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REPORT OF THE BOARD OF TRUSTEES

B of T Report 17-N-21

Subject: Distracted Driver Education and Advocacy

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee D

1 Board of Trustees Report 12-I-19, “Distracted Driver Education and Advocacy” was amended by
2 the addition of the following recommendation:

3
4 That our AMA will escalate the distracted driving campaign to a national level of awareness in
5 coordination with the CDC and the National Education Association to educate elementary up
6 through high school students as well as parents regarding the high-risk behavior of driving
7 while holding cell phones and the opportunity to save lives and avoid injuries, with a review of
8 steps taken and report back to the House at Annual 2020.

10 BACKGROUND

11
12 Distracted driving is any non-driving activity a person engages in while operating a motor vehicle.¹
13 Non-driving activities have the potential to distract the person from the primary task of driving and
14 increase the risk of crashing.¹ There are three main types of distraction: visual – taking your eyes
15 off the road, manual – taking your hands off the wheel, and cognitive – taking your mind off what
16 you are doing.¹ Data shows that, in 2017, crashes involving a distraction led to 3,166 deaths.¹
17 However, identifying distracted drivers can be challenging so the actual numbers are likely much
18 higher.

19
20 Policy H-15952 asks the AMA to: (a) make it a priority to create a national education and advocacy
21 campaign on distracted driving in collaboration with the Centers for Disease Control and
22 Prevention and other interested stakeholders; and (b) explore developing an advertising campaign
23 on distracted driving with report back to the House of Delegates at the 2019 Interim Meeting.

24
25 In working towards implementing the A-19 policy, the AMA had conversations with staff at the
26 Centers for Disease Control and Prevention (CDC). We were informed that their transportation
27 safety work is focused on impaired driving, not distracted driving, since that is where they see the
28 greatest number of injuries and fatalities. While there are evidence-based solutions to address the
29 problem of impaired driving, the evidence is mixed on current strategies to address distracted
30 driving.

31
32 Twenty states and the District of Columbia have passed laws to prohibit hand-held cell phone use
33 by drivers to limit distracted driving and save lives.² Legislatures in other states have specifically
34 prohibited texting while driving or cell phone use by younger drivers or school bus drivers.²
35 Research on the effects of driver cellphone and texting bans has found mixed results.^{3,4} While some
36 jurisdictions have seen promising results, overall there is considerable unsettled evidence regarding
37 the effects of these laws on crash risk.^{3,4}

As a result, the CDC directed us to other partners who were working to address this issue. These organizations included the National Highway Traffic Safety Administration (NHTSA), the lead federal agency on the issue of distracted driving, and the Safe States Alliance, a non-profit professional association whose mission is to strengthen the practice of injury and violence prevention. During our own research, we also came across the resources developed by the National Safety Council (NSC), a non-profit public service association that is focused on eliminating preventable deaths at work, in homes and communities, and on the road through leadership, research, education and advocacy.

EXISTING NATIONAL CAMPAIGNS ON DISTRACTED DRIVING

National Highway Traffic Safety Association (NHTSA)

NHTSA's distracted driver campaign is called "U Drive. U Text. U Pay."⁵ The campaign is focused on educating Americans about the dangers of distracted driving and partnering with the state and local police to enforce laws against distracted driving that help keep us safe. The campaign involves public service announcements as well as a social media campaign sharing stories and tips to help save lives. While states determine laws affecting distracted driving, NHTSA provides federal investments that address the states' specific needs.

National Safety Council (NSC)

The NSC also has a national campaign that is focused on National Distracted Driving Awareness Month, which was designated by Congress in 2010 as the month of April, making this year the 10-year anniversary of the campaign's launch.⁶ The slogan for the NSC campaign is "Just Drive." The campaign encourages drivers to keep their attention where it belongs, on the road. As a part of this campaign, the NSC develops free tools, which include a social media tool kit, fact sheets, a pledge, survivor stories, and posters. These tools can be used to learn more about distraction risks and create awareness of them in your community.

AT&T

AT&T also has a national campaign on distracted driving called "It Can Wait."⁷ This campaign, which includes advertising spanning print, radio, TV and online advertising, also began in 2010. The tools developed as part of this campaign include a pledge to always drive distraction free, advocacy tools – talking points, fact sheets, posters, presentations (school and corporate), media talking points, shareable videos, and a virtual reality experience.

AMA ACTIVITIES

On January 7, 2020, the AMA news team published a story titled, "Distracted driving: Most states aren't cracking down on deadly practice," which highlighted the importance of this issue as well as the AMA's model state distracted driving bill.⁸ The AMA has also used its social media platforms (LinkedIn, Twitter, Facebook and the RFS and MSS Facebook pages) to highlight the issue of distracted driving with 5 posts on this issue so far in 2020 (See Images 1 and 2). Engagements (defined as the total amount of likes, shares, retweets, comments and video views) were 171 with the total impressions (defined as the total number of times social media browsers showed the content) being 18,186.

This story led to the AMA receiving an interview request by CBS News on the issue of distracted driving. The AMA referred the reporter to the Medical Association of Georgia, given its success in

1 addressing distracted driving. The interview was held on January 21, 2020. The AMA's position of
2 calling for states to ban the use of handheld cellphones while driving was highlighted in the
3 segment (See Images 3 and 4).⁹

4
5 The AMA's Advocacy Resource Center did a survey of state medical societies' legislative
6 priorities for 2020. In looking at the public health priorities, only three states indicated that
7 distracted driving is a priority for them this year, with most states prioritizing public health work on
8 tobacco and e-cigarettes (32 states) and vaccines (30 states). (See Figure 1) The AMA has a model
9 state bill, the "Distracted Driving Reduction Act" and is willing to assist medical societies in
10 addressing this issue.

11 12 CONCLUSION

13
14 The Board of Trustees recognizes the importance of preventing distracted driving to lower crash
15 rates and improve public safety. As the AMA was working to implement the directive from A-19,
16 which contained a broad resolve to address distracted driving in collaboration with CDC and other
17 stakeholders, the House of Delegates adopted a second directive at I-19 calling for the AMA to
18 focus on educating elementary up through high school students as well as parents regarding the
19 high-risk behavior of driving while holding cell phones.

20
21 Through the process of reviewing the literature on effective strategies to reduce distracted driving
22 and discussing efforts underway with relevant stakeholders, the Board of Trustees proposes that
23 AMA policy be updated to reflect the fact that hands-free laws may be a step towards reducing
24 distracted driving in some communities, but overall the evidence of their effectiveness in reducing
25 crash rates is mixed. Therefore, AMA policy should be modified to note the three types of
26 distractions (visual, manual and cognitive) and to call for more research to determine the most
27 effective strategies to reduce distracted driving and related crash risks.

28
29 The Board of Trustees further recommends that the directives adopted by House of Delegates be
30 modified and streamlined to delete specific stakeholders that the AMA must work with on a
31 campaign to address distracted driving and to eliminate the focus on "holding cell phones" as it is
32 clear that manual distraction is not the only risky behavior. Furthermore, the Board believes that
33 the directive should remain broadly focused on preventing distracted driving in order to give the
34 AMA the flexibility to address this important issue as appropriate. While plans are underway with
35 stakeholders to develop a national campaign to address distracted driving, at the time of the writing
36 of this report it was too soon to announce them.

37 38 RECOMMENDATION

39
40 The Board of Trustees recommends that Policy H-15.952 be amended by addition and deletion to
41 read as follows and the remainder of the report be filed.

42
43 H-15.952, "The Dangers of Distraction While Operating Hand-Held Devices"

44
45 1. Our AMA encourages physicians to educate their patients regarding the public health risks
46 of ~~text messaging while operating motor vehicles or machinery~~ distracted driving, which
47 includes the risks of visual distraction – taking one's eyes off the road, manual distraction –
48 taking one's hands off the wheel, and cognitive distraction – taking one's mind off what he or
49 she doing, and will advocate for state legislation prohibiting the use of handheld
50 communication devices to text message while operating motor vehicles or machinery.

1 2. Our AMA will: (a) ~~endorse support~~ legislation that would ban the use of hand-held devices
2 while driving, as a step in the right direction towards preventing distracted driving and
3 (b) encourage additional research to identify the most effective strategies to reduce distracted
4 driving-related crash risks.

5 3. Our AMA: (a) recognizes distracted walking as a preventable hazard and encourages
6 awareness of the hazard by physicians and the public; and (b) encourages research into the
7 severity of distracted walking as a public health hazard as well as ways in which to prevent it.

8 4. Our AMA supports public education efforts regarding the dangers of distracted driving,
9 particularly activities that take drivers' eyes off the road, and that the use of earbuds or
10 headphones while driving is dangerous and illegal in some states.

11 5. Our AMA: (a) supports education on the use of earbuds or headphones in both ears during
12 outdoor activities requiring auditory attention, including but not limited to biking, jogging,
13 rollerblading, skateboarding and walking; and (b) supports the use of warning labels on the
14 packaging of hand-held devices utilized with earbuds or headphones, indicating the dangers of
15 using earbuds or headphones in both ears during outdoor activities requiring auditory attention,
16 including but not limited to biking, jogging, rollerblading, skateboarding and walking.

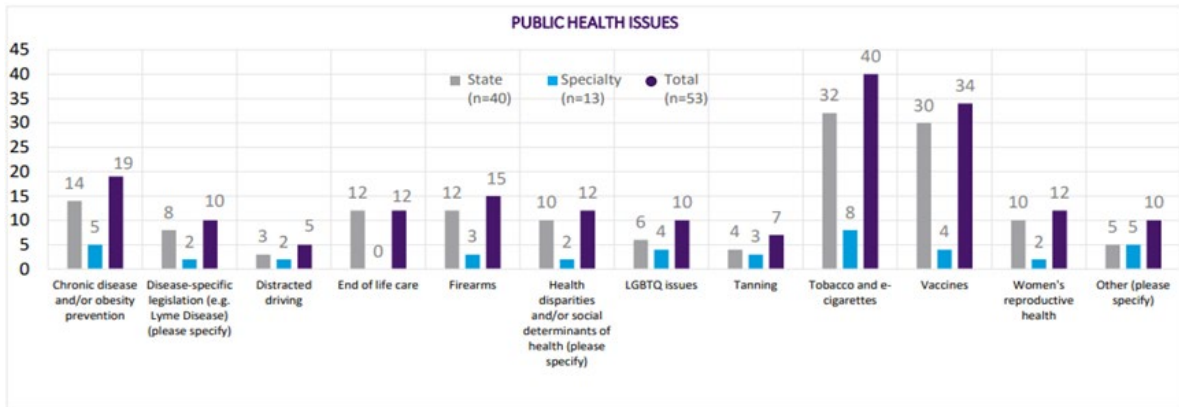
17 6. Our AMA will: (a) make it a priority to create a national education and advocacy campaign
18 on distracted driving in collaboration with ~~the Centers for Disease Control and Prevention and~~
19 ~~other interested stakeholders; and (b) explore developing an advertising campaign on distracted~~
20 ~~driving with report back to the House of Delegates at the 2019 Interim Meeting.~~

21 ~~7. Our AMA will escalate the distracted driving campaign to a national level of awareness in~~
22 ~~coordination with the CDC and the National Education Association to educate elementary up~~
23 ~~through high school students as well as parents regarding the high risk behavior of driving~~
24 ~~while holding cell phones and the opportunity to save lives and avoid injuries, with a review of~~
25 ~~steps taken and report back to the House of Delegates at the 2020 Annual Meeting.~~

Fiscal Note: less than \$500

FIGURE 1

Among respondents who plan to work on public health issues, 40 of the 53 will focus on tobacco and e-cigarettes, and 34 will focus on vaccines.



Q38 Which of the following public health issues does your association expect to work on in 2020? Select all that apply.

42

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IMAGES 1 and 2



IMAGE 3



IMAGE 4



REFERENCES

1. NHTSA, Distracted Driving. Available at <https://www.nhtsa.gov/risky-driving/distracted-driving>. Accessed February 1, 2020.
2. National Conference of State Legislatures. Distracted Driving. Available at <https://www.ncsl.org/research/transportation/spotlight-distracted-driving.aspx>. Accessed February 1, 2020.
3. McCartt AT, Kidd DG, Teoh ER. Driver cellphone and texting bans in the United States: evidence of effectiveness. *Ann Adv Automot Med*. 2014; 58:99–114.
4. Arnold, L. S., Benson, A. J., Tefft, B. C., Barragan, D., Jin, L., Kolek, S., & Horrey, W. J. Effectiveness of Distracted Driving Countermeasures: A Review of the Literature. November 2019, Washington, D.C.: AAA Foundation for Traffic Safety.
5. NHTSA. U DRIVE. U TEXT. U PAY. Campaign. Available at <https://www.nhtsa.gov/campaign/distracted-driving>. Accessed February 1, 2020.
6. National Safety Council, April is Distracted Driving Awareness Month. Available at <https://www.nsc.org/pages/ddam/ddam-materials>. Accessed February 1, 2020.
7. AT&T. It Can Wait. Available at <https://www.itcanwait.com/home>. Accessed February 1, 2020.
8. AMA. Distracted Driving Most States Aren't Cracking Down on Deadly Practice. January 7, 2020. Available at: <https://www.ama-assn.org/delivering-care/public-health/distracted-driving-most-states-aren-t-cracking-down-deadly-practice>.
9. CBS This Morning. Distracted Driving Dangers. Available at <https://www.cbsnews.com/news/texas-family-files-lawsuit-after-teen-killed-by-distracted-driver-watching-porn-mother-says/>. Accessed February 1, 2020.

REPORT 2 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (N-21)
Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems
(Resolution 401-JUN-21)
(Reference Committee D)

EXECUTIVE SUMMARY

BACKGROUND: Policy D-440.922 adopted at the November 2020 Special Meeting of the House of Delegates asked that our American Medical Association (AMA) study the most efficacious manner by which we can continue to achieve our mission of the betterment of public health by recommending ways in which to strengthen the health and public health system infrastructure.

Resolution 401-JUN-21, introduced by the Washington Delegation and referred by the House of Delegates asked that our AMA establish a list of all essential public health services that should be provided in every jurisdiction of the United States; a nationwide system of information sharing and intervention coordination in order to effectively manage nationwide public health issues; a federal data system that can capture the amount of federal, state, and local public health capabilities and spending that occurs in every jurisdiction to assure that their populations have universal access to all essential public health services; and a federal data system that can capture actionable evidence-based outcomes data from public health activities in every jurisdiction.

METHODS: This was a qualitative study in which semi-structured, in-depth interviews lasting 45 minutes were conducted with public health and physician experts (n=17) and members of the AMA Board of Trustees (n=11). Public health experts had federal, state, and local public health experience and were affiliated with governmental public health organizations, national public health organizations, schools of public health, public health foundations, and national medical specialty societies. Stakeholder organizations were identified by the members of the Council on Science and Public Health (CSAPH). Members of the AMA Board of Trustees were asked to participate in interviews at the discretion of the Board Chair.

RESULTS: The public health infrastructure interviews identified eight major gaps or challenges in the U.S. public health infrastructure. These include: (1) the lack of understanding and appreciation for public health; (2) the lack of consistent, sustainable public health funding; (3) legal authority and politicization of public health; (4) the governmental public health workforce; (5) the lack of data and surveillance and interoperability between health care and public health; (6) insufficient laboratory capacity; (7) the lack of collaboration between medicine and public health; and (8) the gaps in the public health infrastructure which contribute to the increasing inequities we see in health outcomes.

CONCLUSION: The Council on Science and Public Health recommends that the AMA outline an organization-wide public health strategy, aligned with the findings of this report, to develop a roadmap of the work being done by the AMA in public health and to share accomplishments as the strategy is implemented. The Council also recommends new policy urging the AMA to actively oppose the limits being placed on the authority of health officials, recognizing the authority to implement evidence-based measures may be necessary to protect the health of the public. We also propose a new policy calling for public health agencies to communicate directly with the health professionals licensed within their jurisdiction. Minor amendments are also suggested to further strengthen our existing public health policies based on the findings of this research.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 2-N-21

Subject: Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems (Resolution 401-JUN-21)

Presented by: Alexander Ding, MD, MS, MBA, Chair

Referred to: Reference Committee D

Policy D-440.922 adopted by the House of Delegates in November 2020 asked that:

Our AMA study the most efficacious manner by which our AMA can continue to achieve its mission of the betterment of public health by recommending ways in which to strengthen the health and public health system infrastructure.

Resolution 401-JUN-21, introduced by the Washington Delegation and referred by the House of Delegates asked that:

Our American Medical Association study the options and/or make recommendations regarding the establishment of:

- 1.a list of all essential public health services that should be provided in every jurisdiction of the United States;
2. a nationwide system of information sharing and intervention coordination in order to effectively manage nationwide public health issues;
3. a federal data system that can capture the amount of federal, state, and local public health capabilities and spending that occurs in every jurisdiction to assure that their populations have universal access to all essential public health services; and
4. a federal data system that can capture actionable evidence-based outcomes data from public health activities in every jurisdiction (Directive to Take Action); and be it further

Our AMA prepare and publicize annual reports on current efforts and progress to achieve universal access to all essential public health services. (Directive to Take Action)

METHODS

This was a qualitative study in which semi-structured, in-depth interviews lasting 45 minutes were conducted with public health and physician experts (n=17) and members of the AMA Board of Trustees (n=11). Public health experts had federal, state, and local public health experience and were affiliated with governmental public health organizations, national public health organizations, schools of public health, public health foundations, and national medical specialty societies. Stakeholder organizations were identified by the members of the Council on Science and Public Health (CSAPH) and organizations were asked to identify a primary and alternate representative to participate in the stakeholder interview. Alternates were interviewed when there were difficulties scheduling with the primary representatives. Due to timing constraints and scheduling conflicts, some organizations were unable to participate. Members of the AMA Board of Trustees were asked

to participate at the discretion of the Board Chair. The individuals who were interviewed provided verbal informed consent and received no financial compensation.

DATA COLLECTION AND ANALYSIS

The Council identified five objectives to guide the public health infrastructure research. The objectives were as follows:

- Understand the current challenges faced by public health professionals and health departments in preventing, detecting, and responding to emerging infectious disease threats and other public health crises.
- Understand physician and public health professionals' perspectives on what solutions need to be implemented to strengthen public health infrastructure to carry out the 10 essential public health services to improve disease and injury prevention and the health of the public
- Identify barriers and opportunities for improved and increased linkages between the public health and health care systems.
- Understand opportunities for the public health system to protect and promote the health of all people in all communities by removing systemic and structural barriers that have resulted in inequities.
- Identify opportunities for the AMA in supporting, developing, and implementing solutions.

The semi-structured interview guide (Appendix A) was developed with input from the members of CSAPH as well as AMA staff, including representatives from the Health, Science, and Ethics and the Center for Health Equity teams. The interview guide began by asking participants to define public health infrastructure, their experience, and the role of their organization in public health. The guide also asked individuals to identify challenges facing our nation's public health system, noting that these challenges could focus on the COVID-19 pandemic or challenges beyond the pandemic. The guide then aimed to give participants the opportunity to ideate possible solutions. Participants were then asked to identify how the AMA can best support solutions to strengthen public health infrastructure. A separate discussion guide was developed for the interviews with AMA trustees (Appendix B), which asked their reaction to the challenges and solutions identified by the external stakeholders and their perspective on the AMA's role in these efforts. The semi-structured interviews were conducted by C + R Research, an independent research firm. All interviews were recorded and transcribed. Transcripts were analyzed by the independent research firm for major themes. All personally identifiable information was removed from the transcripts prior to analysis. The findings of this research were presented to CSAPH and were shared to the Board of Trustees in July and serve as the basis for this report.

BACKGROUND

Public health has been defined as "what we do together as a society to ensure the conditions in which everyone can be healthy."^{1(p0)} CSAPH believes that public health belongs to everyone and is everyone's responsibility. The public health system is broad and has been defined as "all public, private, and voluntary entities that contribute to the delivery of essential public health services within a jurisdiction"² This system includes public health professionals, health care professionals, employers, schools, parks and recreation, community-based organizations, non-governmental organizations, faith-based institutions and more (see Figure 1). However, for purposes of this report, when we talk specifically about strengthening our nation's public health infrastructure, we are talking about the work of governmental public health entities at the federal, state, territorial, local, and tribal levels.¹ The Council acknowledges that additional reports exploring the broader public health system are warranted in the near future.

10 Essential Public Health Services

The 10 Essential Public Health Services (EPHS), originally published in 1994, provide a framework by which the work of public health is to be accomplished in all communities. The 10 EPHS, which were revised in 2020, with input from the AMA, are as follows:

- Assess and monitor population health status, factors that influence health, and community needs and assets.
- Investigate, diagnose, and address health problems and hazards affecting the population.
- Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it.
- Strengthen, support, and mobilize communities and partnerships to improve health.
- Create, champion, and implement policies, plans, and laws that impact health.
- Utilize legal and regulatory actions designed to improve and protect the public's health.
- Assure an effective system that enables equitable access to the individual services and care needed to be healthy.
- Build and support a diverse and skilled public health workforce.
- Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement.
- Build and maintain a strong organizational infrastructure for public health.

Existing AMA Policy D-440.924, "Universal Access for Essential Public Health Services," called for updating the 10 EPHS to bring them in line with current and future public health practice and encourages state, local, tribal, and territorial public health departments to pursue accreditation through the Public Health Accreditation Board (PHAB). The revised EPHS are central to the PHAB framework and inform PHAB standards, which provides a framework for health departments to evaluate their policies, procedures, and programs and to make meaningful improvements.

The Roles of Health Care and Public Health in Prevention

The Council also recognizes that the roles of health care and public health can seem indistinct. The role of health care in prevention is often described as increasing the use of evidence-based preventive services for individual patients and the role of public health is often described as focused on implementing interventions that reach the whole population or a population within a jurisdiction. There is also a shared responsibility for innovative clinical prevention provided outside of the clinical setting (see Figure 2). However, we recognize that there are public health agencies that provide clinical preventive services, particularly in rural communities where there may be a shortage of primary care physicians. There are also health care professionals involved in community-wide prevention efforts.

The COVID-19 Pandemic

Organizations representing U.S. governmental public health agencies have been cautioning for years that their ability to keep the population safe from disease and public health emergencies is constrained by the lack of dedicated and sustained funding.³ In addition to funding, our public health infrastructure has been threatened by high rates of staff turnover and obsolete data collection and reporting methods, which lead to delayed detection and response to public health threats of all types.^{4,5} The COVID-19 pandemic did not create these problems, but it inarguably exposed the cracks that had long existed in our public health infrastructure. For decades, public health professionals have been advocating for greater resources to plan and prepare for just such a crisis.

The challenges of the COVID-19 pandemic response have been well documented.^{6,7} While it is true that there certainly have been errors and omissions in the COVID-19 response, public health leaders should also be recognized for their successes and the tireless work that they have done under incredibly challenging circumstances.⁸ The development, authorization, distribution, and administration of over 300,000,000 doses of safe and effective vaccines in the United States in 20 months since the identification of the SARS-CoV-2 novel pathogen has been nothing short of remarkable.

RESULTS

The public health infrastructure interviews identified eight major gaps or challenges in the U.S. public health infrastructure. These include:

- (1) the lack of understanding and appreciation for public health;
- (2) the lack of consistent, sustainable public health funding;
- (3) legal authority and politicization of public health;
- (4) the governmental public health workforce;
- (5) the lack of data and surveillance and interoperability between health care and public health;
- (6) insufficient laboratory capacity;
- (7) the lack of collaboration between medicine and public health; and
- (8) the gaps in the public health infrastructure which contribute to the increasing inequities we see in health outcomes.

Lack of Understanding and Appreciation for Public Health

Challenge: When public health is working, it is invisible. Because of this, individuals outside of public health too often take it for granted and do not realize the way it impacts health and well-being on a daily basis. The public assumes the air is clean and their food and water is safe without giving the work of public health recognition for these accomplishments. As a result of this invisibility, public health is not prioritized or adequately funded.

There is broad consensus that the gaps we see in the public health infrastructure stem from a broad misunderstanding of what public health is and what it does. Some stakeholders indicated that public health is misunderstood by the public as “health care for poor people” and it is disregarded or devalued given this misjudgment. Others believe governmental and some health care organizations do not fully understand the role of public health professionals. Alternatively, health care is highly visible and well-regarded and is better understood by the public as it has a clear outcome (i.e., treating people when they are sick). Although health care’s mission is an important one, it does little to prevent people from becoming sick in the first place and health care is only one of several determinants of health.⁹

Solution: Prioritize public health by communicating about the work that public health agencies and practitioners do and their vital role in the health of our nation. Medical societies, at the county, state and national levels, can share their power with public health and raise its visibility in their communities. At the individual level, physicians can become advocates for public health programs, activities, policies, and campaigns. Physician groups can encourage more physicians to go into public service roles and provide support for more physicians to specialize in preventive medicine and related disciplines.

“That white coat carries a lot of power with county commissioners and mayors, you know. I’ve worked in state legislatures, and I remember doctor days and you would just be like, oh man,

1 *you know, you've got 40 people walking around in white coats. People respect that, right?*
 2 *Physicians do have an exalted place in our society...so that's a huge thing. We've just never*
 3 *been able to kind of crack that group...as a real advocate."* – Public Health Stakeholder

4
 5 Existing AMA Policy: Our AMA should collaborate with national public health organizations to
 6 explore ways in which public health and clinical medicine can become better integrated; such efforts
 7 may include the development of a common core of knowledge for public health and medical
 8 professionals, as well as educational vehicles to disseminate this information (Policy H-440.912,
 9 “Federal Block Grants and Public Health”).

10 11 *Lack of Consistent, Sustainable Funding*

12
 13 Challenge: Funding for public health is not consistent or sustainable. Stakeholders, in discussing
 14 public health funding referred to it as “anemic” and “emergency of the day” funding. In the past 20
 15 years, the nation has responded to every public health crisis with temporary funding measures that
 16 have not provided state and local public health agencies with the people and the tools needed to
 17 build enduring programs and infrastructure which address the populations health and adequately
 18 prepare for or prevent future emergencies. Shoring up the system will take years of consistent effort
 19 by public health officials and policymakers. While billions are now coming from the Biden
 20 Administration in short-term funding to address the COVID-19 pandemic, the current infrastructure
 21 is ill equipped to handle the large influx of funds. Systems and administrative capabilities to
 22 distribute, manage and oversee spending quickly, adequately and equitably are lacking.

23
 24 *“The system has been so underfunded for so long that it's sort of playing a constant catchup.*
 25 *And now that we have money coming into the system, you have to figure out how to absorb it.”*
 26 – Public Health Stakeholder

27
 28 Solution: Strong and consistent funding levels are necessary for our public health system to respond
 29 to everyday health needs, sustain hard-fought health gains, and prepare for and prevent unexpected
 30 public health emergencies. Consistent and sustainable funding is needed not just for public health
 31 programs, but also for foundational capabilities (i.e., communication and information technology).
 32 Similar to the way that the Federal Emergency Management Agency (FEMA) is consistently funded
 33 to prepare for and respond to the “unexpected crises” regardless of whether they occur, public health
 34 needs a strategy to fund for the long-term future of our population rather than focusing on the
 35 emergency of the day and after-the-fact. A shared common goal between health care and public
 36 health would drive more collaboration and shared funding between medicine and public health.

37
 38 Existing AMA Policy: Our AMA urges Congress and responsible federal agencies to establish set-
 39 asides or stable funding to states and localities for essential public health programs and services,
 40 provide for flexibility in funding but ensure that states and localities are held accountable for the
 41 appropriate use of the funds; and involve national medical and public health organizations in
 42 deliberations on proposed changes in funding of public health programs. The AMA also supports
 43 the continuation of the Preventive Health and Health Services Block Grant, or the securing of
 44 adequate alternative funding, in order to assure preservation of many critical public health programs
 45 for chronic disease prevention and health promotion and will communicate support of the
 46 continuation of the Preventive Health and Health Services Block Grant, or the securing of adequate
 47 alternative funding, to the US Congress (Policy H-440.912 “Federal Block Grants and Public
 48 Health”). The AMA recognizes the importance of flexible funding in public health for unexpected
 49 infectious diseases to improve timely response to emerging outbreaks and build public health
 50 infrastructure at the local level with attention to medically underserved areas (Policy H-440.892,
 51 “Bolstering Public Health Preparedness”).

