ILLINOIS STATE MEDICAL SOCIETY

Resolution 12.2020-23
(A-21)

Introduced by:	Jared Hendren, Arya V. Dadhania, Vanitha Raguveer, Divya Meher Surabhi, MPH and Adrienne DaGue, ISMS Members
Subject:	Using a Vulnerability Index to Increase Resources in Illinois Counties During a Pandemic
Referred to:	Council on Medical Service

Whereas, as of December 12, 2020, more than 17.2 million Americans have been reported to have COVID-19 and over 300,000 have died due to COVID-19[1]; and

Whereas, Black or African American, and Hispanic or Latino persons are 1.7 and 1.8 times more likely to contract COVID-19, respectively, and 2.8 times more likely to die due to COVID-19[2]; and

Whereas, 12 Chicago zip codes with the lowest rates of testing from October 12 to November 19 are all either majority Black or Latino indicating these communities have lower rates of testing despite being disproportionately affected by COVID-19[3]; and

Whereas, as of December 12, 2020, the prevalence of COVID-19 cases in non-metro areas is greater and growing more rapidly than in metro areas[4,5]; and

Whereas, more than half of residents who live in central and southwest IL are more than 10 miles from the closest testing facility[3]; and

Whereas, personal protective equipment (PPE) shortages are occurring in rural health care facilities more often than in urban health care facilities[6]; and

Whereas, a pandemic vulnerability index is designed to aid state and local officials in mitigating and planning for emergencies such as a pandemic[7-13]; and

Whereas, a pandemic vulnerability index specifically designed to predict the non-linear, non-parametric course of the COVID-19 pandemic using county-level, daily epidemiological data, and sociodemographic variables of a county, while being adaptive to the outcomes of pandemic public health response measures is better suited to address the unique nature of a pandemic[14-17]; and

Whereas, counties with greater pandemic vulnerability are more likely to have higher COVID-19 incidence and mortality, especially those with higher percentages of minoritized residents and in less urban areas[12-15]; therefore, be it

RESOLVED, that our ISMS support and advocate for the provision of appropriate funding to organizations and universities to develop accurate, timely models of community vulnerability and to study what resources have been needed in each Illinois county to increase response times and reduce vulnerability and susceptibility for future pandemics; and be it further

RESOLVED, that our ISMS support the adoption of a pandemic vulnerability index that takes into account county-level, daily epidemiological data and sociodemographic variables of a county for use in the process of future pandemic response planning and determining county needs; and be it further

RESOLVED, that our ISMS support the Illinois Department of Public Health and other organizations increasing testing sites and PPE in minoritized communities and rural communities with the highest Pandemic Vulnerability Index scores; and be it further

RESOLVED, that our ISMS support and advocate for giving health care providers, in areas with the most vulnerability, the necessary resources to treat their patients and protect themselves.

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Relevant AMA and AMA-MSS Policy

Influenza Vaccine Availability and Distribution H-440.851
1. Our AMA will continue efforts to communicate strongly to its partners involved in influenza vaccine production and distribution that physicians must receive influenza vaccines in a timely and equitable manner in order to help immunize all patients =6 months of age as recommended by the Center for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP)
2. Our AMA urges manufacturers and distributors of the influenza vaccine provide a dedicated ordering system for small- and medium-size medical practices to pre-order vaccines up to an appropriate volume threshold
3. Our AMA supports federal actions to allow physicians to form purchasing alliances to allow for competitive purchasing of influenza vaccine comparable to large purchasers currently supplying pharmacy and grocery chain stores with influenza vaccine
4. Our AMA will communicate current ACIP recommendations on the influenza vaccine to physicians and assist the CDC in disseminating its informational letters and bulletins to physicians and other providers of the influenza vaccine when they become available in order to ensure compliance with the ACIP recommendations with respect to immunization of patients influenza vaccine
5. Our AMA will work with the CDC and other immunization partners to explore options to provide for timely influenza immunization of indigent or underserved populations, including exploring options to provide for timely redistribution of state and federally funded influenza vaccines to facilities or groups within the state willing to appropriately manage, distribute, and administer the vaccine to indigent or underserved populations.
6. Our AMA will continue to collaborate with the CDC and other stakeholders in influenza vaccination to work to achieve the influenza immunization goals of Healthy People 2020, with particular attention to improving demand for vaccine and achieving stability in the vaccine supply.
7. Our AMA will work with local public health officers through the Federation to respond to community flu vaccine shortages and possible influenza outbreaks to protect the public health.
8. Our AMA will urge the federal government to support, as a national priority, the development of safe and effective influenza vaccines employing new technologies and to continue to support adequate distribution to ensure that there will be an affordable, available and safe supply of influenza vaccine on an annual basis.
CSAPH Rep. 5, I-12, Reaffirmation A-15

