be it

RESOLVED, That our American Medical Association work with publishing and professional organizations, and work with Congress, to raise awareness of possible adverse consequences of the proposed National Institutes of Health Public Access Plan and to mitigate such consequences to ensure continued equitable access to quality clinical research. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 5/19/23

RELEVANT AMA POLICY

NIH Public Access Policy D-460.977
Our AMA will: (1) continue to work with publishing and professional organizations, and continue to work with Congress to prevent any changes to the current policy that requires public release of NIH research articles within 12 months of publication; and (2) continue to advocate that free content be accessed at the AMA's online journal web sites, rather than at a government site, to preserve our brand and to promote use of other AMA resources.
Citation: BOT Rep. 36, A-06; Reaffirmed: BOT Rep. 06, A-16;

High Cost to Authors for Open Access Peer Reviewed Publications D-478.964
Our AMA Board of Trustees will continue to monitor the Federal Trade Commissions actions in relation to predatory publishers and will disseminate the information to our AMA members.
Citation: BOT Rep. 10, I-17; Modified: Speakers Rep., A-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 723
(A-23)

Introduced by: Texas

Subject: Vertical Consolidation in Health Care – Markets or Monopolies

Referred to: Reference Committee G

Whereas, The American health care economy has changed in many ways; and

Whereas, The phenomenon of health care consolidation has changed from practice acquisitions and mergers to now involving joint ventures, strategic alliances, affiliations, and other agreements between companies; and

Whereas, Federal Vertical Merger Guidelines were published on June 30, 2020, yet obvious health industry anticompetitive vertical mergers continue to emerge despite these guidelines; and

Whereas, While there are thresholds that antitrust enforcers can place upon horizontal consolidation, there are no numeric measures or thresholds at this time for antitrust enforcers to place upon entities engaged in vertical consolidation; and

Whereas, When assessing the potential impacts of a health care merger, it is important to ask whether the patient or the public will benefit; and

Whereas, Unregulated mergers and strategic alliances have the potential to reduce competition and allow companies to raise prices and/or decrease quality without losing market share; and

Whereas, Consolidation at levels approaching that of monopolies goes against current calls for health equity, promotes waste, and enables administrative fiscal drain and injustice in the health care workforce; therefore be it

RESOLVED, That our American Medical Association advocate to address the issue of potential antitrust violations as a result of vertical consolidation in the health care industry (Directive to Take Action); and be it further

RESOLVED, That our American Medical Association advocate to address the June 30, 2020, Vertical Merger Guidelines' impact on the physician sector, to prevent anticompetitive mergers, acquisitions, and monopolies/oligopolies. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 5/24/23

REFERENCES
1. King et al. *Preventing Anticompetitive Healthcare Consolidation: Lessons from Five States.* The Source on Healthcare Price & Competition (June 2020). https://sourceonhealthcare.org/profile/preventing-anticompetitive-healthcare-consolidation-lessons-from-five-states/.
2. Brent D. Fulton, Health Care Market Concentration Trends in the United States: Evidence and Policy Responses, *Health Affairs* 36, no. 9 (Sept. 2017): 1530-38. www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0556.
3. Koch TG, Wendling BW, and Wilson NE. How Vertical Integration Affects the Quantity and Cost of Care for Medicare Beneficiaries. *Journal of Health Economics*. 52 (March 2017): 19-32. https://pubmed.ncbi.nlm.nih.gov/28182998/.
4. Vertical Merger Guidelines. U.S. Department of Justice and Federal Trade Commission (June 2020). www.justice.gov/atr/page/file/1290686/download. Accessed on Dec. 17, 2022.
5. Antitrust Regulators Release New Vertical Merger Guidelines. Congressional Research Service (July 2020). https://crsreports.congress.gov/product/pdf/LSB/LSB10521. Accessed on Dec. 17, 2022.

RELEVANT AMA POLICY

Hospital Consolidation H-215.960

Our AMA: (1) affirms that: (a) health care entity mergers should be examined individually, taking into account case-specific variables of market power and patient needs; (b) the AMA strongly supports and encourages competition in all health care markets; (c) the AMA supports rigorous review and scrutiny of proposed mergers to determine their effects on patients and providers; and (d) antitrust relief for physicians remains a top AMA priority; (2) will continue to support actions that promote competition and choice, including: (a) eliminating state certificate of need laws; (b) repealing the ban on physician-owned hospitals; (c) reducing administrative burdens that make it difficult for physician practices to compete; and (d) achieving meaningful price transparency; and (3) will work with interested state medical associations to monitor hospital markets, including rural, state, and regional markets, and review the impact of horizontal and vertical health system integration on patients, physicians and hospital prices.
Citation: CMS Rep. 07, A-19; Reaffirmation I-22;

Health System Consolidation D-215.984

Our AMA will: (1) study nationwide health system and hospital consolidation in order to assist policymakers and the federal government in assessing healthcare consolidation for the benefit of patients and physicians who face an existential threat from healthcare consolidation; and (2) regularly review and report back on these issues to keep the House of Delegates apprised on relevant changes that may impact the practice of medicine, with the first report no later than the 2023 Annual Meeting.
Citation: Res. 702, A-22;