Legal Authority and Politicization of Public Health

Challenge: The COVID-19 pandemic raised concerns about the structure of our public health system due to the politicization of specific public health measures to mitigate the spread or impact of the pandemic. Concerns were raised about the interference with the scientific guidance put out by the CDC and the impact that had on both public trust and the willingness to follow evidence-based recommendations. Concerns were also raised about collaboration and the lack of consistent messaging across the federal, state, territorial, local, and tribal levels. It was noted that at the state level, in some jurisdictions, public health leaders may have believed that requiring certain public health measures was the right thing to do (e.g., requiring masks or vaccines for returning college students), but they would not say it because the governor was not in favor of it.

“You must remember that public health is a confederated system. Based on the Tenth Amendment to the U.S. Constitution, the responsibility for public health falls to the states. Federal government can pump as much money as they’d like into it, but that money goes through governors’ offices. So, you have any number of governors...who have, throughout the pandemic, taken policy positions that were 180 degrees opposite public health practice recommendations.” – Public Health Stakeholder

Concerns were also raised that state legislatures have passed laws to severely limit the legal authority of public health agencies, necessary to protect the population from serious illness, injury, and death, which will lead to preventable tragedies.¹⁰ Public health is not in a position, on its own, to be able defend against the curtailing of public health authorities.

Solution: There was agreement among the stakeholders that public health agencies need to be able to communicate openly and make recommendations to protect and promote the health of the public based on the science. It was noted that some federal agencies seem to be able to navigate this better than others, including during the pandemic. How to best achieve this for the CDC and state health agencies in particular was not agreed upon. However, there was broad support for advocating for public health officials to have the authority they need to lead and make evidence-based decisions including emergency declarations. This includes defending against efforts by legislatures to strip that power away or efforts by governors to countermand evidence-based recommendations.

“I think the AMA and the state medical societies really need to take a strong stance on that. This is a health and medical issue. I mean, if you can’t act quickly to curtail...infectious disease outbreaks, or maybe environmental disasters...and, do that in an evidence-based way...we could find ourselves in serious trouble.” – Public Health Stakeholder

Existing AMA Policy: Our AMA: (1) recognizes the Office of the United States Surgeon General as the esteemed position of the “nation’s doctor;” and (2) calls for the Office of the United States Surgeon General to be free from the undue influence of politics, and be guided by science and the integrity of his/her role as a physician in fulfilling the highest calling to promote the health and welfare of all people (Policy H-440.863, “Restoring the Independence of the Office of the US Surgeon General”).

Workforce Shortages

Challenge: There is a growing public health workforce shortage at the local, state, and federal levels. Within the next few years, state and federal public health agencies could lose up to half of their workforce to retirement and to the private sector. Due to local and state budget crises and federal budget cuts, the potential for a shortage of highly skilled public health professionals has become

more immediate and severe in scope. In addition, governmental public health salaries are not competitive with other industries. Recent public health graduates are opting for careers in other industries. Public health agencies struggle to attract and retain top talent because they cannot afford to pay them salaries comparable to the private sector.

“Even though schools of public health are producing a lot of public health-trained graduates, they’re not going into governmental public health where we need them at that federal, state and local level because of differences in pay parity with the private sector...it’s very difficult to get highly-trained individuals because of competition with private sector in areas, for example, like informatics that IT and informatics, which is a very large and growing area of public health.” – Public Health Stakeholder

Public health workers might be at risk for negative mental health consequences because of stresses associated with the prolonged demand for responding to the pandemic and for implementing an unprecedented vaccination campaign.¹¹ Among a survey of 26,174 state, tribal, local, and territorial public health workers, 53.0 percent reported symptoms of at least one mental health condition in the past 2 weeks (during the pandemic).¹¹ Symptoms were more prevalent among those who were unable to take time off or who worked ≥ 41 hours per week.¹¹ The COVID-19 pandemic has been exceptionally challenging for the public health workforce due to the personal threats to their safety or even the safety of their family members that some public health officials have faced.

The turnover that we’re experiencing right now is extraordinary. There are lots of things driving that, it’s just been a horrific time to be in public health, in any capacity, given the attacks on individuals, the attacks on science, the undermining of authority, all of those things make these jobs incredibly challenging...and so we’re now in a position where I’m seeing people leaving the field, leaving these positions and there is not a workforce at the ready to stand into those roles. So, figuring out what that pipeline of public health professionals is, is absolutely critical.” – Physician Stakeholder

Solution: To strengthen the workforce, the first step should be to raise the visibility of public health as a potential career choice and promote it as a valuable component to keeping populations healthy. In addition, providing competitive salaries would also help attract talent, as would student debt reduction or elimination programs and loan repayment programs. The public health workforce is aging and efforts to recruit young talent are direly needed. Supporting strengthening of the Commissioned Corps of the US Public Health Service, the Epidemic Intelligence Service Program and the expansion of preventive medicine residency programs and occupation and environmental health residency programs are also important solutions. There is also an important role for health care in standing up for science, against misinformation, and supporting health officials who are facing threats.

Existing AMA Policy: Our AMA will work to support increased federal funding for training of public health physicians through the Epidemic Intelligence Service program and work to support increased federal funding for preventive medicine residency training programs (Policy D-305.964 “Support for the Epidemic Intelligence Service (EIS) Program and Preventive Medicine Residency Expansion”). Our AMA strongly supports the continuation of the Commissioned Corps of the US Public Health Service (Policy H-440.989 “Continuation of the Commissioned Corps”). Our AMA supports investments that strengthen our nation’s public health infrastructure and the public health workforce (Policy H-440.820, “Vector-Borne Diseases”).

Our AMA: (1) acknowledges and will act to reduce the incidence of antagonistic actions against physicians as well as other health care workers including first responders and public health

officials, outside as well as within the workplace, including physical violence, intimidating actions of word or deed, and cyber-attacks (Policy H-515.950, “Protecting Physicians and Other Healthcare Workers in Society”).

Antiquated Data Systems

Challenge: Public health data systems are outdated and in dire need of modernization. This issue was brought to light during the COVID-19 crisis. Many public health agencies did not have access to real-time data around testing results and incidence of infections and illness to efficiently respond to the emerging crisis. Health departments are often unable to access accurate, complete, and timely data to effectively surveil disease outbreaks and promote healthy communities. Many state and local public health departments rely on paper documents, phone calls, and faxes to communicate. Many also require manual input of data into systems with limited functionality. Consistency of demographic data collection has been particularly poor. Race and ethnicity data for infections, hospitalizations, and deaths have been missing, or slow to be published, in many states.

Financial investments were made to modernize the health care data infrastructure, but the same has not happened on the public health side. In health care, data is collected in the electronic health record (EHR) and despite there being requirements for data to be reported to public health, it can be days and weeks before public health is alerted. When public health receives case reports, they are often missing key information, including race and ethnicity data. Reports are also missing data elements like a patient’s address, so public health cannot geo-locate or map the cases to determine if there’s an outbreak occurring in a particular area. Case reports are also often missing a patient’s phone number, which is needed to conduct interviews for contact tracing. Furthermore, clinical medicine is not getting what it needs from public health. Clinicians should be able to work very closely with state and local health departments to get population-based data about their practice community.

Public health department data and systems are siloed. They work independently of each other and do not have an easy way to share information across state lines or even, at times, between agencies within a given state, preventing them from efficiently supporting each other. It is important to note that even with public health data modernization, data shared with public health agencies for review and action, will only be shared in accordance with applicable health care privacy and public health reporting laws. Improving antiquated data systems will overall improve data governance and security as well as improving access to vital surveillance data.

Solution: Data are the foundation to both population medicine and public health and rapid access to timely and accurate data are essential to drive decision-making. Priorities for public health data modernization should include automating the reporting of clinical and laboratory data from clinical health area data systems to public health. Clinicians should be incentivized to upgrade their EHR systems to support electronic case reporting and be incentivized to submit complete case reports and timely case reports. For example, if the case report is complete, including the race and ethnicity information, then clinicians should receive a bonus.

The U.S. also need to ensure interoperability among health care and public health as well as among core public health surveillance systems. There are core pieces of the public health data infrastructure that need to be modernized, such as the National Notifiable Diseases Surveillance System and the vital records systems which capture data from births and deaths annually and which can signal changes in trends, monitor urgent events and provide faster notification of cause of death. It is also important to support modernization of our syndromic surveillance system, so public health receives

1 data in real-time from hospital emergency departments and urgent care centers to maintain a pulse
2 on emergency-type visits and how the health care system is being impacted by emerging syndromes.

3
4 Existing AMA Policy: Our AMA recognizes public health surveillance as a core public health
5 function that is essential to inform decision making, identify underlying causes and etiologies, and
6 respond to acute, chronic, and emerging health threats and recognizes the important role that
7 physicians play in public health surveillance through reporting diseases and conditions to public
8 health authorities. The AMA supports increased federal, state, and local funding to modernize our
9 nation's public health data systems to improve the quality and timeliness of data and supports
10 electronic case reporting, which alleviates the burden of case reporting on physicians through the
11 automatic generation and transmission of case reports from electronic health records to public health
12 agencies for review and action in accordance with applicable health care privacy and public health
13 reporting laws. The AMA will advocate for increased federal coordination and funding to support
14 the modernization and standardization of public health surveillance systems data collection by the
15 Centers for Disease Control and Prevention and state and local health departments and supports data
16 standardization that provides for minimum national standards, while preserving the ability of states
17 and other entities to exceed national standards based on local needs and/or the presence of
18 unexpected urgent situations (Policy H-440.813, "Public Health Surveillance"). Our AMA
19 encourages hospitals and other entities that collect patient encounter data to report syndromic (i.e.,
20 symptoms that appear together and characterize a disease or medical condition) data to public health
21 departments in order to facilitate syndromic surveillance, assess risks of local populations for
22 disease, and develop comprehensive plans with stakeholders to enact actions for mitigation,
23 preparedness, response, and recovery (Policy H-440.892, "Bolstering Public Health Preparedness").

24 *Insufficient Laboratory Capacity*

25
26
27 Challenge: Our nation lacks the capacity to conduct adequate testing and surveillance of infectious
28 diseases and other pathogens, including a lack of whole genome sequencing during the pandemic
29 needed to identify SARS-CoV-2 variants. Public health labs have the technology to identify a wider
30 range of diseases and are therefore expected to support clinical labs. However, public health labs
31 often lack the resources needed to keep up with the workload, that has been especially true during
32 the pandemic. Throughout the pandemic, all laboratories have faced challenges obtaining the
33 necessary testing supplies. While public, commercial and hospital labs have shared resources
34 throughout the pandemic, this has varied by jurisdiction and has occurred informally based on
35 relationships among lab directors rather than systematically or consistently

36
37 Solution: Our public health labs at the state and local level need to be better resourced and would
38 benefit from more formal relationships between them and commercial labs, hospital and academic
39 labs, and the CDC. The components of the laboratory community, though they may have different
40 missions, need to see themselves as partners within a very interconnected system. As a nation, we
41 need to do more whole genome sequencing, working with urgent care clinics, emergency
42 departments, and hospitals, so that trends in virus variants can be identified and tracked. We also
43 need to strengthen and broaden supplies within the Strategic National Stockpile and the capacity to
44 ramp up production of supplies domestically; overreliance on international sources of supplies can
45 be a national security issue.

46
47 Existing AMA Policy: Our AMA supports the Centers for Disease Control and Prevention's
48 national Laboratory Response Network for communicating, coordinating, and collaborating with
49 physicians and laboratory professionals on public health concerns (Policy H-440.891, "Support of
50 the National Laboratory Response Network"). Our AMA: (1) encourages payers, regulators and
51 providers to make clinical variant data and their interpretation publicly available through a system

that assures patient and provider privacy protection; and (2) encourages laboratories to place all clinical variants and the clinical data that was used to assess the clinical significance of these results, into the public domain which would allow appropriate interpretation and surveillance for these variations that can impact the public's health (Policy D-460.971, "Genome Analysis and Variant Identification"). Our AMA urges Congress and the Administration to work to ensure adequate funding and other resources for the CDC, the National Institutes of Health (NIH), the Strategic National Stockpile and other appropriate federal agencies, to support the maintenance of and the implementation of an expanded capacity to produce the necessary vaccines, anti-microbial drugs, medical supplies, and personal protective equipment, and to continue development of the nation's capacity to rapidly manufacture the necessary supplies needed to protect, treat, test and vaccinate the entire population and care for large numbers of seriously ill people, without overreliance on unreliable international sources of production (Policy H-440.847, "Pandemic Preparedness").

Lack of Collaboration between Health Care and Public Health

Challenge: While the work of health care and public health are interconnected, the work is done in silos. Both physicians and public health practitioners that were interviewed expressed a strong desire for more collaboration. Some of the challenges in collaborating were mentioned previously around data modernization and the need to share information between health care and public health. Physicians also expressed frustration that they do not hear directly from their state and local health departments. During the pandemic, most physicians received updates on what is happening in their community through the news media. There is a desire for health departments to provide updates to clinicians in their jurisdictions directly. Beyond collaboration between health agencies and the physicians in their jurisdiction, there is also the desire for more collaboration between medicine and public health at the local, state and national levels among their professional organizations.

Solution: A critical component to improving public health infrastructure is to promote more collaboration and communication pathways between medicine and public health. There is a need to jointly arrive as the point of consensus that prevention is a shared goal which, if emphasized, will advance both fields. To that end, we need a "health" system--not divided between public health and health care, which unites in its shared goal of prevention. Greater collaboration also means that health-related jobs become easier, with fewer high-risk patients needing clinical care and more prevention activities to reduce demand on the health care system. The AMA should use some of its political capital, in collaboration with national public health organizations, to rebuild our public health infrastructure.

It is worth noting that in 1994, the AMA and the American Public Health Association (APHA) co-convened the Medicine and Public Health Initiative (MPHI).¹² In 1996, MPHI hosted a Congress inviting 400 representatives from Medicine & Public Health and provided grants at the state/local level to build sustainable, collaborative partnerships. By the year 2000, changes in leadership at the state and national level resulted in difficulty sustaining momentum. In 2002, following the September 11th attacks, the presidents of the AMA and APHA reiterated their dedication to MPHI. In 2004, the AMA and the CDC hosted the First National Preparedness Congress. This collaboration was not sustained due to shifting priorities. The Council urges consideration of the best way for clinical medicine and for our AMA and member organizations of the Federation of Medicine to collaborate with public health in a meaningful and sustainable way going forward.

Existing AMA Policy: Our AMA (1) encourages medical societies to establish liaison committees through which physicians in private practice and officials in public health can explore issues and mutual concerns involving public health activities and private practice; (2) seeks increased dialogue, interchange, and cooperation among national organizations representing public health professionals

and those representing physicians in private practice or academic medicine; (3) actively supports promoting and contributing to increased attention to public health issues in its programs in medical science and education; (4) continues to support the providing of medical care to poor and indigent persons through the private sector and the financing of this care through an improved Medicaid program; (5) encourages public health agencies to focus on assessment of problems, assurance of healthy living conditions, policy development, and other related activities; and (6) encourages physicians in private practice and those in public health to work cooperatively, striving to ensure better health for each person and an improved community as enjoined in the Principles of Medical Ethics (Policy H-440.960, “Organized Medicine and Public Health Collaboration”).

Ensuring Equity

Challenge: The gaps in the public health infrastructure mentioned previously all contribute to health inequities. The COVID-19 pandemic highlighted the equity gap in health outcomes for marginalized communities, as shown by the substantially higher rates of infection, hospitalization, and death in marginalized communities compared with White people. Incomplete data and fragmented access to data prevents public health from accurately identifying populations at greatest risk and prioritizing efforts and funding. Inadequate and inequitable funding means increased disparities in health outcomes because resources will not reach those in most need. The workforce needs to change so it has more people who are known and trusted in their communities, working on many of the issues that we face. These efforts require resources, and there are currently insufficient resources to support those kinds of meaningful efforts.

“Public health is for everybody. It’s just not for the poor. It’s not just for the rich. Public health is something that everyone should have access to. But some people need more help than others to get that access. And that’s got to be solved.” – Physician Stakeholder

Many practicing physicians lack the training to consider and address the social determinants of health with their patients. Limited time for patient visits contributes to doctors not having time to address social determinants during a regular visit even if they are trained in understanding and incorporating the social determinants of health. Physicians do not have to do this work alone; public health is here to address the social determinants of health in communities collaboratively, but we need a common language and a common understanding.

“I think as physicians, we increasingly realize that our patients’ diseases that we’re treating them for, diabetes, whatever, are being driven by risk behaviors that they’re taking that we don’t always feel like our counseling ... is effective ... without other interventions at the community level. Living conditions, social environment, institutional things, inequities that are happening, that are affecting their freedom, and housing, and transportation, ... are affecting the disease that shows up in our office.” – Physician Stakeholder

Solution: All of these gaps in the public health infrastructure contribute to the increasing inequities we see in health outcomes in the United States. Fragmented access to data prevents public health from accurately prioritizing efforts. Access to data is needed to inform equitable policy. Adequate funding is needed to decrease inequities in health outcomes and ensure resources reach those in most need. The workforce that is leading the charge against inequities needs to include more persons who look like the population it serves. Equity involves engagement with communities in an ongoing and meaningful way so those most affected by public health challenges are part of the conversations and part of the solutions.

1 Existing AMA Policy: Health equity, defined as optimal health for all, is a goal toward which our
 2 AMA will work by advocating for health care access, research, and data collection; promoting
 3 equity in care; increasing health workforce diversity; influencing determinants of health; and
 4 voicing and modeling commitment to health equity (Policy H-180.944, “Plan for Continued
 5 Progress Toward Health Equity”).

6 DISCUSSION

9 When public health stakeholders were asked about the work the AMA does in public health, there
 10 was little recognition of current public health activities. Some stakeholders referenced the work the
 11 AMA has done to address tobacco use and more were familiar with the AMA’s health equity
 12 strategy, which had been released around the time of the interviews. When asked about the AMA’s
 13 role in strengthening public health infrastructure, public health stakeholders highlighted the
 14 following as the strengths of the AMA and where the organization should focus its efforts:

- 16 ▪ Communicating - Raise the visibility of public health to ensure the work public health
 17 professionals do is not invisible; share power--ensuring public health is at the table;
- 18 ▪ Advocating - Elevate physicians’ and organized medicine’s influence in policy and support
 19 initiatives that focus more on public health; help build bi-partisan support for public health;
 20 and
- 21 ▪ Educating - Help further emphasize public health and the social determinants of health in
 22 medical education, support training opportunities for medical students in health departments
 23 (see Appendix C, which outlines relevant existing activities).

24
 25 Public health stakeholders encouraged the AMA to be a champion for public health while
 26 maintaining our brand position of being in the health care sector.

27
 28 The AMA trustees who were interviewed as a part of this research strongly agreed with the
 29 challenges that were identified by the public health stakeholders as impacting our nation’s public
 30 health infrastructure. There was also general agreement that these efforts would fit within the
 31 AMA’s current strategic arcs. Trustees recommended solutions that are on-brand, fiscally
 32 responsible, and aligned with current strategy and operating goals. Some trustees cautioned that the
 33 AMA should not try to do all of these things, but to pick a few where the organization can be the
 34 most impactful. In addition to communicating, advocating, and educating, the trustees felt the AMA
 35 was well-equipped to be a convener and should focus on this while also engaging in other
 36 opportunities.

37 CONCLUSION

39
 40 There is widespread recognition that our nation’s public health infrastructure needs to be
 41 strengthened. The AMA already has extensive policy aligned with many of the challenges and
 42 solutions outlined in this report. These policies, adopted by the House of Delegates over the past
 43 decades, serve as the basis for the AMA to act. We recognize that there are many programs and
 44 initiatives happening across the organization that are relevant to this work. Members of the AMA
 45 Board of Trustees who participated in this process indicated that this work fits into the AMA’s
 46 currently articulated strategic priorities. Therefore, your Council on Science and Public Health
 47 recommends that the AMA outline an organization-wide public health strategy, aligned with the
 48 findings of this report, to develop a clear roadmap of the work being done by the AMA in public
 49 health and to share accomplishments as the strategy is implemented. The Council also recommends
 50 new policy urging the AMA to actively oppose the limits being placed on the authority of health
 51 officials, recognizing the authority to implement evidence-based measures, including mandates, may

be necessary to protect the health of the public. The Council also calls on the AMA to advocate for the solutions identified through this research, including sustainable funding to support public health infrastructure, incentives to help recruit and retain staff within the governmental public health workforce, public health data modernization and efforts to promote interoperability between health care and public health, and efforts to ensure equitable access to public health funding and programs. The Council also proposes new policy encouraging public health agencies to communicate directly with the health professionals licensed within their jurisdiction. We recognize that some jurisdictions are doing this well, but in many jurisdictions, there is little communication between health care professionals and their public health agency. Minor amendments are also suggested to further strengthen our existing public health policies based on the findings of this research.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following be adopted in lieu of Resolution 401-JUN-21 and the remainder of the report be filed.

1. That Policy D-440.922, "Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems" be amended by addition and deletion to read as follows:

Our AMA will: (1) champion the betterment of public health by enhancing advocacy and support for programs and initiatives that strengthen public health systems, to address pandemic threats, health inequities and social determinants of health outcomes; ~~and (2) study the most efficacious manner by which our AMA can continue to achieve its mission of the betterment of public health by recommending~~ (2) develop an organization-wide strategy on public health including ways in which the AMA can to strengthen the health and public health system infrastructure and report back as needed on progress; (3) work with the Federation and other stakeholders to strongly support the legal authority of health officials to enact reasonable, evidence-based public health measures, including mandates, when necessary to protect the public from serious illness, injury, and death and actively oppose efforts to strip such authority from health officials; (4) advocate for (a) consistent, sustainable funding to support our public health infrastructure, (b) incentives, including loan forgiveness and debt reduction, to help strengthen the governmental public health workforce in recruiting and retaining staff, (c) public health data modernization and data governance efforts as well as efforts to promote interoperability between health care and public health; and (d) efforts to ensure equitable access to public health funding and programs. (Modify Current AMA Policy)

2. That Policy H-440.960, "Organized Medicine and Public Health Collaboration" be amended by addition and deletion to read as follows:

Our AMA (1) encourages medical societies to establish liaison committees through which physicians in private practice and officials in public health can explore issues and mutual concerns involving public health activities and private practice; (2) seeks increased dialogue, interchange, and cooperation among national organizations representing public health professionals, including representatives from governmental public health, and those representing physicians in private practice or those employed in health systems and in academic medicine (3) actively supports promoting and contributing to increased attention to public health issues in its programs in medical science and education; ~~(4) continues to support the providing of medical care to poor and indigent persons through the private sector and the financing of this care through an improved Medicaid program;~~ (5) encourages public health agencies to focus on assessment of problems, assurance of healthy living conditions, policy development, and other related activities; and (6) encourages physicians in private practice and those in public

health to work cooperatively, striving to ensure better health for each person and an improved community as enjoined in the Principles of Medical Ethics; and (6) encourages state and local health agencies to communicate directly with physicians licensed in their jurisdiction about the status of the population's health, the health needs of the community, and opportunities to collectively strengthen and improve the health of the public. (Modify Current AMA Policy)

3. That AMA Policy H-440.912, "Federal Block Grants and Public Health" which calls on the AMA to collaborate with national public health organizations to explore ways in which public health and clinical medicine can become better integrated and urges Congress and responsible federal agencies to: (a) establish set-asides or stable funding to states and localities for essential public health programs and services, (b) provide for flexibility in funding but ensure that states and localities are held accountable for the appropriate use of the funds; be reaffirmed. (Reaffirm Current AMA Policy)

4. That AMA Policy H-440.989, "Continuation of the Commissioned Corps," be amended by addition to read as follows:

Our AMA strongly supports the expansion and continuation of the Commissioned Corps of the US Public Health Service and recognize the need for it to be adequately funded. (Modify Current AMA Policy)

5. That our AMA reaffirm Policies D-305.964, "Support for the Epidemic Intelligence Service (EIS) Program and Preventive Medicine Residency Expansion," and D-295.327, "Integrating Content Related to Public Health and Preventive Medicine Across the Medical Education Continuum." (Reaffirm Current AMA Policy)

6. That our AMA reaffirm Policy H-440.89, "Support of the National Laboratory Response Network," and Policy D-460.971, "Genome Analysis and Variant Identification." (Reaffirm Current AMA Policy)

7. That our AMA amend Policy H-440.813, "Public Health Surveillance" by addition and deletion to read as follows:

Our AMA: (1) recognizes public health surveillance as a core public health function that is essential to inform decision making, identify underlying causes and etiologies, and respond to acute, chronic, and emerging health threats; (2) recognizes the important role that physicians play in public health surveillance through reporting diseases and conditions to public health authorities; (3) encourages state legislatures to engage relevant state and national medical specialty societies as well as public health agencies when proposing mandatory reporting requirements to ensure they are based on scientific evidence and meet the needs of population health; (4) recognizes the need for increased federal, state, and local funding to modernize our nation's public health data systems to improve the quality and timeliness of data; (5) supports the CDC's data modernization initiative, including electronic case reporting, which alleviates the burden of case reporting on physicians through the automatic generation and transmission of case reports from electronic health records to public health agencies for review and action in accordance with applicable health care privacy and public health reporting laws; (6) will advocate for incentives for physicians to upgrade their EHR systems to support electronic case reporting as well as incentives to submit case reports that are timely and complete; (67) will share updates with physicians and medical societies on public health surveillance and the progress made toward implementing electronic case reporting; (78) will advocate for increased federal coordination and funding to support the modernization and standardization of public

1 health surveillance systems data collection by the Centers for Disease Control and Prevention
2 and state and local health departments; ~~and~~ (89) supports data standardization that provides for
3 minimum national standards, while preserving the ability of states and other entities to exceed
4 national standards based on local needs and/or the presence of unexpected urgent situations.
5 (Modify Current AMA Policy)

Fiscal Note: \$650,000

Figure 1

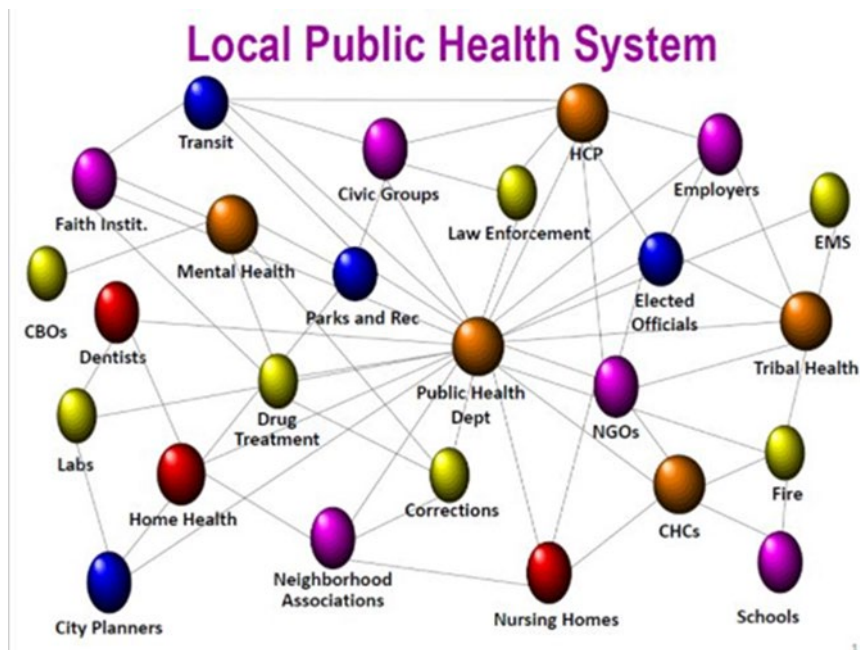
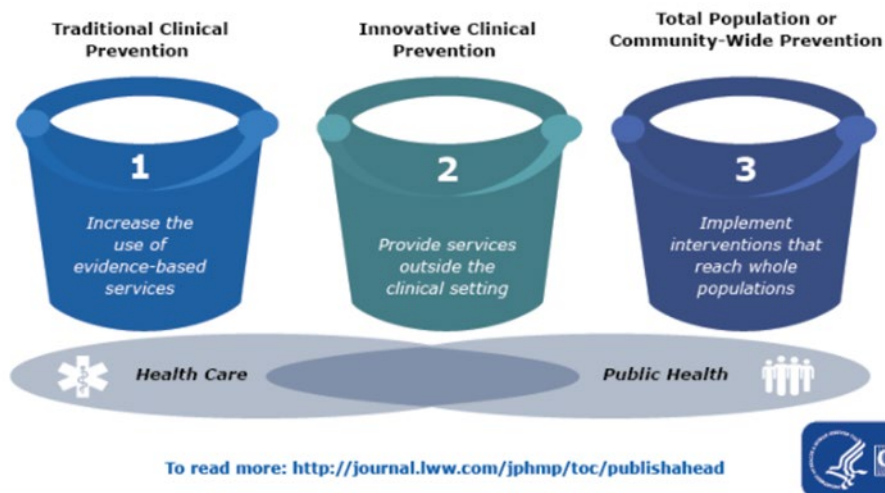


Figure 2



REFERENCES

1. DeSalvo KB. Public Health 3.0: A Call to Action for Public Health to Meet the Challenges of the 21st Century. *Prev Chronic Dis*. 2017;14. doi:10.5888/pcd14.170017
2. CDC - 10 Essential Public Health Services - CSTLTS. Published March 18, 2021. Accessed August 28, 2021. <https://www.cdc.gov/publichealthgateway/publichealthservices/essentialhealthservices.html>
3. The Impact of Chronic Underfunding on America's Public Health System: Trends, Risks, and Recommendations, 2020. tfah. Accessed March 18, 2021. <https://www.tfah.org/report-details/publichealthfunding2020/>
4. September 23 P on, 2019. Early Achievements from "Data: Elemental to Health" Campaign | HIMSS. Published September 23, 2019. Accessed September 1, 2021. <https://www.himss.org/news/early-achievements-data-elemental-health-campaign>
5. Public Health Workforce Interests and Needs Survey (PH WINS). JPHMP Direct. Accessed March 18, 2021. <https://jphmpdirect.com/public-health-workforce-interests-and-needs-survey-ph-wins/>
6. Covid Proved the C.D.C. Is Broken. Can It Be Fixed? - The New York Times. Accessed August 28, 2021. <https://www.nytimes.com/2021/06/16/magazine/cdc-covid-response.html>
7. DeSalvo K, Hughes B, Bassett M, et al. Public Health COVID-19 Impact Assessment: Lessons Learned and Compelling Needs. *NAM Perspect*. Published online April 7, 2021. doi:10.31478/202104c
8. Hawkins R, Ruebush E, Plescia M. Public Health Strengths During the COVID-19 Response. *J Public Health Manag Pract*. 2021;27(3):329-331. doi:10.1097/PHH.0000000000001369
9. Century I of M (US) C on A the H of the P in the 21st. *Understanding Population Health and Its Determinants*. National Academies Press (US); 2002. Accessed September 27, 2021. <https://www.ncbi.nlm.nih.gov/books/NBK221225/>
10. Proposed-Limits-on-Public-Health-Authority-Dangerous-for-Public-Health-FINAL-5.24.21pm.pdf. Accessed September 3, 2021. <https://www.naccho.org/uploads/downloadable-resources/Proposed-Limits-on-Public-Health-Authority-Dangerous-for-Public-Health-FINAL-5.24.21pm.pdf>
11. Symptoms of Depression, Anxiety, Post-Traumatic Stress Disorder, and Suicidal Ideation Among State, Tribal, Local, and Territorial Public Health Workers During the COVID-19 Pandemic — United States, March–April 2021 | MMWR. Accessed August 28, 2021. <https://www.cdc.gov/mmwr/volumes/70/wr/mm7026e1.htm>
12. Lasker RD, Committee on Medicine and Public Health NYA of M, Abramson D. *Medicine & Public Health: The Power of Collaboration*. Center for the Advancement of Collaborative Strategies in Health, the New York Academy of Medicine; 1997. Accessed August 30, 2021. <https://nyuscholars.nyu.edu/en/publications/medicine-amp-public-health-the-power-of-collaboration>

APPENDIX A

#24495 Public Health Infrastructure Interviews

Background and Objectives

The American Medical Association's Council on Science and Public Health is assessing ways to strengthen our nation's public health infrastructure, and the AMA's role in supporting and improving public health systems. More specifically:

- Understand the current challenges faced by public health professionals and health departments in preventing, detecting, and responding to emerging infectious disease threats and other public health crises.
- Understand physician and public health professionals' perspectives on what solutions need to be implemented to strengthen public health infrastructure to carry out the 10 essential public health services to improve disease and injury prevention and the health of the public
- Identify barriers and opportunities for improved and increased linkages between the public health and health care systems.
- Understand opportunities for the public health system to protect and promote the health of all people in all communities by removing systemic and structural barriers that have resulted in inequities.
- Identify opportunities for the AMA in supporting, developing, and implementing solutions.

