

American Medical Association Minority Affairs Consortium

Policy Compendium

As of October 2007

Foreword

This booklet contains policy excerpts from the AMA's PolicyFinder that are of special interest to the Minority Affairs Consortium and does not represent the complete list of AMA policies. For a complete listing of all AMA policies, consult the AMA's PolicyFinder at <http://www.ama-assn.org/ama/noindex/category/11760.html>.

TABLE OF CONTENTS

Foreword.....	i
Anti-Discrimination	1
Cultural Competence	1
Diversity / Medical Education	3
Health Insurance.....	8
HIV.....	9
Interpreter Services.....	10
Medicaid	10
Mental Health.....	11
Minority Health / Racial and Ethnic Health Disparities.....	11
⇒ Obesity	
⇒ Pay-for-Performance Programs	
Minority Patient Care and Research.....	17
Physician-Specific Health Care Data.....	20
⇒ Race/Ethnicity Data Collection	
Population-Based Health Care.....	20
⇒ Hispanics/Latinos	20
⇒ Asian-Americans and Pacific Islanders.....	21
⇒ Native Americans/American Indians	21
Undocumented/Immigrant Patients	24
Violence and Abuse	24
Visa and Immigration	24
AMA: House of Delegates.....	25



AMA Policy Compendium on Issues Relating to Minority Health and Minority Physicians

Anti-Discrimination

B-1.50 Discrimination

Membership in any category of the American Medical Association or in any of its constituent associations shall not be denied or abridged because of sex, color, creed, race, religion, disability, ethnic origin, national origin, sexual orientation, age, or for any other reason unrelated to character or competence. Nor shall membership in any category of the AMA or in any of its constituent associations be denied to any person who meets the requirements for membership as set forth in these Bylaws and in the bylaws of the applicant's respective constituent association. In considering applicants for membership, information as to the character, ethics, professional status, and professional activities of the individual may be considered.

H-65.990 Civil Rights Restoration

The AMA reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age. (BOT Rep. LL, I-86; Amended by Sunset Report, I-96; Modified: Res. 410, A-03)

H-65.992 Continued Support of Human Rights and Freedom

Our AMA continues (1) to support the dignity of the individual, human rights and the sanctity of human life, and (2) to oppose any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies. (Sub. Res. 107, A-85; Modified by CLRPD Rep. 2, I-95; Reaffirmation A-00; Reaffirmation A-05; Modified: BOT Rep. 11, A-07)

H-215.965 Hospital Visitation Privileges for GLBT Patients

Our American Medical Association encourage all hospitals to add to their rules and regulations, and to their Patient's Bill of Rights, language permitting same sex couples and their dependent children the same hospital visitation privileges offered to married couples. (OMSS Res. 733, A-06)

Cultural Competence

D-150.993 Obesity and Culturally Competent Dietary and Nutritional Guidelines

Our AMA and its Minority Affairs Consortium will study and recommend improvements to the US Department of Agriculture's Dietary Guidelines for Americans and Food Guide Pyramid so these resources fully incorporate cultural and socioeconomic considerations as well as racial and ethnic health disparity information in order to reduce obesity rates in the minority

community, and report its findings and recommendations to the AMA House of Delegates by the 2004 Annual Meeting. (Res. 428, A-03)

D-440.978 Culturally Responsive Dietary and Nutritional Guidelines

Our AMA and its Minority Affairs Consortium will: (1) encourage the United States Department of Agriculture (USDA) Food Guide Pyramid Reassessment Team to include culturally effective guidelines that include listing an array of ethnic staples and use multicultural symbols to depict serving size in their revised Dietary Guidelines for Americans and Food Guide Pyramid; (2) seek ways to assist physicians with applying the final USDA Dietary Guidelines for Americans and Food Guide Pyramid in their practices as appropriate; and (3) monitor existing research and identify opportunities where organized medicine can impact issues related to obesity, nutritional and dietary guidelines, racial and ethnic health disparities as well as assist physicians with delivering culturally effective care. (BOT Rep. 6, A-04)

H-295.874 Educating Medical Students for Cultural Competence: What do we know?

Our AMA recommends studying the integration of cultural competence training in graduate and continuing medical education and publicizing successful models. (CME Rep. 11, A-06)

H-295.897 Enhancing the Cultural Competence of Physicians

The AMA will: (1) continue to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula; (2) continue research into the need for and effectiveness of training in cultural competence, using existing mechanisms such as the annual medical education surveys and focus groups at regularly scheduled meetings; (3) form an expert national advisory panel (including representation from the AMA Minority Affairs Consortium and International Medical Graduate Section) to consult on all areas related to enhancing the cultural competence of physicians, including developing a list of resources on cultural competencies for physicians and maintaining it and related resources in an electronic database; (4) assist physicians in obtaining information about and/or training in culturally effective health care through development of an annotated resource database on the AMA home page, with information also available through postal distribution on diskette and/or CD-ROM; and (5) seek external funding to develop a five-year program for promoting cultural competence in and through the education of physicians, including a critical review and comprehensive plan for action, in collaboration with the AMA Consortium on Minority Affairs and the medical associations that participate in the consortium (National Medical Association, National Hispanic Medical Association, and Association of American Indian Physicians,) the American Medical Women's Association, the American Public Health Association, the American Academy of Pediatrics, and other appropriate groups. The goal of the program would be to restructure the continuum of medical education and staff and faculty development programs to deliberately emphasize cultural competence as part of professional practice. (CME Rep. 5, A-98)

H-295.905 Promoting Culturally Competent Health Care

The AMA encourages medical schools to offer electives in culturally competent health care with the goal of increasing awareness and acceptance of cultural differences between patient and provider. (Res. 306, A-97)

H-350.965 Culturally Effective Health Care

Our AMA renews its commitment to supporting the importance of culturally effective health care in eliminating disparities and to exploring ways to provide physicians with tools for improving the cultural effectiveness of their practices. (Res. 718, I-02)

H-480.963 Folk Remedies Among Ethnic Subgroups

The AMA: (1) does not recommend the sole use of unvalidated folk remedies to treat disease without scientific evidence regarding their safety or efficacy; (2) encourages research to determine the safety and efficacy of folk remedies; (3) physicians should be aware that the use of folk remedies may delay patients from seeking medical attention or receiving conventional therapies with proven benefit for disease treatment and prevention; (4) practicing physicians should routinely ask patients whether they are using folk medicine or family remedies for their symptoms. Physicians can educate patients about the level of scientific information available about the therapy they are using, as well as conventional therapies that are known to be safe and efficacious; and (5) physicians should be aware of folk remedies in use and the level of scientific information available about such remedies, and should include this information when discussing conventional treatments and therapies with their patients. (CSA Rep. 13, A-97)

Diversity / Medical Education**D-200.987 Physician Re-Entry**

Our American Medical Association, in collaboration with appropriate state and specialty societies, the Accreditation Council on Graduate Medical Education, the American Board of Medical Specialties, and the Federation of State Medical Boards study the issue of physician re-entry into practice after a leave of absence from practice or a limitation of certain aspects of practice, including a consideration of issues related to retraining, certification, and credentialing. (Res. 316, A-06)

