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REPORT OF THE BOARD TRUSTEES

B of T Report 3-A-18

Subject: 2017 Grants and Donations

Presented by: Gerald E. Harmon, MD, Chair

This informational financial report details all grants or donations received by the American Medical Association during 2017.
# American Medical Association

**Grants & Donations received by AMA**

**For the Year Ended December 31, 2017**

**Amounts in thousands**

<table>
<thead>
<tr>
<th>Funding Institution</th>
<th>Project</th>
<th>Amount Received</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency for Healthcare Research &amp; Quality (subcontracted through Northwestern University)</td>
<td>Midwest Small Practice Care Transformation Research Alliance</td>
<td>$ 299</td>
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<tr>
<td>Centers for Disease Control and Prevention (subcontracted through National Association of Chronic Disease Directors)</td>
<td>Diabetes Technical Assistance and Support</td>
<td>243</td>
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<tr>
<td>Centers for Disease Control and Prevention (subcontracted through YMCA)</td>
<td>Diabetes Prevention Program</td>
<td>9</td>
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<tr>
<td>Centers for Medicare Medicaid Services</td>
<td>Transforming Clinical Practices Initiative — Support and Alignment Networks</td>
<td>453</td>
</tr>
<tr>
<td>Centers for Medicare &amp; Medicaid Services (subcontracted through Mathematica Policy Research, Inc.)</td>
<td>Quality Measures for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees</td>
<td>53</td>
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<tr>
<td>Substance Abuse and Mental Health Services Administration (subcontracted through American Academy of Addiction Psychiatry)</td>
<td>Providers Clinical Support System for Opioid Therapies</td>
<td>$ 91</td>
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<tr>
<td><strong>Government Funding</strong></td>
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<td><strong>1,148</strong></td>
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<tr>
<td>American Association of Colleges of Osteopathic Medicine</td>
<td>Accelerating Change in Medical Education Initiative</td>
<td>13</td>
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<tr>
<td>American College of Physicians</td>
<td>International Congress On Peer Review and Scientific Publication</td>
<td>10</td>
</tr>
<tr>
<td>American Medical Association Foundation via contributions from Eli Lilly and Company</td>
<td>Accelerating Change in Medical Education Conference</td>
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<tr>
<td>American Medical Association Foundation via contributions from Genentech, Inc.</td>
<td>Accelerating Change in Medical Education Conference</td>
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<tr>
<td>American Medical Association Foundation via contributions from Pfizer, Inc.</td>
<td>Accelerating Change in Medical Education Conference</td>
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<tr>
<td>American Medical Association Foundation via contributions from The Physicians Foundation</td>
<td>Joy in Medicine Research Summit</td>
<td>57</td>
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<td>American Osteopathic Association</td>
<td>Accelerating Change in Medical Education Initiative</td>
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<td>Public Library of Science</td>
<td>International Congress On Peer Review and Scientific Publication</td>
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<td>Stanford University</td>
<td>International Congress On Peer Review and Scientific Publication</td>
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<td>The Marcus Foundation, Inc.</td>
<td>Evaluation of a Virtual Interactive Platform in Enhancing Diagnostic Reasoning and Improving Diagnostic</td>
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<tr>
<td><strong>Nonprofit Contributors</strong></td>
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<td>BioMed Central</td>
<td>International Congress On Peer Review and Scientific Publication</td>
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<td>Copyright Clearance Center, Inc.</td>
<td>International Congress On Peer Review and Scientific Publication</td>
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<td>Precision Computer Works, Inc.</td>
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<td>Wolters Kluwer Health</td>
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<tr>
<td>Contributions less than $5,000</td>
<td>International Congress On Peer Review and Scientific Publication</td>
<td>2</td>
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<tr>
<td>Contributions less than $5,000</td>
<td>International Medical Graduates Section Reception</td>
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<tr>
<td><strong>Other Contributors</strong></td>
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<td><strong>70</strong></td>
</tr>
<tr>
<td><strong>Total Grants and Donations</strong></td>
<td></td>
<td><strong>$ 2,216</strong></td>
</tr>
</tbody>
</table>
Subject: Update on Corporate Relationships

Presented by: Gerald E. Harmon, MD, Chair

PURPOSE

The purpose of this informational report is to update the House of Delegates (HOD) on the results of the Corporate Review process from January 1 through December 31, 2017. Corporate activities that associate the American Medical Association (AMA) name or logo with a company, non-Federation association or foundation, or include commercial support, currently undergo review and recommendations by the Corporate Review Team (CRT) (Appendix A).