Methodology and Sample

N=30-33 External stakeholders

- Government and Public Health (n=10)
- National Public Health (n=6)
- Federation of Medicine (n=12)
- Foundations (n=2)

Note on in-depth interviews format:

Questions might not be asked in the order below and all questions will likely not be asked. Rather, they are used as a guideline for the discussion. We will aim to have a natural conversation with the interviewees and touch upon the topics as they become part of the discussion and as they are relevant to the interviewee.

Intros (2-3 minutes)

- C+R Research – independent market research firm
- Talking with Physicians and Public Health Professionals like you for research purposes but don't belong to any health organization – think of me as a neutral third-party
- No wrong answers!

- I'm a moderator, not an expert in this field, so I may ask you to clarify things along the way
- Documenting the interview with audio (for notetaking and report writing purposes only)
- Other C+R and AMA researchers may join your interview to observe your responses. They may also view session recordings or notes in the future. The AMA may publish research reports or articles that include your anonymous comments and experiences shared. C+R and the AMA will not provide any details with its use of the information resulting from the interview which would allow any third party to identify you, nor will it use this information in any way that can be damaging to you.
- Questions before we get started?

BACKGROUND AND CONTEXT

5 minutes

- First off, we mentioned that we would be talking about the public health infrastructure in our interview today. From your perspective, how do you define "public health infrastructure"?
- Can you briefly describe your organization/your position and how long you have been in that role?
- How would you describe your background in terms of your expertise or involvement in public health?
 - *Understand whether their focus is research, epidemiology, policy & management, environmental health, etc.*
 - *Understand primary issue/area of focus within the field of public health (e.g., immunizations, maternal health, gun violence, health equity, etc.)*
- What previous roles have you had related to public health (in other organizations)? *Listen for if they were previously a state/local health official*

For Governmental/National Public Health Organizations:

- What is the role of your organization and/or members in the public health system?
- Can you briefly **describe your location or jurisdiction/population of focus?**

For physicians/primary care organizations:

- How do you or your members support or interact with the public health system?
- Can you briefly **describe your location or jurisdiction/population of focus?**

CURRENT CHALLENGES

15 minutes

Now I'd like to talk more about the challenges facing our nation's public health system. You are welcome to focus this conversation on COVID-19, as we understand it's likely a main part of what your organization is currently focused on, or you can consider challenges beyond the pandemic.

Successes + What Works Well

- **National Public Health Organizations:**
 - What are some **"big picture" successes** your organization/members/our public health system have had?

- What's an example of a **“small success”** your organization/members/our public health system have had on a given day or week?
- Please share some **examples of how your organization/members/the public health system has successfully collaborated** with physicians or healthcare delivery systems to address a public health issue.
- *Probe: how do we sure the **10 Essential Public Health Services** are available to all people in all communities?*
- *Probe: is there an explicit strategy to advance equity?* Please describe any explicit **strategies to advance equity** that you/your organization/members use consistently.

- **National Physician Organizations:**

- What are some **examples of how physicians/your members/health care systems have successfully collaborated** with public health agencies? Have these been sustained?
- Please share an **example from your or your organization's perspective** of when the public health and healthcare sectors were in **alignment** on a significant public health issue in your local community and/or nationally.
- *Probe: how do we sure the **10 Essential Public Health Services** are available to all people in all communities?*
- *Probe: Do you have an explicit strategy to advance equity?* Please describe any explicit **strategies to advance equity** that your organization/members use consistently.

Previous and/or Ongoing Challenges

- What would you say are the three to five **biggest challenges facing the nation's public health infrastructure** today?
 - Why do you think each of these is an important issue?
- How would you prioritize these issues?
 - *Probes: authority, communication, collaboration across levels of government, public health workforce, data modernization, linkages between health care and public health, ensuring equity*
 - **Physician Orgs:** How do challenges in public health infrastructure impact physician practices and patients?
- *Probes: for those who are former state/local health officials to think about what they needed when they were in that job and what would have been most beneficial.*
- **[For each challenge mentioned]** Tell me about a recent challenge the public health system faced. These challenges can be specific to the COVID-19 pandemic or on issues other than the pandemic.
 - What was the issue/challenge?
 - What made it challenging or difficult?
 - What was the plan to resolve this issue?
 - How was it implemented (whether successfully or unsuccessfully)?
 - What were the outcomes?
 - What was the impact on health equity?
 - What did you or your organization learn from this? What will be done differently in the future?

Repeat as time allows to understand multiple issues and their context.

IDEATE FUTURE SOLUTIONS**10-15 minutes**

Now that we've talked about these challenges, I'd like to hear more from you about your thoughts on how these can be solved.

- From your perspective, what do you think **needs to be done to improve** the public health infrastructure?
- Thinking back to each of those challenges you have faced, what would have made these issues easier to solve?
- **National Public Health Organizations:**
 - What can help your **organization/members/the public health system** be more successful in their efforts?
 - What can help you/your members/the public health be more successful in your/their job?
 - What would improve collaboration between medicine and public health and lead to better health outcomes for patients and communities?
- **National Physician Organizations:**
 - What would improve collaboration between medicine and public health and lead to better health outcomes for patients and communities?
 - What is the perspective of physicians/your members on linking the principles of public health (upstream approaches) into the language and practice of medicine?
How do we move health care upstream to improve the structural and social drivers of health and equity?
- What's **one thing you'd want to change** that would make the work of the public health system easier, more effective and equitable tomorrow?
 - What about making the next few weeks/months easier more effective and equitable?
 - And the next few years?
- How would you **prioritize** these changes?
 - What should be focused on first? What is most important?
 - What are areas that could be addressed at a later time?
- What **goals** do you or your organization already have in place to address these in the future?
 - Which are more short-term, and which are longer term goals?
- Which organizations (for profit, not-for-profit, public, private) would be part of the solution to the U.S.'s public health infrastructure problems? What roles/contributions would they have in the solution?
- *If time allows.* Who would be a **reliable and trustworthy source** for you related to recommendations on how to better manage future public health issues?
 - Why are these sources more reliable than others? *Probe to get beyond simply peer reviewed research or the CDC.*

AMA POTENTIAL SOLUTIONS + WRAP UP

10 minutes

I'd like to talk more specifically about how the AMA can **support efforts to strengthen public health infrastructure**.

- Public Health Orgs: In what way(s), does/do the AMA already help support you in your role/organization improve public health?
- Physician Orgs: In what ways does the AMA already support you in addressing the upstream factors that impact health?
- Thinking back to your previous challenges, how, if at all, can the AMA help with these?
 - What can the AMA do to help you face these challenges in a better way?
 - What would the AMA need to do? What would this solution look like?
 - What should the AMA provide?
- Do you have any **final words of advice** for those designing and implementing future public health policies, recommendations, and programs?

Moderator will check with back room for additional questions, thank and close

APPENDIX B

#24495 Public Health Infrastructure Interviews FINAL GUIDE – Internal B.O.T. Interviews 45 minutes

Background and Objectives

The American Medical Association's Council on Science and Public Health is assessing ways to strengthen our nation's public health infrastructure, and the AMA's role in supporting and improving public health systems. More specifically:

- Understand the current challenges faced by public health professionals and health departments in preventing, detecting, and responding to emerging infectious disease threats and other public health crises.
- Understand physician and public health professionals' perspectives on what solutions need to be implemented to strengthen public health infrastructure to carry out the 10 essential public health services to improve disease and injury prevention and the health of the public
- Identify barriers and opportunities for improved and increased linkages between the public health and health care systems.
- Understand opportunities for the public health system to protect and promote the health of all people in all communities by removing systemic and structural barriers that have resulted in inequities.
- Identify opportunities for the AMA in supporting, developing, and implementing solutions.

Methodology and Sample

N=11 Internal B.O.T. Members

Note on in-depth interviews format:

Questions might not be asked in the order below and all questions will likely not be asked. Rather, they are used as a guideline for the discussion. We will aim to have a natural conversation with the interviewees and touch upon the topics as they become part of the discussion and as they are relevant to the interviewee.

Intros (2-3 minutes)

- C+R Research – independent market research firm
- Working with the AMA and talking with internal board members like you as well as external stakeholders in public health – think of me as a neutral third-party
- No wrong answers!
- I'm a moderator, not an expert in this field, so I may ask you to clarify things along the way

- Documenting the interview with audio (for notetaking and report writing purposes only)
- Other C+R and AMA researchers may join your interview to observe your responses. Just a reminder that this is all for research purposes and your responses will be reported back in the aggregate along with other board members like you.
- Questions before we get started?

BACKGROUND AND CONTEXT

2-3 minutes

- Can you briefly describe **your role** as it relates to the AMA and how long you have been in that role?
- Today, we are going to be talking about the public health infrastructure as well as ways AMA can help. When I say **public health infrastructure**, I am talking about the governmental public health system at the federal, state, local, territorial and tribal levels.
Can you describe **your background** along with any previous involvement in efforts **related to public health** (if applicable)?

CURRENT CHALLENGES

10 minutes

As you may know, we just completed an initial round of interviews with external public health experts from a variety of organizations. They provided their perspective on what challenges are facing our nation's public health infrastructure today. But before we talk about what they told us, I'm curious what your perspective is.

Challenges (Unaided) – 3 minutes

- Just briefly, what would you say are the top three **biggest challenges facing the nation's public health infrastructure** today?
 - *Listen for and probe around any mentions of misperceptions of public health, funding, workforce, data modernization, collaboration between healthcare and public health, equity issues, etc.*
- How do these challenges **impact your practice or your patients?** *(do not ask if respondent is not a clinician)*

Challenges (Aided) – 7 minutes

- When we spoke with the external public health stakeholders, here are some of the **biggest challenges they mentioned**. I am curious to get your perspective on these and hear how you would prioritize them.
HAVE RESPONDENT RANK ORDER CHALLENGES FROM HIGHEST TO LOWEST PRIORITY
 - Perception problems/lack of understanding of public health (i.e., public health is invisible)
 - Lack of consistent, sustainable funding
 - Workforce/staffing issues

- Data modernization and lack of interoperability with health care
- Lack of collaboration between healthcare and public health
- Equity issues

IDEATE FUTURE SOLUTIONS

15 minutes

Now that we've talked about these challenges, I'd like to hear more from you about your thoughts on **how the AMA could help address each of these areas.**

- **[For each challenge mentioned, ask in order of priority] What could the AMA do to help solve this challenge?**
 - What would the potential solution(s) look like?
 - Who would need to be involved?
 - What would it take to accomplish this? (what would have to happen?)
- In addition to the solutions we just discussed, here are some other ideas the external stakeholders mentioned as **possible solutions, which include the AMA's role in strengthening the public health system.** I'd like to get your perspective on which of these the AMA feels best suited to support and why.
 - **Collaboration Between Medicine and Public Health**
For example, sharing of data across public health and healthcare, more communication between public health and health care, sharing the common goal of prevention, etc.
 - **Prioritizing Public Health**
For example, raising the visibility of our public health system to help ensure the work they do is not invisible and share power ensuring their voice is at the table.
 - **Advocating for Sustainable Public Health Funding**
For example, advocating at the federal level for sustainable funding for the public health infrastructure (communications, IT, workforce) and services (immunizations, chronic disease, injury prevention to ensure that public health isn't only funded well in a crisis.

Working with state/county medical societies to advocate for evidence-based public health policies as well as support for public health authority during emergencies.
 - **Data Modernization**
For example, supporting interoperability between health care and public health as well as incentives for health care professionals who report timely, accurate and complete data on notifiable conditions to public health agencies.

Supporting incentives for clinicians to upgrade the EHR systems to support electronic case reporting.

- **Strengthening the Public Health Workforce**

*For example, supporting incentives for those who work in governmental public health so public health can attract the talent it needs to be successful.
Prioritizing physician and medical student education in public health as well as education focusing on, equity and the social determinants of health.*

Supporting residency programs for preventive medicine specialists.

- How would you **prioritize** these changes?
 - What should be focused on first? What is most important?
 - What are areas that could be addressed at a later time?

AMA POTENTIAL SOLUTIONS + WRAP UP

15 minutes

I'd like to talk more specifically about what else the AMA can do to **support efforts to strengthen public health infrastructure.**

- How does strengthening the public health system **fit into the AMA's current strategic plan and operating goals?** *Moderator may reference slide for strategic plan and operating goals*
- What do you think the AMA **should do** to further strengthen the public health infrastructure beyond what it is already doing?
 - What should the AMA do to strengthen collaboration between medicine and public health?
- What, if anything, would you **caution the AMA not to do or not to get involved in?**
- Do you have any **final words of advice** for those considering the AMA's role in strengthening public health infrastructure?

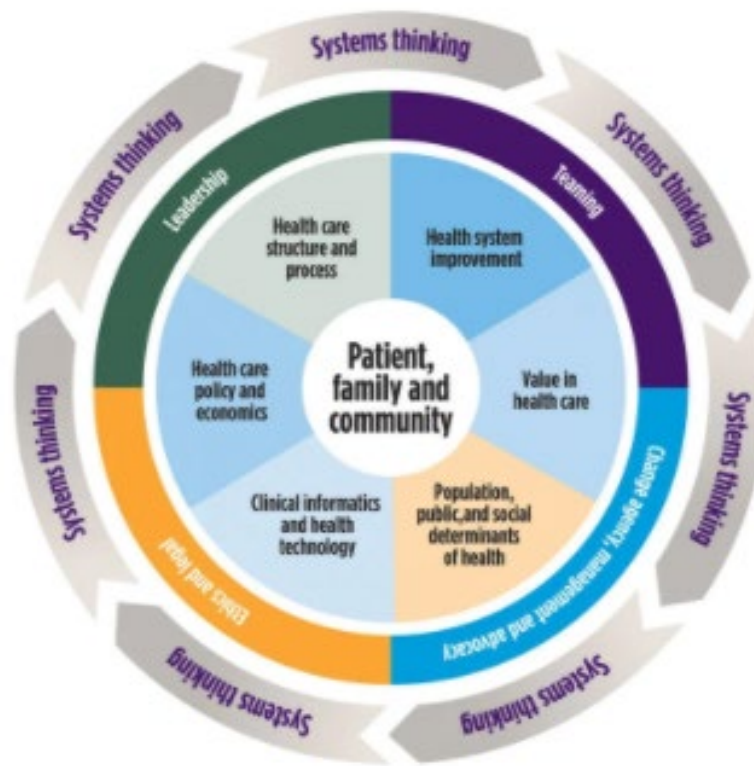
Moderator will check with back room for additional questions, thank and close

APPENDIX C

Health System Science

Health systems science (HSS) is the third pillar of medical science, along with the basic and clinical sciences. It involves understanding how care is delivered, how health care professionals work together to deliver that care and how the health system can improve patient care and health care delivery. It is critical for the successful functioning of a health system. Physicians need to know the domains of health systems science, understand how it intersects with the basic and clinical sciences and explore how it can maximize health for patients and society.

The HSS curriculum includes issues related to how social determinants of health effect the entire population and the improvement strategies at the population health level to address gaps in care such as the organized assessment, monitoring or measurement of key health metrics necessary to improve health outcomes for a group of individuals.



Core functional, foundational, and linking domains of health systems science

AMA ACE Consortium**Relevant exemplar medical school efforts in the consortium, funded by AMA grants:**

- Brown Warren Alpert School of Medicine established the Primary Care-Population Medicine in which students receive a Masters of Science in Population Medicine in addition to their MD <https://pcpm.med.brown.edu/curriculum/scm-curriculum>
- AT Still School of Osteopathic Medicine in Arizona embeds 2nd-4th year medical students in underserved communities where they perform needs assessments and work with

community health center leadership and community stakeholders to perform community-based research, quality improvement or service projects that recognize the local, social and economic determinants of health.

- Florida International University Herbert Wertheim College of Medicine (FIU HWCOM) NeighborhoodHELP program places medical students on inter-professional teams that perform home visits that have resulted in increased use of preventive health services and a trend toward decreasing the use of the emergency department as a regular place of care. The program also allows for collaboration with local hospitals to improve population health outcomes.
- Similarly, University of Texas Rio Grande Valley School of Medicine (UTRGV) places medical students on inter-professional teams that serve colonias, impoverished rural settlements in unincorporated areas along the U.S./Mexico border, providing integrated care and connecting patients and families with public health services
- The University of California, Davis, School of Medicine (UC Davis) established a model three-year education track, the “Davis Accelerated Competency-based Education in Primary Care” (ACE-PC) that addresses pressing societal needs by including work with medically underserved populations and enhanced training in population management, chronic disease management, and preventive health skills

AMA Reimagining Residency initiative

The goal of the Reimagining Residency grant program is to transform residency training to best address the workplace needs of our current and future health care system. It supports bold and innovative projects that provide a meaningful and safe transition from undergraduate medical education to graduate medical education, establish new curricular content and experiences to enhance readiness for practice and promote well-being in training.

Examples of relevant projects:

- Montefiore is developing a curriculum in social determinants of health in four primary care residency programs.
- COMPADRE is a collaboration between OHSU and UC-Davis to address workforce in the predominantly rural and indigenous communities in the corridor between their institutions. They are providing training in those communities, so trainees understand the social context for care and the community resources available to support their work.
- The FIRST program at UNC expanding its 3+3+3 model (3 years of medical school, 3 years of residency, 3 years of early career mentorship) to 4 regions in the state (3 of them AHECs) and across disciplines. This is also an effort to link training and early career experience to community resources.
- Penn State is collaborating with Geisinger, Allegheny, and Kaiser Permanente to define the personal and learning environment characteristics that contribute the creation of “systems citizens” – those physicians who effectively navigate health systems and appropriately apply system and community resources to the care of their patients.

REPORT 3 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (N-21)
Physician Involvement in State Regulations of Motor Vehicle Operation and/or Firearm Use by
Individuals with Cognitive Deficits Due to Traumatic Brain Injury
(Resolution 424-A-19)
(Reference Committee D)

EXECUTIVE SUMMARY

Objective. This report summarizes the evidence around cognitive deficits, including traumatic brain injury (TBI), the legal landscape of cognitive impairment as it relates to firearm ownership and driving, and the role of the physician in adjudicating fitness. While the resolution specifically cites TBI, there is currently limited research available on TBI and driving or firearm ownership. As such, more well-studied cognitive deficits (such as dementias) are examined to provide context.

Methods. English language reports were selected from searches of the PubMed and Google Scholar databases from January 2011 to July 2021 using the search terms “medical advisory board” and “gun” or “firearm” or “driver license” or “motor vehicle;” “cognitive impairment” or “dementia” or “traumatic brain injury” and “gun” or “firearm” or “driver license” or “motor vehicle.” Additional articles were identified by manual review of the reference lists of pertinent publications. Websites managed by federal and state agencies and applicable regulatory and advocacy organizations were also reviewed for relevant information

Results. The role of the physician in adjudicating fitness for driver licensing and firearm ownership are primarily dictated by individual state policies. Differences in state policies, such as the duration of revocation, severity of symptoms and appeals process were noted. Generally, a medical advisory board is utilized for driver licensing adjudication and appeals. For firearm ownership, cognitive impairment-based removals are more uncommon and extreme risk protection orders have only recently become established in a smaller number of states, with varying roles of physician involvement.

Conclusion. Given the unpredictable nature of symptom progression in an individual living with TBI, it is difficult to compare to the current regulatory framework with other cognitive impairments, such as dementias. Your Council recommends that additional research is needed to understand TBI as a risk factor for harming oneself or others in order to inform the development of policies and protocols for the revocation or reinstatement for the purposes of driver licenses and firearm ownership

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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 3-N-21

Subject: Physician Involvement in State Regulations of Motor Vehicle Operation and/or Firearm Use by Individuals with Cognitive Deficits Due to Traumatic Brain Injury

Presented by: Alexander Ding, MD, MS, MBA, Chair

Referred to: Reference Committee D

INTRODUCTION

Resolution 424-A-19, “Physician Involvement in State Regulations of Motor Vehicle Operation and/or Firearm Use by Individuals with Cognitive Deficits Due to Traumatic Brain Injury,” introduced by the American Academy of Physical Medicine and Rehabilitation and referred by the American Medical Association (AMA) House of Delegates (HOD) asked:

That our AMA reaffirm current AMA Policy H-145.999, stating it supports stricter enforcement of current federal and state gun legislation and that our AMA advocate for physician-led committees in each state to give further recommendations to the state regarding driving and/or gun use by individuals who are cognitively impaired and/or a danger to themselves or others.

This report summarizes the evidence around cognitive deficits, including traumatic brain injury (TBI), the legal landscape of cognitive impairment as it relates to firearm ownership and driving, and the role of the physician in adjudicating fitness. While the resolution specifically cites TBI, there is currently limited research available on TBI and driving or firearm ownership. As such, more well-studied cognitive deficits (such as dementias) are examined to provide context.

METHODS

English language reports were selected from searches of the PubMed and Google Scholar databases from January 2011 to July 2021 using the search terms “medical advisory board” and “gun” or “firearm” or “driver license” or “motor vehicle;” “cognitive impairment” or “dementia” or “traumatic brain injury” and “gun” or “firearm” or “driver license” or “motor vehicle.” Additional articles were identified by manual review of the reference lists of pertinent publications. Websites managed by federal and state agencies and applicable regulatory and advocacy organizations were also reviewed for relevant information.

OVERVIEW OF COGNITIVE IMPAIRMENT

Cognitive impairment describes a durable characteristic in which an individual has difficulty concentrating, learning, remembering, or exercising sound judgment during everyday tasks due to illness or injury. Cognitive impairment is not limited to a specific condition or disease, but severe cases are typically associated with degenerative brain diseases, such as Alzheimer’s, Parkinson’s or Lewy Body disease. In these cases, cognitive impairment can be measured using the Global Deterioration Scale, which ranges from 1 (no cognitive impairment) to 7 (severe dementia).¹ Age is

the primary risk factor for cognitive impairment. Current estimates suggest that there are approximately 44 million individuals worldwide living with dementia, nearly double the number of cases from 1990.² While a portion of this increase can be attributed to improved screening and awareness of dementia, it also is a key indicator of the impending “silver tsunami” as the baby boomer generation (birth years 1946-1964) ages.^{3,4}

It is generally accepted that individuals experiencing dementia, or other forms of cognitive impairment, may be at increased risk for harming themselves or others. To reduce injuries and deaths, while respecting their autonomy and rights, it is recognized that some activities, such as driving or firearm access, may need to be restricted in this population.