11.1.3 Allocating Limited Health Care Resources

1. A physicians' primary ethical obligation is to promote the well-being of their patients. Policies for allocating scarce health care resources can impede their ability to fulfill that obligation, whether those policies address situations of chronically limited resources, such as ICU (intensive care unit) beds, medications, or solid organs for transplantation, or "triage" situations in times of scarcity, such as access to ventilators during an influenza pandemic.
2. As professionals dedicated to protecting the interests of their patients, physicians thus have a responsibility to contribute their expertise to developing allocation policies that are fair and safeguard the welfare of patients.
3. Individually and collectively through the profession, physicians should advocate for policies and procedures that allocate scarce health care resources fairly among patients, in keeping with the following criteria: (a) Base allocation policies on criteria relating to medical need, including urgency of need, likelihood and anticipated duration of benefit, and change in quality of life. In limited circumstances, it may be appropriate to take into consideration the amount of resources required for successful treatment. It is not appropriate to base allocation policies on social worth, perceived obstacles to treatment, patient contribution to illness, past use of resources, or other non-medical characteristics. (b) Give first priority to those patients for whom treatment will avoid premature death or extremely poor outcomes, then to patients who will experience the greatest change in quality of life, when there are very substantial differences among patients who need access to the scarce resource(s). (c) Use an objective, flexible, transparent mechanism to determine which patients will receive the resource(s) when there are not substantial differences among patients who need access to the scarce resource(s). (d) Explain the applicable allocation policies or procedures to patients who are denied access to the scarce resource(s) and to the public.
AMA Principles of Medical Ethics I, VII

Improving the Health of Black and Minority Populations H-350.972

1. Our AMA supports 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. Our AMA supports the 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. Our AMA supports advising our AMA representatives to the LCME to request data collection on medical school curricula concerning the health needs of minorities.
4. Our AMA supports 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, Modified: CSAPH Rep. 1, A-11

Racial and Ethnic Disparities in Health Care H-350.974

1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment.
2. Our 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.
3. The elimination of racial and ethnic disparities in health care is an issue of highest priority for the American Medical Association.
4. The AMA emphasizes three approaches it believes should be given high priority: A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform. B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities. C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities
5. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality.
6. Our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.
7. Our AMA (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.

CLRPD Rep. 3, I-98, Appended and Reaffirmed: CSA Rep.1, I-02, Reaffirmed: BOT Rep. 4, A-03, Reaffirmed in lieu of Res. 106, A-12, Appended: Res. 952, I-17, Reaffirmed: CMS Rep. 10, A-19

Hospital Disaster Plans and Medical Staffs H-225.941
1. Our AMA encourages appropriate stakeholders to examine the barriers and facilitators that medical staffs will encounter following a natural or other disaster.
2. Our AMA encourages hospitals to incorporate, within their hospital disaster plans, workplace, and personal preparedness efforts that reduce barriers to staff responses during a natural or other disaster, both within their institutions and across the community. Res. 916, I-17

Fiscal Note:

n/a

Existing ISMS policy related to this issue:

All medical societies should cooperate with and contribute to disaster control plans in their communities. (HOD 1980 Amended; Last BOT Review 2014)

Illinois residents should be provided access to all medically indicated immunizations. Physicians are requested to provide this protection or to encourage the local public health agency to perform this function, and to encourage enforcement of current immunization laws. In addition, physicians should be encouraged to participate in epidemiological studies (especially as related to “search and destroy” methods for communicable diseases) which have been endorsed by the local or state medical society. ISMS continues to support the need for physical examinations of, and updating of immunizations for, school children in the State of Illinois on school entry, at 5th grade and 9th grade levels, in keeping with preventive medicine measures presently in existence in the state. Measures to assure compliance of the school health mandates by school districts in Illinois should be maintained. Every school district should be consulted by health departments planning any mass immunization campaign. In counties where there is no public health department, the Illinois Department of Public Health should contact either the county medical society or local physicians (whichever is appropriate) for coordination of the immunization program. If private facilities are utilized during a mass immunization campaign, normal reimbursement procedures may be employed, but no charge shall be made for the cost of vaccine paid for by the federal government. (HOD 1991 Amended; Reaffirmed 2017; Last BOT Review 2014)