D-200.985 Strategies for Enhancing Diversity in the Physician Workforce

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: a. Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; b. Diversity or minority affairs offices at medical schools; c. Financial aid programs for students from groups that are underrepresented in medicine; and d. Financial support programs to recruit and develop faculty members from underrepresented groups. 2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas. 3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community. 4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty. 5. Through the identification of models and strategies at the national and state/regional levels, our AMA will study and report back at the 2009 Annual Meeting on the following: a. The status of efforts to assure adequate funding for diversity initiatives; b. The current status of underservice and access to care in the US (regionally and by population); and c. The recruitment and retention of physicians to practice in underserved areas and to work with underserved populations. 6. Our AMA will collaborate with the AAMC, the Educational Commission for Foreign Medical Graduates, and the Federation of State Medical Boards to study the contribution of

international medical graduates to the overall diversity and distribution of the US medical workforce and report at the 2008 Annual Meeting. (CME Rep. 1, I-06)

D-200.988 Strategies for Increasing Diversity in the Health Care Workforce

Our American Medical Association commend the Institute of Medicine on its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and develop recommendations for specific strategies to increase workforce diversity with a report back to the House of Delegates at the 2007 Annual Meeting. (Res. 304, A-06)

D-200.993 Revisions to AMA Policy on the Physician Workforce

Our AMA will, through its Councils, Sections, Minority Affairs Consortium, and other organizations, develop strategies to implement its workforce policy, through research, advocacy, and other relevant means; and collaborate with state and specialty societies and other interested groups to develop a national consensus on physician workforce policy. (CME Rep. 2, I-03; Reaffirmation I-06)

D-275.972 Spoken English Proficiency Component of the United States Medical Licensing Examination

Our AMA will take no action to request the elimination of the Spoken English Proficiency score from the USMLE Step 2 CS. (CME Rep. 8, A-06)

D-350.994 Continued Support for Diversity in Medical Education

Our AMA will publicly state and reaffirm its strong opposition to the reduction of opportunities used to increase the number of minority and premedical students in training. (Res. 325, A-03)

G-610.040 Promoting Diversity

Our AMA encourages: (1) state medical associations and national medical specialty societies to review the composition of their AMA delegations with regard to enhancing diversity. As one means of encouraging greater awareness and responsiveness to diversity, our AMA will prepare and distribute a state-by-state demographic analysis of the House of Delegates, with comparisons to the physician population and to our AMA physician membership every other year starting in 2003; and (2) the Federation (in nominating or sponsoring candidates for leadership positions), the House of Delegates (in electing Council and Board members), and the Board, the Speakers, and the President (in appointing or nominating physicians for service on AMA Councils or in other leadership positions) to consider the need to enhance and promote diversity. (CLRPD Rep. A, A-92; Reaffirmed: CLRPD Rep. 5, I-96; Modified: CLRPD Rep. 2, I-00 ; Consolidated: CLRPD Rep. 3, I-01; Amended: CLRPD Rep. 3, A-02)

G-635.021 Outreach Strategy: Minority Physicians

Our AMA: (1) encourages the efforts of the Federation to continue to involve minority physicians in both membership and leadership positions at all levels; and (2) supports active recruitment of minority physicians into membership through all reasonable means and encourages their participation in leadership positions within our AMA. (Res. 259, A-89; Reaffirmed: Sunset Report, A-00; Consolidated: CLRPD Rep. 3, I-01)

H-200.952 Diversity in Medical Education

Our American Medical Association commend the Institute of Medicine for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health-Care Workforce," and support the concept that a racially and ethnically diverse educational experience results in better educational outcomes (New HOD Policy); and (2) encourage medical schools, health care

institutions, managed care and other appropriate groups to develop policies articulating the value and importance of diversity as a goal that benefits all participants, and strategies to accomplish that goal. (Res. 305, A-06)

H-200.955 Revisions to AMA Policy on the Physician Workforce

It is AMA policy that: (1) any workforce planning efforts, done by the AMA or others, should utilize data on all aspects of the health care system, including projected demographics of both providers and patients, the number and roles of other health professionals in providing care, and practice environment changes. Planning should have as a goal appropriate physician numbers, specialty mix, and geographic distribution. (2) Our AMA encourages and collaborates in the collection of the data needed for workforce planning and in the conduct of national and regional research on physician supply and distribution. The AMA will independently and in collaboration with state and specialty societies, national medical organizations, and other public and private sector groups, compile and disseminate the results of the research. (3) The medical profession must be integrally involved in any workforce planning efforts sponsored by federal or state governments, or by the private sector. (4) In order to enhance access to care, our AMA collaborates with the public and private sectors to ensure an adequate supply of physicians in all specialties and to develop strategies to mitigate the current geographic maldistribution of physicians. (5) There is a need to enhance underrepresented minority representation in medical schools and in the physician workforce, as a means to ultimately improve access to care for minority and underserved groups. (6) There should be no decrease in the number of funded graduate medical education (GME) positions. Any increase in the number of funded GME positions, overall or in a given specialty, and in the number of US medical students should be based on a demonstrated regional or national need. (7) Our AMA will collect and disseminate information on market demands and workforce needs, so as to assist medical students and resident physicians in selecting a specialty and choosing a career. (CME Rep. 2, I-03; Reaffirmation I-06)

H-305.968 Medicare Direct and Indirect Medical Education Costs 1996 Consensus Statement on Physician Workforce

“...The communities that are traditionally underserved are characterized by location - rural or inner city - or by the race and ethnicity of the population. To increase the likelihood that U.S. medical school graduates will establish practices in these communities, federal funds should be provided to encourage and support medical school efforts to expand the opportunities students have to gain experience in rural and inner city communities so that they will have an appreciation of the needs and challenges of practice in these communities.

Historically, minority physicians have been more likely than non-minority physicians to establish practices in communities with minority populations. Given this, medical schools should be supported and encouraged in their efforts to increase the diversity of their student bodies so that they will be able to graduate an increasing number of minority physicians. To complement medical school efforts to increase the number of their graduates who might establish practices in traditionally underserved communities, federal incentives should be provided to encourage students to pursue careers as generalist physicians and to establish practices in these communities.”

H-350.974 Racial and Ethnic Disparities in Health Care

Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic

discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association. The AMA emphasizes three approaches that it believes should be given high priority: (1) Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform. (2) Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities. (3) Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons. (CLRPD Rep. 3, I-98; Appended and Reaffirmed:: CSA Rep.1, I-02; Reaffirmed: BOT Rep. 4, A-03)

H-350.964 Racial Ethnic Disparities in Health Care

Our AMA opposes the elimination of programs or mechanisms designed to increase the number of minority physicians. (BOT Rep. 4, A-03)

H-350.968 Progress in Medical Education: the Medical School Admission Process

Our AMA encourages increased recruitment and retention of faculty members from underrepresented minority groups as part of efforts to increase the number of individuals from underrepresented minority groups entering and graduating from US medical schools. (CME Rep. 8, I-99)

H-350.969 Medical Education for Members in Underserved Minority Populations

Our AMA: (1) actively opposes the reduction of resources and opportunities used to increase the number of minority medical and premedical students in training; (2) uses its influence in states and local communities to increase the representation of minority group members in medical education, as long as domestic health care disparities exist between minority populations and the greater population at-large; and (3) supports the need for an increase in the participation of under-represented minorities as investigators, trainees, reviewers, and subjects in peer review biomedical research at all levels. (Sub. Res. 316, A-99; Reaffirmed CME Rep. 8, I-99)

H-350.970 Diversity in Medical Education

Our AMA will: (1) request that the AMA Foundation seek ways of supporting innovative programs that strengthen pre-medical and pre-college preparation for minority students; (2) support and work in partnership with local state and specialty medical societies and other relevant groups to provide education on and promote programs aimed at increasing the number of minority medical school admissions; applicants who are admitted; and (3) encourage medical schools to consider the likelihood of service to underserved populations as a medical school admissions criterion. (BOT Rep. 15, A-99)

H-350.971 AMA Initiatives Regarding Minorities

The House of Delegates commends the leaders of our AMA and the National Medical Association for having established a successful, mutually rewarding liaison and urges that this relationship be expanded in all areas of mutual interest and concern. Our AMA will develop publications, assessment tools, and a survey instrument to assist physicians and the federation with minority issues. The AMA will continue to strengthen relationships with minority physician organizations, will communicate its policies on the health care needs of minorities, and will monitor and report on progress being made to address racial and ethnic disparities in care. It is the policy of our AMA to establish a mechanism to facilitate the development and implementation of a comprehensive, long-range, coordinated strategy to address issues and concerns affecting minorities, including minority health, minority medical education, and minority membership in the AMA.