Traumatic Brain Injury

TBI is an emerging area of scrutiny, not only in the medical profession, but in the public sphere, raising questions as to whether individuals with TBI may be at higher risk of harming themselves or others. TBI occurs when an individual receives a blow to the head. It can be categorized broadly in two ways: mode of injury (closed/non-penetrative or open/penetrative) and severity (mild, moderate or severe).⁵ Secondary injuries from the initial impact may include increased intracranial pressure, decreased cerebral perfusion and intracranial hemorrhage. Persons with TBI commonly experience loss of consciousness, headache, nausea, fatigue, depression, mood swings and difficulty concentrating.⁶ In the most severe cases, persons with TBI may be left with persistent and severe cognitive impairment or they may remain in a comatose state long after their initial injury. While symptoms typically abate after approximately six months, many patients report lifelong complications from even a single, mild incident of TBI.⁷ Common causes of TBI include falls, motor vehicle crashes, sports injuries and gunshot wounds. Unlike other forms of cognitive impairment, persons living with TBI may recover and regain some or all cognitive function and motor skills, this is especially true in cases where rehabilitation is sought. This makes understanding symptom progression particularly difficult.⁸

It is estimated that approximately 1.1 percent of the U.S. population experiences life-long effects from TBI.⁹ Of particular interest to this report is the connection between TBI and later-in-life development of neurodegenerative disease such as dementias, including Alzheimer’s and Parkinson’s.¹⁰ Studies have suggested that patients who have experienced at least one incident of TBI in their life are up to 4 times more likely to develop Alzheimer’s in their lifetime, with more severe incidents (such as those resulting in loss of consciousness) resulting in the highest risk.¹¹⁻¹³ One of the historic difficulties of diagnosing and treating TBI has been managing the sequelae that may not manifest until much later in life. For example, studies have shown that cognitive function post-TBI can steadily improve for up to 10 years only to be followed by a sharp decline.¹⁴

With regard to whether individuals with TBI may be at higher risk of harming themselves or others, data suggest TBI may be a risk factor for violent behavior and suicide. One study found that approximately 40 percent of patients monitored at 3, 6 and 12 months post-TBI presented signs of aggression.¹⁵ Similarly, several studies have shown TBI is a risk factor for intimate partner violence and violent criminal behavior,¹⁶⁻²¹ and a study of Vietnam war veterans with TBI found a correlation between lesions of the prefrontal cortex and a positive implicit attitude towards violence.²² Additionally, violent behavior may present as self-harm, as a 35-year retrospective study in Denmark found the absolute suicide rate was over double (41 vs 20 per 100,000 person-years) for patients with diagnosed TBI at any severity,²³ and this risk increases with subsequent head traumas.²⁴

1 DRIVER LICENSING

2
3 There is no constitutionally protected right to maintain a driver license, and there are clear
4 guidelines for the role of the physician in protecting their patients from unsafe driving. In
5 collaboration with the U.S. Department of Transportation and the National Highway Traffic Safety
6 Administration, the AMA previously developed and published guidance for physicians. While this
7 guidance is presented in the context of an aging driver, potential cognitive and noncognitive
8 impairment from a previous TBI can occur at any age.²⁵

9
10 In brief, the guidance suggests that physicians perform a battery of tests to assess driving skills
11 (visual acuity, spatial awareness, dexterity, memory). If a physician believes that their patient is
12 unfit to drive, they are advised to counsel the patient and their family or caregivers to voluntarily
13 retire from driving and surrender their driver license, or they may refer the patient for occupational
14 therapy. In the case of TBI, this is especially critical as surveys have shown that half of drivers
15 recovering from mild TBI have no intention of self-moderating driving behavior.²⁶

16
17 Depending on the state, the physician may also have legal responsibilities as dictated by their
18 medical licensing board. Some states, such as California, mandate that all physicians report to the
19 Department of Motor Vehicles (DMV) any instances of patients with disorders resulting in loss of
20 consciousness or severe impairment of motor vehicle operation. Other instances where a physician
21 has a good faith belief that a driver is a risk to public safety are encouraged to be reported, but not
22 required to do so. Some states, such as Kansas, explicitly do not require a physician to report this
23 information and further require the physician to obtain written consent from the patient before
24 releasing any information to the DMV. Additional state-level differences to be aware of include the
25 legal protection (or liability) that a physician may be entitled to in the event of an accident from a
26 known unsafe driver, and whether the physician may submit a DMV referral anonymously.

27 FIREARM OWNERSHIP

28
29
30 Firearm ownership in the United States is largely controlled by the Second Amendment to the
31 Constitution, which indicates that “the right of the people to keep and bear Arms, shall not be
32 infringed.” However, Supreme Court decisions in *District of Columbia v. Heller* (2008) and
33 *McDonald v. City of Chicago* (2010) found that this right is not absolute and may be limited
34 appropriately by federal, state and local governments.^{27,28} Limits to firearm ownership relevant to
35 this report fall into two categories: cognitive impairment restrictions and risk-based removals.

36
37 It should be noted that instances of interpersonal firearm violence committed by people with
38 mental illness often attract media and public scrutiny. However, only 4 percent of all interpersonal
39 firearm violence in the United States can be attributed to individuals with mental illness.²⁹ By
40 comparison, up to 74 percent of deaths by suicide are related to a diagnosed mental illness.³⁰

41 *Firearm Ownership and Possession Restrictions*

42
43
44 Federal law 18 U.S.C. § 922(d) prevents the sale of a firearm or ammunition to any person that
45 “has been adjudicated as a mental defective or has been committed to any mental institution,”
46 although all but 4 states (Colorado, Indiana, Kentucky and New Hampshire) have additional
47 restrictions related to mental health and firearm ownership.³¹ The resulting patchwork of
48 restrictions and regulatory authorities has been criticized for ineffectiveness. For example, the
49 gunman responsible for the deaths of 32 people at Virginia Tech in 2007 had been found to be
50 mentally unfit by a court in 2005 after accusations of stalking. The shooter was required by the
51 court to attend treatment, but due to his treatment being on an outpatient basis, he was not

1 prevented from purchasing the firearms used in the mass shooting, as federal law requires
2 involuntary commitment.³²

3
4 All states but one (Hawaii) do not allow restrictions on firearm purchases on the basis of diagnosis
5 alone. This practice of requiring an individual risk assessment is consistent with the
6 recommendations of the American Psychiatric Association (APA).³³ While a practitioner may
7 report the status of an individual's diagnosis or treatment to a third party, that is not sufficient to
8 bar the purchasing of a firearm (outside of Hawaii).

9
10 At the federal level, individuals adjudicated to be mentally unfit to own a firearm are reported to
11 the National Instant Criminal Background Check System (NICS). Firearm dealers who hold a
12 federal firearms license must process all potential buyers through NICS prior to selling them a
13 firearm. Since 1998, firearm sales have been denied 1,970,264 times due to failing a NICS
14 background check, but only 3 percent of them have been due to mental health concerns.³⁴ Several
15 factors may have contributed to this relatively low rate of rejection, such as a lack of mandatory
16 reporting of mental health data by states, the inability for states to report violations of their stricter
17 purchasing restrictions, and a lack of clarity around NICS reporting and the Health Insurance
18 Portability and Protection Act (which was clarified in 2016).^{35,36}

19 20 *Firearm Removals*

21
22 Once an individual has legally purchased a firearm, the primary means for removal are through
23 extreme risk protection orders (ERPOs), although they may go by other names depending on the
24 state, such as gun violence restraining orders (California), or risk warrants (Connecticut).
25 Currently, 19 states (and the District of Columbia) have some version of ERPO law that allows for
26 the petitioning of a court to remove firearms from the possession of someone deemed high risk.³⁷
27 ERPO laws have recently gained momentum, with 8 of the 20 states having passed legislation
28 during the 2018 session immediately following the school shooting in Parkland, Florida. In June
29 2021, under the direction of President Biden, the Department of Justice released model legislation
30 for states to follow if they wished to enact ERPO laws.³⁸ A 2018 report from this Council further
31 discusses the role of the physician in firearm safety and ERPOs.³⁹ ERPO laws are still new, but
32 research suggests that while public awareness remains low, California's approach has shown signs
33 of success in removing firearms from individuals threatening mass shooting events.^{40,41}

34
35 By contrast, Oklahoma passed an anti-ERPO law in May 2020 which prohibits any county or local
36 government from enacting ERPO laws. Texas, Alaska, Georgia, Minnesota and Kansas legislatures
37 have all introduced anti-ERPO laws which have not passed at the time of writing. State legislators
38 in these jurisdictions have argued that ERPO laws may infringe upon the First, Second, Fourth and
39 Fifth Amendment, but in limited court proceedings, these arguments have been rejected.^{37,42-44}

40
41 The exact implementation of ERPO laws varies from state to state, but broadly they allow for a
42 process in which a court can hear a petition to remove firearms and ammunition from the
43 possession of an individual.⁴⁵ The laws largely differ in three major areas: who may petition the
44 court, the burden of evidence required to approve the removal, and the duration of the removal and
45 the overturning of the individual's rights to otherwise possess a firearm. The most narrowly drafted
46 state legislation allows law enforcement officers or their agencies to petition a court to remove
47 firearms, where other states allow some combination of household members, intimate partners,
48 employers, coworkers, or school officials to additionally file an ERPO. Most relevant to this report,
49 Maryland and the District of Columbia allow healthcare providers to file ERPO petitions as well,
50 although professional groups have varying ways of defining and measuring risky behavior.⁴⁶ An
51 individual may or may not be notified that a petition for an ERPO against them has been made, and

1 law enforcement may be empowered to seize an individual's weapons within 24 hours and then to
 2 prevent the individual from regaining possession of their firearms until a hearing has been held,
 3 which, per some state statutes, can extend for up to a year.

4 *Firearm Ownership and Cognitive Impairment*

5
 6 Studies have indicated that up to 60 percent of outpatients living with dementia are in households
 7 containing firearms, placing them at higher risk for death by suicide.^{47,48} Older adults die by suicide
 8 at rates disproportionate with the general population and firearms are the most common means.⁴⁹
 9 Caregivers for those with dementia have been surveyed and over 70 percent feel that the caregiver
 10 plays a key role in firearm safety, but only 5 percent of caregivers had training or guidance.⁵⁰ The
 11 Veteran's Health Administration has developed guidance for counseling family or caregivers on
 12 creating a safe environment if firearms are accessible to a person living with dementia.⁵¹

13
 14 As described above, the progression of TBI is unpredictable. Some report no behavioral or physical
 15 effects for many years only to be followed by a steep decline, while others report a full recovery of
 16 function. Currently, conditions such as chronic traumatic encephalopathy (CTE) from sports
 17 injuries can only be diagnosed posthumously which would make any blanket policy around TBI
 18 and firearm ownership difficult to craft and implement. However, TBI does increase the risk of
 19 developing other neurological conditions, such as dementias which have more established
 20 protocols for evaluating cognitive fitness.^{10,52-54} Depending on the progression of TBI, a similar
 21 approach to that used for dementia may be appropriate.
 22
 23

24 *Medical Advisory Boards*

25
 26 Legal requirements and medical thresholds for firearm ownership and driver licensing in the event
 27 of cognitive impairment vary from state to state. To ensure that the physician's voice is heard in the
 28 process, states can implement a medical advisory board (MAB) at several different points: to create
 29 best practices guidelines, to perform the medical assessment, or to evaluate appeals for
 30 reinstatement.
 31

32 MABs are much more commonly utilized in the case of driver licensing. A summary of MAB roles
 33 from state to state can be found in a 2017 NHTSA publication.⁵⁵ In brief, the MAB may be
 34 involved in all steps of the process. In New York, input from the MAB is given to the DMV for
 35 developing the regulations dictating a driver's fitness. Other states use their MABs on a case-by-
 36 case basis. Louisiana's MAB is forwarded complaints from the DMV for evaluation, whereas
 37 Maine's MAB is engaged only on driver appeal. Some states, like Montana, do not retain a MAB at
 38 all. It should also be noted that the function of state MABs are dependent not only on statutory
 39 authority but also on funding, which has historically not been consistent.
 40

41 For firearm ownership, there are no known MABs in the country. In Texas, a MAB has been used
 42 to review cognitive fitness for concealed handgun licenses, but the MAB is not used for purchasing
 43 firearms or reviewing ERPOs. In 2020, a bill was introduced in the New York state legislature
 44 (S7065) to require anyone seeking to purchase a firearm to submit to a mental health screening, but
 45 it did not receive a vote in the committee that first had hearings on the bill. Countries as diverse as
 46 Argentina, Turkey, Ukraine, Croatia, France, Spain, Japan and Israel require either a mental health
 47 evaluation or access to medical records prior to purchasing any firearm.⁵⁶
 48

49 Given the unpredictable nature of symptom progression in an individual living with TBI, including
 50 the potential for recovery, the role of a MAB in both driver licensing and firearm ownership
 51 becomes more critical. For example, many states utilize their MAB to develop a protocol for

1 reinstating the driver's license of an individual living with epilepsy, a disease which can be
2 managed with medication or other interventions. A typical procedure involves the revocation of the
3 driver's license, followed by an appeals process in which the individual must go a set amount of
4 time without a seizure event (3-18 months depending on the state) followed by an individual risk
5 assessment performed by the MAB.⁵⁷ More research is needed to understand TBI as a risk factor
6 for harming oneself or others in order to inform the development of policies and protocols for the
7 revocation or reinstatement for the purposes of driver licenses and firearm ownership.

8 9 CURRENT AMA POLICY

10
11 The AMA has a multitude of policies regarding firearm violence, mental health and/or driver
12 licensing as listed in the appendix of this report. AMA policy clearly defines firearm violence as a
13 public health threat and aims to limit high-risk individuals from possessing firearms in order to
14 protect themselves and others from morbidity and mortality. Most relevant to this report include
15 AMA policies on "Medical Advisory Boards in Driver Licensing" (H-15.995), "Firearms and
16 High-Risk Individuals" (H-145.972) and "Violence Prevention" (H-145.970).

17 18 DISCUSSION

19
20 When creating and implementing policy related to TBI, one must acknowledge the non-linear
21 progression of even mild TBI. Many people who suffer a concussion will go on to live
22 complication-free lives after their initial recovery, whereas others may be at risk of cognitive
23 decline decades later. The potential for increased risk, even after long symptom-free periods, need
24 to be balanced with individual dignity, constitutional rights, and physician liability.

25
26 With respect to driver licensing, AMA policy is clear, guidance has been published in collaboration
27 with the U.S. Department of Transportation, and physicians are being utilized on MABs in 32
28 states as of 2015.⁵⁵ With respect to firearm ownership, the AMA supports the establishment of
29 laws, such as ERPOs allowing family members, intimate partners, household members, and law
30 enforcement personnel to petition a court for the removal of a firearm when there is a high or
31 imminent risk for violence.

32
33 In CSAPH Report 4-A-18, "The Physician's Role in Firearm Safety," the Council identified those
34 individuals considered to be high-risk of firearm violence to themselves or others and the report
35 supported common-sense laws allowing for the removal of firearms in certain circumstances. In the
36 case of TBI, where there can be a large range of severity, non-linear progression and a lack of
37 conclusive diagnostic testing, a diagnosis alone may not be sufficient to quantify risk of harm to
38 oneself or others.

39
40 With the Biden administration signaling an interest in passing a federal ERPO law and increasing
41 pressure on states to pass standardized ERPO laws, opportunities may exist to develop guidance for
42 physicians and courts, similar to the work previously done around driver licensing. The AMA has
43 developed a CME module to prepare physicians to counsel their patients on firearm safety.⁵⁸ The
44 module is designed to assist physicians in recognizing risk factors that increase the potential for
45 firearm injury and death, identifying barriers to communicating with patients about firearm safety,
46 and effectively communicating with patients to reduce the risk of firearm injury and death.

1 RECOMMENDATIONS

2
3 The Council on Science and Public Health recommends that the following be adopted and the
4 remainder of the report be filed:

- 5
6 1. Our AMA encourages research on cognitive impairment, including traumatic brain injury
7 (TBI), as a risk factor for driving and/or firearm ownership, and the role of the physician in
8 preventing morbidity and mortality (New HOD Policy).
9
10 2. That Policy H-15.995, "Medical Advisory Boards in Driver Licensing," advocating for
11 state governments to create and maintain medical advisory boards to oversee driver
12 licensing, be reaffirmed. (Reaffirm Current HOD Policy)
13
14 3. That Policy H-145.972, "Firearms and High-Risk Individuals," which advocates for ERPO
15 laws and protocols for removing firearms from those deemed to be high-risk in the wake of
16 a petition from concerned parties, be reaffirmed. (Reaffirm Current HOD Policy)
17
18 4. That Policy H-145.970, "Violence Prevention," calling upon state and federal government
19 entities to strengthen and promote the use of the NICS background check system, be
20 reaffirmed. (Reaffirm Current HOD Policy)
21
22 5. That Policy H-145.976, "Firearm Safety Counseling in Physician-Led Health Care Teams,"
23 which protects the right of a physician to counsel a patient and/or their family about the
24 risks of gun ownership and appropriate safety measures, be reaffirmed. (Reaffirm Current
25 HOD Policy)

Fiscal Note: Less than \$1000

REFERENCES

1. Reisberg B, Ferris SH, de Leon MJ, Crook T. The Global Deterioration Scale for assessment of primary degenerative dementia. *The American journal of psychiatry*. 1982.
2. Launer LJ. Statistics on the burden of dementia: need for stronger data. *The Lancet Neurology*. 2019;18(1):25-27.
3. Sarkar A, Irwin M, Singh A, Riccetti M, Singh A. Alzheimer's disease: the silver tsunami of the 21st century. *Neural regeneration research*. 2016;11(5):693.
4. Bartels SJ, Naslund JA. The underside of the silver tsunami—older adults and mental health care. *New England Journal of Medicine*. 2013;368(6):493-496.
5. Frieden TR, Houry D, Baldwin G. Traumatic brain injury in the United States: epidemiology and rehabilitation. *CDC NIH Rep to Congr*. 2015:1-74.
6. Zollman FS. *Manual of traumatic brain injury: Assessment and management*. Springer Publishing Company; 2016.
7. Rabinowitz AR, Levin HS. Cognitive sequelae of traumatic brain injury. *Psychiatric Clinics*. 2014;37(1):1-11.
8. Zarshenas S, Colantonio A, Horn SD, Jaglal S, Cullen N. Cognitive and motor recovery and predictors of long-term outcome in patients with traumatic brain injury. *Archives of physical medicine and rehabilitation*. 2019;100(7):1274-1282.
9. Zaloshnja E, Miller T, Langlois JA, Selassie AW. Prevalence of long-term disability from traumatic brain injury in the civilian population of the United States, 2005. *The Journal of head trauma rehabilitation*. 2008;23(6):394-400.
10. Wilson L, Stewart W, Dams-O'Connor K, et al. The chronic and evolving neurological consequences of traumatic brain injury. *The Lancet Neurology*. 2017;16(10):813-825.
11. Guo Z, Cupples L, Kurz A, et al. Head injury and the risk of AD in the MIRAGE study. *Neurology*. 2000;54(6):1316-1323.
12. Fleminger S, Oliver D, Lovestone S, Rabe-Hesketh S, Giora A. Head injury as a risk factor for Alzheimer's disease: the evidence 10 years on; a partial replication. *Journal of Neurology, Neurosurgery & Psychiatry*. 2003;74(7):857-862.
13. Ramos-Cejudo J, Wisniewski T, Marmar C, et al. Traumatic brain injury and Alzheimer's disease: the cerebrovascular link. *EBioMedicine*. 2018;28:21-30.
14. Pretz CR, Dams-O'Connor K. Longitudinal description of the glasgow outcome scale-extended for individuals in the traumatic brain injury model systems national database: a National Institute on Disability and Rehabilitation Research traumatic brain injury model systems study. *Archives of physical medicine and rehabilitation*. 2013;94(12):2486-2493.
15. Roy D, Vaishnavi S, Han D, Rao V. Correlates and prevalence of aggression at six months and one year after first-time traumatic brain injury. *The Journal of neuropsychiatry and clinical neurosciences*. 2017;29(4):334-342.
16. Farrer TJ, Frost RB, Hedges DW. Prevalence of traumatic brain injury in intimate partner violence offenders compared to the general population: A meta-analysis. *Trauma, Violence, & Abuse*. 2012;13(2):77-82.
17. Leon-Carrion J, Ramos FJC. Blows to the head during development can predispose to violent criminal behaviour: rehabilitation of consequences of head injury is a measure for crime prevention. *Brain injury*. 2003;17(3):207-216.
18. Grafman J, Schwab K, Warden D, Pridgen A, Brown H, Salazar AM. Frontal lobe injuries, violence, and aggression: a report of the Vietnam Head Injury Study. *Neurology*. 1996;46(5):1231-1231.
19. Williams WH, Chitsabesan P, Fazel S, et al. Traumatic brain injury: a potential cause of violent crime? *The Lancet Psychiatry*. 2018;5(10):836-844.
20. Blakey SM, Wagner HR, Naylor J, et al. Chronic pain, TBI, and PTSD in military veterans: A link to suicidal ideation and violent impulses? *The Journal of Pain*. 2018;19(7):797-806.

21. McIsaac KE, Moser A, Moineddin R, et al. Association between traumatic brain injury and incarceration: a population-based cohort study. *CMAJ open*. 2016;4(4):E746.
22. Cristofori I, Zhong W, Mandoske V, et al. Brain regions influencing implicit violent attitudes: a lesion-mapping study. *Journal of neuroscience*. 2016;36(9):2757-2768.
23. Madsen T, Erlangsen A, Orlovska S, Mofaddy R, Nordentoft M, Benros ME. Association between traumatic brain injury and risk of suicide. *Jama*. 2018;320(6):580-588.
24. Bryan CJ, Clemans TA. Repetitive traumatic brain injury, psychological symptoms, and suicide risk in a clinical sample of deployed military personnel. *JAMA psychiatry*. 2013;70(7):686-691.
25. Wang C, Kosinski CJ, Schwartzberg JG, Shanklin AV, Association AM. *Physician's guide to assessing and counseling older drivers*. American Medical Association; 2003.
26. Preece MH, Geffen GM, Horswill MS. Return-to-driving expectations following mild traumatic brain injury. *Brain injury*. 2013;27(1):83-91.
27. *District of Columbia v. Heller*, 554 570(Supreme Court 2008).
28. *McDonald v. City of Chicago, Ill*, 561 742(Supreme Court 2010).
29. Swanson JW, McGinty EE, Fazel S, Mays VM. Mental illness and reduction of gun violence and suicide: bringing epidemiologic research to policy. *Annals of epidemiology*. 2015;25(5):366-376.
30. Li Z, Page A, Martin G, Taylor R. Attributable risk of psychiatric and socio-economic factors for suicide from individual-level, population-based studies: a systematic review. *Social science & medicine*. 2011;72(4):608-616.
31. Possession of Firearms by People With Mental Illness. National Conference of State Legislatures. <https://www.ncsl.org/research/civil-and-criminal-justice/possession-of-a-firearm-by-the-mentally-ill.aspx>. Updated January 5 2018. Accessed July 7, 2021.
32. Rosenberg J. Mass shootings and mental health policy. *J Soc & Soc Welfare*. 2014;41:107.
33. Pinals DA, Appelbaum PS, Bonnie R, Fisher CE, Gold LH, Lee LW. American Psychiatric Association: position statement on firearm access, acts of violence and the relationship to mental illness and mental health services. *Behavioral sciences & the law*. 2015;33(2-3):195-198.
34. Federal Denials. Federal Bureau of Investigations. <https://www.fbi.gov/file-repository/federal-denials.pdf>. Published 2021. Accessed July 13, 2021.
35. Bagalman E, Chu VS, Redhead CS. Submission of Mental Health Records to NICS and the HIPAA Privacy Rule. 2013.
36. Gold LH, Vanderpool D. Legal Regulation of Restoration of Firearms Rights After Mental Health Prohibition. *The journal of the American Academy of Psychiatry and the Law*. 2018;46(3):298-308.
37. Pomeranz JL, Ochoa G. Firearm extreme risk protection order laws and preemption: new developments and outstanding issues, 50 states, 2020. *American journal of preventive medicine*. 2021.
38. Extreme Risk Protection Order Model Legislation. United States Department of Justice. <https://www.justice.gov/doj/reducing-gun-violence/commentary-extreme-risk-protection-order-model-legislation>. Published 2021. Updated 06/07/2021. Accessed 07/15, 2021.
39. Gilchick R. *The Physician's Role in Firearm Safety*. Council on Science and Public Health;2018.
40. Wintemute GJ, Pear VA, Schleimer JP, et al. Extreme risk protection orders intended to prevent mass shootings: a case series. *Annals of internal medicine*. 2019;171(9):655-658.
41. Kravitz-Wirtz N, Aubel AJ, Pallin R, Wintemute GJ. Public Awareness of and Personal Willingness to Use California's Extreme Risk Protection Order Law to Prevent Firearm-Related Harm. Paper presented at: JAMA Health Forum2021.
42. *Hope v. State*, 834 713(Ind: Court of Appeals 2005).
43. *Redington v. State*, 992 823(Ind: Court of Appeals 2013).

44. *Davis v. Gilchrist County Sheriff's Office*, 280 524(Fla: Dist. Court of Appeals, 1st Dist. 2019).
45. Frattaroli S, Sharfstein JM. Extreme Risk Protection Orders—A Tool for Clinicians to Prevent Gun Violence. Paper presented at: JAMA Health Forum 2021.
46. Conrick K, Davis A, Rooney L, et al. 0027 Extreme risk protection orders: understanding the role of health professionals. In: BMJ Publishing Group Ltd; 2021.
47. Spangenberg KB, Wagner MT, Hendrix S, Bachman DL. Firearm presence in households of patients with Alzheimer's disease and related dementias. *Journal of the American Geriatrics Society*. 1999;47(10):1183-1186.
48. Seyfried LS, Kales HC, Ignacio RV, Conwell Y, Valenstein M. Predictors of suicide in patients with dementia. *Alzheimer's & dementia*. 2011;7(6):567-573.
49. Grinshteyn E, Hemenway D. Violent death rates in the US compared to those of the other high-income countries, 2015. *Preventive medicine*. 2019;123:20-26.
50. Betz ME, Azrael D, Johnson RL, et al. Views on firearm safety among caregivers of people with Alzheimer disease and related dementias. *JAMA network open*. 2020;3(7):e207756-e207756.
51. VHA Dementia Steering Committee Recommendations for Dementia Care in the VHA Health Care System. Veteran's Health Administration.
https://www.va.gov/GERIATRICS/docs/VHA_DSC_RECOMMENDATIONS_SEPT_2016_9-12-16.pdf. Updated 09/2016. Accessed 07/16, 2021.
52. Li Y, Li Y, Li X, et al. Head injury as a risk factor for dementia and Alzheimer's disease: a systematic review and meta-analysis of 32 observational studies. *PloS one*. 2017;12(1):e0169650.
53. Gavett BE, Stern RA, Cantu RC, Nowinski CJ, McKee AC. Mild traumatic brain injury: a risk factor for neurodegeneration. *Alzheimer's research & therapy*. 2010;2(3):1-3.
54. Betz ME, McCourt AD, Vernick JS, Ranney ML, Maust DT, Wintemute GJ. Firearms and dementia: clinical considerations. In: American College of Physicians; 2018.
55. Lococo KH, Sifrit KJ, Stutts JC, Staplin L, TransAnalytics L. *Medical Review Practices for Driver Licensing Volume 3: Guidelines and Processes in the United States*. United States. Department of Transportation. National Highway Traffic Safety ...;2017.
56. Parker S. Balancing act: Regulation of civilian firearm possession. *Small Arms Survey 2011: States of Security*. 2011:1-91.
57. Ma BB, Bloch J, Krumholz A, et al. Regulating drivers with epilepsy in Maryland: results of the application of a United States consensus guideline. *Epilepsia*. 2017;58(8):1389-1397.
58. The Physician's Role in Promoting Firearm Safety. <https://edhub.ama-assn.org/interactive/17579432>. Updated December 1, 2018.

RELEVANT AMA POLICY

H-470.954, “Reduction of Sports-Related Injury and Concussion”

1. Our AMA will: (a) work with appropriate agencies and organizations to promote awareness of programs to reduce concussion and other sports-related injuries across the lifespan; and (b) promote awareness that even mild cases of traumatic brain injury may have serious and prolonged consequences.
 2. Our AMA supports the adoption of evidence-based, age-specific guidelines on the evaluation and management of concussion in all athletes for use by physicians, other health professionals, and athletic organizations.
 3. Our AMA will work with appropriate state and specialty medical societies to enhance opportunities for continuing education regarding professional guidelines and other clinical resources to enhance the ability of physicians to prevent, diagnose, and manage concussions and other sports-related injuries.
 4. Our AMA urges appropriate agencies and organizations to support research to: (a) assess the short- and long-term cognitive, emotional, behavioral, neurobiological, and neuropathological consequences of concussions and repetitive head impacts over the life span; (b) identify determinants of concussion and other sports-related injuries in pediatric and adult athletes, including how injury thresholds are modified by the number of and time interval between head impacts and concussions; (c) develop and evaluate effective risk reduction measures to prevent or reduce sports-related injuries and concussions and their sequelae across the lifespan; and (d) develop objective biomarkers to improve the identification, management, and prognosis of athletes suffering from concussion to reduce the dependence on self-reporting and inform evidence-based, age-specific guidelines for these patients.
 5. Our AMA supports research into the detection, causes, and prevention of injuries along the continuum from subconcussive head impacts to conditions such as chronic traumatic encephalopathy (CTE).
- CSAPH Rep. 3, A-15; Appended: Res. 905, I-16.

H-25.991, “Alzheimer's Disease”

- 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.
- CSA Rep. 6, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Appended: Res. 503, A-16; Appended: Res. 915, I-16.

H-15.954, “Older Driver Safety”

- (1) Our AMA recognizes that the safety of older drivers is a growing public health concern that is best addressed through multi-sector efforts to optimize vehicle design, the driving environment, and the individual's driving capabilities, and:
 - (a) believes that because physicians play an essential role in helping patients slow their rate of functional decline, physicians should increase their awareness of the medical conditions, medications, and functional deficits that may impair an individual's driving performance, and counsel and manage their patients accordingly;
 - (b) encourages physicians to familiarize themselves with driver assessment and rehabilitation options, refer their patients to such programs whenever appropriate, and defer recommendations on permanent driving cessation until establishing that a patient's driving safety cannot be maintained through medical interventions or driver rehabilitation;
 - (c) urges physicians to know and adhere to their state's reporting statutes for medically at-risk drivers; and
 - (d) encourages continued scientific investigation into strategies for the assessment and management of driving safety in the clinical setting.
 - (2) Our AMA encourages physicians to use the Physician's Guide to Assessing and Counseling Older Drivers as an educational tool to assist them in helping their patients.
- CSA Rep. 6, A-03; Reaffirmed: CSAPH Rep. 1, A-13.