BACKGROUND

At the 2002 Annual Meeting, the HOD approved revised principles to govern the American Medical Association’s (AMA) corporate relationships, HOD Policy G-630.040, “Principles on Corporate Relationships.” These “Guidelines for American Medical Association Corporate Relationships” were incorporated into the corporate review process, are reviewed regularly, and were reaffirmed at the 2012 Annual Meeting. AMA managers are responsible for reviewing AMA projects to ensure they fit within these guidelines.

YEAR 2017 RESULTS

In 2017, forty-four new activities were considered and approved through the corporate review process. Of the forty-four projects recommended for approval, thirteen were conferences or events, nine were education, content or grants, nineteen were collaborations or affiliations, and three were member service provider programs (Appendix B).

CONCLUSION

The Board of Trustees (BOT) continues to evaluate the CRT review process to balance risk assessment with the need for external collaborations that advance the AMA’s strategic focus.
Appendix A

CORPORATE REVIEW PROCESS OVERVIEW

The Corporate Review Team (CRT) includes senior managers from the following areas: Strategy, Finance, Health Solutions Group (HSG), Advocacy, Federation Relations, Office of the General Counsel, Medical Education, Publishing, Ethics, Enterprise Communications and Marketing (ECM), Physician Engagement (PE), and Health and Science.

The CRT evaluates each project with the following criteria:

- Type, purpose and duration of the activity;
- Audience;
- Company, association, foundation, or academic institution involved (due diligence reviewed);
- Source of external funding;
- Use of the AMA logo;
- Fit or conflict with AMA Corporate Guidelines;
- Editorial control/copyright;
- Exclusive or non-exclusive nature of the arrangement;
- Status of single and multiple supporters; and
- Risk assessment for AMA.

The CRT reviews and makes recommendations regarding the following types of activities that utilize AMA name and logo:

- Industry-supported web, print, or conference projects directed to physicians or patients that do not adhere to Accreditation Council for Continuing Medical Education (ACCME) Standards and Essentials.
- AMA sponsorship of external events.
- Independent and company-sponsored foundation supported projects.
- AMA licensing and publishing programs. (These corporate arrangements involve licensing AMA products or information to corporate or non-profit entities in exchange for a royalty and involve the use of AMA’s name, logo, and trademarks. This does not include database or CPT licensing.)
- Member service provider programs such as new affinity or insurance programs and member benefits.
- Third-party relationships such as joint ventures, business partnerships, or co-branding programs directed to members.
- Non-profit association collaborations outside the Federation. The CRT reviews all non-profit association projects (Federation or non-Federation) that involve corporate sponsorship.
- Collaboration with academic institutions only if there is corporate sponsorship.

For the above specified activities, if the CRT recommends approval, the project proceeds.
In addition to CRT review, the Executive Committee of the Board must review and approve CRT recommendations for the following AMA activities:

- Any activity directed to the public with external funding.
- Single-sponsor activities that do not meet ACCME Standards and Essentials.
- Activities involving risk of substantial financial penalties for cancellation.
- Upon request of a dissenting member of the CRT.
- Any other activity upon request of the CRT.

All Corporate Review recommendations are summarized annually for information to the Board of Trustees. The BOT informs the HOD of all corporate arrangements at the Annual Meeting.
## SUMMARY OF CORPORATE REVIEW
### RECOMMENDATIONS FOR 2017