Such an effort should include the following components: (1) Development, coordination, and strengthening of AMA resources devoted to minority health issues and recruitment of minorities into medicine; (2) Increased awareness and representation of minority physician perspectives in the Association's policy development, advocacy, and scientific activities; (3) Collection, dissemination, and analysis of data on minority physicians and medical students, including AMA membership status, and on the health status of minorities; (4) Response to inquiries and concerns of minority physicians and medical students; and (5) Outreach to minority physicians and minority medical students on issues involving minority health status, medical education, and participation in organized medicine. (CLRPD Rep. 3, I-98)

H-350.978 Minorities in the Health Professions

The policy of our AMA is that (1) Each educational institution should accept responsibility for increasing its enrollment of members of underrepresented groups. (2) Programs of education for health professions should devise means of improving retention rates for students from underrepresented groups. (3) Health profession organizations should support the entry of disabled persons to programs of education for the health professions, and programs of health profession education should have established standards concerning the entry of disabled persons. (4) Financial support and advisory services and other support services should be provided to disabled persons in health profession education programs. Assistance to the disabled during the educational process should be provided through special programs funded from public and private sources. (5) Programs of health profession education should join in outreach programs directed at providing information to prospective students and enriching educational programs in secondary and undergraduate schools. (6) Health profession organizations, especially the organizations of professional schools, should establish regular communication with counselors at both the high school and college level as a means of providing accurate and timely information to students about health profession education. (7) The AMA reaffirms its support of: (a) efforts to increase the number of black Americans and other minority Americans entering and graduating from U.S. medical schools; and (b) increased financial aid from public and private sources for students from low income, minority and socioeconomically disadvantaged backgrounds. (8) The AMA supports counseling and intervention designed to increase enrollment, retention, and graduation of minority medical students, and supports legislation for increased funding for the HHS Health Careers Opportunities Program. (CLRPD Rep. 3, I-98)

H-350.979 Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession

Our AMA supports increasing the representation of minorities in the physician population by: (1) Supporting efforts to increase the applicant pool of qualified minority students by:

(a) Encouraging state and local governments to make quality elementary and secondary education opportunities available to all; (b) Urging medical schools to strengthen or initiate programs that offer special premedical and precollegiate experiences to underrepresented minority students; (c) urging medical schools and other health training institutions to develop new and innovative measures to recruit underrepresented minority students, and (d) Supporting legislation that provides targeted financial aid to financially disadvantaged students at both the collegiate and medical school levels. (2) Encouraging all medical schools to reaffirm the goal of increasing representation of underrepresented minorities in their student bodies and faculties. (3) Urging medical school admission committees to consider minority representation as one factor in reaching their decisions. (4) Increasing the supply of minority health professionals. (5) Continuing its efforts to increase the proportion of minorities in medical schools and medical school faculty. (6) Facilitating communication between medical school admission committees and premedical counselors concerning the relative importance of requirements, including grade point average and Medical College Aptitude Test scores. (7) Continuing to urge for state legislation that will provide funds for medical education both directly to medical schools and indirectly through financial support to students. (8) Continuing to provide strong support for federal legislation that provides financial assistance for able students whose financial need is such that otherwise they would be unable to attend medical school. (CLRPD Rep. 3, I-98)

H-350.980 AMA's Role in Preparing Minority and Disadvantaged Youth for Careers in Medicine and the Health Professions

The policy of our AMA is to: (1) Initiate the development of a multi-organizational commission on minority health and education designed to coordinate programs and initiatives to address issues relating to the improvement of minority health and the enrollment and retention of minorities in medical school. (2) Pursue this commission in conjunction with other appropriate national organizations including the National Medical Association. (3) Encourage, sponsor, and promote, as appropriate, the development of innovative elementary, secondary, and undergraduate school programs designed to better prepare minority students and socioeconomically disadvantaged students for careers in medicine and the other health professions. (4) Strongly encourage state, county, medical specialty societies, medical schools, and individual physicians to make an ongoing commitment to participate in these or other programs designed to better prepare minority students for careers in medicine and the other health professions. (5) Encourage individual physicians to make a personal, ongoing commitment to participate in elementary, secondary, and undergraduate school programs designed to better prepare minority students and students from socioeconomically disadvantaged background for careers in medicine and the other health professions. (CLRPD Rep. 3, I-98)

H-350.982 Project 3000 by 2000 - Medical Education for Under-Represented Minority Students

Our AMA supports the concept of the Association of American Medical Colleges' project "3000 by 2000," which has as its objective achieving 3000 under-represented minority students entering medical schools annually by the year 2000. (CLRPD Rep. 3, I-98)

Health Insurance

D-185.989 Expanding Health Insurance Coverage to the Uninsured: 2007 and Beyond

Our AMA will: (1) review the appropriate scope of required health insurance benefits for such benefits to qualify for purposes of tax credit or other federal subsidy; (2) review the

financing of health care for and/or insurance coverage for those with chronic illness or who are experiencing catastrophic health expenses; and (3) conduct new tax credit simulations on varying components of its proposal to expand health insurance coverage and choice. (CMS Rep. 5, I-06)

D-290.985 Protecting Children, Adolescents and Young Adults in Medicaid and the State Children's Health Insurance (SCHIP) Program

Our AMA will actively: (1) encourage state and county medical societies to advocate for initiatives to ensure that all eligible children, adolescents, and young adults are enrolled in Medicaid and SCHIP; (2) advocate for federal and state funding for Medicaid and SCHIP so that funding is sufficient to support enrollment of and provision of necessary services to all eligible children, adolescents, and young adults; and (3) encourage state and county medical societies to work to ensure that services to children, adolescents, and young adults meet Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Standards. (Res. 108, A-06)

H-165.847 Comprehensive Health System Reform

Comprehensive health system reform, which achieves health care for all Americans while improving the physician practice environment, be of the highest priority for our American Medical Association. (Res. 613, A-06)

H-290.971 Expanding Enrollment for the State Children's Health Insurance Program (SCHIP)

Our AMA continues to support: a. health insurance coverage of all children as a strategic priority; b. efforts to expand coverage to uninsured children who are eligible for the State Children's Health Insurance Program (**SCHIP**) and Medicaid through improved and streamlined enrollment mechanisms; c. the reauthorization of **SCHIP** in 2007; and d. supports the use of enrollment information for participation in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and/or the federal school lunch assistance program as documentation for **SCHIP** eligibility in order to allow families to avoid duplication and the cumbersome process of re-documenting income for child health coverage. (Res. 118, A-07; CMS Rep. 1, A-07)