Ethics Opinion 8.2, “Impaired Drivers & Their Physicians”

A variety of medical conditions can impair an individual's ability to operate a motor vehicle safely, whether a personal car or boat or a commercial vehicle, such as a bus, train, plane, or commercial vessel. Those who operate a vehicle when impaired by a medical condition pose threats to both public safety and their own well-being. Physicians have unique

opportunities to assess the impact of physical and mental conditions on patients' ability to drive safely and have a responsibility to do so in light of their professional obligation to protect public health and safety. In deciding whether or how to intervene when a patient's medical condition may impair driving, physicians must balance dual responsibilities to promote the welfare and confidentiality of the individual patient, and to protect public safety.

Not all physicians are in a position to evaluate the extent or effect of a medical condition on a patient's ability to drive, particularly physicians who treat patients only on a short-term basis. Nor do all physicians necessarily have appropriate training to identify and evaluate physical or mental conditions in relation to the ability to drive. In such situations, it may be advisable to refer a potentially at-risk patient for assessment.

To serve the interests of their patients and the public, within their areas of expertise physicians should:

- (a) Assess at-risk patients individually for medical conditions that might adversely affect driving ability, using best professional judgment and keeping in mind that not all physical or mental impairments create an obligation to intervene.
- (b) Tactfully but candidly discuss driving risks with the patient and, when appropriate, the family when a medical condition may adversely affect the patient's ability to drive safely. Help the patient (and family) formulate a plan to reduce risks, including options for treatment or therapy if available, changes in driving behavior, or other adjustments.
- (c) Recognize that safety standards for those who operate commercial transportation are subject to governmental medical standards and may differ from standards for private licenses.
- (d) Be aware of applicable state requirements for reporting to the licensing authority those patients whose impairments may compromise their ability to operate a motor vehicle safely.
- (e) Prior to reporting, explain to the patient (and family, as appropriate) that the physician may have an obligation to report a medically at-risk driver:
 - (i) when the physician identifies a medical condition clearly related to the ability to drive;
 - (ii) when continuing to drive poses a clear risk to public safety or the patient's own well-being and the patient ignores the physician's advice to discontinue driving; or
 - (iii) when required by law.
- (f) Inform the patient that the determination of inability to drive safely will be made by other authorities, not the physician.
- (g) Disclose only the minimum necessary information when reporting a medically at-risk driver, in keeping with ethics guidance on respect for patient privacy and confidentiality.

Issued: 2016

H-15.995, "Medical Advisory Boards in Driver Licensing"

Our AMA (1) endorses the establishment of state motor vehicle department medical advisory boards to improve licensure of vehicle operators and to reduce incidence of injury and death and (2) urges state medical associations to encourage establishment of such boards and to work actively with them.

Res. 2, A-72; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20.

H-160.972, "Physician Representation on State and National Health Care Advisory Bodies"

The AMA urges Congress, and others who select members of state and national health advisory bodies, to increase the proportion of physicians in active clinical practice serving on these bodies, with selected members being recommended by state or national medical associations.

Sub. Res. 110, A-88; Reaffirmed: Sunset Report, I-98. Reaffirmed: BOT Rep. 23, A-09; Reaffirmed: BOT Rep. 09, A-19

H-145.975, "Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care"

1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.

2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.

3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.

Sub. Res. 221, A-13; Appended: Res. 416, A-14; Reaffirmed: Res. 426, A-16; Reaffirmed: BOT Rep. 28, A-18; Reaffirmation: A-18; Modified: CSAPH Rep. 04, A-18; Reaffirmation: I-18

D-145.995, “Gun Violence as a Public Health Crisis”

Our AMA: (1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and
(2) will actively lobby Congress to lift the gun violence research ban.
Res. 1011, A-16; Reaffirmation: A-18; Reaffirmation: I-18.

H-145.996, “Firearm Availability”

1. Our AMA: (a) advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.
2. Our AMA supports requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms.
3. Our AMA supports “gun violence restraining orders” for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as “red-flag” laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and “red-flag” laws, we also support the importance of due process so that individuals can petition for their rights to be restored.
Res. 140, I-87; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: BOT Rep. 12, A-16; Appended: Res. 433, A-18; Reaffirmation: I-18; Modified: BOT Rep. 11, I-18

H-145.999, “Gun Regulation”

Our AMA supports stricter enforcement of present federal and state gun legislation and the imposition of mandated penalties by the judiciary for crimes committed with the use of a firearm, including the illegal possession of a firearm.
Sub. Res. 31, I-81; Reaffirmed: CLRPD Rep. F, I-91; Amended: BOT Rep. I-93-50; Reaffirmed: Res. 409, A-00; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Modified: Res. 401, A-17; Reaffirmation: I-18.

H-145.972, “Firearms and High-Risk Individuals”

Our AMA supports: (1) the establishment of laws allowing family members, intimate partners, household members, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms; (3) expanding domestic violence restraining orders to include dating partners; (4) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons; (5) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and (6) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals.
CSAPH Rep. 04, A-18; Reaffirmed: BOT Rep. 11, I-18.

H-145.991, “Waiting Periods for Firearm Purchases”

The AMA supports using its influence in matters of health to effect passage of legislation in the Congress of the U.S. mandating a national waiting period that allows for a police background and positive identification check for anyone who wants to purchase a handgun from a gun dealer anywhere in our country.
Sub. Res. 34, I-89; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Modified: Res. 401, A-17; Reaffirmation: A-18; Reaffirmation: I-18

H-145.970, “Violence Prevention”

Our AMA: (1) encourages the enactment of state laws requiring the reporting of all classes of prohibited individuals, as defined by state and federal law, to the National Instant Criminal Background Check System (NICS); (2) supports federal funding to provide grants to states to improve NICS reporting; and (3) encourages states to automate the reporting of relevant information to NICS to improve the quality and timeliness of the data.

H-145.976, “Firearm Safety Counseling in Physician-Led Health Care Teams”

1. Our AMA: (a) will oppose any restrictions on physicians' and other members of the physician-led health care team's ability to inquire and talk about firearm safety issues and risks with their patients; (b) will oppose any law restricting physicians' and other members of the physician-led health care team's discussions with patients and their families about firearms as an intrusion into medical privacy; and (c) encourages dissemination of educational materials related to firearm safety to be used in undergraduate medical education.

2. Our AMA will work with appropriate stakeholders to develop state-specific guidance for physicians on how to counsel patients to reduce their risk for firearm-related injury or death, including guidance on when and how to ask sensitive questions about firearm ownership, access, and use, and clarification on the circumstances under which physicians are permitted or may be required to disclose the content of such conversations to family members, law enforcement, or other third parties.

Res. 219, I-11; Reaffirmation A-13; Modified: Res. 903, I-13; Appended: Res. 419, A-17; Reaffirmed: CSAPH Rep. 04, A-18.

H-145.971, “Development and Implementation of Recommendations for Responsible Media Coverage of Mass Shootings”

Our AMA encourages the Centers for Disease Control and Prevention, in collaboration with other public and private organizations, to develop recommendations and/or best practices for media coverage of mass shootings, including informed discussion of the limited data on the relationship between mental illness and gun violence, recognizing the potential for exacerbating stigma against individuals with mental illness.

Res. 212, I-18; Modified: Res. 934, I-19.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 401
(N-21)

Introduced by: Senior Physicians Section

Subject: Endorsement of Public Health Measures to End the COVID-19 Pandemic and Promotion of Research and Insurance Coverage to Define and Delimit the Emerging Issue of Post Acute Covid Syndrome

Referred to: Reference Committee D

Whereas, The COVID-19 pandemic has recently surpassed 40 million cases in the US and 650,000 deaths, with more than 10% of new cases reported in the past 30 days¹, and

Whereas, The COVID-19 pandemic has exacerbated health inequities in any number of ways, including disproportionately negatively affecting seniors and other marginalized and minoritized populations; and

Whereas, On September 9, 2021, President Joe Biden announced a sweeping set of new policies, recommendations, executive orders and specific mandates designed to control the resurgence of COVID-19, particularly in light of dangerous emerging variants with increasing contagious and pathological properties; and

Whereas, In the “Path out of Pandemic” Plan, <https://www.whitehouse.gov/covidplan/>, the White House has proposed a sweeping set of public health and other measures designed to thwart the escalating “Pandemic of the Unvaccinated”; and

Whereas, The American Medical Association Senior Physicians Section, many of whose members may be especially vulnerable to COVID-19, strongly endorses in principle President Biden’s sweeping and timely public health measures aimed at ending the pandemic; and

Whereas, AMA has through public statements endorsed many of the principles embedded in the “Path out of the Pandemic” plans, including notably the concepts of mandatory vaccination in general, and mandatory vaccination of health care workers in particular as effective means aimed at ending the pandemic¹ which are consistent with recent HOD policy^{2,3}, and

Whereas, Ending the pandemic will allow our AMA to better address health inequities and other efforts to enhance its mission to better the health of the American public and to address the emerging issue of Post Acute Covid Syndrome⁴; therefore be it

RESOLVED, That our American Medical Association through its advocacy and public relations divisions promote and support all public health recommendations relating to the Covid-19 emergency that are consistent with sound scientific principles and law, and not inconsistent with evolving AMA policy (Directive to Take Action); and be it further

RESOLVED, That our AMA promote and encourage through all available means the further investigation of PACS, and third-party support for evaluation and care of COVID-19 long-hauler patients. (Directive to Take Action)

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

Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

We wrote the initial draft within minutes of President Biden's public address dealing with the urgency of taking bolder action to end the "Pandemic of the Unvaccinated" that has seen the emergence of one of the most communicable and deadly Covid 19 variants sweep across the country. Although our AMA President Gerald Harmon, MD issued a public statement supporting the Biden initiative within a few hours, we feel it needs support of strong new and specific policy enacted by the AMA HOD. Yes, there is prior AMA policy, but it is generic and does not address this new threat that is aggravated by extensive anti scientific comments in the public media and amplified by misinformation and disinformation.

The AMA Senior Physician Section is uniquely qualified to introduce this resolution given the preponderance of our age demographics, longstanding experience in formulating public policy (thanks to the contributions of many of our members in relevant AMA Councils, Specialty Societies and Sections and leadership over many years). We crafted specific language that give lots of freedom to add details as needed and avoided unnecessary constraints affecting the BOT and current leadership.

REFERENCES

¹Centers for Disease Control and Prevention (CDC), [COVID Data Tracker](#)

²AMA Press Release [AMA in support of COVID-19 vaccine mandates for health care workers](#), July 26, 2021

³AMA Statement, [AMA encourages COVID-19 vaccine mandates to defeat pandemic](#), August 24, 2021

⁴Phillips, S & Williams, M. Confronting Our Next National Health Disaster — Long-Haul Covid
N Engl J Med 2021; 385:577-579, DOI: 10.1056/NEJMp2109285.

RELEVANT AMA POLICY

Digital Vaccine Credential Systems and Vaccine Mandates in COVID-19 H-440.808

COVID-19 and COVID-19 vaccines raise unique challenges. To meet these challenges, our AMA:

1. Encourages the development of clear, strong, universal, and enforceable federal guidelines for the design and deployment of digital vaccination credentialing services (DVCS), and that before decisions are taken to implement use of vaccine credentials:

- a. vaccine is widely accessible;
- b. equity-centered privacy protections are in place to safeguard data collected from individuals;
- c. provisions are in place to ensure that vaccine credentials do not exacerbate inequities; and
- d. credentials address the situation of individuals for whom vaccine is medically contraindicated.

2. Recommends that decisions to mandate COVID-19 vaccination be made only:

- a. After a vaccine has received full approval from the U.S. Food and Drug Administration through a Biological Licenses Application;
- b. In keeping with recommendations of the Advisory Committee on Immunization Practices for use in the population subject to the mandate as approved by the Director of the Centers for Disease Control and Prevention;
- c. When individuals subject to the mandate have been given meaningful opportunity to voluntarily accept vaccination; and
- d. Implementation of the mandate minimizes the potential to exacerbate inequities or adversely affect already marginalized or minoritized populations.

3. Encourages the use of well-designed education and outreach efforts to promote vaccination to protect both public health and public trust.

4. Recommends that vaccination credentials not be provided on the basis of natural immunity or prior SARS-CoV-2 infection.

Citation: BOT Rep. 18, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 402
(N-21)

Introduced by: Medical Student Section

Subject: Expansion on Comprehensive Sexual Health Education

Referred to: Reference Committee D

Whereas, Data from the Centers for Disease Control and Prevention's Youth Risk Behavior Surveillance System indicate that 41.2% of all high school students are sexually active, and 11.5% have had 4 or more partners;¹ and

Whereas, Of the 39 states and D.C. that mandate some form of sex education, only 12 states mandate that sex education be medically accurate, and 16 states mandate that HIV education be medically accurate;^{2,3} and

Whereas, Comprehensive sex education is defined as a medically accurate, age appropriate and evidenced-based teaching approach which stresses abstinence and other methods of contraception equally in order to prevent negative health outcomes for teenagers;⁴ and

Whereas, A study surveying adolescents aged 15-24 reported over half (60.4% of females and 64.6% males) engaging in fellatio within the past year, while fewer than 10% (7.6% females and 9.3% males) used a condom;⁵ and

Whereas, There is a lack of knowledge among adolescents regarding the importance of condoms, dental dams and alternative barrier protection methods use during oral sex to prevent the spread of STIs;⁵⁻⁷ and

Whereas, When sex education is taught, only 20 states and D.C. require provision of information on contraception;³ and

Whereas, Several studies have shown parents tasked with teaching their children sexual education frequently needed support in information, motivation, and strategies to achieve competency⁸; and

Whereas, LGBTQ youth are at higher risk for sexual health complications due to differing sexual practices and behaviors;⁹ and

Whereas, Current sex education initiatives negatively impact transgender youth and their sexual health by failing to appropriately address their behavior, leading rates of HIV more than 4 times the national average, and increased likelihood to experience coerced sexual contact;⁹ and

Whereas, The GLSEN 2013 National School Climate Survey found that fewer than five percent of LGBT students had health classes that included positive representations of LGBT-related topics.² Among Millennials surveyed in 2015, only 12% said their sex education classes covered same-sex relationships;^{9,10} and

1 Whereas, LGBTQ youth are at a significantly higher risk of teen pregnancy involvement
2 (between two and seven times the rate of their heterosexual peers);¹¹ and

3
4 Whereas, When sex education is taught, seven states prohibit sex educators from discussing
5 LGBTQ relationships and identities or require homosexuality to be framed negatively if it is
6 discussed;³ and

7
8 Whereas, In 2010, the federal government redirected funds from abstinence-only programs to
9 evidence-based teen pregnancy prevention programs;¹² and

10
11 Whereas, In 2017, 31 federal and state bills were introduced to advance comprehensive
12 sexuality education, but only 4 were enacted or passed;^{2,13} and

13
14 Whereas, The 2018 CDC School Health Profile determined that only 17.6% of middle schools
15 across all the states taught comprehensive sex education encompassing topics including
16 pregnancy and STIs;¹⁴ and

17
18 Whereas, Since 2000, estimated medical costs of \$6.5 billion dollars were associated with the
19 treatment of young people with sexually transmitted infections, excluding costs of HIV/AIDS;¹⁵
20 and

21
22 Whereas, Forty states and D.C. require school districts to involve parents in sex education
23 and/or HIV education, of which nearly all states allow parents the option to remove their child
24 from such education;¹¹ and

25
26 Whereas, Some high-risk populations such as teenagers in foster care may not be able to
27 receive adequate reproductive and sexual health education in their home;^{16,17} and

28
29 Whereas, Regardless of political affiliation, parents overwhelmingly report that sex education is
30 important and should include topics such as puberty, healthy relationships, abstinence, birth
31 control, and STIs;¹⁸ and

32
33 Whereas, The rate of teenage pregnancy and STIs in the US has remained consistently higher
34 than many other industrialized countries;¹⁹⁻²¹ and

35
36 Whereas, The US teen birth rate declined by 9% between 2009 and 2010, with evidence
37 showing that during this time, there was a significant increase in teen use of contraceptives and
38 no significant change in teen sexual activity, highlighting the importance of education on
39 contraception in decreasing teen births²²; and

40
41 Whereas, Studies have found that abstinence-based sex education has insignificant effect on
42 improving teen birth rates, abortion rates, are not effective in delaying initiation of sexual
43 intercourse or changing other sexual risk-taking behaviors, and may actually increase STI rates
44 in states with smaller populations;²³⁻²⁵ and

45
46 Whereas, Comprehensive sex education has been shown to be effective at changing
47 knowledge, attitudes, and behaviors related to sexual health and reproductive knowledge as
48 well as reducing sexual activity, numbers of sexual partners, teen pregnancy, HIV, and STI
49 rates;^{23,26-28} and

Whereas, The federal government has recognized the advantages of comprehensive sex education and has dedicated funds for these programs including the Personal Responsibility Education Program (PREP), a state-grant program from the federal government that funds comprehensive sex education;^{29,30} and

Whereas, As of 2017, 41 PREP programs that emphasize abstinence and contraception equally with a focus on individualized decision making have been vigorously reviewed, endorsed, and funded by the HHS;²⁹ and

Whereas, Federal funding has increased the amount of funding for abstinence based programs by 67% since the 2018 Consolidation of Appropriations act;³⁰ and

Whereas, The American College of Obstetricians and Gynecologists (ACOG), Society for Adolescent Health and Medicine's (SAHM), and the American Public Health Association have all adopted official positions of support for comprehensive sexuality education;³¹⁻³³ and

Whereas, The AMA has existing policy acknowledging the importance and public health benefit of sex education, including Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools H-170.968; Health Information and Education H-170.986; and Comprehensive Health Education H-170.977, but falls short of underscoring the importance of comprehensive sex education in schools or advocating for actual implementation; and

Whereas, Lack of funding for comprehensive sex education programs means they are less likely to be taught; therefore be it

RESOLVED, That our American Medical Association amend Policy H-170.968, "Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools," by addition and deletion to read as follows:

Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools, H-170.968

(1) ~~Recognizes that the primary responsibility for family life education is in the home, and additionally s~~ Supports the concept of a ~~complementary~~ family life and sexuality education program in the schools at all levels, at local option and direction;

(2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms dental dams, and other barrier protection methods available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of LGBTQ+ ~~gay, lesbian, and bisexual~~ youth; (f) appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities;

1 (g) include ample involvement of parents, health professionals, and other concerned
2 members of the community in the development of the program; (h) are part of an
3 overall health education program; and (i) include culturally competent materials that
4 are language-appropriate for Limited English Proficiency (LEP) pupils;
5 (3) Continues to monitor future research findings related to emerging initiatives that
6 include abstinence-only, school-based sexuality education, and consent
7 communication to prevent dating violence while promoting healthy relationships, and
8 school-based condom availability programs that address sexually transmitted diseases
9 and pregnancy prevention for young people and report back to the House of Delegates
10 as appropriate;
11 (4) Will work with the United States Surgeon General to design programs that address
12 communities of color and youth in high risk situations within the context of a
13 comprehensive school health education program;
14 (5) Opposes the sole use of abstinence-only education, as defined by the 1996
15 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems;
16 (6) Endorses comprehensive family life education in lieu of abstinence-only education,
17 unless research shows abstinence-only education to be superior in preventing
18 negative health outcomes;
19 (7) Supports federal funding of comprehensive sex education programs that stress the
20 importance of ~~abstinence in~~ preventing unwanted teenage pregnancy and sexually
21 transmitted infections via comprehensive education, and also teach about including
22 contraceptive choices, abstinence, and safer sex, and opposes federal funding of
23 community-based programs that do not show evidence-based benefits; and
24 (8) Extends its support of comprehensive family-life education to community-based
25 programs promoting abstinence as the best method to prevent teenage pregnancy and
26 sexually-transmitted diseases while also discussing the roles of condoms and birth
27 control, as endorsed for school systems in this policy;
28 (9) Supports the development of sexual education curriculum that integrates dating
29 violence prevention through lessons on healthy relationships, sexual health, and
30 conversations about consent; and
31 (10) Encourages physicians and all interested parties to ~~conduct research and~~ develop
32 best-practice, evidence-based, guidelines for sexual education curricula that are
33 developmentally appropriate as well as medically, factually, and technically accurate.
34 (Modify Current HOD Policy)

Fiscal Note: Minimal - less than \$1,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Sexual health education has been an important but often neglected topic in the United States. Research indicates that sexual health education is of paramount importance to the wellness and health of adolescents and teens. The current abstinence only until marriage (AOUM) sex education is outdated and does not provide proper support and education to our youths. Medically accurate and comprehensive sexual health education will more than likely decrease the rate of STIs transmission and accidental pregnancies, among many other benefits. The LGBTQ+ community especially could benefit tremendously from improved training on sexual health education due to increased awareness of complications of unsafe sexual practices as well as promote tolerance towards the community. This resolution lends much needed focus on utilizing the primary school setting as the principle method of providing medically accurate and comprehensive sexual health education. Given the recent increases in anti-LGBTQ+ legislation, it is vital that our AMA take action to better protect this vulnerable population, to show that their health and safety is truly a priority, and to make clear our stance that LGBTQ+ health s deserves equal attention and protection.

References:

1. Kann L, McManus T, Harris WA, et al. Youth Risk Behavior Surveillance United States, 2015. *MMWR Surveill Summ.* 2016;65(6):1-174. doi:10.15585/mmwr.ss6506a1
2. *2017 Sex Ed State Legislative Year-End Report.*; 2017. www.siecus.org. Accessed April 9, 2020.
3. Sex and HIV Education | Guttmacher Institute. <https://www.guttmacher.org/state-policy/explore/sex-and-hiv-education>. Accessed April 9, 2020.
4. ACOG. <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Adolescent-Health-Care/Comprehensive-Sexuality-Education?IsMobileSet=false>. Accessed April 9, 2020.
5. Goldstein R, Halpern-Felsher B. Adolescent Oral Sex and Condom Use: How Much Should We Worry and What Can We Do? *J Adolesc Heal.* 2018;62(4):363-364. doi:10.1016/j.jadohealth.2018.01.002
6. Gomez M, Ogunbajo A, Fortenberry JD, Trent M, Arrington-Sanders R. The Use of Condoms and Dental Dams During First Same-Sex Sexual Experiences (SSE) of Adolescent African-American Men Who Have Sex With Men. *J Adolesc Heal.* 2014;54(2):S4. doi:10.1016/j.jadohealth.2013.10.024
7. Richters J, Prestage G, Schneider K, Clayton S. Do women use dental dams? Safer sex practices of lesbians and other women who have sex with women. *Sex Health.* 2010;7(2):165-169. doi:10.1071/SH09072
8. <https://www.sciencedirect.com/science/article/pii/S1877042815055573>
9. LGBT-Inclusive Sex Education Means Healthier Youth and Safer Schools - Center for American Progress. <https://www.americanprogress.org/issues/lgbtq-rights/news/2013/06/21/67411/lgbt-inclusive-sex-education-means-healthier-youth-and-safer-schools/>. Accessed April 9, 2020.
10. EXECUTIVE SUMMARY A CALL TO ACTION: LGBTQ YOUTH NEED INCLUSIVE SEX EDUCATION SUPPORTED DISCUSSION OF SEXUAL ORIENTATION AS PART OF SEX EDUCATION IN HIGH SCHOOL 78+ 22 + P 78% of Parents SUPPORTED DISCUSSION OF SEXUAL ORIENTATION AS PART OF SEX EDUCATION IN MIDDLE SCHOOL Background and Funding.
11. Saewyc EM, Poon CS, Homma Y, Skay CL. Stigma management? The links between enacted stigma and teen pregnancy trends among gay, lesbian, and bisexual students in British Columbia. *Can J Hum Sex.* 2008;17(3):123-140.
12. Kappeler EM, Farb AF. Historical context for the creation of the Office of Adolescent Health and the teen pregnancy prevention program. *J Adolesc Heal.* 2014;54(3 SUPPL.):S3-S9. doi:10.1016/j.jadohealth.2013.11.020
13. 42 U.S. Code § 710 - Sexual risk avoidance education | U.S. Code | US Law | LII / Legal Information Institute. <https://www.law.cornell.edu/uscode/text/42/710>. Accessed April 9, 2020.
14. School Health Profiles | Data | Adolescent and School Health | CDC. <https://www.cdc.gov/healthyyouth/data/profiles/index.htm>. Accessed April 9, 2020.
15. State Policies on Sex Education in Schools. <https://www.ncsl.org/research/health/state-policies-on-sex-education-in-schools.aspx>. Accessed April 9, 2020.
16. Combs KM, Begun S, Rinehart DJ, Taussig H. Pregnancy and Childbearing Among Young Adults Who Experienced Foster Care. *Child Maltreat.* 2018;23(2):166-174. doi:10.1177/1077559517733816
17. STDs Continue to Rise in the U.S. Press Release | CDC. <https://www.cdc.gov/nchhstp/newsroom/2019/2018-STD-surveillance-report-press-release.html>. Accessed April 9, 2020.
18. Kantor L, Levitz N. Parents' views on sex education in schools: How much do Democrats and Republicans agree? Syed EU, ed. *PLoS One.* 2017;12(7):e0180250. doi:10.1371/journal.pone.0180250
19. NVSS - Birth Data. <https://www.cdc.gov/nchs/nvss/births.htm>. Accessed April 9, 2020.
20. Martin JA, Hamilton BE, Osterman MJK, Driscoll AK, Drake P. *National Vital Statistics Reports Volume 67, Number 8, November 7, 2018.* Vol 67.; 2017. https://www.cdc.gov/nchs/data_access/Vitalstatsonline.htm. Accessed April 9, 2020.
21. Azzopardi PS, Hearps SJC, Francis KL, et al. Progress in adolescent health and wellbeing: tracking 12 headline indicators for 195 countries and territories, 1990–2016. *Lancet.* 2019;393(10176):1101-1118. doi:10.1016/S0140-6736(18)32427-9

22. Guttmacher Institute, New government data finds sharp decline in teen births: increased contraceptive use and shifts to more effective contraceptive methods behind this encouraging trend, news in context, Dec. 1, 2011, <<http://www.guttmacher.org/media/inthenews/2011/12/01/index.html>
23. Santelli JS, Kantor LM, Grilo SA, et al. Abstinence-Only-Until-Marriage: An Updated Review of U.S. Policies and Programs and Their Impact. *J Adolesc Heal.* 2017;61(3):273-280. doi:10.1016/j.jadohealth.2017.05.031
24. Carr JB, Packham A. The Effects of State-Mandated Abstinence-Based Sex Education on Teen Health Outcomes. *Health Econ.* 2017;26(4):403-420. doi:10.1002/hec.3315
25. Lemon KD. Sex Education in America: Abstaining from Comprehensive Facts. *J Midwifery Women's Heal.* 2018;64(2):149-153. doi:10.1111/jmwh.12901
26. Denford S, Abraham C, Campbell R, Busse H. A comprehensive review of reviews of school-based interventions to improve sexual-health. *Health Psychol Rev.* 2017;11(1):33-52. doi:10.1080/17437199.2016.1240625
27. Fonner VA, Armstrong KS, Kennedy CE, O'Reilly KR, Sweat MD. School based sex education and HIV prevention in lowand middle-income countries: A systematic review and meta-analysis. *PLoS One.* 2014;9(3):e89692. doi:10.1371/journal.pone.0089692
28. Rabbitte M, Enriquez M. The Role of Policy on Sexual Health Education in Schools: Review. *J Sch Nurs.* 2019;35(1):27-38. doi:10.1177/1059840518789240
29. *A New Foundation For American Greatness.*; 2018.
30. Abstinence Education Programs: Definition, Funding, and Impact on Teen Sexual Behavior | The Henry J. Kaiser Family Foundation. <https://www.kff.org/womens-health-policy/fact-sheet/abstinence-education-programs-definition-funding-and-impact-on-teen-sexual-behavior/>. Accessed April 9, 2020.
31. Comprehensive Sexuality Education | ACOG. <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2016/11/comprehensive-sexuality-education>. Accessed April 9, 2020.
32. Society for Adolescent Health and Medicine. Abstinence-Only-Until-Marriage Policies and Programs: An Updated Position Paper of the Society for Adolescent Health and Medicine. *J Adolesc Heal.* 2017;61(3):400-403. doi:10.1016/j.jadohealth.2017.06.001
33. Sexuality Education as Part of a Comprehensive Health Education Program in K to 12 Schools. <https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2015/01/23/09/37/sexuality-education-as-part-of-a-comprehensive-health-education-program-in-k-to-12-schools>. Accessed April 9, 2020.

