WHEREAS, Aerospace medicine is an internationally recognized, unique specialty of medicine with advanced education requirements supporting all domains of aviation and space flight; and

WHEREAS, In over a century of support, the Aerospace Medicine Team, led by aerospace medicine physicians, has advanced the art and science of every human flight endeavor, resulting in improved safety, reduced mishaps, and enhanced mission accomplishment; and

WHEREAS, Aerospace medicine physicians are required to maintain their professional knowledge and standing with state medical licensure, current specialty board certifications, continuing medical education activities, and ongoing privileging; and have extensive knowledge, skills, and professional self-regulation in the full and total range of the practice of aerospace medicine; and

WHEREAS, In an effort to reduce costs and pass-on legal liability, there has been a trend in managed medical care, US commercial airlines/space activities and in the US governmental departments to replace aerospace medicine physicians with non-aerospace medicine and mid-level providers, resulting in significantly increased risk and reduced safety margins; and

WHEREAS, 193 countries are signatories to the Convention on International Civil Aviation ("Chicago Convention"), which obliges the governments to reciprocally implement certain international regulatory standards, including physician responsibility pertaining to medical fitness of license holders, prevention of ill health and management of public health events in aviation; therefore be it

RESOLVED, That our American Medical Association recognize the unique contributions and advanced qualifications of aerospace medicine professionals, and specifically oppose any and all efforts to remove, reduce or replace aerospace medicine physician leadership in civilian, corporate or government aerospace medicine programs and aircrew healthcare support teams; (Directive to Take Action) and be it further

RESOLVED, That our AMA advocate for compliance with international agreements, to include advocating against other mid-level provider scope of practice expansions that threaten the safety, health, and well-being of aircrew, patients, support personnel and the flying public. (Directive to Take Action)

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

Received: 10/26/21
AUTHORS STATEMENT OF PRIORITY

This resolution addresses concerning trends in government / industry that are removing medical departments and specific aviation / space expertise in the military, aviation and commercial space sectors.

Despite AMA’s strong policy on scope of practice, companies / government organizations have moved to marginalize physician specialists. Most major airlines have outsourced medical support. The US Air Force has minimized participation of specialists in the Air Force Medical Service, which also supports US Space Force. Even the house of medicine is beginning to lose sight of “physician-led” teams (H-160.912, .906 & .908) in advising / supporting these industries. A trained Aerospace Medicine specialist has been proven over the last century to have the unique knowledge, skills and experience to manage medical risk in the aviation and space environments.

Continuing growth of commercial aerospace industry & the establishment of US Space Force has put workforce pressures on the nation’s aerospace medicine specialists. AM residencies are struggling to keep pace with demand (H-45.993).

This requests AMA to adopt language addressing an urgent problem facing this developing situation, and is consistent with existing policy D-35.985 and scope of practice policies. While this situation does not affect most physicians, no specific policy exists on this topic. The specialty society (AsMA) and AOA have enacted similar policy. The AMA’s voice could have positive impact. It clearly only affects a sub-group/specialty of US physicians. While it is likely not a “top priority”, this resolution could be considered a “medium priority” but due to the timeliness and gap in policy, more likely should be considered a “high priority” resolution.

RELEVANT AMA POLICY

The Structure and Function of Interprofessional Health Care Teams H-160.912
1. Our AMA defines ‘team-based health care’ as the provision of health care services by a physician-led team of at least two health care professionals who work collaboratively with each other and the patient and family to accomplish shared goals within and across settings to achieve coordinated, high-quality, patient-centered care.
2. Our AMA will advocate that the physician leader of a physician-led interprofessional health care team be empowered to perform the full range of medical interventions that she or he is trained to perform.
3. Our AMA will advocate that all members of a physician-led interprofessional health care team be enabled to perform medical interventions that they are capable of performing according to their education, training and licensure and the discretion of the physician team leader in order to most effectively provide quality patient care.
4. Our AMA adopts the following principles to guide physician leaders of health care teams:
   a. Focus the team on patient and family-centered care.
   b. Make clear the team’s mission, vision and values.
   c. Direct and/or engage in collaboration with team members on patient care.
   d. Be accountable for clinical care, quality improvement, efficiency of care, and continuing education.
   e. Foster a respectful team culture and encourage team members to contribute the full extent of their professional insights, information and resources.
   f. Encourage adherence to best practice protocols that team members are expected to follow.
   g. Manage care transitions by the team so that they are efficient and effective, and transparent
to the patient and family. 

h. Promote clinical collaboration, coordination, and communication within the team to ensure efficient, quality care is provided to the patient and that knowledge and expertise from team members is shared and utilized.

i. Support open communication among and between the patient and family and the team members to enhance quality patient care and to define the roles and responsibilities of the team members that they encounter within the specific team, group or network.

j. Facilitate the work of the team and be responsible for reviewing team members’ clinical work and documentation.

k. Review measures of ‘population health’ periodically when the team is responsible for the care of a defined group.

5. Our AMA encourages independent physician practices and small group practices to consider opportunities to form health care teams such as through independent practice associations, virtual networks or other networks of independent providers.

6. Our AMA will advocate that the structure, governance and compensation of the team should be aligned to optimize the performance of the team leader and team members.