HIV

D-20.992 Improving Access to Rapid HIV Testing: An Update

Our AMA: (1) supports the Centers for Disease Control and Prevention's (CDC) 2006 Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Health Care Settings; (2) will continue to work with the CDC to implement the revised recommendations for HIV testing of adults, adolescents and pregnant women in health care settings, including exploring the publication of a guide on the use of rapid HIV testing in primary care settings; and (3) will identify legal and funding barriers to the implementation of the CDC's HIV testing recommendations and develop strategies to overcome these barriers. (CSAPH Rep. 2, I-06)

Interpreter Services

D-385.978 Language Interpreters

Our AMA will: (1) continue to work to obtain federal funding for medical interpretive services; (2) redouble its efforts to remove the financial burden of medical interpretive services from physicians; (3) urge the Administration to reconsider its interpretation of Title VI of the Civil Rights Act of 1964 as requiring medical interpretive services without reimbursement; (4) consider the feasibility of a legal solution to the problem of funding medical interpretive services; and (5) work with governmental officials and other organizations to make language interpretive services a covered benefit for all health plans inasmuch as health plans are in a superior position to pass on the cost of these federally mandated services as a business expense. (Res. 907, I-03; Reaffirmed in lieu of Res. 722, A-07)

H-160.924 Use of Language Interpreters in the Context of the Patient-Physician Relationship

AMA policy is that: (1) further research is necessary on how the use of **interpreters**--both those who are trained and those who are not--impacts patient care; (2) treating physicians shall respect and assist the patients' choices whether to involve capable family members or friends to provide language assistance that is culturally sensitive and competent, with or without an interpreter who is competent and culturally sensitive; (3) physicians continue to be resourceful in their use of other appropriate means that can help facilitate communication--including print materials, digital and other electronic or telecommunication services with the understanding, however, of these tools' limitations--to aid LEP patients' involvement in meaningful decisions about their care; and (4) physicians cannot be expected to provide and fund these translation services for their patients, as the Department of Health and Human Services' policy guidance currently requires; when trained medical interpreters are needed, the costs of their services shall be paid directly to the interpreters by patients and/or third party payers and physicians shall not be required to participate in payment arrangements. (BOT Rep. 8, I-02; Reaffirmation I-03; Reaffirmed in lieu of Res. 722, A-07)

H-385.928 Patient Interpreters

Our AMA supports sufficient federal appropriations for patient interpreter services and will take other necessary steps to assure physicians are not directly or indirectly required to pay for interpreter services mandated by the federal government. (Res. 219, I-01; Reaffirmed: BOT Rep 8, I-02; Reaffirmation I-03; Reaffirmed in lieu of Res. 722, A-07)

Medicaid

H-290.973 Medicaid Citizenship Documentation Interim Final Rule

Our AMA strongly urges the Centers for Medicare and Medicaid Services to amend 42 CFR 435.407 (a) to specify that the state Medicaid agency's record of payment for the birth of an individual in a US hospital is satisfactory documentary evidence of both identity and citizenship. (Res. 702, I-06)

Mental Health

H-345.980 Advocating for Reform in Payment of Mental Health and Addiction Services

Our AMA will advocate that funding levels for public sector mental health and addiction services not be decreased in the face of governmental budgetary pressures, especially because private sector payment systems are not in place to provide accessibility and affordability for mental health and addiction services to our citizens. (Res. 205, A-06)

D-180.998 Insurance Parity for Mental Health and Psychiatry

Our AMA in conjunction with the American Psychiatric Association and other interested organizations will develop model state legislation for the use of state medical associations and specialty societies to promote legislative changes assuring parity for the coverage of mental illness, alcoholism, and substance abuse. (Res. 215, I-98; Reaffirmation I-03; Reaffirmed in lieu of Res. 910, I-06)

D-185.994 Mental Health Parity

Our AMA, along with the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry, will circulate a letter for state medical societies and specialty societies to sign urging the United States Senate and House of Representatives to bring federal mental health insurance coverage parity legislation to a vote during the 108th Congress. (Res. 706, A-03; Reaffirmation I-03; Reaffirmed in lieu of Res. 910, I-06)

D-345.992 Promoting Parity for the Treatment of Mental Illness and Substance Use Disorders

Our AMA will work in conjunction with interested state and specialty societies to prepare a report which includes a summary and analysis of existing parity legislation and a review of the research on the impact of parity on access, quality, and the cost of health care at both the state and federal level. (Res. 910, I-06)

Minority Health / Racial and Ethnic Health Disparities

D-350.995 Reducing Racial and Ethnic Disparities in Health Care

Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations: (1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care. (2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities. (3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities. (BOT Rep. 4, A-03)

D-350.996 Strategies for Eliminating Minority Health Care Disparities

Our American Medical Association: (1) commend the Institute of Medicine (IOM) on its report, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," and that all applicable AMA Councils be requested to formally review the IOM report and its recommendations and submit reports back to the AMA House of Delegates at the 2003 Interim Meeting from their areas of expertise with specific strategies to move towards the elimination of racial and ethnic health care disparities; and (2) identify and incorporate

strategies specific to the elimination of minority health care disparities in its ongoing advocacy and public health efforts, as appropriate. (Res. 731, I-02)

D-350.999 Medical Education for Members in Underserved Minority Populations

In conjunction with the Minority Affairs Consortium and other appropriate organizations, develop a plan for implementation of a national conference on access to health care in accordance with AMA policy H-160.959, and present that plan at A-2000.

D-440.954 Addressing Obesity

Our AMA will: (1) assume a leadership role in collaborating with other interested organizations, including national medical specialty societies, the American Public Health Association, the Center for Science in the Public Interest, and the AMA Alliance, to discuss ways to finance a comprehensive national program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; (2) encourage state medical societies to collaborate with interested state and local organizations to discuss ways to finance a comprehensive program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; and (3) continue to monitor and support state and national policies and regulations that encourage healthy lifestyles and promote obesity prevention. (BOT Rep. 11, I-06)

E-9.121 Racial Disparities in Health Care

Disparities in medical care based on immutable characteristics such as race must be avoided. Whether such disparities in health care are caused by treatment decisions, differences in income and education, sociocultural factors, or failures by the medical profession, they are unjustifiable and must be eliminated. Physicians should examine their own practices to ensure that racial prejudice does not affect clinical judgment in medical care. (I, IV) Issued March 1992 based on the report "Black-White Disparities in Health Care," adopted December 1989 (JAMA. 1990; 263: 2344-2346; Updated June 1994)

H-140.872 Physician Pay-for-Performance Programs

Physician pay-for-performance (PFP) compensation arrangements should be designed to improve health care quality and patient safety by linking remuneration to measures of individual, group, or organizational performance. To uphold their ethical obligations, physicians who are involved with PFP programs must take appropriate measures to promote patients' well-being. (1) Physicians who are involved in the design or implementation of PFP programs should advocate for: (a) incentives that are intended to promote health care quality and patient safety, and are not primarily intended to contain costs; (b) program flexibility that allows physicians to accommodate the varying needs of individual patients; **(c) adjustment of performance measures by risk and case-mix in order to avoid discouraging the treatment of high-risk individuals and populations;** (d) processes to make practice guidelines and explanations of their intended purposes and the clinical findings upon which they are based available to participating physicians. (2) Practicing physicians who participate in PFP programs while providing medical services to patients should: (a) maintain primary responsibility to their patients and provide competent medical care, regardless of financial incentives; **(b) support access to care for all people and avoid selectively treating healthier patients for the purpose of bolstering their individual or group performance outcomes;** (c) be aware of evidence-based practice guidelines and the findings upon which they are based; (d) always provide care that considers patients' individual needs and preferences, even if that care conflicts with applicable practice guidelines; (e) not participate in PFP programs that incorporate incentives that conflict with physicians' professional values or otherwise compromise

physicians' abilities to advocate for the interests of individual patients. (CEJA Rep. 3, I-05; Reaffirmation A-06; Reaffirmation I-06)