RELEVANT AMA POLICY

Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools H-170.968

- (1) Recognizes that the primary responsibility for family life education is in the home, and additionally supports the concept of a complementary family life and sexuality education program in the schools at all levels, at local option and direction;
- (2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of gay, lesbian, and bisexual youth; (f) appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities; (g) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; (h) are part of an overall health education program; and (i) include culturally competent materials that are language-appropriate for Limited English Proficiency (LEP) pupils;
- (3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate;

- (4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program;
 - (5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems;
 - (6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes;
 - (7) Supports federal funding of comprehensive sex education programs that stress the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections, and also teach about contraceptive choices and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and
 - (8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy;
 - (9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, and conversations about consent; and
 - (10) Encourages physicians and all interested parties to develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate.
- CSA Rep. 7 and Reaffirmation: I-99; Reaffirmed: Res. 403, A-01; Modified: Res. 441, A-03; Appended: Res. 834, I-04; Reaffirmed: CSAPH Rep. 7, A-09; Modified: Res. 405, A-16; Appended: Res. 401, A-16; Appended: Res. 414, A-18; Appended: Res. 428, A-18

Television Broadcast of Sexual Encounters and Public Health Awareness H-485.994

The AMA urges television broadcasters, producers, and sponsors to encourage education about safe sexual practices, including but not limited to condom use and abstinence, in television programming of sexual encounters, and to accurately represent the consequences of unsafe sex.

Res. 421, A-91; Reaffirmed: CSA Rep. 3, A-95; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15

Health Information and Education H-170.986

- (1) Individuals should seek out and act upon information that promotes appropriate use of the health care system and that promotes a healthy lifestyle for themselves, their families and others for whom they are responsible. Individuals should seek informed opinions from health care professionals regarding health information delivered by the mass media self-help and mutual aid groups are important components of health promotion/disease and injury prevention, and their development and maintenance should be promoted.
- (2) Employers should provide and employees should participate in programs on health awareness, safety and the use of health care benefit packages.
- (3) Employers should provide a safe workplace and should contribute to a safe community environment. Further, they should promptly inform employees and the community when they know that hazardous substances are being used or produced at the worksite.
- (4) Government, business and industry should cooperatively develop effective worksite programs for health promotion and disease and injury prevention, with special emphasis on substance abuse.

- (5) Federal and state governments should provide funds and allocate resources for health promotion and disease and injury prevention activities.
 - (6) Public and private agencies should increase their efforts to identify and curtail false and misleading information on health and health care.
 - (7) Health care professionals and providers should provide information on disease processes, healthy lifestyles and the use of the health care delivery system to their patients and to the local community.
 - (8) Information on health and health care should be presented in an accurate and objective manner.
 - (9) Educational programs for health professionals at all levels should incorporate an appropriate emphasis on health promotion/disease and injury prevention and patient education in their curricula.
 - (10) Third party payers should provide options in benefit plans that enable employers and individuals to select plans that encourage healthy lifestyles and are most appropriate for their particular needs. They should also continue to develop and disseminate information on the appropriate utilization of health care services for the plans they market.
 - (11) State and local educational agencies should incorporate comprehensive health education programs into their curricula, with minimum standards for sex education, sexual responsibility, and substance abuse education. Teachers should be qualified and competent to instruct in health education programs.
 - (12) Private organizations should continue to support health promotion/disease and injury prevention activities by coordinating these activities, adequately funding them, and increasing public awareness of such services.
 - (13) Basic information is needed about those channels of communication used by the public to gather health information. Studies should be conducted on how well research news is disseminated by the media to the public. Evaluation should be undertaken to determine the effectiveness of health information and education efforts. When available, the results of evaluation studies should guide the selection of health education programs.
- BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmation: A-07; Reaffirmation: A-15; Reaffirmed: BOT Rep. 15, A-19

Comprehensive Health Education H-170.977

- (1) Educational testing to confirm understanding of health education information should be encouraged. (2) The AMA accepts the CDC guidelines on comprehensive health education. The CDC defines its concept of comprehensive school health education as follows: (a) a documented, planned, and sequential program of health education for students in grades pre-kindergarten through 12; (b) a curriculum that addresses and integrates education about a range of categorical health problems and issues (e.g., human immunodeficiency virus (HIV) infection, drug misuse, drinking and driving, emotional health, environmental pollution) at developmentally appropriate ages; (c) activities to help young people develop the skills they will need to avoid: (i) behaviors that result in unintentional and intentional injuries; (ii) drug and alcohol misuse; (iii) tobacco use; (iv) sexual behaviors that result in HIV infection, other sexually transmitted diseases, and unintended pregnancies; (v) imprudent dietary patterns; and (vi) inadequate physical activity; (d) instruction provided for a prescribe amount of time at each grade level; (e) management and coordination in each school by an education professional trained to implement the program; (f) instruction from teachers who have been trained to teach the subject; (g) involvement of parents, health professionals, and other concerned community members; and (h) periodic evaluations, updating, and improvement.
- BOT Rep. X, A-92; Modified: CME Rep. 2, A-03; Reaffirmation: A-04; Reaffirmed: CSAPH Rep. 7, A-09; Modified: CSAPH Rep. 01, A-19

HIV/AIDS Education and Training H-20.904

(1) Public Information and Awareness Campaigns

Our AMA:

- a) Supports development and implementation of HIV/AIDS health education programs in the United States by encouraging federal and state governments through policy statements and recommendations to take a stronger leadership role in ensuring interagency cooperation, private sector involvement, and the dispensing of funds based on real and measurable needs. This includes development and implementation of language- and culture-specific education programs and materials to inform minorities of risk behaviors associated with HIV infection.
- b) Our AMA urges the communications industry, government officials, and the health care communities together to design and direct efforts for more effective and better targeted public awareness and information programs about HIV disease prevention through various public media, especially for those persons at increased risk of HIV infection;
- c) Encourages education of patients and the public about the limited risks of iatrogenic HIV transmission. Such education should include information about the route of transmission, the effectiveness of universal precautions, and the efforts of organized medicine to ensure that patient risk remains immeasurably small. This program should include public and health care worker education as appropriate and methods to manage patient concern about HIV transmission in medical settings. Statements on HIV disease, including efficacy of experimental therapies, should be based only on current scientific and medical studies;
- d) Encourages and will assist physicians in providing accurate and current information on the prevention and treatment of HIV infection for their patients and communities;
- e) Encourages religious organizations and social service organizations to implement HIV/AIDS education programs for those they serve.

(2) HIV/AIDS Education in Schools

Our AMA:

- a) Endorses the education of elementary, secondary, and college students regarding basic knowledge of HIV infection, modes of transmission, and recommended risk reduction strategies;
- b) Supports efforts to obtain adequate funding from local, state, and national sources for the development and implementation of HIV educational programs as part of comprehensive health education in the schools.

(3) Education and Training Initiatives for Practicing Physicians and Other Health Care Workers

Our AMA supports continued efforts to work with other medical organizations, public health officials, universities, and others to foster the development and/or enhancement of programs to provide comprehensive information and training for primary care physicians, other front-line health workers (specifically including those in addiction treatment and community health centers and correctional facilities), and auxiliaries focusing on basic knowledge of HIV infection, modes of transmission, and recommended risk reduction strategies.

CSA Rep. 4, A-03; Appended: Res. 516, A-06; Modified: CSAPH 01, A-16; Reaffirmed: Res. 916, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 403
(N-21)

Introduced by: Medical Student Section

Subject: Providing Reduced Parking for Patients

Referred to: Reference Committee D

Whereas, In the United States, an estimated four million individuals fail to receive annual medical care due to transportation barriers¹; and

Whereas, Many patients with common illnesses attend multiple outpatient appointments a year, such as one study which showed 47% of patients with hypertension had four or more visits in 2014²; and

Whereas, Parking prices at some of the country's largest medical centers can be as high as \$20 to \$43 per day³⁻⁴; and

Whereas, The public transportation system in the United States varies greatly within the country in terms of usage, location, and infrastructure, with most of the public transport concentrated in the Northeast⁵; and

Whereas, Approximately only a third of patients are within walking distance to their nearest public transportation in certain metropolitan medical centers⁶; and

Whereas, Public transport is not readily available in all locations, such as rural areas where the scarcity of local physicians can still require patients to drive to urban areas for care⁷; and

Whereas, Programs such as non-emergency patient/medical transportation (NEMT) are often limited to approved patients within Medicaid and can have many disadvantages, including restrictions on the type and number of rides, the necessity of a social worker to coordinate transportation, having to schedule days in advance, and carpooling with other patients leading to longer travel and wait times⁸; and

Whereas, The average cost of an NEMT in 2014 was \$28, and this price rises in rural and suburban areas that are farther from medical centers^{8,9}; and

Whereas, When surveying older Americans, the group that utilizes the most inpatient and outpatient healthcare, rideshare services were not seen as a practical option, with 74% of patients reporting no knowledge of these services and only 1.7% making use of them¹⁰; and

Whereas, In a study of patients with heart disease, individuals reported the high cost of parking at healthcare facilities as a financial barrier to attending multiple specialist appointments¹¹; and

Whereas, In a study of factors influencing family burden in pediatric hematology/oncology, parking was cited as one of the most disproportionately distressing factors¹²; and

1 Whereas, Nonmedical costs, such as transportation, meals, and child care, have been reported
2 to range from \$50 to \$165 a day, further contributing to a family's financial stress¹³; and
3

4 Whereas, The lower the financial burden a patient has, the less likely they are to miss
5 appointments and adhere to treatment, preventing high cost emergent situations that would lead
6 to hospitals losing money on patients who cannot pay¹⁴; and
7

8 Whereas, Reduced parking fees have been cited as an incentive for patients to travel to
9 hospitals that can offer better treatment than local counterparts¹⁵; and
10

11 Whereas, A minority of hospitals rely on nonpatient care income to offset revenue losses, such
12 that providing parking vouchers would only represent a minor loss in revenue while providing a
13 major benefit to patients¹⁶; and
14

15 Whereas, Many hospitals have already implemented programs for patient parking such as
16 reduced monthly rates and free validated parking¹⁷⁻¹⁹; and
17

18 Whereas, Several associations of healthcare facilities focus on developing solutions for and
19 advocating improvements in social and economic aspects of healthcare, including the American
20 Hospital Association, the Federation of American Hospitals, and the Children's Hospital
21 Association²⁰⁻²⁷; and
22

23 Whereas, The American Hospital Association is a national organization of "5,000 hospitals,
24 health care systems, networks, [and] other providers of care" and publishes standards and
25 guidelines on various social and economic aspects of care^{20,21}; and
26

27 Whereas, The Federation of American Hospitals is a national organization of over 1,000
28 hospitals that are not tax-exempt, including for-profit hospitals, and advocates their priorities²²⁻²⁴;
29 and
30

31 Whereas, The Children's Hospital Association is a national organization of over 220 pediatric
32 hospitals and develops and shares solutions with its members on various social and economic
33 aspects of care^{26,27}; therefore be it
34

35 RESOLVED, That our American Medical Association work with relevant stakeholders to
36 recognize parking fees as a burden of care for patients and to implement mechanisms for
37 reducing parking costs. (Directive to Take Action)

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

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

The COVID-19 pandemic has shown light upon the many inequities in and barriers to accessibility of care. One of these barriers is transportation and parking fees. Parking fees at large medical centers can be up to nearly \$50 per day. This cost is prohibitive to low-income and low-SES patients and families. It is unconscionable that healthcare facilities should profit off their patients' need to park at a healthcare facility in order to receive needed care. Studies have documented that patients see parking costs as a significant stress and a financial barrier to attending appointments. Further, many patients have already missed important healthcare appointments due to the pandemic, and given that the long-term consequences of COVID-19 will make it necessary for many more individuals to attend multiple follow-up appointments in the coming months and years. Our AMA should act now to begin to work to reduce this barrier and burden, to ensure our patients are able to access the care they need as we learn to address the long-term effects of this ongoing pandemic.

References:

1. Traveling towards disease: transportation barriers to health care access. Syed ST, Gerber BS, Sharp LKJ Community Health. 2013 Oct; 38(5):976-93.
2. Ashman JJ, Rui P, Schappert SM. Age differences in visits to office-based physicians by adults with hypertension: United States, 2013. NCHS data brief, no 263. Hyattsville, MD: National Center for Health Statistics. 2016.
3. "Parking Rates". Uth.Edu, 2020, <https://www.uth.edu/parking/parking/parking-rates.htm>.
4. Nyp.Org, 2020, <https://www.nyp.org/realestate/parking/helmsley-medical-tower>.
5. Coughlin SS, King J. Breast and cervical cancer screening among women in metropolitan areas of the United States by county-level commuting time to work and use of public transportation, 2004 and 2006. *BMC Public Health*. 2010;10:146. Published 2010 Mar 19. doi:10.1186/1471-2458-10-146
6. Cheng AC, Levy MA. Determining Burden of Commuting for Treatment Using Online Mapping Services - A Study of Breast Cancer Patients. *AMIA Annu Symp Proc*. 2018;2017:555-564. Published 2018 Apr 16.
7. Douthitt, N., et al. "Exposing some important barriers to healthcare access in the rural USA." *Public health* 129.6 (2015): 611-620.
8. Chaiyachati KH, Hubbard RA, Yeager A, et al. Rideshare-Based Medical Transportation for Medicaid Patients and Primary Care Show Rates: A Difference-in-Difference Analysis of a Pilot Program. *J Gen Intern Med*. 2018;33(6):863-868. doi:10.1007/s11606-018-4306-0
9. Texas A&M Transportation Institute. Examining the effects of separate non-emergency medical transportation (NEMT) brokerages on transportation coordination. March 2014. <https://groups.tti.tamu.edu/transit-mobility/files/2015/12/TCRP-B-44-Review-and-Summary-of-Relevant-Literature-FinalR.pdf>
10. E-hail (Rideshare) Knowledge, Use, Reliance, and Future Expectations among Older Adults. Vivoda JM, Harmon AC, Babulal GM, Zikmund-Fisher BJ *Transp Res Part F Traffic Psychol Behav*. 2018 May; 55():426-434.
11. Dhaliwal KK, King-Shier K, Manns BJ, Hemmelgarn BR, Stone JA, Campbell DJ. Exploring the impact of financial barriers on secondary prevention of heart disease. *BMC Cardiovasc Disord*. 2017;17(1):61. Published 2017 Feb 14. doi:10.1186/s12872-017-0495-4
12. Abrams HR, Leeds HS, Russell HV, Hellsten MB. Factors Influencing Family Burden in Pediatric Hematology/Oncology Encounters. *J Patient Cent Res Rev*. 2019;6(4):243-251. Published 2019 Oct 28. doi:10.17294/2330-0698.1710
13. Chang, Lenisa V., et al. "Lost earnings and nonmedical expenses of pediatric hospitalizations." *Pediatrics* 142.3 (2018): e20180195.
14. Tran VT, Barnes C, Montori VM, Falissard B, Ravaud P. Taxonomy of the burden of treatment: a multi-country web-based qualitative study of patients with chronic conditions. *BMC Med*. 2015;13:115. Published 2015 May 14. doi:10.1186/s12916-015-0356-x
15. Resio BJ, Chiu AS, Hoag JR, et al. Motivators, Barriers, and Facilitators to Traveling to the Safest Hospitals in the United States for Complex Cancer Surgery. *JAMA Netw Open*. 2018;1(7):e184595. Published 2018 Nov 2. doi:10.1001/jamanetworkopen.2018.4595
16. Singh, S. and Song, P., 2020. Nonoperating Revenue And Hospital Financial Performance: Do Hospitals Rely On Income From Nonpatient Care Activities To Offset Losses On Patient Care?. [online] *Insights.ovid.com*. Available at: <<https://insights.ovid.com/health-care-management-review/hcmre/2013/07/000/nonoperating-revenue-hospital-financial/3/00004010>>
17. "Parking". *Medstar Georgetown University Hospital*, 2020, <https://www.medstargeorgetown.org/for-patients/patients-and-visitors/directions-maps-and-parking/parking/>.
18. "Parking Information". *Medstar Washington Hospital Center*, 2020, <https://www.medstarwashington.org/for-patients/patients-and-visitors/directions-maps-parking-and-public-transportation/parking-and-entrances/>.
19. Parking | *Hartfordhospital.Org* | *Hartford Hospital*. *Hartfordhospital.Org*, 2020, <https://hartfordhospital.org/patients-and-visitors/for-patients/parking>.
20. "About the American Hospital Association." American Hospital Association. <https://www.aha.org/about>. Accessed April 8, 2020.

21. Tran VT, Barnes C, Montori VM, Falissard B, Ravaud P. Taxonomy of the burden of treatment: a multi-country web-based qualitative study of patients with chronic conditions. *BMC Med.* 2015;13:115. Published 2015 May 14. doi:10.1186/s12916-015-0356-x
22. "Standards/Guidelines." American Hospital Association. <https://www.aha.org/taxonomy/term/134>. Accessed April 8, 2020.
23. "Mission Statement." Federation of American Hospitals. <https://www.fah.org/about-fah/mission-statement>. Accessed April 8, 2020.
24. "Issues & Advocacy." Federation of American Hospitals. <https://www.fah.org/issues-advocacy/issues-advocacy>. Accessed April 8, 2020.
25. "Exempt Organization Types." US Department of Treasury, Internal Revenue Service (IRS). <https://www.irs.gov/charities-non-profits/exempt-organization-types>. Updated December 21, 2019. Accessed April 8, 2020.
26. "About the Association." Children's Hospital Association. <https://www.childrenshospitals.org/About-Us/About-the-Association>. Accessed April 8, 2020.
27. "Programs and Services." Children's Hospital Association. <https://www.childrenshospitals.org/Programs-and-Services>. Accessed April 8, 2020.

RELEVANT AMA POLICY

Non-Emergency Patient Transportation Systems H-130.954

Our AMA:

1. supports the education of physicians, first responders, and the public about the costs associated with inappropriate use of emergency patient transportation systems; and
2. encourages the development of non-emergency patient transportation systems that are affordable to the patient, thereby ensuring cost effective and accessible health care for all patients.

Sub. Res. 812, I-93; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed in lieu of Res. 101, A-12; Modified: CMS Rep. 02, I-18

Controlling Cost of Medical Care H-155.966

The AMA urges the American Hospital Association and all hospitals to encourage the administrators and medical directors to provide to the members of the medical staffs, housestaff and medical students the charges for tests, procedures, medications and durable medical equipment in such a fashion as to emphasize cost and quality consciousness and to maximize the education of those who order these items as to their costs to the patient, to the hospital and to society in general.

Sub. Res. 75, I-81; Reaffirmed: CLRPD Rep. F, I-91; Res. 801, A-93; CMS Rep. 12, A-95; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmation: A-08; Reaffirmed in lieu of Res. 5, A-12

Voluntary Health Care Cost Containment H-155.998

1. All physicians, including physicians in training, should become knowledgeable in all aspects of patient-related medical expenses, including hospital charges of both a service and professional nature.
2. Physicians should be cost conscious and should exercise discretion, consistent with good medical care, in determining the medical necessity for hospitalization and the specific treatment, tests and ancillary medical services to be provided a patient.

Res. 34, A-78; Reaffirmed: CLRPD Rep. C, A-89; Res. 100, I-89; Res. 822, A-93; Reaffirmed: BOT Rep. 40, I-93; CMS Rep. 12, A-95; Reaffirmed: Res. 808, I-02; Modified: CMS Rep. 4, A-12

Health Promotion and Disease Prevention H-425.993

The AMA (1) reaffirms its current policy pertaining to the health hazards of tobacco, alcohol, accidental injuries, unhealthy lifestyles, and all forms of preventable illness; (2) advocates intensified leadership to promote better health through prevention; (3) believes that preventable

illness is a major deterrent to good health and accounts for a major portion of our country's total health care expenditures; (4) actively supports appropriate scientific, educational and legislative activities that have as their goals: (a) prevention of smoking and its associated health hazards; (b) avoidance of alcohol abuse, particularly that which leads to accidental injury and death; (c) reduction of death and injury from vehicular and other accidents; and (d) encouragement of healthful lifestyles and personal living habits; (5) advocates that health be considered one of the goals in transportation planning and policy development including but not limited to the establishment, expansion, and continued maintenance of affordable, accessible, barrier-free, reliable, and preferably clean-energy public transportation; and (6) strongly emphasizes the important opportunity for savings in health care expenditures through prevention.

Presidential Address, A-82; Reaffirmed: CMRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: BOT Rep. 8, I-06; Reaffirmed: CSAPH Rep. 01, A-16; Modified: Res. 923, I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 404
(N-21)

Introduced by: Medical Student Section

Subject: Increase Employment Services Funding for People with Disabilities

Referred to: Reference Committee D

Whereas, The American Disabilities Act defines “disability” as “a physical or mental impairment that substantially limits one or more major life activities of such individual, a record of such an impairment, or being regarded as having such an impairment”¹; and

Whereas, Adults with disabilities experience health disparities related to social determinants of health, as they are less likely to have jobs with competitive wages, more likely to live in poverty, and more likely to experience mental health issues²; and

Whereas, People with disabilities have been disproportionately affected by the COVID-19 pandemic, in terms of both health outcomes and economically, with unemployment rates that are nearly double the unemployment rates of nondisabled people³⁻⁵; and

Whereas, One in five people with disabilities, or approximately one million people in the US, lost their job during the COVID-19 pandemic, compared to one in seven people in the general population⁶; and

Whereas, Between 2019 and 2020, the percentage of people with disabilities who were employed fell from 19.2% to 17.9%, whereas non-disabled people saw a decrease in employment from 66.3% to 61.8%⁷; and

Whereas, Almost half of unemployed disabled individuals endorse barriers to employment, while less than 10% of individuals with disabilities have been able to use career assistance programs⁸; and

Whereas, Existing literature demonstrates that employment training programs are highly beneficial for students with disabilities to gain competitive employment, and many have success rates of 100% employment for their students^{2,9}; and

Whereas, The Workforce Innovation and Opportunity Act of 2014 (WIOA) provides state grants through the Department of Labor for employment and training services for people with disabilities, serving over 46,000 adults with disabilities and 26,000 youth with disabilities in 2018^{10,11}; and

Whereas, WIOA reserves 15% of its budget for Vocational Rehabilitation programs to assist students with disabilities through a transition from school to employment¹⁰; and

1 Whereas, In order to sustain the services provided to the community, Centers for Independent
2 Living (CIL) programs developed by the WIOA independently raised six times the federal
3 appropriation of funds in 2019, contributing to a 27% increase in utilization of resources to assist
4 with transition from youth to adult life²; and

5
6 Whereas, Lack of funding has been increasingly detrimental during the COVID-19 pandemic,
7 with community programs through WIOA reporting over 30% of employment service
8 programming closed due to COVID-19¹²; and

9
10 Whereas, The Arc, an organization that trains and employs thousands of individuals with
11 disabilities nationally, reported that employment programs have struggled during the COVID-19
12 pandemic due to funding concerns, and 44% of agencies through The Arc had to lay-off or
13 furlough staff^{13,14}; and

14
15 Whereas, Section 188 of WIOA requires that employment services provide equal opportunities
16 for individuals with disabilities to participate in services and receive appropriate
17 accommodations; however, the COVID-19 pandemic has created disparities in receiving these
18 accommodations¹⁵; and

19
20 Whereas, AMA Policy H-90.967 and MSS Policy 25.002 encourage government agencies and
21 other organizations to provide psychosocial support for people with disabilities, but do not
22 include employment benefits; and

23
24 Whereas, As employment and socioeconomic status are social determinants of health closely
25 linked to health outcomes, increased resources for employment support programs would
26 provide equitable solutions for the drastic disparities that the COVID-19 pandemic has created
27 for people with disabilities¹⁶; therefore be it

28
29 RESOLVED, That our American Medical Association support increased resources for
30 employment services to reduce health disparities for people with disabilities. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

People with disabilities have been disproportionately affected by the COVID-19 pandemic, with job loss rates that are nearly double the unemployment rates of nondisabled people. Employment is a social determinant of health, and disparities in employment status for people with disabilities could contribute to worse health outcomes. Existing policy H-90.967 encourages government agencies to provide psychosocial support for people with disabilities, yet social determinants of health including employment and socioeconomic status are not included. This resolution is an impactful ask requesting increased funding for employment services to provide people with disabilities with more equitable employment and socioeconomic opportunities, through existing federal and state programs which have demonstrated evidence-based success. This resolution is especially timely considering that Congress is currently considering ending a federal program that allows subminimum wages for workers with disabilities, so that AMA advocacy on this issue could provide an important voice to an issue of justice, equity, and better health outcomes for people with disabilities.. Improving employment opportunities through increased access to resources will contribute to improved social determinants of health and reduced health disparities for people with disabilities.

References:

1. Americans with Disabilities Act of 1990, 42 U.S.C. § 12101. <https://www.ada.gov/pubs/adastatute08.htm#12102>
2. Annual Report on Centers for Independent Living Program. Year 2019 (2020). Administration for Community Living. Retrieved on 3/16/21 from https://acl.gov/sites/default/files/programs/2020-11/PY19CILReport508%20FINAL_0.pdf.
3. Eric Emerson, Roger Stancliffe, Chris Hatton, Gwynnyth Llewellyn, Tania King, Vaso Totsika, Zoe Aitken, Anne Kavanagh, The impact of disability on employment and financial security following the outbreak of the 2020 COVID-19 pandemic in the UK, *Journal of Public Health*, 2021;,. fdaa270, <https://doi.org/10.1093/pubmed/fdaa270>
4. Kong M, Thompson LA. Considerations for Young Children and Those With Special Needs as COVID-19 Continues. *JAMA Pediatr*. 2020 Oct 1;174(10):1012. doi: 10.1001/jamapediatrics.2020.2478. PMID: 32870247.
5. Employment for Persons with a Disability: Analysis of Trends During the COVID-19 Pandemic (2020). Office of Disability Employment Policy. Retrieved on 3/16/21 from https://www.dol.gov/sites/dolgov/files/OASP/evaluation/pdf/ODEP_Employment-for-PWD-AnalysisofTrendsDuringCOVID_Feb-Sept.pdf.
6. Smith, A. A Million People with Disabilities Have Lost Jobs During the Pandemic. The Society for Human Resource Management. Aug 28, 2020. <https://www.shrm.org/ResourcesAndTools/legal-and-compliance/employment-law/Pages/coronavirus-unemployment-people-with-disabilities.aspx>
7. US Bureau of Labor Statistics. PERSONS WITH A DISABILITY: LABOR FORCE CHARACTERISTICS — 2020. February 24, 2021. <https://www.bls.gov/news.release/pdf/disabl.pdf>.
8. Persons with a Disability: Barriers to Employment and Other Labor-Related Issues News Release (2020). US Bureau of Labor Statistics. Retrieved on 3/16/21 from https://www.bls.gov/news.release/archives/dissup_05012020.htm.
9. Wehman P, Sima AP, Ketchum J, West MD, Chan F, Luecking R. Predictors of successful transition from school to employment for youth with disabilities. *J Occup Rehabil*. 2015 Jun;25(2):323-34. doi: 10.1007/s10926-014-9541-6. PMID: 25240394.
10. WIOA Programs (n.d.). US Department of Labor. Retrieved on March 8, 2021 from <https://www.dol.gov/agencies/eta/wioa/about>
11. WIOA Adult Performance Report (2020). US Department of Labor. Retrieved on 3/16/21 from <https://www.doleta.gov/Performance/Results/AnnualReports/PY2018/PY-2018-WIOA-National-Performance-Summary-3.27.2020.pdf>.
12. Wright, R. (2020). COVID-19 and the Workforce: Impacts on Workers with Disabilities. The Council of State Governments. Retrieved on 3/16/21 from <https://web.csg.org/covid19/2020/07/14/covid-19-and-the-workforce-impacts-on-workers-with-disabilities/>.
13. Katz, P. (2020). The Workplace in 2020: Getting People With Disabilities Back to Work Safely During COVID-19. The Arc. Retrieved on 3/16/21 from <https://thearc.org/the-workplace-in-2020-getting-people-with-disabilities-back-to-work-safely-during-covid-19/>.
14. Supported Employment During COVID-19: Resources for Virtual Employment Supports (2020). The Arc. Retrieved on 3/16/21 from https://www.arcind.org/wp-content/uploads/2020/05/Supported-Employment-Tools-and-Best-Practices-during-COVID-19_05.18.20.pdf.
15. The Workforce Innovation and Opportunity Act (WIOA) (n.d.). National Parent Center on Transition and Employment. Retrieved on 3/16/21 from <https://www.pacer.org/transition/learning-center/laws/workforce-innovation.asp>.
16. "Disability & Socioeconomic Status." American Psychological Association 2020. Accessed April 17, 2020. <https://www.apa.org/pi/ses/resources/publications/disability>.