Health Care Entity Consolidation D-383.980

Our AMA will (1) study the potential effects of monopolistic activity by health care entities that may have a majority of market share in a region on the patient-doctor relationship; and (2) develop an action plan for legislative and regulatory advocacy to achieve more vigorous application of antitrust laws to protect physician practices which are confronted with potentially monopolistic activity by health care entities.
Citation: (BOT Rep. 8, I-15)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 728
(A-23)

Introduced by: Texas

Subject: Discharge Consolidated Clinical Document Architecture (C-CDA) Minimum Data Set Content and Order Priority

Referred to: Reference Committee G

Whereas, The 21st Century Cures Act and federal incentive programs require more electronic sharing of patient information; and

Whereas, When patients are discharged from the hospital, electronic discharge data are typically shared with the patient's physician; and

Whereas, The federal Office of the National Coordinator for Health Information Technology has standardized many data elements, but there is severe lack of consistency in how those data elements are electronically shared and displayed; and

Whereas, Electronic discharge data often are not prioritized in a standardized way that facilitates physician review and understanding; and

Whereas, Electronic health record vendors are not required to organize the data elements in a specific manner for discharge summaries; and

Whereas, The Texas Medical Association and the Texas Health Service Authority are adopting and promoting the standardized Consolidated Clinical Document Architecture (C-CDA) discharge summary content and order; and

Whereas, The Sequoia Project (a national, trusted advocate for nationwide health information exchange) in the Data Usability Workgroup Implementation Guide Version 1 also has published the C-CDA minimum data set content; therefore be it

RESOLVED, That our American Medical Association support use of standardized minimum data set content such as the standardized Consolidated Clinical Document Architecture (C-CDA) for use in an electronic discharge summary with electronic health record vendors and health information exchanges, with inclusion of the following elements:

Discharge Consolidated Clinical Document Architecture (C-CDA) Minimum Data-Set Content and Order Priority

1. Discharge summary narrative (aka hospital course)
2. Discharge medications
3. Allergies
4. Admission diagnosis
5. Discharge diagnosis
6. Procedures – including interventional radiology, cardiac catheterization, and operative procedures

7. Diagnostic imaging – advanced imaging, for example: MRI, CT, PET, nuclear imaging, ultrasound, echo, and venous Doppler
8. Laboratory – first and last laboratory result for every test recommended, rare tests – which are performed only once – included (e.g., ANA rheumatoid test)
9. Consultations
10. Assessment and plan (includes future orders for follow-up with primary care physician and diagnostic tests)
11. Problem list.

(New HOD Policy)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 5/24/23

RELEVANT AMA POLICY

Principles for Hospital Sponsored Electronic Health Records D-478.973
1. Our AMA will promote electronic health record (EHR) interoperability, data portability, and health IT data exchange testing as a priority of the Office of the National Coordinator for Health Information Technology (ONC).
2. Our AMA will work with EHR vendors to promote transparency of actual costs of EHR implementation, maintenance and interface production.
3. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) and ONC to identify barriers and potential solutions to data blocking to allow hospitals and physicians greater choice when purchasing, donating, subsidizing, or migrating to new EHRs.
4. Our AMA will advocate that sponsoring institutions providing EHRs to physician practices provide data access and portability to affected physicians if they withdraw support of EHR sponsorship.
Citation: BOT Rep. 1, I-15; Reaffirmed: BOT Rep. 45, A-18; Reaffirmed: BOT Rep. 19, A-18;

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.
Citation: 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; Reaffirmed: CMS Rep. 2, A-22;

Information Technology Standards and Costs D-478.996
1. Our AMA will: (a) encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems; (b) work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices; (c) review the following issues when participating in or commenting on initiatives to create a NHII: (i) cost to physicians at the office-based level; (ii) security of electronic records; and (iii) the standardization of electronic systems; (d) continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records; and (e) continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems.
2. Our AMA advocates that physicians: (a) are offered flexibility related to the adoption and use of new certified Electronic Health Records (EHRs) versions or editions when there is not a sufficient choice of EHR products that meet the specified certification standards; and (b) not be financially penalized for certified EHR technology not meeting current standards.
Citation: Res. 717, A-04; Reaffirmation, A-05; Appended: Sub. Res. 707, A-06; Reaffirmation A-07; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation I-08; Reaffirmation I-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmed: Res. 205, A-11; Reaffirmed in lieu of Res. 714, A-12; Reaffirmed in lieu of Res. 715, A-12; Reaffirmed in lieu of Res. 724, A-13; Reaffirmation I-13; Reaffirmation A-14; Reaffirmed: BOT Rep. 03, I-16;

Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 204, I-17; Reaffirmation: I-17; Reaffirmed: BOT Rep. 45, A-18; Reaffirmed: BOT Rep. 19, A-18; Reaffirmation: A-19; Reaffirmed: CMS Rep. 7, I-20; Reaffirmation: A-22;