H-150.944 Combating Obesity and Health Disparities

Our AMA supports efforts to: (1) reduce health disparities by basing food assistance programs on the health needs of their constituents; (2) provide vegetables, fruits, legumes, grains, vegetarian foods, and healthful nondairy beverages in school lunches and food assistance programs; and (3) ensure that federal subsidies encourage the consumption of products low in fat and cholesterol. (Res. 413, A-07)

H-245.986 Infant Mortality in the United States

It is the policy of the AMA: (1) to work with the World Health Organization toward the development of standardized international methodology for collecting infant mortality data, which will include collecting information regarding racial/ethnic background in order to document the needs of infants, children, and adolescents of subpopulations of society, and will improve the basis on which international comparisons are made; (2) to continue to work to increase public awareness of the flaws in comparisons of infant mortality data between countries, as well as of the problems that contribute to infant mortality in the United States; (3) to continue to address the problems that contribute to infant mortality within its ongoing health of the public activities. In particular, the special needs of adolescents and the problem of teen pregnancy should continue to be addressed by the adolescent health initiative; and (4) to be particularly aware of the special health access needs of pregnant women and infants, especially racial and ethnic minority group populations, in its advocacy on behalf of its patients. (BOT Rep. U, I-91; Modified by BOT Rep. 8, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmation A-07)

H-350.971 AMA Initiatives Regarding Minorities (repeated from diversity section)

The House of Delegates commends the leaders of our AMA and the National Medical Association for having established a successful, mutually rewarding liaison and urges that this relationship be expanded in all areas of mutual interest and concern. Our AMA will develop publications, assessment tools, and a survey instrument to assist physicians and the federation with minority issues. The AMA will continue to strengthen relationships with minority physician organizations, will communicate its policies on the health care needs of minorities, and will monitor and report on progress being made to address racial and ethnic disparities in care. It is the policy of our AMA to establish a mechanism to facilitate the development and implementation of a comprehensive, long-range, coordinated strategy to address issues and concerns affecting minorities, including minority health, minority medical education, and minority membership in the AMA. Such an effort should include the following components: (1) Development, coordination, and strengthening of AMA resources devoted to minority health issues and recruitment of minorities into medicine; (2) Increased awareness and representation of minority physician perspectives in the Association's policy development, advocacy, and scientific activities; (3) Collection, dissemination, and analysis of data on minority physicians and medical students, including AMA membership status, and on the health status of minorities; (4) Response to inquiries and concerns of minority physicians and medical students; and (5) Outreach to minority physicians and minority medical students on issues involving minority health status, medical education, and participation in organized medicine. (CLRPD Rep. 3, I-98)

H-440.902 Obesity as a Major Health Concern

The AMA: (1) recognizes obesity in children and adults as a major public health problem; (2) will study the medical, psychological and socioeconomic issues associated with obesity, including reimbursement for evaluation and management of obese patients; (3) will work with other professional medical organizations, and other public and private organizations to

develop evidence-based recommendations regarding education, prevention, and treatment of obesity; (4) recognizes that racial and ethnic disparities exist in the prevalence of obesity and diet-related diseases such as coronary heart disease, cancer, stroke, and diabetes and recommends that physicians use culturally responsive care to improve the treatment and management of obesity and diet-related diseases in minority populations; and (5) supports the use of cultural and socioeconomic considerations in all nutritional and dietary research and guidelines in order to treat overweight and obese patients. (Res. 423, A-98; Reaffirmed and Appended: BOT Rep. 6, A-04)

H-450.943 Effects of Pay-for-Performance on Minority Health Disparities

Our AMA urge that physicians with expertise in eliminating racial and ethnic health disparities be involved in the design, implementation and evaluation of pay-for-performance programs. (Res. 210, A-06)

H-450.947 Pay-for-Performance Principles and Guidelines

(1) The following *Principles for Pay-for-Performance and Guidelines for Pay-for-Performance* are the official policy of our AMA.

PRINCIPLES FOR PAY-FOR-PERFORMANCE PROGRAMS

Physician pay-for-performance (PFP) programs that are designed primarily to improve the effectiveness and safety of patient care may serve as a positive force in our health care system. Fair and ethical PFP programs are patient-centered and link evidence-based performance measures to financial incentives. Such PFP programs are in alignment with the following five AMA principles:

1. Ensure quality of care - Fair and ethical PFP programs are committed to improved patient care as their most important mission. Evidence-based quality of care measures, created by physicians across appropriate specialties, are the measures used in the programs. Variations in an individual patient care regimen are permitted based on a physician's sound clinical judgment and should not adversely affect PFP program rewards.

2. Foster the patient/physician relationship - Fair and ethical PFP programs support the patient/physician relationship and overcome obstacles to physicians treating patients, regardless of patients' health conditions, ethnicity, economic circumstances, demographics, or treatment compliance patterns.

3. Offer voluntary physician participation - Fair and ethical PFP programs offer voluntary physician participation, and do not undermine the economic viability of non-participating physician practices. These programs support participation by physicians in all practice settings by minimizing potential financial and technological barriers including costs of start-up.

4. Use accurate data and fair reporting - Fair and ethical PFP programs use accurate data and scientifically valid analytical methods. Physicians are allowed to review, comment and appeal results prior to the use of the results for programmatic reasons and any type of reporting.

5. Provide fair and equitable program incentives - Fair and ethical PFP programs provide new funds for positive incentives to physicians for their participation, progressive quality improvement, or attainment of goals within the program. The eligibility criteria for the incentives are fully explained to participating physicians. These programs support the goal of quality improvement across all participating physicians.

GUIDELINES FOR PAY-FOR-PERFORMANCE PROGRAMS

Safe, effective, and affordable health care for all Americans is the AMA's goal for our health care delivery system. The AMA presents the following guidelines regarding the formation and implementation of fair and ethical pay-for-performance (PFP) programs. These guidelines augment the AMA's "Principles for Pay-for-Performance Programs" and provide

AMA leaders, staff and members with operational boundaries that can be used in an assessment of specific PFP programs.