<table>
<thead>
<tr>
<th>Project No.</th>
<th>Project Description</th>
<th>Corporations</th>
<th>Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>27797</td>
<td><strong>Sandy Hook Promise Gala</strong> – Continue AMA sponsorship, name and logo use for the June 2017 event.</td>
<td>Sandy Hook Promise, The Sorenson Family, Standard and Poor (S&amp;P) Global, Inc., Verizon Wireless, Mehlman Castagnetti Rosen &amp; Thomas, Akin Gump Strauss Hauer &amp; Feld, LLP, American Health Care Association (AHCA), Discovery Communications, Inc., Bank of America, Lockheed Martin Corporation, Anthem, Inc., Association for Accessible Medicines (AAM), American Telephone &amp; Telegraph, Inc. (AT&amp;T), General Dynamics Corporation, CVS Health, PepsiCo, Inc., Lumina Foundation, Genentech, Inc. (A Member of the Roche Group), Comcast Corporation, Blue Cross / Blue Shield Association, Pharmaceutical Research and Manufacturers of America (PhRMA), Amalgamated Band, Pacific Gas &amp; Electric Company (PG&amp;E), National Association of Broadcasters (NAB), Aetna Inc., Liberty Partners Group, LLC, Managed Funds Association (MFA)</td>
<td>5/10/2017</td>
</tr>
</tbody>
</table>
27981 Alliance for Health Policy Dinner – Repeating AMA sponsorship for 2017 event to support advocacy.

28216 Bellin Health Training Days – AMA sponsorship, name and logo use for Bellin Health conference for their nine step practice transformation framework.

28451 National Quality Forum (NQF) Annual Conference Sponsorship – Continue AMA sponsorship, name and logo use for NQF Annual Conference “Fulfilling The Quality Mandate.”