Citation: Joint CME-CMS Rep., I-12; Reaffirmation I-13; Reaffirmed: CMS Rep. 1, I-15; Reaffirmed: BOT Action in response to referred for decision: Res. 718, A-17

Models / Guidelines for Medical Health Care Teams H-160.906

1. Our AMA defines ‘physician-led’ in the context of team-based health care as the consistent use by a physician of the leadership knowledge, skills and expertise necessary to identify, engage and elicit from each team member the unique set of training, experience, and qualifications needed to help patients achieve their care goals, and to supervise the application of these skills.

2. Our AMA supports the following elements that should be considered when planning a team-based care model according to the needs of each physician practice:

Patient-Centered:

a. The patient is an integral member of the team.

b. A relationship is established between the patient and the team at the onset of care, and the role of each team member is explained to the patient.

c. Patient and family-centered care is prioritized by the team and approved by the physician team leader.

d. Team members are expected to adhere to agreed-upon practice protocols.

e. Improving health outcomes is emphasized by focusing on health as well as medical care.

f. Patients' access to the team, or coverage as designated by the physician-led team, is available twenty-four hours a day, seven days a week.

g. Safety protocols are developed and followed by all team members.

Teamwork:

h. Medical teams are led by physicians who have ultimate responsibility and authority to carry out final decisions about the composition of the team.

i. All practitioners commit to working in a team-based care model.

j. The number and variety of practitioners reflects the needs of the practice.

k. Practitioners are trained according to their unique function in the team.

l. Interdependence among team members is expected and relied upon.

m. Communication about patient care between team members is a routine practice.

n. Team members complete tasks according to agreed-upon protocols as directed by the physician leader.

Clinical Roles and Responsibilities:

o. Physician leaders are focused on individualized patient care and the development of treatment plans.

p. Non-physician practitioners are focused on providing treatment within their scope of practice
consistent with their education and training as outlined in the agreed upon treatment plan or as
delegated under the supervision of the physician team leader.

q. Care coordination and case management are integral to the team’s practice.
r. Population management monitors the cost and use of care, and includes registry development
for most medical conditions.

Practice Management:
s. Electronic medical records are used to the fullest capacity.
t. Quality improvement processes are used and continuously evolve according to physician-led
team-based practice assessments.
u. Data analytics include statistical and qualitative analysis on cost and utilization, and provide
explanatory and predictive modeling.
v. Prior authorization and precertification processes are streamlined through the adoption of
electronic transactions.

Citation: CMS Rep. 6, A-14; Reaffirmed: CMS Rep. 07, A-16; Reaffirmed: CMS Rep. 05, A-17

Payment Mechanisms for Physician-Led Team-Based Health Care H-160.908
1. Our AMA advocates that physicians who lead team-based care in their practices receive the
payments for health care services provided by the team and establish payment disbursement
mechanisms that foster physician-led team-based care.
2. Our AMA advocates that payment models for physician-led team-based care should be
determined by physicians working collaboratively with hospital and payer partners to design
models best suited for their particular circumstances.
3. Our AMA advocates that physicians make decisions about payment disbursement in
consideration of team member contributions, including but not limited to:
   a. Volume of services provided;
   b. Intensity of services provided;
   c. Profession of the team member;
   d. Training and experience of the team member; and
   e. Quality of care provided.
4. Our AMA advocates that an effective payment system for physician-led team-based care
should:
   a. Reflect the value provided by the team and that any savings accrued by this value should be
      shared by the team;
   b. Reflect the time, effort and intellectual capital provided by individual team members;
   c. Be adequate to attract team members with the appropriate skills and training to maximize the
      success of the team; and
   d. Be sufficient to sustain the team over the time frame that it is needed.
Citation: CMS Rep. 1, I-13; Reaffirmed: CMS Rep. 1, I-15; Reaffirmed: CMS Rep. 08, A-16

Support for Physician Led, Team Based Care D-35.985
Our AMA:
1. Reaffirms, will proactively advance at the federal and state level, and will encourage state
and national medical specialty societies to promote policies H-35.970, H-35.973, H-35.974, H-
160.950, H-360.987, H 405.969 and D-35.988.
2. Will identify and review available data to analyze the effects on patients? access to care in
the opt-out states (states whose governor has opted out of the federal Medicare physician
supervision requirements for anesthesia services) to determine whether there has been any
increased access to care in those states.
3. Will identify and review available data to analyze the type and complexity of care provided by
all non-physician providers, including CRNAs in the opt-out states (states whose governor has
opted out of the federal Medicare physician supervision requirements for anesthesia services),
compared to the type and complexity of care provided by physicians and/or the anesthesia care team.

4. Will advocate to policymakers, insurers and other groups, as appropriate, that they should consider the available data to best determine how non-physicians can serve as a complement to address the nation's primary care workforce needs.

5. Will continue to recognize non-physician providers as valuable components of the physician-led health care team.

6. Will continue to advocate that physicians are best qualified by their education and training to lead the health care team.

7. Will call upon the Robert Wood Johnson Foundation to publicly announce that the report entitled, "Common Ground: An Agreement between Nurse and Physician Leaders on Interprofessional Collaboration for the Future of Patient Care" was premature; was not released officially; was not signed; and was not adopted by the participants.