Quality of Care

- The primary goal of any PFP program must be to promote quality patient care that is safe and effective across the health care delivery system, rather than to achieve monetary savings.
- Evidence-based quality of care measures must be the primary measures used in any program. 1. All performance measures used in the program must be prospectively defined and developed collaboratively across physician specialties. 2. Practicing physicians with expertise in the area of care in question must be integrally involved in the design, implementation, and evaluation of any program. 3. All performance measures must be developed and maintained by appropriate professional organizations that periodically review and update these measures with evidence-based information in a process open to the medical profession. 4. Performance measures should be scored against both absolute values and relative improvement in those values. 5. Performance measures must be subject to the best-available risk- adjustment for patient demographics, severity of illness, and co-morbidities. 6. Performance measures must be kept current and reflect changes in clinical practice. Except for evidence-based updates, program measures must be stable for two years. 7. Performance measures must be selected for clinical areas that have significant promise for improvement.
- Physician adherence to PFP program requirements must conform with improved patient care quality and safety.
- Programs should allow for variance from specific performance measures that are in conflict with sound clinical judgment and, in so doing, require minimal, but appropriate, documentation.
- PFP programs must be able to demonstrate improved quality patient care that is safer and more effective as the result of program implementation.
- PFP programs help to ensure quality by encouraging collaborative efforts across all members of the health care team.
- Prior to implementation, pay-for-performance programs must be successfully pilot-tested for a sufficient duration to obtain valid data in a variety of practice settings and across all affected medical specialties. Pilot testing should also analyze for patient de-selection. If implemented, the program must be phased-in over an appropriate period of time to enable participation by any willing physician in affected specialties.
- Plans that sponsor PFP programs must prospectively explain these programs to the patients and communities covered by them.

Patient/Physician Relationship

- Programs must be designed to support the patient/physician relationship and recognize that physicians are ethically required to use sound medical judgment, holding the best interests of the patient as paramount.
- Programs must not create conditions that limit access to improved care. 1. Programs must not directly or indirectly disadvantage patients from ethnic, cultural, and socio-economic groups, as well as those with specific medical conditions, or the physicians who serve these patients. 2. Programs must neither directly nor indirectly disadvantage patients and their physicians, based on the setting where care is delivered or the location of populations served (such as inner city or rural areas).
- Programs must neither directly nor indirectly encourage patient de-selection.
- Programs must recognize outcome limitations caused by patient non-compliance, and sponsors of PFP programs should attempt to minimize non-compliance through plan design.

Physician Participation

- Physician participation in any PFP program must be completely voluntary.
- Sponsors of PFP programs must notify physicians of PFP program implementation and offer physicians the opportunity to opt in or out of the PFP program without affecting the existing or offered contract provisions from the sponsoring health plan or employer.
- Programs must be designed so that physician nonparticipation does not threaten the economic viability of physician practices.
- Programs should be available to any physicians and specialties who wish to participate and must not favor one specialty over another. Programs must be designed to encourage broad physician participation across all modes of practice.
- Programs must not favor physician practices by size (large, small, or solo) or by capabilities in information technology (IT). 1. Programs should provide physicians with tools to facilitate participation. 2. Programs should be designed to minimize financial and technological barriers to physician participation.
- Although some IT systems and software may facilitate improved patient management, programs must avoid implementation plans that require physician practices to purchase health-plan specific IT capabilities.
- Physician participation in a particular PFP program must not be linked to participation in other health plan or government programs.
- Programs must educate physicians about the potential risks and rewards inherent in program participation, and immediately notify participating physicians of newly identified risks and rewards.
- Physician participants must be notified in writing about any changes in program requirements and evaluation methods. Such changes must occur at most on an annual basis.

Physician Data and Reporting

- Patient privacy must be protected in all data collection, analysis, and reporting. Data collection must be administratively simple and consistent with the Health Insurance Portability and Accountability Act (HIPAA).
- The quality of data collection and analysis must be scientifically valid. Collecting and reporting of data must be reliable and easy for physicians and should not create financial or other burdens on physicians and/or their practices. Audit systems should be designed to ensure the accuracy of data in a non-punitive manner. 1. Programs should use accurate administrative data and data abstracted from medical records. 2. Medical record data should be collected in a manner that is not burdensome and disruptive to physician practices. 3. Program results must be based on data collected over a significant period of time and relate care delivered (numerator) to a statistically valid population of patients in the denominator.
- Physicians must be reimbursed for any added administrative costs incurred as a result of collecting and reporting data to the program.
- Physicians should be assessed in groups and/or across health care systems, rather than individually, when feasible.
- Physicians must have the ability to review and comment on data and analysis used to construct any performance ratings prior to the use of such ratings to determine physician payment or for public reporting. 1. Physicians must be able to see preliminary ratings and be given the opportunity to adjust practice patterns over a reasonable period of time to more closely meet quality objectives. 2. Prior to release of any physician ratings, programs must have a mechanism for physicians to see and appeal their ratings in writing. If requested by the physician, physician comments must be included adjacent to any ratings.
- If PFP programs identify physicians with exceptional performance in providing effective and safe patient care, the reasons for such performance should be shared with physician program participants and widely promulgated.

- The results of PFP programs must not be used against physicians in health plan credentialing, licensure, and certification. Individual physician quality performance information and data must remain confidential and not subject to discovery in legal or other proceedings.
- PFP programs must have defined security measures to prevent the unauthorized release of physician ratings.

Program Rewards

- Programs must be based on rewards and not on penalties.
- Program incentives must be sufficient in scope to cover any additional work and practice expense incurred by physicians as a result of program participation.
- Programs must offer financial support to physician practices that implement IT systems or software that interact with aspects of the PFP program.
- Programs must finance bonus payments based on specified performance measures with supplemental funds.
- Programs must reward all physicians who actively participate in the program and who achieve pre-specified absolute program goals or demonstrate pre-specified relative improvement toward program goals.
- Programs must not reward physicians based on ranking compared with other physicians in the program.
- Programs must provide to all eligible physicians and practices a complete explanation of all program facets, to include the methods and performance measures used to determine incentive eligibility and incentive amounts, prior to program implementation.
- Programs must not financially penalize physicians based on factors outside of the physician's control.
- Programs utilizing bonus payments must be designed to protect patient access and must not financially disadvantage physicians who serve minority or uninsured patients.

(2) Our AMA opposes private payer, Congressional, or Centers for Medicare and Medicaid Services pay-for-performance initiatives if they do not meet the AMA's "Principles and Guidelines for Pay-for-Performance." (BOT Rep. 5, A-05; Reaffirmation A-06; Reaffirmed: Res. 210, A-06; Reaffirmed in lieu of Res. 215, A-06; Reaffirmed in lieu of Res. 226, A-06; Reaffirmation I-06; Reaffirmation A-07)

Minority Patient Care and Research

D-55.998 Encourage Appropriate Colorectal Cancer Screening

Our AMA, in conjunction with interested organizations and societies, will promote educational and public awareness programs to assure that physicians actively encourage their patients to be screened for colon **cancer** and precursor lesions, and to improve patient awareness of appropriate guidelines, particularly within minority populations and for all high risk groups, including all individuals over age 50. (Res. 510, A-03)

D-350.993 Establishing an FDA Minority Health Committee

Our AMA: (1) and its Minority Affairs Consortium will urge the United States Congress to establish a Food and Drug Administration Minority Health Committee to address effective strategies to increase the participation of minority patients and investigators in clinical trials and medical research as one way to eliminate health disparities; (2) through its MAC, will provide information to minority physicians on the benefits of being a clinical trial investigator; (3) will encourage and work with the appropriate organizations to include more minorities in clinical trials and medical research as patients and investigators as one way to eliminate

racial and ethnic health disparities; and (4) will urge the US Congress and the FDA to develop an incentive program, like the Pediatric Incentive Program, that will encourage increasing the number of minorities in clinical trials and medical research. (Res. 426, A-05)

D-370.988 Hematopoietic Stem Cell Transplantation: Utilization of and Minority Representation on the National Bone Marrow Donor Registry