 Alliance for Health Policy (formerly Alliance for Health Reform) 8/4/2017

Bellin Health Systems Institute for Healthcare Improvement (IHI) 6/22/2017

National Quality Forum (NQF) 11/21/2017

Merck & Co., Inc.
Janssen Global Services, LLC
Kaiser Permanente
Novartis, AG
Deloitte
Compassus
America’s Essential Hospitals Utilization Review Accreditation Commission (URAC)
Henry Ford Health System
Battelle Memorial Institute
Heron Therapeutics, Inc.
American Health Care Association (AHCA) / National Center for Assisted Living (NCAL)
Federation of American Hospitals
American Hospital Association (AHA)
Health Care Service Corporation (HCSC)
UnitedHealth Group
Encompass Health Corporation
Relias
WellDoc, Inc.
Zero Suicide Institute
National Committee for Quality Assurance (NCQA)
Unite Us
Fair Health, Inc.
<table>
<thead>
<tr>
<th>ID</th>
<th>Event Description</th>
<th>Sponsor(s)</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>29117</td>
<td><strong>American Conference on Physician Health (ACPH)</strong> – AMA name and logo association with Stanford University and the Mayo Clinic for conference on physician well-being.</td>
<td>Stanford University, Mayo Clinic, The Physician Foundation, Coalition for Physician Well-Being</td>
<td>1/20/17</td>
</tr>
<tr>
<td>29472</td>
<td><strong>2017 Sling Health Demo Day</strong> – AMA sponsoring national Sling Health Demo Day.</td>
<td>Sling Health, Bank of America, St. Louis Bioscience (BioSTL), St. Louis Cardinals, Community Development Ventures, Inc., Entrepreneur’s Organization, iSelect, Pharmaceutical Research and Manufacturers of America (PhRMA), St. Louis Local Businesses (Randall’s, Sameem’s, Schlafly, Urban Chestnut), St. Louis Metropolitan Medical Society</td>
<td>4/27/17</td>
</tr>
<tr>
<td>29797</td>
<td><strong>Reach Media Collaboration</strong> – AMA Improving Health Outcomes (IHO) sponsorship of the Tom Joyner Family Reunion and Take a Loved One to the Doctor Day events.</td>
<td>Read Media Limited, Community Health of South Florida, Inc.</td>
<td>6/22/17</td>
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<tr>
<td><strong>29938</strong></td>
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</tbody>
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<thead>
<tr>
<th>AMA / AHIMA Clinical Documentation Improvement (CDI) Outpatient Workshop – AMA and AHIMA co-sponsoring a one day workshop on CDI.</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Health Information Management Association</td>
</tr>
<tr>
<td><strong>30050</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2017 Forbes Healthcare Summit – AMA name, logo and sponsorship to highlight opioid epidemic and showcase new AMA initiatives.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forbes America’s Biopharmaceutical Companies Bayer CVS Health Northwell Health City of Hope Comprehensive Cancer Center</td>
</tr>
<tr>
<td><strong>30210</strong></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>2018 National Rx Drug Abuse &amp; Heroine Summit – AMA name and logo use as event supporter.</th>
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</thead>
<tbody>
<tr>
<td>The National Rx Drug Abuse &amp; Heroine Summit</td>
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<td><strong>30362</strong></td>
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### EDUCATION, CONTENT OR GRANTS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Organisation/Grant</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>29414</td>
<td><strong>Teaching EMR</strong> – AMA name and logo use on Regenstrief Teaching EMR website and materials as acknowledgement of AMA’s Accelerating Change in Medical Education grant support.</td>
<td>The Regenstrief Institute</td>
<td>4/6/2017</td>
</tr>
<tr>
<td>29570</td>
<td><strong>Evaluation of Interactive Virtual Technology in Teaching (i-Human Platform)</strong> – A controlled AMA research study to evaluate the effectiveness of interactive technology, assess diagnostic reason and improve accuracy utilizing the i-Human platform and funding from the Marcus Foundation.</td>
<td>The Marcus Foundation i-Human Patients, Inc.</td>
<td>5/4/2017</td>
</tr>
<tr>
<td>29749</td>
<td><strong>Sling Health – Chapter Expansion Grants</strong> – An AMA grant, name and logo association with Sling Health for student chapter expansion and community on AMA Physician Network.</td>
<td>Sling Health</td>
<td>6/6/2017</td>
</tr>
<tr>
<td>29866</td>
<td><strong>Support for Human Diagnosis Project’s Uninsured Digital Physician Consult Program</strong> – The AMA support for MacArthur grant process.</td>
<td>Human Diagnosis Project MacArthur Foundation American College of Physicians</td>
<td>7/7/2017</td>
</tr>
<tr>
<td>30190</td>
<td><strong>Content Collaboration with Ingenious Med</strong> – AMA name and logo association with AMA content on Ingenious Med website.</td>
<td>Ingenious Med</td>
<td>9/12/2017</td>
</tr>
<tr>
<td>Code</td>
<td>COLLABORATIONS/AFFILIATIONS</td>
<td>Date</td>
<td></td>
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<tr>
<td>30492</td>
<td><strong>AMA and <em>The Atlantic</em>: Custom Content Digital Platform</strong> – AMA developed content for use in an AMA / <em>The Atlantic</em> co-branded platform.</td>
<td>10/16/2017</td>
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<tr>
<td>30540</td>
<td><strong>Collaboration with Gaples Institute</strong> – Integrative Cardiology nutrition curriculum for AMA Education Center.</td>
<td>10/24/2017</td>
<td></td>
</tr>
<tr>
<td>30804</td>
<td><strong>AMA-AAPL Physician Leadership Education Curriculum</strong> – Physician Satisfaction and Practice Sustainability (PS2) and the AMA Education Center in partnership with the American Academy of Physician Leadership (AAPL) to develop co-branded physician leadership curriculum.</td>
<td>11/21/2017</td>
<td></td>
</tr>
<tr>
<td>25556</td>
<td><strong>Addition of American Stroke Association to the Target: BP Initiative</strong> – Addition of American Stroke Association to previously approved AMA Improving Health Outcomes (IHO), and American Heart Association, Target: BP program.</td>
<td>7/21/2017</td>
<td></td>
</tr>
<tr>
<td>27962</td>
<td><strong>Collaborative Study on Opioid Prescribing Activity with Premier Inc.</strong> – Premier / AMA collaboration, name and logo association on research designed to reduce opioid-related harms.</td>
<td>10/12/2017</td>
<td></td>
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<tr>
<td>Code</td>
<td>Description</td>
<td>Organization(s)</td>
<td>Date</td>
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<td>-----------------------------------------------------</td>
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<tr>
<td>28930</td>
<td><strong>AMA Collaboration with Samsung SHealth</strong> – AMA to grant Samsung a non-exclusive, royalty free license to display AMA IHO diabetes resources in the Samsung SHealth phone application for U.S. users.</td>
<td>Samsung</td>
<td>9/15/2017</td>
</tr>
<tr>
<td>28964</td>
<td><strong>AMA Physician Opportunities Portal (POP)</strong> – Organization name and logo association with AMA POP interactive tool to identify extra clinical opportunities.</td>
<td>National Court Appointed Special Advocates (CASA) Association</td>
<td>4/17/2017</td>
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<tr>
<td>29341</td>
<td><strong>AMA / KPMG Co-branded MACRA Survey</strong> – A survey to gather physician feedback on the start of the MACRA Quality Payment Program.</td>
<td>Klynveld Peat Marwick Goerdeler (KPMG)</td>
<td>3/7/2017</td>
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<tr>
<td>29414</td>
<td><strong>AMA / Accenture Co-branded Cybersecurity Research</strong> – A physician survey on cybersecurity and HIPAA compliance.</td>
<td>Accenture</td>
<td>3/23/2017</td>
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<tr>
<td>29520</td>
<td><strong>Health Affairs Precision Health Sponsorship</strong> – Co-sponsorship of a “precision medicine” theme issue of the <em>Health Affairs</em> journal.</td>
<td>The Robert Wood Johnson Foundation Precision Health Economics, Illumina, Pharmaceutical Research and Manufacturers of America (PhRMA), Genentech, Inc. (A Member of the Roche Group), Patients Center Outcomes Research Institute (PCORI)</td>
<td>4/19/2017</td>
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<tr>
<td>29723</td>
<td><strong>AMA Collaboration with Pew and Medstar on EHR Best Practices</strong> – Conduct research and publish report to improve usability and safety of EHRs.</td>
<td>PEW Charitable Trusts, MedStar Health Research Institute</td>
<td>6/27/2017</td>
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</tbody>
</table>
Center for Healthcare Innovation Sponsorship – The AMA name and logo to be used on the website and program collateral for The 7th annual Diversity, Inclusion, & Life Sciences Symposium.