RELEVANT AMA POLICY

H-90.967 Support for Persons with Intellectual Disabilities

Our AMA encourages appropriate government agencies, non-profit organizations, and specialty societies to develop and implement policy guidelines to provide adequate psychosocial resources for persons with intellectual disabilities, with the goal of independent function when possible.

Res. 01, A-16

D-90.992 Preserving Protections of the Americans with Disabilities Act of 1990

1. Our AMA supports legislative changes to the Americans with Disabilities Act of 1990, to educate state and local government officials and property owners on strategies for promoting access to persons with a disability.

2. Our AMA opposes legislation amending the Americans with Disabilities Act of 1990, that would increase barriers for disabled persons attempting to file suit to challenge a violation of their civil rights.

3. Our AMA will develop educational tools and strategies to help physicians make their offices more accessible to persons with disabilities, consistent with the Americans With Disabilities Act as well as any applicable state laws.

Res. 220, I-17

H-90.971 Enhancing Accommodations for People with Disabilities

Our AMA encourages physicians to make their offices accessible to patients with disabilities, consistent with the Americans with Disabilities Act (ADA) guidelines.

Res. 705, A-13

H-90.969 Early Intervention for Individuals with Developmental Delay

(1) Our AMA will continue to work with appropriate medical specialty societies to educate and enable physicians to identify children with developmental delay, autism and other developmental disabilities, and to urge physicians to assist parents in obtaining access to appropriate individualized early intervention services. (2) Our AMA supports a simplified process across appropriate government agencies to designate individuals with intellectual disabilities as a medically underserved population.

CCB/CLRPD Rep. 3, A-14; Reaffirmed: Res. 315, A-17

H-90.986 SSI Benefits for Children with Disabilities

The AMA will use all appropriate means to inform members about national outreach efforts to find and refer children who may qualify for Supplemental Security Income benefits to the Social Security Administration and promote and publicize the new rules for determining disability.

Res. 420, A-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CMS Rep. 4, A-13

H-160.890 Support for Housing Modification Policies

Our AMA supports improved access to housing modification benefits for populations that require modifications in order to mitigate preventable health conditions, including but not limited to the elderly, the disabled and other persons with physical and/or mental disabilities.

Res. 806, I-19

H-290.970 Federal Legislation on Access to Community-Based Services for People with Disabilities

Our AMA strongly supports reform of the Medicaid program established under title XIX of the Social Security Act (42 U.S.C. 1396) to provide services in the most appropriate settings based upon the individual's needs, and to provide equal access to community-based attendant services and supports.

Res. 917, I-07; Reaffirmed: BOT Rep. 22, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 405
(N-21)

Introduced by: Medical Student Section

Subject: Formal Transitional Care Program for Children and Youth with Special Health Care Needs

Referred to: Reference Committee D

Whereas, Children and youth with special health care needs (CYSHCN) are those whose health care needs are more complex and require specialized care for their physical, behavioral, or emotional development beyond that required by children generally¹; and

Whereas, “Special health care needs” include any chronic conditions, such as cystic fibrosis, cerebral palsy, congenital defects/conditions, type 1 diabetes and other similar health conditions^{1,2}; and

Whereas, Almost 20% of children between 12 and 18 years of age have a special health care need³; and

Whereas, People with disabilities are described as having an activity limitation or who use assistance or perceive themselves as having a disability⁴; and

Whereas, Most of CYSHCN do not fall under the formal definition of “disabled” and are under their own category given that⁴; and

Whereas, Ninety percent of CYSHCN, who previously faced high rates of childhood mortality, now increasingly survive to adulthood due to advances in medicine and therefore need the appropriate care they received as children and young adults⁵; and

Whereas, Pediatric practices do not routinely start planning for transition to adult care until around the patient is 18 years of age, and many pediatric practices do not have the available policies, plans, or educational materials for a proper transition⁶; and

Whereas, Adult clinicians often do not have the specific infrastructure, education, and training to care for young adults with pediatric-onset conditions⁷; and

Whereas, Research demonstrates that CYSHCN currently are inadequately supported during the transition from pediatric to adult health care⁶⁻⁹; and

Whereas, Transitioning from pediatric to adult services, particularly for CYSHCN, is associated with decreased medication adherence, decreased patient engagement, increased avoidable hospitalization, and other health risks like permanent end-organ damage and even an early death^{8, 10}; and

1 Whereas, The transition to adult services occurs during a developmental period marked by
2 increased risky behavior¹¹, indicating the need for stability and clear planning to promote good
3 outcomes and continued treatment adherence; and
4

5 Whereas, The ability of pediatricians and adult clinicians to communicate effectively during the
6 transition to adult care results in better health outcomes for the individual¹²; and
7

8 Whereas, The American Academy of Pediatrics, the American Academy of Family Physicians,
9 and the American College of Physicians have released and reaffirmed a consensus statement
10 supporting high-quality, planned transitions of care for all youth, especially CYSHCN¹³; and
11

12 Whereas, Transitional Clinical Report and Algorithm was published as basic guidelines to set up
13 potential transition systems¹³; and
14

15 Whereas, After nearly 10 years of effort and research since the Transitional Clinical Report and
16 Algorithm was published, some effective models of transition systems were made by reputable
17 organizations, like National Standards for CYSHCN, but none have been nationally
18 established^{13,14}; and
19

20 Whereas, Current AMA policy encourages physicians to establish transitional care programs for
21 children with disabilities (H-60.974), but existing language is not inclusive of all children with
22 special health care needs¹⁶; therefore be it

1 RESOLVED, That our American Medical Association amend Policy H-60.974, "Children and
2 Youth with Disabilities," by addition and deletion to read as follows, to strengthen our AMA
3 policy and to include a population of patients that do not fall under "disability" but also need
4 extra care, especially when transitioning to adult health care, that they are currently not
5 receiving due to a gap:

6
7 H-60.974: CHILDREN AND YOUTH WITH DISABILITIES AND WITH SPECIAL
8 HEALTH CARE NEEDS

9 It is the policy of the AMA: (1) to inform physicians of the special health care needs of
10 children and youth with disabilities and children and youth with special health care needs
11 (CYSHCN);

12 (2) to encourage physicians to pay special attention during the preschool physical
13 examination to identify physical, emotional, or developmental disabilities that have not
14 been previously noted;

15 (3) to encourage physicians to provide services to children and youth with disabilities
16 and CYSHCN that are family-centered, community-based, and coordinated among the
17 various individual providers and programs serving the child;

18 (4) to encourage physicians to provide schools with medical information to ensure that
19 children and youth with disabilities and CYSHCN receive appropriate school health
20 services;

21 (5) to encourage physicians to establish formal transition programs or activities that help
22 adolescents with disabilities, and CYSHCN, and their families to plan and make
23 the transition to the adult medical care system;

24 (6) to inform physicians of available educational and other local resources, as well as
25 various manuals that would help prepare them to provide family-centered health care;
26 and

27 (7) to encourage physicians to make their offices accessible to patients with disabilities
28 and CYSHCN, especially when doing office construction and renovations. (Modify
29 Current HOD Policy)

Fiscal Note: Minimal - less than \$1,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

This resolution aims to resolve gaps in existing AMA policy to address the critical healthcare needs of children and youth with special healthcare needs (CYSHCN), a vulnerable population, as they transition from pediatric to adult medical care. CYSHCN often requires long-term health services from multiple sectors of the healthcare field. The children and their families tend to face many barriers to care especially if they belong to a minority population. The medical literature clearly illustrates how imperative it is to support patients, particularly CYSHCN, during this transition period to optimize medication adherence, patient engagement, and end-organ function. The American Academy of Pediatrics, the American Academy of Family Physicians, and the American College of Physicians have already released a consensus statement supporting high-quality, planned transitions of care for all youth, especially CYSHCN. However, existing AMA policy, most notably policy H-60.974, currently addresses only youth with disabilities. While some CYSHCN may have an activity limitation or perceive themselves as having a disability, many CYSHCN do not fall under the formal definition of “disabled” and are thus forgotten under current AMA policy. Therefore, while current policy affirms the complex nature of care for this population and encourages transition programs for children with disabilities, as the policy is written currently it ignores a large swath of vulnerable patients. For these reasons, the AMA should prioritize this critical and timely issue to protect a vulnerable population that is falling through the gaps in current policy.

References:

1. Children and Youth with Special Healthcare Needs in Emergencies | CDC. (2019). Retrieved 13 March 2021, from <https://www.cdc.gov/childrenanddisasters/children-with-special-healthcare-needs.html>.
2. Children and Youth with Special Health Care Needs. (2020). Retrieved 13 March 2021, from <https://www.dhs.wisconsin.gov/prevention-healthy-living/maternal-and-child-health/children-and-youth-special-health-care-needs>.
3. Castillo, C., & Kitsos, E. (2017). Transitions From Pediatric to Adult Care. *Global pediatric health*, 4, 2333794X17744946. Retrieved 13 March 2021, from <https://doi.org/10.1177/2333794X17744946>.
4. Disability and Health | Healthy People 2020. (2020). Retrieved 13 March 2021, from <https://www.healthypeople.gov/2020/topics-objectives/topic/disability-and-health/objectives>.
5. Stoeck, P., Cheng, N., Berry, A., Bazemore, A., & Robert L. Phillips, J. (2012). Health Care Transition Counseling for Youth with Special Health Care Needs. *American Family Physician*, 86(11), 1024-1024. Retrieved 13 March 2021, from <https://www.aafp.org/afp/2012/1201/p1024.html>.
6. Lebrun-Harris, L., McManus, M., Ilango, S., Cyr, M., McLellan, S., Mann, M., & White, P. (2018). Transition Planning Among US Youth With and Without Special Health Care Needs. *Pediatrics*, 142(4), e20180194. doi: 10.1542/peds.2018-0194.
7. Cohen E, Gandhi S, Toulany A, et al. (2016). Health care use during transfer to adult care among youth with chronic conditions. *Pediatrics*. 137(3):e20152734pmid:26933203.
8. Gray WN, Schaefer MR, Resmini-Rowlinson A, Wagoner ST. (2018). Barriers to transition from pediatric to adult care: a systematic review. *J Pediatr Psychol*. 43(5):488–502pmid:29190360.
9. Chu PY, Maslow GR, von Isenburg M, Chung RJ. (2015). Systematic review of the impact of transition interventions for adolescents with chronic illness on transfer from pediatric to adult healthcare. *J Pediatr Nurs*. 30(5):e19–e27pmid:26209872.
10. Bhawra, J, Toulany, A, Cohen, E, Hepburn, CM, Guttman, A. Primary care interventions to improve transition of youth with chronic health conditions from paediatric to adult healthcare: a systematic review. *BMJ Open*. 2016;6:e011871. doi:10.1136/bmjopen-2016-011871.
11. Sawici G.S, Ostrenga J., Petren K., Fink A.K., D'Agostino E., Strassle C., Schechter M.S., Rosenfeld M. (2017). Risk Factors for Gaps in Care during Transfer from Pediatric to Adult Cystic Fibrosis Programs in the US. *Annals of the American Thoracic Society*, 15(2) 234-40. Retrieved from <https://doi.org/10.1513/AnnalsATS.201705-357OC>.
12. Huang J., et al. (2011). Transition to Adult Care: Systematic Assessment of Adolescents with Chronic Illnesses and their Medical Teams. *J. Pediatr*. 159(6), 994-998. DOI: 10.1016/j.jpeds.2011.05.038.
13. White, P., & Cooley, W. (2018). Supporting the Health Care Transition From Adolescence to Adulthood in the Medical Home. *Pediatrics*, 142(5), e20182587. doi: 10.1542/peds.2018-2587.
14. National Standards for CYSHCN. (2020). Retrieved 13 March 2021, from <https://cyshcnstandards.amchp.org/app-national-standards/#/>.
15. AMA-MSS policy 160.039MSS, Addressing Health Disparities Through Improved Transition of Care from Pediatric to Adult Care
16. AMA policy H-60.974, Children and Youth with Disabilities
17. McManus, M.A., Pollack, L.R., Cooley W.C., McAllister J.W., Lotstein, D., Strickland, B., Mann, MY. (2013). Current status of transition preparation among youth with special needs in the United States. *Pediatrics*, 131(6), 1090-7. Retrieved 13 March 2021, from <https://www.ncbi.nlm.nih.gov/pubmed/23669518>.

18. Lebrun-Harris L.A., McManus M.A., Ilango S.M., Cyr M., McLellan S.B., Mann M.Y., White P.H. (2018). Transition planning among US youth with and without special health care needs. *Pediatrics*, 142(4) e20180194; DOI: <https://doi.org/10.1542/peds.2018-0194>.
19. Mocerri, P., et al. (2015). From adolescents to adults with congenital heart disease: The role of transition. *Eur J Pediatr*. 174:847-854. DOI:10.1007/s00431-015-2557-x.
20. Francis A., Johnson DW., Craig., Wong G. (2017). Moving on: transitioning young people with chronic kidney disease to adult care. *Pediatr Nephrol* (2018) 33:973-983. DOI: 10.1007/s00467-017-3728-y.
21. Iyengar, J., Thomas, I. H., & Soleimanpour, S. A. (2019). Transition from pediatric to adult care in emerging adults with type 1 diabetes: a blueprint for effective receivership. *Clinical diabetes and endocrinology*, 5, 3. <https://doi.org/10.1186/s40842-019-0078-7>.
22. Bregman, S., & Frishman, W. (2018). Impact of Improved Survival in Congenital Heart Disease on Incidence of Disease. *Cardiology In Review*, 26(2), 82-85. Doi: 10.1097/crd.0000000000000178.
23. Hurley, M. N., McKeever, T. M., Prayle, A. P., Fogarty, A. W., & Smyth, A. R. (2014). Rate of improvement of CF life expectancy exceeds that of general population—observational death registration study. *Journal of cystic fibrosis : official journal of the European Cystic Fibrosis Society*, 13(4), 410–415. <https://doi.org/10.1016/j.jcf.2013.12.002>.

RELEVANT AMA POLICY

H-60.974: Children and Youth with Disabilities

It is the policy of the AMA: (1) to inform physicians of the special health care needs of children and youth with disabilities;

(2) to encourage physicians to pay special attention during the preschool physical examination to identify physical, emotional, or developmental disabilities that have not been previously noted;

(3) to encourage physicians to provide services to children and youth with disabilities that are family-centered, community-based, and coordinated among the various individual providers and programs serving the child;

(4) to encourage physicians to provide schools with medical information to ensure that children and youth with disabilities receive appropriate school health services;

(5) to encourage physicians to establish formal transition programs or activities that help adolescents with disabilities and their families to plan and make the transition to the adult medical care system;

(6) to inform physicians of available educational and other local resources, as well as various manuals that would help prepare them to provide family-centered health care; and

(7) to encourage physicians to make their offices accessible to patients with disabilities, especially when doing office construction and renovations.

CSA Reo. J, 1-91 Modified: Sunset Report, I-01; CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 1, A-21

H-160.942: Evidence-Based Principles of Discharge and Discharge Criteria

(1) The AMA defines discharge criteria as organized, evidence-based guidelines that protect patients' interests in the discharge process by following the principle that the needs of patients must be matched to settings with the ability to meet those needs.

(2) The AMA calls on physicians, specialty societies, insurers, and other involved parties to join in developing, promoting, and using evidence-based discharge criteria that are sensitive to the physiological, psychological, social, and functional needs of patients and that are flexible to meet advances in medical and surgical therapies and adapt to local and regional variations in health care settings and services.

(3) The AMA encourages incorporation of discharge criteria into practice parameters, clinical guidelines, and critical pathways that involve hospitalization.

(4) The AMA promotes the local development, adaption and implementation of discharge criteria.

(5) The AMA promotes training in the use of discharge criteria to assist in planning for patient care at all levels of medical education. Use of discharge criteria will improve understanding of

the pathophysiology of disease processes, the continuum of care and therapeutic interventions, the use of health care resources and alternative sites of care, the importance of patient education, safety, outcomes measurements, and collaboration with allied health professionals.

(6) The AMA encourages research in the following areas: clinical outcomes after care in different health care settings; the utilization of resources in different care settings; the actual costs of care from onset of illness to recovery; and reliable and valid ways of assessing the discharge needs of patients.

(7) The AMA endorses the following principles in the development of evidence-based discharge criteria and an organized discharge process:

(a) As tools for planning patients' transition from one care setting to another and for determining whether patients are ready for the transition, discharge criteria are intended to match patients' care needs to the setting in which their needs can best be met.

(b) Discharge criteria consist of, but are not limited to: (i) Objective and subjective assessments of physiologic and symptomatic stability that are matched to the ability of the discharge setting to monitor and provide care. (ii) The patient's care needs that are matched with the patient's, family's, or caregiving staff's independent understanding, willingness, and demonstrated performance prior to discharge of processes and procedures of self care, patient care, or care of dependents. (iii) The patient's functional status and impairments that are matched with the ability of the care givers and setting to adequately supplement the patients' function. (iv) The needs for medical follow-up that are matched with the likelihood that the patient will participate in the follow-up. Follow-up is time-, setting-, and service-dependent. Special considerations must be taken to ensure follow-up in vulnerable populations whose access to health care is limited.

(c) The discharge process includes, but is not limited to: (i) Planning: Planning for transition/discharge must be based on a comprehensive assessment of the patient's physiological, psychological, social, and functional needs. The discharge planning process should begin early in the course of treatment for illness or injury (prehospitalization for elective cases) with involvement of patient, family and physician from the beginning. (ii) Teamwork: Discharge planning can best be done with a team consisting of the patient, the family, the physician with primary responsibility for continuing care of the patient, and other appropriate health care professionals as needed. (iii) Contingency Plans/Access to Medical Care: Contingency plans for unexpected adverse events must be in place before transition to settings with more limited resources. Patients and caregivers must be aware of signs and symptoms to report and have a clearly defined pathway to get information directly to the physician, and to receive instructions from the physician in a timely fashion. (iv) Responsibility/Accountability: Responsibility/accountability for an appropriate transition from one setting to another rests with the attending physician. If that physician will not be following the patient in the new setting, he or she is responsible for contacting the physician who will be accepting the care of the patient before transfer and ensuring that the new physician is fully informed about the patient's illness, course, prognosis, and needs for continuing care. If there is no physician able and willing to care for the patient in the new setting, the patient should not be discharged. Notwithstanding the attending physician's responsibility for continuity of patient care, the health care setting in which the patient is receiving care is also responsible for evaluating the patient's needs and assuring that those needs can be met in the setting to which the patient is to be transferred. (v) Communication: Transfer of all pertinent information about the patient (such as the history and physical, record of course of treatment in hospital, laboratory tests, medication lists, advanced directives, functional, psychological, social, and other assessments), and the discharge summary should be completed before or at the time of transfer of the patient to another setting. Patients should not be accepted by the new setting without a copy of this patient information and complete instructions for continued care. (8) The AMA supports the position that the care of

the patient treated and discharged from a treating facility is done through mutual consent of the patient and the physician; and (9) Policy programs by Congress regarding patient discharge timing for specific types of treatment or procedures be discouraged.

CSA Rep. 4, A-96, Reaffirmation I-96; Modified by Res. 216, A-97; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: BOT Rep. 1, A-08; Reaffirmed: CMS Rep. 07, I-16; Reaffirmed: BOT Rep. 16, A-19

H-165.877: Increasing Coverage for Children

Our AMA: (1) supports appropriate legislation that will provide health coverage for the greatest number of children, adolescents, and pregnant women; (2) recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary interim step toward universal access; (3) places particular emphasis on advocating policies and proposals designed to expand the extent of health expense coverage protection for presently uninsured children and recommends that the funding for this coverage should preferably be used to allow these children, by their parents or legal guardians, to select private insurance rather than being placed in Medicaid programs; (4) supports, and encourages state medical associations to support, a requirement by all states that all insurers in that jurisdiction make available for purchase individual and group health expense coverage solely for children up to age 18; (5) encourages state medical associations to support study by their states of the need to extend coverage under such children's policies to the age of 23; (6) seeks to have introduced or support federal legislation prohibiting employers from conditioning their provision of group coverage including children on the availability of individual coverage for this age group for direct purchase by families; (7) advocates that, in order to be eligible for any federal or state premium subsidies or assistance, the private children's coverage offered in each state should be no less than the benefits provided under Medicaid in that state and allow states flexibility in the basic benefits package; (8) advocates that state and/or federal legislative proposals to provide premium assistance for private children's coverage provide for an appropriately graduated subsidy of premium costs for insurance benefits; (9) supports an increase in the federal and/or state sales tax on tobacco products, with the increased revenue earmarked for an income-related premium subsidy for purchase of private children's coverage; (10) advocates consideration by Congress, and encourage consideration by states, of other sources of financing premium subsidies for children's private coverage; (11) supports and encourages state medical associations and local medical societies to support, the use of school districts as one possible risk pooling mechanism for purchase of children's health insurance coverage, with inclusion of children from birth through school age in the insured group; (12) supports and encourages state medical associations to support, study by states of the actuarial feasibility of requiring pure community rating in the geographic areas or insurance markets in which policies are made available for children; and (13) encourages state medical associations, county medical societies, hospitals, emergency departments, clinics and individual physicians to assist in identifying and encouraging enrollment in Medicaid of the estimated three million children currently eligible for but not covered under this program.

Sub. Res. 208, A-97, CMS Rep.7, A-97; Reaffirmation A-99, Reaffirmed: CMS Rep. 5, I-99; Reaffirmed: Res. 238 and Reaffirmation A-00; Reaffirmation A-02, Reaffirmation A-05; Consolidated: CMS Rep.7, I-05, Reaffirmation A-07; Reaffirmation A-08, Modified: Speakers Rep.2, I-14; Reaffirmed: CMS Rep. 01, A-18

H-290.982: Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured

AMA policy is that our AMA: (1) urges that Medicaid reform not be undertaken in isolation, but rather in conjunction with broader health insurance reform, in order to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients; (2) encourages physicians to participate in efforts to enroll children in adequately funded Medicaid and State Children's Health Insurance Programs using the mechanism of "presumptive eligibility," whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be, in fact, eligible. (3) encourages states to ensure that within their Medicaid programs there is a pluralistic approach to health care financing delivery including a choice of primary care case management, partial capitation models, fee-for-service, medical savings accounts, benefit payment schedules and other approaches; (4) calls for states to create mechanisms for traditional Medicaid providers to continue to participate in Medicaid managed care and in State Children's Health Insurance Programs; (5) calls for states to streamline the enrollment process within their Medicaid programs and State Children's Health Insurance Programs by, for example, allowing mail-in applications, developing shorter application forms, coordinating their Medicaid and welfare (TANF) application processes, and placing eligibility workers in locations where potential beneficiaries work, go to school, attend day care, play, pray, and receive medical care; (6) urges states to administer their Medicaid and SCHIP programs through a single state agency; (7) strongly urges states to undertake, and encourages state medical associations, county medical societies, specialty societies, and individual physicians to take part in, educational and outreach activities aimed at Medicaid-eligible and SCHIP-eligible children. Such efforts should be designed to ensure that children do not go without needed and available services for which they are eligible due to administrative barriers or lack of understanding of the programs; (8) supports requiring states to reinvest savings achieved in Medicaid programs into expanding coverage for uninsured individuals, particularly children. Mechanisms for expanding coverage may include additional funding for the SCHIP earmarked to enroll children to higher percentages of the poverty level; Medicaid expansions; providing premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level; providing some form of refundable, advanceable tax credits inversely related to income; providing vouchers for recipients to use to choose their own health plans; using Medicaid funds to purchase private health insurance coverage; or expansion of Maternal and Child Health Programs. Such expansions must be implemented to coordinate with the Medicaid and SCHIP programs in order to achieve a seamless health care delivery system, and be sufficiently funded to provide incentive for families to obtain adequate insurance coverage for their children; (9) advocates consideration of various funding options for expanding coverage including, but not limited to: increases in sales tax on tobacco products; funds made available through for-profit conversions of health plans and/or facilities; and the application of prospective payment or other cost or utilization management techniques to hospital outpatient services, nursing home services, and home health care services; (10) supports modest co-pays or income-adjusted premium shares for non-emergent, non-preventive services as a means of expanding access to coverage for currently uninsured individuals; (11) calls for CMS to develop better measurement, monitoring, and accountability systems and indices within the Medicaid program in order to assess the effectiveness of the program, particularly under managed care, in meeting the needs of patients. Such standards and measures should be linked to health outcomes and access to care;

- (12) supports innovative methods of increasing physician participation in the Medicaid program and thereby increasing access, such as plans of deferred compensation for Medicaid providers. Such plans allow individual physicians (with an individual Medicaid number) to tax defer a specified percentage of their Medicaid income;
 - (13) supports increasing public and private investments in home and community-based care, such as adult day care, assisted living facilities, congregate living facilities, social health maintenance organizations, and respite care;
 - (14) supports allowing states to use long-term care eligibility criteria which distinguish between persons who can be served in a home or community-based setting and those who can only be served safely and cost-effectively in a nursing facility. Such criteria should include measures of functional impairment which take into account impairments caused by cognitive and mental disorders and measures of medically related long-term care needs;
 - (15) supports buy-ins for home and community-based care for persons with incomes and assets above Medicaid eligibility limits; and providing grants to states to develop new long-term care infrastructures and to encourage expansion of long-term care financing to middle-income families who need assistance;
 - (16) supports efforts to assess the needs of individuals with intellectual disabilities and, as appropriate, shift them from institutional care in the direction of community living;
 - (17) supports case management and disease management approaches to the coordination of care, in the managed care and the fee-for-service environments;
 - (18) urges CMS to require states to use its simplified four-page combination Medicaid / Children's Health Insurance Program (CHIP) application form for enrollment in these programs, unless states can indicate they have a comparable or simpler form; and
 - (19) urges CMS to ensure that Medicaid and CHIP outreach efforts are appropriately sensitive to cultural and language diversities in state or localities with large uninsured ethnic populations.
- BOT Rep. 31, I-97, Reaffirmed by CMS Rep. 2, A-98; Reaffirmation A-99 and Reaffirmed: Res. 104, A-99; Appended: CMS Rep 2, A-99, Reaffirmation A-00; Appended: CMS Rep. 6, A-01, Reaffirmation A-02; Modified: CMS Rep. 8, A-03; Reaffirmed: CMS Rep. 1, A-05, Reaffirmation A-05; Reaffirmation A-07, Modified: CMS Rep. 8, A-08; Reaffirmation A-11, Modified: CMS Rep. 3, I-11; Reaffirmed: CMS Rep. 02, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 406
(N-21)

Introduced by: Resident and Fellow Section

Subject: Addressing Gaps in Patient and Provider Knowledge to Increase HPV Vaccine Uptake and Prevent HPV-Associated Oropharyngeal Cancer

Referred to: Reference Committee D

1 Whereas, The annual incidence of human papilloma virus (HPV)-associated oropharyngeal
2 squamous cell carcinoma (OPSCC) in the United States has risen steadily over the past several
3 decades¹; and

4
5 Whereas, The majority of new OPSCC diagnoses are associated with underlying oropharyngeal
6 HPV infection¹; and

7
8 Whereas, OPSCC now accounts for the largest burden of HPV-associated cancer diagnoses in
9 the United States, with over 80% of cases occurring in men²; and

10
11 Whereas, HPV-16 accounts for 90 to 95% of HPV-associated OPSCC³; and

12
13 Whereas, All Food and Drug Administration-approved HPV vaccines demonstrate efficacy
14 against HPV-16³; and

15
16 Whereas, While HPV vaccination rates are overall improving, only 54.2% of adolescents aged
17 13-17 years had completed the HPV vaccine series in 2019⁴; and

18
19 Whereas, Despite equivalent vaccine schedule recommendations from the Centers for Disease
20 Control and Prevention, vaccine uptake among males remains lower than females⁵; and

21
22 Whereas, Awareness regarding the association between HPV infection and OPSCC remains
23 low among pediatricians, and public awareness is minimal, with only 0.8% of respondents in an
24 online survey of 2,126 adults identifying HPV as a risk factor for mouth and throat cancer^{6,7}; and

25
26 Whereas, The strength and comprehensiveness of the healthcare provider's recommendation
27 are frequently cited as key factors influencing both parents and adult patients to pursue HPV
28 vaccination⁸⁻¹¹; and

29
30 Whereas, There is no evidence-based screening test available for OPSCC; and

31
32 Whereas, Our AMA supports increased physician and public awareness about HPV-associated
33 diseases, as well as the availability of the HPV vaccine (policy H-440.872); therefore be it

1 RESOLVED, That our American Medical Association amend current policy H-440.872 "HPV
2 Vaccine and Cervical Cancer Prevention Worldwide," by addition and deletion to read as
3 follows:
4

- 5 1. Our AMA (a) urges physicians to educate themselves and their patients
6 about all HPV-mediated and associated diseases, HPV vaccination, as well
7 as routine cervical cancer screening; and (b) encourages the development
8 and funding of programs targeted at HPV vaccine introduction and cervical
9 cancer screening in countries without organized cervical cancer screening
10 programs.
11
- 12 2. Our AMA will intensify efforts to improve awareness and understanding
13 about all HPV-mediated and associated diseases, the availability and
14 efficacy of HPV vaccinations, and the need for routine cervical cancer
15 screening in the general public.
16
- 17 3. Our AMA (a) encourages the integration of HPV vaccination and routine
18 cervical cancer screening into all appropriate health care settings and visits
19 for adolescents and young adults, (b) supports the availability of the HPV
20 vaccine and routine cervical cancer screening to appropriate patient groups
21 that benefit most from preventive measures, including but not limited to low-
22 income and pre-sexually active populations, and (c) recommends HPV
23 vaccination for all groups for whom the federal Advisory Committee on
24 Immunization Practices recommends HPV vaccination.
25
- 26 4. Our AMA supports efforts (a) to enhance awareness in the general public
27 regarding the association between HPV infection and oropharyngeal
28 squamous cell carcinoma, and (b) to further develop oropharyngeal
29 squamous cell carcinoma screening tools. (Modify Current HOD Policy);
30 and be it further
31

32 RESOLVED, That our AMA amend current policy H-440.872 "HPV Vaccine and Cervical Cancer
33 Prevention Worldwide" by title change to "HPV Vaccine and Cervical HPV-mediated Cancer
34 Prevention Worldwide"; (Modify Current HOD Policy) and be it further
35

36 RESOLVED, That our AMA reaffirm Policies D-170.995 "Human Papillomavirus (HPV) Inclusion
37 in our School Education Curricula," and D-440.955 "Insurance Coverage for HPV Vaccine."
38 (Reaffirm HOD Policy)

Fiscal Note: Minimal - less than \$1,000

Received: 10/12/21

AUTHORS STATEMENT OF PRIORITY

The AMA has policy regarding HPV-associated diseases including cervical cancer, but with the increase in HPV-associated oropharyngeal cancer amongst our patients, having increased awareness amongst physicians and patients will help to address this incidence and allow the AMA to continue its work in advocating for evidence-based medicine.