Our AMA will: (1) monitor National Marrow Donor Program (NMDP) efforts to maintain a Registry that is large in number, representative of all racial and ethnic groups, and diverse in its human leukocyte antigen (HLA) types; these efforts include projects that aim to increase minority recruitment, retain existing donors, and recruit donors to replace those lost through attrition; (2) encourage the NMDP to expand its efforts to increase utilization of the Registry through projects aimed at increasing patient and physician awareness of the NMDP, and at reducing the time and cost of stem cell procurement; and (3) encourage the NMDP to enhance efforts to increase the number of umbilical cord blood units donated to the Registry; particular attention should be paid to increasing donation by minorities. (CSAPH Rep. 7, A-07)

D-450.977 Patient Adherence to Treatment Plans

Our AMA will compile and make available a list of existing resources and tools that have been developed to assist physicians and patients in optimizing patient adherence. (Res. 505, A-06)

H-315.996 Scientific Accuracy in Racial, Ethnic and Religious Designations in Medical Records

The AMA advocates precision in racial, ethnic and religious designations in medical records, with information obtained from the patient, always respecting the personal privacy of the patient. (Res. 4, I-83; Reaffirmed: CLRPD Rep. I-93-1)

H-350.972 Improving the Health of Black and Minority Populations

Our AMA supports: (1) A greater emphasis on minority access to health care and increased health promotion and disease prevention activities designed to reduce the occurrence of illnesses that are highly prevalent among disadvantaged minorities. (2) Authorization for the Office of Minority Health to coordinate federal efforts to better understand and reduce the incidence of illness among U.S. minority Americans as recommended in the 1985 Report to the Secretary's Task Force on Black and Minority Health. (3) Continuing efforts for improving the health status of minority Americans through the Pepper Commission. (4) Continued encouragement at the federal and state levels to expand Medicaid coverage to include all those below the federal poverty level. (5) The speedy implementation of the JCAHO's policy that hospitals provide for effective communication with predominant population groups served by each hospital. (6) Encouraging employers to offer health insurance for employees working in companies of 25 persons or more. (7) Advising our AMA representatives to the LCME to request data collection on medical school curricula concerning the health needs of minorities. (8) The promotion of health education through schools and community organizations aimed at teaching skills of health care system access, health promotion, disease prevention, and early diagnosis. (CLRPD Rep. 3, I-98; Reaffirmation A-01)

H-350.973 Sickle Cell Anemia

Our AMA supports: (1) Research and educational efforts directed to the profession and the public for the prevention of sickle cell anemia and the development of treatment forms. (2) Efforts to evaluate the effectiveness of screening and counseling programs and involvement with issues in genetic counseling. (3) Ongoing research programs. The AMA recommends that all sickle cell programs have input in the planning stage from the local African American

community and all other sectors that would be involved and affected by sickle cell disease. (CLRPD Rep. 3, I-98)

H-370.974 Working Toward an Increased Number of Minorities Registered as Potential Bone Marrow Donors

The AMA supports efforts to increase the number of all potential bone marrow donors registered in national bone marrow registries, especially minority donors, to improve the odds of successful HLA matching and bone marrow transplantation. (Res. 501, I-94; Reaffirmed: CSA Rep. 6, A-04)

H-410.995 Participation in the Development of Practice Guidelines by Individuals Experienced in the Care of Minority and Indigent Patients

Our AMA encourages those experienced in the care of poor and minority patients (e.g., minority and public hospital providers and organizations) to participate actively in the development of clinical guidelines, practice parameters, patient management guidelines, medical practice guidelines, etc. (Res. 87, A-90; Reaffirmed: Sunset Report, I-00)

H-425.976 Preconception Care

Our American Medical Association support the 10 recommendations developed by the Centers for Disease Control and Prevention for improving preconception health care; and (2) our AMA support the education of physicians and the public about the importance of preconception care as a vital component of a woman's reproductive health. (Res. 414, A-06)

H-425.980 Screening and Early Detection of Prostate Cancer

Our AMA believes that:(1) the launching of mass screening programs for the early detection of prostate cancer is premature at this time. (2) All men who would be candidates for and interested in active treatment for prostate cancer should be provided with information regarding their risk of prostate cancer and the potential benefits and harms of prostate cancer screening, sufficient to support well-informed decision making. (3) Prostate cancer screening, if elected by the informed patient, should include both prostate-specific antigen testing and digital rectal examination. (4) Men most likely to benefit from tests for early detection of prostate cancer should have a life expectancy of at least 10 years and include: (a) Men 40 years of age or older of African American descent; (b) Men 40 years of age or older with an affected first-degree relative; and (c) Men 50 years of age or older. (CSA rep. 9, A-00)

H-460.924 Race and Ethnicity as Variables in Medical Research

Our AMA policy is that: (1) race and ethnicity are valuable research variables when used and interpreted appropriately; (2) health data be collected on patients, by race and ethnicity, in hospitals, managed care organizations, independent practice associations, and other large insurance organizations; (3) physicians recognize that race and ethnicity are conceptually distinct; (4) our AMA supports research into the use of methodologies that allow for multiple racial and ethnic self-designations by research participants; (5) our AMA encourages investigators to recognize the limitations of all current methods for classifying race and ethnic groups in all medical studies by stating explicitly how race and/or ethnic taxonomies were developed or selected; (6) our AMA encourages appropriate organizations to apply the results from studies of race-ethnicity and health to the planning and evaluation of health services; and (7) our AMA continues to monitor developments in the field of racial and ethnic classification so that it can assist physicians in interpreting these findings and their implications for health care for patients. (CSA Rep. 11, A-98; Appended: Res. 509, A-01)

H-460.942 Enrollment in Clinical Trials

The AMA supports and encourages researchers and funding agencies to establish mechanisms to ensure that research on human subjects reflects the diversity of the American population, including women and minorities and their subpopulations. (Sub. Res. 507, A-94; Reaffirmed: CSA Rep. 6, A-04)

Physician-Specific Health Care Data**D-630.972 Progress Report on Res. 606-A-06 Improving Collection of AMA Race/Ethnicity Data**

Our American Medical Association will: 1. Continue to work with the Association of American Medical Colleges to collect race/ethnicity information through the student matriculation file and the GME census including automating the integration of this information into the Masterfile. 2. Implement a test reinstating race/ethnicity questions on the annual physician survey. If the results of the test show this to be an effective mechanism for collecting these data elements, reinstate the questions for the entire survey population. 3. Adopt the Centers for Disease Control and Prevention's minimum recommended list of race/ethnicity categories providing for multiple designations of race and ethnicity. 4. Modify AMA systems that support the data collection and transfer of these data elements as necessary. 5. Revise AMA Policy H-460.924, Race and Ethnicity as Variables in Medical Research, to protect and ensure the appropriate use and/or release of the data collected under these programs. Such language is to be submitted for consideration at the 2007 Annual Meeting. (BOT Rep. 24, I-06)

D-630.973 Improving Collection of AMA Race/Ethnicity Data

Our American Medical Association will explore strategies to consistently collect race and ethnicity data on all physicians in its database; (2) work to standardize race and ethnicity classification codes across all AMA databases and to update incomplete records in its existing databases with race/ethnicity data; (3) any use of collected race/ethnicity data shall comply with applicable state and federal restrictions on such use); (4)and conduct a needs assessment to identify, and if appropriate, adopt appropriate technologies and infrastructures to help improve the completeness, consistency, reliability and standardization of our AMA race and ethnicity data collection with a progress report back to the House of Delegates at the 2006 Interim meeting. (Res. 606, A-06)