Partners HealthCare Digital Health Provider Adoption Study – AMA collaboration and logo use for Partners HealthCare research study to improve clinical adoption of digital health solutions.

Human Diagnosis Project Alliance – AMA name and logo association with Alliance to address gaps in specialty care for the underserved.

2017 TEDMED Collaboration – Recognition as TEDMED global partner for the AMA.
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Organization(s)</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>30208</td>
<td><strong>Lucro Collaboration</strong> – To improve digital health solutions through integration of AMA guidelines and solutions into Lucro’s healthcare marketplace platform.</td>
<td>Lucro Global, LLC</td>
<td>9/15/2017</td>
</tr>
</tbody>
</table>
| 30260 | **Physician Innovation Network (PIN) Supporters** – Recognizing organizations that contribute resources or cross promote the AMA Physician Innovation Network. | Physician Innovation Network (PIN)  
MATTER  
Sling Health  
Lucro Global, LLC  
Healthbox, LLC  
AngelMD, Inc.  
Texas Medical Center Accelerator (TMCx)  
Plug and Play Tech Center  
Techstars Corporation  
Society of Physicians Entrepreneurs (SOPE)  
Red Crow Crowd, Inc.  
Health 2047  
SMART  
1776  
Node Health  
Healthcare Innovation and Technology Lab, Inc. (HITLAb)  
Cambia Health Solutions, Inc.  
BluePrint Health  
StartUP Health  
Catalyst HTI  
Health 2.0  
Insight Product Development, LLC  
Health: Further  
American Association of Retired Persons (AARP)  
MedStar Health | 9/15/2017  |
| 30233 | **AMA / HITRUST Collaboration** – Workshop on cybersecurity frameworks for small physician practices. | Health Information Trust Alliance (HITRUST)  
Binder Dijker Otte (BDO) Global | 9/22/2017  |
<table>
<thead>
<tr>
<th>Integrated Health Model Initiative (IHMI) Collaborators</th>
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<tbody>
<tr>
<td>– AMA name and logo association with external companies as supporters of the IHMI digital platform.</td>
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</tbody>
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<thead>
<tr>
<th>Company Name</th>
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<tbody>
<tr>
<td>International Business Machines (IBM)</td>
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<tr>
<td>Prometheus Research</td>
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<td>Apervita</td>
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<td>Cerner</td>
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<tr>
<td>CareCloud</td>
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<td>American Heart Association (AHA)</td>
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<tr>
<td>Patient-Centered Outcomes Research Institute (PCORI)</td>
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<td>Private Company Price Index (PCPI)</td>
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<td>NEST Coordinating Center (NESTcc)</td>
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<td>American Diabetes Association (ADA)</td>
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<td>Patients Like Me</td>
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<td>American Medical Informatics Association (AMIA)</td>
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<td>Snowed</td>
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<td>CareMore</td>
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<td>The Geisinger Health System (GHS)</td>
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<td>Bioreference Laboratories</td>
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<td>Clinical Architecture</td>
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<td>M*Modal</td>
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<td>Optum360</td>
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<td>Intermountain Healthcare</td>
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<td>Partners Healthcare</td>
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<td>University of California San Francisco (UCSF)</td>
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<td>American Society of Anesthesiology (ASA)</td>
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<tr>
<td>American College of Cardiology (ACC)</td>
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<td>American Academy of Pediatrics (AAP)</td>
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<td>American Academy of Allergy, Asthma, &amp; Immunology (AAAAI)</td>
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<td>American College of Physicians (ACP)</td>
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<td>American College of Surgeons (ACS)</td>
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<td>Healthcare Trust of America (HTA)</td>
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<td>Minnesota Mining and Manufacturing (3M)</td>
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<td>Partners Healthcare</td>
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<tr>
<td>Kaiser Permanente</td>
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</tbody>
</table>