1. Pytynia KB, Dahlstrom KR, Sturgis EM. Epidemiology of HPV-associated oropharyngeal cancer. *Oral Oncol.* 2014;50(5):380-386. doi:10.1016/j.oraloncology.2013.12.019
2. Centers for Disease Control and Prevention. Cancers Associated with Human Papillomavirus, United States—2013–2017. USCS Data Brief, no 18. Atlanta, GA: Centers for Disease Control and Prevention, US Department of Health and Human Services; 2020.
3. Chaturvedi AK, Engels EA, Pfeiffer RM, et al. Human papillomavirus and rising oropharyngeal cancer incidence in the United States. *J Clin Oncol.* 2011;29(32):4294-4301. doi:10.1200/JCO.2011.36.4596
4. Elam-Evans LD, Yankey D, Singleton JA, et al. National, Regional, State, and Selected Local Area Vaccination Coverage Among Adolescents Aged 13-17 Years - United States, 2019. *MMWR Morb Mortal Wkly Rep.* 2020;69(33):1109-1116.
5. Timbang MR, Sim MW, Bewley AF, Farwell DG, Mantravadi A, Moore MG. HPV-related oropharyngeal cancer: a review on burden of the disease and opportunities for prevention and early detection. *Hum Vaccin Immunother.* 2019;15(7-8):1920-1928. doi:10.1080/21645515.2019.1600985
6. Luryi AL, Yarbrough WG, Niccolai LM, et al. Public awareness of head and neck cancers: a cross-sectional survey. *JAMA Otolaryngol Head Neck Surg.* 2014;140(7):639-646. doi:10.1001/jamaoto.2014.867
7. Mehta V, Holmes S, Master A, Leblanc B, Caldito LG, Bocchini J Jr. Knowledge of HPV-Related Oropharyngeal Cancer and Use of Human Papillomavirus Vaccines by Pediatricians in Louisiana. *J La State Med Soc.* 2017;169(2):37-42.
8. Holman DM, Benard V, Roland KB, Watson M, Liddon N, Stokley S. Barriers to human papillomavirus vaccination among US adolescents: a systematic review of the literature. *JAMA Pediatr* 2014; 168:76-82.
9. Rosenthal SL, Weiss TW, Zimet GD, Ma L, Good MB, Vichnin MD. Predictors of HPV vaccine uptake among women aged 19-26: importance of a physician's recommendation. *Vaccine* 2011; 29:890-5.
10. Lu PJ, Williams WW, Li J, et al. Human papillomavirus vaccine initiation and awareness: U.S. young men in the 2010 National Health Interview Survey. *Am J Prev Med* 2013; 44:330-8.
11. McRee AL, Reiter PL, Chantala K, Brewer NT. Does framing human papillomavirus vaccine as preventing cancer in men increase vaccine acceptability? *Cancer epidemiology, biomarkers & prevention: a publication of the American Association for Cancer Research, cosponsored by the American Society of Preventive Oncology* 2010; 19:1937-44

RELEVANT AMA POLICY

HPV Vaccine and Cervical Cancer Prevention Worldwide H-440.872

1. Our AMA (a) urges physicians to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine cervical cancer screening; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and cervical cancer screening in countries without organized cervical cancer screening programs.
2. Our AMA will intensify efforts to improve awareness and understanding about HPV and associated diseases, the availability and efficacy of HPV vaccinations, and the need for routine cervical cancer screening in the general public.
3. Our AMA (a) encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits for adolescents and young adults, (b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations, and (c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination.

Citation: Res. 503, A-07Appended: Res. 6, A-12

Human Papillomavirus (HPV) Inclusion in our School Education Curricula D-170.995

Our AMA will: (1) strongly urge existing school health education programs to emphasize the high prevalence of human papillomavirus in all genders, the causal relationship of HPV to cancer and genital lesions, and the importance of routine pap tests in the early detection of cancer; (2) urge that students and parents be educated about HPV and the availability of the HPV vaccine; and (3) support appropriate stakeholders to increase public awareness of HPV vaccine effectiveness for all genders against HPV-related cancers.

Citation: Res. 418, A-06Reaffirmed: CSAPH Rep. 01, A-16Modified: Res. 404, A-18

Insurance Coverage for HPV Vaccine D-440.955

Our AMA: (1) supports the use and administration of Human Papillomavirus vaccine as recommended by the Advisory Committee on Immunization Practices; (2) encourages insurance carriers and other payers to appropriately cover and adequately reimburse the HPV vaccine as a standard policy benefit for medically eligible patients; and (3) will advocate for the development of vaccine assistance programs to meet HPV vaccination needs of uninsured and underinsured populations.

Citation: Res. 818, I-06Reaffirmed: CMS Rep. 01, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 407
(N-21)

Introduced by: Resident and Fellow Section

Subject: Traumatic Brain Injury and Access to Firearms

Referred to: Reference Committee D

1 Whereas, Traumatic brain injury (TBI) is a prevalent issue in society with approximately 1.7
2 million incidents annually, a third of which contribute to injury-related deaths in the US; and
3

4 Whereas, Although extensive research is conducted in the field to better assess interventions in
5 limiting consecutive brain damage after the initial head trauma, the actual mechanisms of neural
6 recovery are poorly understood; and
7

8 Whereas, An increased focus is placed on therapies to treat individuals who have sustained
9 brain injury and to improve their long-term recovery as many of these individuals suffer from
10 significant cognitive, behavioral, and communicative disabilities which interfere with their daily
11 activities and lives; and
12

13 Whereas, Approximately 20% of patients develop long-term medical complications such as
14 epilepsy, Alzheimer's disease, Parkinson's syndrome, and depression in addition to their initial
15 medical treatments after sustaining injury which costs the nation's healthcare more than \$56
16 billion each year; and
17

18 Whereas, There are some very important policies that the AMA has supported that relate to
19 gun violence and injury prevention. In H-145-997, the AMA acknowledges that firearms are a
20 public health problem, encourages research into innovative manufacturing techniques,
21 advocates for additional funding toward developing new safer weapon designs, and promotes
22 education programs for firearm safety and prevention; and
23

24 Whereas, Our AMA has since developed several other corollary policies surrounding firearm
25 violence prevention and intervention. Some of these policies asked for the establishment of
26 preventative measures which would target the sale and manufacture of guns, specifically to
27 decrease the availability. AMA policies calling for a waiting period preceding any firearm
28 purchase include H-145.991, H-145.992, and H-145.996. Policies calling for the imposition of
29 background checks for handgun purchases include H-145.991, H-145.996, H-145.970, and
30 H-145.972; and
31

32 Whereas, TBI is a wide-ranging diagnosis that encompasses a variety of phenotypes and
33 amending current policy would be more effective if intentionally defines TBI and high-risk
34 individuals; and
35

36 Whereas, Our AMA has policy supporting screening by physicians for a number of public
37 health and health concerns, including, not limited to: intimate partner and family violence (D-
38 515.980, H- 515.981), potential violent behavior within mental health assessments (H-
39 145.975), alcohol and drug use (H-30.942, H-95.922), pediatric mental health screening (H-

345.977), social and economic risk factors (H-160.896), maternal depression (D-420.991), and adverse childhood events (H-515.952); and

Whereas, While our AMA has policy regarding sports-related injuries and concussions, which includes TBI, there is not any policy that involves the importance of screening for active symptoms or history of TBI in settings such as primary care, pediatrics, psychiatry, neurology, schools, homeless shelters, within the criminal justice system, and athletic communities; and

Whereas, Failing to identify TBI may have severe consequences. Screening tools like the Ohio State University TBI-ID Method (OSU-TBI-ID), Brain Injury Screening Questionnaire (BISQ), HELPS Brain Injury Screening Tool, and Brain Check Survey may aid in the identification of those at risk for more severe consequences, and allow for supportive measures such as vocational rehabilitation or cognitive rehabilitation; therefore be it

RESOLVED, That our American Medical Association reaffirm Policy H-145.972 "Firearms and High-Risk Individuals" (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA amend Policy H-145.975 "Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care," by addition and deletion to read as follows:

...2. Our AMA supports initiatives designed to enhance access to the comprehensive assessment and treatment of mental illness health and concurrent substance use disorders; in patients with traumatic brain injuries, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.

3. Our AMA work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to evaluate the risk of potential violent behavior in patients with traumatic brain injuries.

~~3.~~ 4. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.

(Modify Current HOD Policy)

Fiscal Note: Minimal - less than \$1,000

Received: 10/12/21

AUTHORS STATEMENT OF PRIORITY

This policy is lower priority. It will update current AMA policies to better address the burden traumatic brain injuries place on patients and ensure appropriate access to dangerous weapons.

RELEVANT AMA POLICY

Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975

1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.

2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.

3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.

Citation: Sub. Res. 221, A-13; Appended: Res. 416, A-14; Reaffirmed: Res. 426, A-16; Reaffirmed: BOT Rep. 28, A-18; Reaffirmation: A-18; Modified: CSAPH Rep. 04, A-18; Reaffirmation: I-18

Screening and Brief Interventions For Alcohol Problems H-30.942

Our AMA in conjunction with medical schools and appropriate specialty societies advocates curricula, actions and policies that will result in the following steps to assure the health of patients who use alcohol: (a) Primary care physicians should establish routine alcohol screening procedures (e.g., CAGE) for all patients, including children and adolescents as appropriate, and medical and surgical subspecialists should be encouraged to screen patients where undetected alcohol use could affect care. (b) Primary care physicians should learn how to conduct brief intervention counseling and motivational interviewing. Such training should be incorporated into medical school curricula and be subject to academic evaluation. Physicians are also encouraged to receive additional education on the pharmacological treatment of alcohol use disorders and co-morbid problems such as depression, anxiety, and post-traumatic stress disorder. (c) Primary care clinics should establish close working relationships with alcohol treatment specialists, counselors, and self-help groups in their communities, and, whenever feasible, specialized alcohol and drug treatment programs should be integrated into the routine clinical practice of medicine.

Citation: CSA Rep. 14, I-99; Reaffirmation I-01; Modified: CSAPH Rep. 1, A-11; Reaffirmation: A-18

Substance Use and Substance Use Disorders H-95.922

Our AMA:

(1) will continue to seek and participate in partnerships designed to foster awareness and to promote screening, diagnosis, and appropriate treatment of substance misuse and substance use disorders;

(2) will renew efforts to: (a) have substance use disorders addressed across the continuum of medical education; (b) provide tools to assist physicians in screening, diagnosing, intervening, and/or referring patients with substance use disorders so that they have access to treatment; (c) develop partnerships with other organizations to promote national policies to prevent and treat these illnesses, particularly in adolescents and young adults; and (d) assist physicians in becoming valuable resources for the general public, in order to reduce the stigma and enhance knowledge about substance use disorders and to communicate the fact that substance use disorder is a treatable disease; and

(3) will support appropriate federal and state legislation that would enhance the prevention, diagnosis, and treatment of substance use disorders.

Citation: CSAPH Rep. 01, A-18; Reaffirmed: BOT Rep. 14, I-20

Violence Prevention H-145.970

Our AMA: (1) encourages the enactment of state laws requiring the reporting of all classes of prohibited individuals, as defined by state and federal law, to the National Instant Criminal Background Check System (NICS); (2) supports federal funding to provide grants to states to improve NICS reporting; and (3) encourages states to automate the reporting of relevant information to NICS to improve the quality and timeliness of the data.

Citation: BOT Rep. 11, I-18

Firearms and High-Risk Individuals H-145.972

Our AMA supports: (1) the establishment of laws allowing family members, intimate partners, household members, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms; (3) expanding domestic violence restraining orders to include dating partners; (4) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons; (5) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and (6) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals.

Citation: CSAPH Rep. 04, A-18; Reaffirmed: BOT Rep. 11, I-18

Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975

1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.

2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.

3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.

Citation: Sub. Res. 221, A-13; Appended: Res. 416, A-14; Reaffirmed: Res. 426, A-16; Reaffirmed: BOT Rep. 28, A-18; Reaffirmation: A-18; Modified: CSAPH Rep. 04, A-18; Reaffirmation: I-18

Improving Pediatric Mental Health Screening H-345.977

Our AMA: (1) recognizes the importance of, and supports the inclusion of, mental health (including substance use, abuse, and addiction) screening in routine pediatric physicals; (2) will work with mental health organizations and relevant primary care organizations to disseminate recommended and validated tools for eliciting and addressing mental health (including substance use, abuse, and addiction) concerns in primary care settings; and (3) recognizes the importance of developing and implementing school-based mental health programs that ensure at-risk children/adolescents access to appropriate mental health screening and treatment services and supports efforts to accomplish these objectives.

Citation: Res. 414, A-11; Appended: BOT Rep. 12, A-14; Reaffirmed: Res. 403, A-18

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.

Citation: BOT Rep. 39, A-18; Reaffirmed: CMS Rep. 10, A-19

Adverse Childhood Experiences and Trauma-Informed Care H-515.952

1. Our AMA recognizes trauma-informed care as a practice that recognizes the widespread impact of trauma on patients, identifies the signs and symptoms of trauma, and treats patients by fully integrating knowledge about trauma into policies, procedures, and practices and seeking to avoid re-traumatization.

2. Our AMA supports:

- a. evidence-based primary prevention strategies for Adverse Childhood Experiences (ACEs);
- b. evidence-based trauma-informed care in all medical settings that focuses on the prevention of poor health and life outcomes after ACEs or other trauma at any time in life occurs;
- c. efforts for data collection, research and evaluation of cost-effective ACEs screening tools without additional burden for physicians;
- d. efforts to educate physicians about the facilitators, barriers and best practices for providers implementing ACEs screening and trauma-informed care approaches into a clinical setting; and
- e. funding for schools, behavioral and mental health services, professional groups, community and government agencies to support patients with ACEs or trauma at any time in life.

Citation: Res. 504, A-19

Improving Screening and Treatment Guidelines for Intimate Partner Violence (IPV) Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals (LGBTQ) D-515.980

Our AMA will: (1) promote crisis resources for LGBTQ patients that cater to the specific needs of LGBTQ survivors of IPV; (2) encourage physicians to familiarize themselves with resources available in their communities for LGBTQ survivors of IPV; (3) advocate for federal funding to support programs and services for survivors of IPV that do not discriminate against underserved communities, including on the basis of sexual orientation and gender identity; (4) encourage research on intimate partner violence in the LGBTQ community to include studies on the prevalence, the accuracy of screening tools, effectiveness of early detection and interventions, as well as the benefits and harms of screening; and (5) encourage the dissemination of research to educate physicians and the community regarding the prevalence of IPV in the LGBTQ population, the accuracy of screening tools, effectiveness of early detection and interventions, as well as the benefits and harms of screening.

Citation: Res. 903, I-17; Modified: CSAPH Rep. 01, I-18

Family Violence-Adolescents as Victims and Perpetrators H-515.981

The AMA (1) (a) encourages physicians to screen adolescents about a current or prior history of maltreatment. Special attention should be paid to screening adolescents with a history of alcohol and drug misuse, irresponsible sexual behavior, eating disorders, running away, suicidal behaviors, conduct disorders, or psychiatric disorders for prior occurrences of maltreatment; and (b) urges physicians to consider issues unique to adolescents when screening youths for abuse or neglect. (2) encourages state medical society violence prevention committees to work with child protective service agencies to develop specialized services for maltreated adolescents, including better access to health services, improved foster care, expanded shelter and independent living facilities, and treatment programs. (3) will investigate research and resources on effective parenting of adolescents to identify ways in which physicians can promote parenting styles that reduce stress and promote optimal development. (4) will alert the national school organizations to the increasing incidence of adolescent maltreatment and the need for training of school staff to identify and refer victims of maltreatment. (5) urges youth correctional facilities to screen incarcerated youth for a current or prior history of abuse or neglect and to refer maltreated youth to appropriate medical or mental health treatment programs. (6) encourages the National Institutes of Health and other organizations to expand continued research on adolescent initiation of violence and abuse to promote understanding of how to prevent future maltreatment and family violence.

Citation: CSA Rep. I, A-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13

Improving Treatment and Diagnosis of Maternal Depression Through Screening and State-Based Care Coordination D-420.991

Our AMA: (1) will work with stakeholders to encourage the implementation of a routine protocol for depression screening in pregnant and postpartum women presenting alone or with their child during prenatal, postnatal, pediatric, or emergency room visits; (2) encourages the development of training materials related to maternal depression to advise providers on appropriate treatment and referral pathways; and (3) encourages the development of state-based care coordination programs (e.g., staffing a psychiatrist and care coordinator) to assure appropriate referral, treatment and access to follow-up maternal mental health care.

Citation: Res. 910, I-17

Waiting Periods for Firearm Purchases H-145.991

The AMA supports using its influence in matters of health to effect passage of legislation in the Congress of the U.S. mandating a national waiting period that allows for a police background and positive identification check for anyone who wants to purchase a handgun from a gun dealer anywhere in our country.

Citation: Sub. Res. 34, I-89; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Modified: Res. 401, A-17; Reaffirmation: A-18; Reaffirmation: I-18

Waiting Period Before Gun Purchase H-145.992

The AMA supports legislation calling for a waiting period of at least one week before purchasing any form of firearm in the U.S.

Citation: Res. 171, A-89; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Reaffirmation: A-18

Firearm Availability H-145.996

1. Our AMA: (a) advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.

2. Our AMA supports requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms.

3. Our AMA supports "gun violence restraining orders" for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as "red-flag" laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and "red-flag" laws, we also support the importance of due process so that individuals can petition for their rights to be restored.

Citation: Res. 140, I-87; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: BOT Rep. 12, A-16; Appended: Res. 433, A-18; Reaffirmation: I-18; Modified: BOT Rep. 11, I-18

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997

1. Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths.

Therefore, the AMA:

(A) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;

(B) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;

(C) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;

(D) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;

(E) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;

(F) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and

(G) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.

2. Our AMA will advocate for firearm safety features, including but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or misappropriation of the weapon by a non-registered user; and support legislation and regulation to standardize the use of these firearm safety features on weapons sold for non-military and non-peace officer use within the U.S.; with the aim of establishing manufacturer liability for the absence of safety features on newly manufactured firearms.

Citation: CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appended: Res. 403, I-99; Reaffirmation A-07; Reaffirmation A-13; Appended: Res. 921, I-13; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmation: A-18; Reaffirmation: I-18; Appended: Res. 405, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 408
(N-21)

Introduced by: New York

Subject: Ensuring Affordability and Equity in COVID-19 Vaccine Boosters

Referred to: Reference Committee D

1 Whereas, Development of COVID-19 vaccine was developed in record time in response to a
2 worldwide pandemic emergency; and
3

4 Whereas, The federal government funded development and purchase of COVID-19 vaccine for
5 no cost distribution to the states, allowing the possibility of equity in the administration of this
6 precious commodity; and
7

8 Whereas, Booster doses are likely to be needed to maintain the health and economy of our
9 country; and
10

11 Whereas, Such boosters must be equitably available to all willing recipients in the states around
12 our country to maintain herd immunity; therefore be it
13

14 RESOLVED, That our American Medical Association support the public purchase and cost-free
15 distribution of COVID-19 booster vaccine doses. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000

Received: 10/11/21

AUTHORS STATEMENT OF PRIORITY

This resolution is critically important to ensure the health of America. The COVID-19 booster has been debated and has been authorized by the CDC and FDA for those with compromised immune systems and those age 65 and older. Indications are that immune response from previous vaccinations does not last well in all patients and booster shots will be required. Many patients have already begun to receive their Covid booster shots. Physicians and the organizations which represent us have a responsibility to ensure that booster shots are available to those needing it, and indeed with time to all Americans. The AMA must take a position supporting the availability of booster shots without cost to those needing and/or wanting them.

RELEVANT AMA POLICY

COVID-19 Vaccination Rollout to Emergency Departments and Urgent Care Facilities D-440.918

Our AMA will work with other relevant organizations and stakeholders to lobby the current Administration for the distribution of COVID-19 vaccinations to our nation's emergency departments and urgent care facilities during the COVID-19 public health emergency.

Citation: Res. 228, A-21

Financing of Adult Vaccines: Recommendations for Action H-440.860

1. Our AMA supports the concepts to improve adult immunization as advanced in the Infectious Diseases Society of America's 2007 document "Actions to Strengthen Adult and Adolescent Immunization Coverage in the United States," and support the recommendations as advanced by the National Vaccine Advisory Committee's 2008 white paper on pediatric vaccine financing.
2. Our AMA will advocate for the following actions to address the inadequate financing of adult vaccination in the United States:

Provider-related

- a. Develop a data-driven rationale for improved vaccine administration fees.
- b. Identify and explore new methods of providing financial relief for adult immunization providers through, for example, vaccine company replacement systems/deferred payment/funding for physician inventories, buyback for unused inventory, and patient assistance programs.
- c. Encourage and facilitate adult immunization at all appropriate points of patient contact; e.g., hospitals, visitors to long-term care facilities, etc.
- d. Encourage counseling of adults on the importance of immunization by creating a mechanism through which immunization counseling alone can be reimbursed, even when a vaccine is not given.

Federal-related

- a. Increase federal resources for adult immunization to: (i) Improve Section 317 funding so that the program can meet its purpose of improving adult immunizations; (ii) Provide universal coverage for adult vaccines and minimally, uninsured adults should be covered; (iii) Fund an adequate universal reimbursement rate for all federal and state immunization programs.
- b. Optimize use of existing federal resources by, for example: (i) Vaccinating eligible adolescents before they turn 19 years of age to capitalize on VFC funding; (ii) Capitalizing on public health preparedness funding.
- c. Ease federally imposed immunization burdens by, for example: (i) Providing coverage for Medicare-eligible individuals for all vaccines, including new vaccines, under Medicare Part B; (ii) Creating web-based billing mechanisms for physicians to assess coverage of the patient in real time and handle the claim, eliminating out-of-pocket expenses for the patient; (iii) Simplifying the reimbursement process to eliminate payment-related barriers to immunization.
- d. The Centers for Medicare & Medicaid Services should raise vaccine administration fees annually, synchronous with the increasing cost of providing vaccinations.

State-related

- a. State Medicaid programs should increase state resources for funding vaccines by, for example: (i) Raising and funding the maximum Medicaid reimbursement rate for vaccine administration fees; (ii) Establishing and requiring payment of a minimum reimbursement rate for administration fees; (iii) Increasing state contributions to vaccination costs; and (iv) Exploring the possibility of mandating immunization coverage by third party payers.
- b. Strengthen support for adult vaccination and appropriate budgets accordingly.

Insurance-related

1. Provide assistance to providers in creating efficiencies in vaccine management by: (i) Providing model vaccine coverage contracts for purchasers of health insurance; (ii) Creating simplified rules for eligibility verification, billing, and reimbursement; (iii) Providing vouchers to

patients to clarify eligibility and coverage for patients and providers; and (iv) Eliminating provider/public confusion over insurance payment of vaccines by universally covering all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines.

- b. Increase resources for funding vaccines by providing first-dollar coverage for immunizations.
- c. Improve accountability by adopting performance measurements.
- d. Work with businesses that purchase private insurance to include all ACIP-recommended immunizations as part of the health plan.
- e. Provide incentives to encourage providers to begin immunizing by, for example: (i) Including start up costs (freezer, back up alarms/power supply, reminder-recall systems, etc.) in the formula for reimbursing the provision of immunizations; (ii) Simplifying payment to and encouraging immunization by nontraditional providers; (iii) Facilitating coverage of vaccines administered in complementary locations (e.g., relatives visiting a resident of a long-term care facility).

Manufacturer-related

Market stability for adult vaccines is essential. Thus: (i) Solutions to the adult vaccine financing problem should not deter research and development of new vaccines; (ii) Solutions should consider the maintenance of vibrant public and private sector adult vaccine markets; (iii) Liability protection for manufacturers should be assured by including Vaccine Injury Compensation Program coverage for all ACIP-recommended adult vaccines; (iv) Educational outreach to both providers and the public is needed to improve acceptance of adult immunization.

3. Our AMA will conduct a survey of small- and middle-sized medical practices, hospitals, and other medical facilities to identify the impact on the adult vaccine supply (including influenza vaccine) that results from the large contracts between vaccine manufacturers/distributors and large non-government purchasers, such as national retail health clinics, other medical practices, and group purchasing programs, with particular attention to patient outcomes for clinical preventive services and chronic disease management.

Citation: CSAPH Rep. 4, I-08; Reaffirmation I-10; Reaffirmation: I-12; Reaffirmation I-14;
Reaffirmed: CMS Rep. 3, I-20

An Urgent Initiative to Support COVID-19 Vaccination and Information Programs D-440.921

Our AMA will institute a program to promote the integrity of a COVID-19 vaccination information program by: (1) educating physicians on speaking with patients about COVID-19 infection and vaccination, bearing in mind the historical context of “experimentation” with vaccines and other medication in communities of color, and providing physicians with culturally appropriate patient education materials; (2) educating the public about up-to-date, evidence-based information regarding COVID-19 and associated infections as well as the safety and efficacy of COVID-19 vaccines, by countering misinformation and building public confidence; (3) forming a coalition of health care and public health organizations inclusive of those respected in communities of color committed to developing and implementing a joint public education program promoting the facts about, promoting the need for, and encouraging the acceptance of COVID-19 vaccination; (4) supporting ongoing monitoring of COVID-19 vaccines to ensure that the evidence continues to support safe and effective use of vaccines among recommended populations; and (5) educating physicians and other healthcare professionals on means to disseminate accurate information and methods to combat medical misinformation online.

Citation: Res. 408, I-20; Reaffirmed: Res. 228, A-21 Reaffirmed: Res. 421, A-21