Population-Based Health Care**Hispanics/Latinos****D-255.992 Opposition to Employment of Non-certified International Medical Graduates**

Our AMA, in conjunction with the California Medical Association, will recommend to the California legislature and the California Hispanic Healthcare Association, other solutions to the California physician shortage including (1) maximizing their use of existing programs such as the National Health Service Corps and the J-1 visa waiver program, and (2) recruiting Spanish-speaking physicians who have recently retired by assisting them with state licensing and liability concerns. Our AMA, in conjunction with state medical societies, will respond to attempts by states to employ non-certified physicians for patient care by recommending solutions to those states such as (1) maximizing their use of existing

programs such as the National Health Service Corps and the J-1 visa waiver program, and (2) recruiting physicians who have recently retired by assisting them with state licensing and liability concerns. (Res. 320, A-03)

H-350.975 Improving Healthcare of Hispanic Populations in the United States

It is the policy of our AMA to: (1) Encourage health promotion and disease prevention through educational efforts and health publications specifically tailored to the Hispanic community. (2) Promote the development of substance abuse treatment centers and HIV/AIDS education and prevention programs that reach out to the Hispanic community. (3) Encourage the standardized collection of consistent vital statistics on Hispanics by appropriate state and federal agencies. (4) Urge federal and local governments, as well as private institutions, to consider including Hispanic representation on their health policy development organization. (5) Support organizations concerned with Hispanic health through research and public acknowledgment of the importance of national efforts to decrease the disproportionately high rates of mortality and morbidity among Hispanics. (6) Promote research into effectiveness of Hispanic health education methods. (7) Continue to study the health issues unique to Hispanics, including the health problems associated with the United States/Mexican border. (CLRPD Rep. 3, I-98)

Asian-Americans and Pacific Islanders

D-350.998 Health Initiatives on Asian-Americans and Pacific Islanders

Our AMA will expand its minority health policies to include Asian Americans and Pacific Islanders. (Res. 404, A-00)

Native Americans/American Indians

D-350.992 Medicaid Coverage for American Indian and Alaska Native Children

Our AMA will advocate for immediate changes in Medicaid regulations to allow American Indian/Alaska Native (AI/AN) children who are eligible for Medicaid in their home state to be automatically eligible for Medicaid in the state in which the Bureau of Indian Affairs boarding school is located. (BOT Action in response to referred for decision Res. 102, A-06; Reaffirmed: Res. 221, A-07)

H-350.962 Reauthorization of the Indian Health Care Improvement Act

Our AMA (1) supports reauthorization of the **Indian Health Care Improvement Act** and (2) will report back on this issue at the 2008 Annual Meeting. (Res. 221, A-07)

H-350.976 Improving Health Care of American Indians

Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens. (2) The federal government provide sufficient funds to support needed health services for American Indians. (3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians in an effort to improve their quality of life. (4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs. (5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians. (6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents. (7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these

problems. (8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians. (9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside. (10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians. (11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations. (CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07)

H-350.977 Indian Health Service

The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population. (2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation. (3) Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps. (4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued. (5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population. (CLRPD Rep. 3, I-98)

H-350.981 AMA Support of American Indian Health Career Opportunities

AMA policy on American Indian health career opportunities is as follows: (1) Our AMA, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded. (2) Our AMA support the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals. (3) Our AMA utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and that particular emphasis be placed on the need for additional health professionals to work among the American Indian population. (4) Our AMA continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs, and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations. (CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07)

H-495.982 Tax-Free Tobacco Products

Our AMA encourages Native American nations to stop selling tax-free tobacco products because of the profound public health implications of the sale of tax-free tobacco products. (CSA Rep. 3, A-04) Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population. (2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation. (3) Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps. (4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued. (5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population. (CLRPD Rep. 3, I-98)

Undocumented/Immigrant Patients

H-160.956 Federal Funding for Safety Net Care for Undocumented Aliens

Our AMA will lobby Congress to adequately appropriate and dispense funds for the current programs that provide reimbursement for the health care of undocumented aliens. (Sub. Res. 207, A-93; Reaffirmed BOT Rep. 17 - I-94; Reaffirmed by Ref. Cmt. B, A-96; Reaffirmation A-02; Reaffirmation A-07)

H-440.876 Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients

1. Our AMA: (a) opposes any policies, regulations or legislation that would criminalize or punish physicians and other health care providers for the act of giving medical care to patients who are **undocumented** immigrants; (b) opposes any policies, regulations, or legislation requiring physicians and other health care providers to collect and report data regarding an individual patient's legal resident status; and (c) opposes proof of citizenship as a condition of providing health care. 2. Our AMA will work with local and state medical societies to immediately, actively and publicly oppose any legislative proposals that would criminalize the provision of health care to **undocumented** residents and report back on this issue at the 2008 Annual Meeting. (Res. 920, I-06; Reaffirmed and Appended: Res. 140, A-07)

Violence and Abuse

H-65.974 Gender-Based Violence

Our American Medical Association oppose inhumane treatment of people of both genders; (2) our AMA encourage the development of programs to educate and alert all cultures to remaining practices of inhumane treatment based on gender and promote recognition of abusive practices and adequate health care for victims thereof; and (3) our AMA encourage the development of programs to educate and alert all cultures to remaining practices of inhumane treatment based on gender and promote recognition of abusive practices and adequate health care for victims thereof. (Res. 404, A-06)

H-515.962 Renewed Focus on Domestic Violence

Our AMA will renew its commitment to combat family and intimate partner **violence** by including violence prevention and education as part of the ongoing strategic planning process. (Res. 610, A-07)

Visa and Immigration

H-160.920 Financial Impact of Immigration on the American Health System

Our AMA supports legislative and regulatory changes to require the federal government to make reasonable payments to physicians for the federally mandated care they provide to patients, regardless of the immigration status of the patient. (CMS Rep. 3, A-07)

D-255.985 Conrad 30 - J-1 Visa Waivers

Our American Medical Association lobby for the reauthorization of the Conrad 30 J-1 Visa waiver program; and (2) our AMA advocate that the J-1 Visa waiver slots be increased from 30 to 50 per state. (Res. 233, A-06)

D-255.987 J-1 Visa Service Requirement

Our American Medical Association lobby the U.S. Department of State to change the current J-1 Visa waiver policy to allow for exceptions on a “case-by-case” basis where the continuous service requirement can be waived, such as in cases of documented abusive and intolerable employment conditions. (BOT Rep. 11, A-06)

H-255.975 J-1 Exchange Visitor Program (J-1 Visa)

Policy of the AMA states: the purpose of the physician J-1 Visa Exchange Program is to ameliorate physician specialty shortages in other countries; and the AMA will work to correct the problems of inconsistency, lack of accountability, and non-compliance in the administration of the physician J-1 Visa Exchange Program. (CME Rep. 2, A-97; Modified and Reaffirmed: CME Rep. 2, A-07)

AMA: House of Delegates

D-600.966 Professional Interest Medical Association Representation in the House of Delegates

Profession Interest Medical Associations granted representation in our AMA House since June 2006 include:

The American Association of Physicians of Indian Origin and the Korean American Medical Association are granted representation in the AMA House of Delegates. (June 2006) (BOT Rep. 18, A-06)

(Rev. 10/07/wk)