9/22/2017
### HumanDx
- Apple
- Samsung
- Google
- Logical Observation Identifiers Names and Codes (LOINC)
- United Healthcare
- UC Health

### Rand Payment Model Study
- **AMA name and logo on co-branded study book. Study entitled, “Effects of health care payment models on physician practice in the United States.”**
- **RAND**
- **10/12/2017**

### HIMSS Annual Conference Collaboration
- **Continuing AMA participation and logo use for HIMSS annual conference.**
- **Healthcare Information and Management Systems Society (HIMSS)**
- **10/16/2017**

### Collaborative Study on Antibiotic Stewardship with The Pew Charitable Trusts
- **Pew / AMA name and logo use on research to assess prescribing practices and the need for antibiotic stewardship in outpatient healthcare settings.**
- **The Pew Charitable Trusts**
- **10/20/2017**

### Member Service Provider Programs

| 29057 | **AMA Insurance Agency**  
(AMAI) Digital Platform – | Next Generation Insurance Group LLC | 1/12/2017 |
|       | AMA Insurance relationship with NextGen Insurance Group for digital insurance customer acquisition platform. | | |
|       | **AMA Insurance Agency**  
Subject: Redefining AMA's Position on ACA and Healthcare Reform

Presented by: Gerald E. Harmon, MD, Chair

At the 2013 Annual Meeting of the House of Delegates (HOD), the HOD adopted Policy D-165.938, “Redefining AMA’s Position on ACA and Healthcare Reform,” which called on our American Medical Association (AMA) to “develop a policy statement clearly outlining this organization’s policies” on a number of specific issues related to the Affordable Care Act (ACA) and health care reform. The adopted policy went on to call for our AMA to report back at each meeting of the HOD. BOT Report 6-I-13, “Redefining AMA’s Position on ACA and Healthcare Reform,” accomplished the original intent of the policy. This report serves as an update on the issues and related developments occurring since the most recent meeting of the HOD.

EFFORTS TO REPEAL THE ACA

Beginning prior to the introduction on March 7, 2017 of the component parts of what would become the American Health Care Act through the Senate’s failure to adopt the so-called “skinny bill” in the early morning hours of July 28, 2017, the AMA consistently engaged with policy makers in support of AMA policies related to the Affordable Care Act. While acknowledging that improvements were needed in the ACA, the AMA opposed repeal on the basis of several policy points adopted by the House of Delegates. Specifically:

- Ensure that individuals currently covered do not become uninsured and take steps toward coverage and access for all Americans;
- Maintain key insurance market reforms, such as pre-existing conditions, guaranteed issue and parental coverage for young adults;
- Stabilize and strengthen the individual insurance market;
- Ensure that low/moderate income patients are able to secure affordable and meaningful coverage;
- Ensure that Medicaid, The Children’s Health Insurance Program (CHIP) and other safety net programs are adequately funded;
- Reduce regulatory burdens that detract from patient care and increase costs;
- Provide greater cost transparency throughout the health care system;
- Incorporate common sense medical liability reforms; and
- Continue the advancement of delivery reforms and new physician-led payment models to achieve better outcomes, higher quality and lower spending trends.

A number of factors played into the inability of Congress to advance repeal of the ACA, including the decision to act under the limitations imposed by the budget reconciliation process and efforts to go beyond ACA reform to include significantly restructuring the financing of the Medicaid program without hearings or stakeholder input. Ideological differences among Republican members of Congress and discomfort with projections of significant increases in the number of Americans without health insurance as a result of Congressional action further compromised the pathway to repeal.
Following the failure to repeal ACA as a whole or in part, Congress was expected to turn to efforts to stabilize the current system in the short term through continuing Cost-Sharing Reduction (CSR) payments to health plans and reinsurance. However, despite bipartisan efforts to reach agreement, no plan to strengthen the ACA marketplaces had been brought to the floor for a vote. On October 12, 2017, President Trump announced that we would end CSR payments, which had continued to be made during pending litigation on their legality. On the same day, the President signed an Executive Order directing relevant agencies to explore options for more people to buy health insurance that is exempt from many of the ACA’s requirements.

As a result of the Executive Order, the Administration has released two proposed rules. The first, released January 4, 2018, would allow more flexibility to groups and small businesses to join together in an association health plan (AHP). While the AMA supports efforts to maximize health plan choices for individuals and small businesses, the policy of the House of Delegates also calls on the AMA to work with federal legislators to ensure that AHP programs safeguard state and federal patient protection laws. In comments to the Department of Labor (DOL) on the proposal, the AMA urged DOL to withdraw the proposed rule and work with state insurance commissioners and health care stakeholders to seek a solution that would expand affordable insurance coverage options through AHPs without undermining state authority to regulate AHPs to protect patients and physicians against such things as fraud and insurer solvency. AMA expressed concern that “DOL’s proposal does not maintain key consumer protections and does not meet the AMA’s key principles on health system reform ... and would result in substandard health insurance coverage.”

The AMA also warned that without proper oversight to account for insolvency and fraud, AHPs have the potential to increase already high insurance premiums and overall health care costs, while threatening patients’ health and financial security and the financial stability of physician practices and made recommendations to address those concerns.

On February 20, 2018, the Administration released a second proposed rule in keeping with the Executive Order, this time to make it easier for individuals to buy health plans that do not comply with ACA coverage requirements. The proposal would extend the time that consumers may be covered by short-term, limited duration health plans that are not required to comply with coverage requirements from three months to 364 days. These plans may not provide coverage for pre-existing conditions and benefits such as maternity care and mental health care are often excluded. Critics have charged that the proposal would fracture the individual market, though administration officials have disagreed with that assessment. At this writing, the AMA is reviewing the proposal.

Throughout the autumn of 2017, Congress also turned its attention to tax reform. While many in Congress had considered the possibility of using tax reform to repeal portions of the ACA, such as the requirement to obtain coverage, to take advantage of the protections from filibuster afforded it by the Reconciliation process, others expressed serious reservations. Many thought that including efforts to undermine ACA would erode support for the tax legislation. On November 8, 2017, the Congressional Budget Office (CBO) released an estimate that repeal of the individual mandate would result in 13 million fewer individuals having health coverage and premiums increasing an average of 10 percent. However, CBO also predicted that repeal would produce $338 billion in budgetary savings over 10 years, savings which could be used to offset some of the deficits produced by the growing tax cut proposal. On November 16, 2017, the Tax Cuts and Jobs Act bill passed the House by a vote of 227-205. The Senate followed on December 2, 2017 on a vote of 51-49. On December 19, the reconciled version of the Tax Cuts and Jobs Act passed both chambers and was signed into law by President Trump December 22, 2017. The new law eliminates the penalty for failure to obtain coverage repealing the individual mandate beginning in 2019.
REPEAL AND APPROPRIATE REPLACEMENT OF THE SGR AND PAY-FOR-
PERFORMANCE

Our AMA continues to work with Congress and the Administration on the implementation of and
improvements to the Quality Payment Program (QPP) established by the Medicare Access and
CHIP Reauthorization Act (MACRA). Considerable progress was made in this regard through

On February 9, 2018, the President signed the Bipartisan Budget Act of 2018. The budget bill
accomplished a number of critical Congressional priorities, including enacting continuing
appropriations through March 22 and setting spending caps for fiscal years 2018 and 2019,
suspending the debt ceiling for approximately one year, providing badly needed disaster relief
(including increased Medicaid spending for Puerto Rico and the U.S. Virgin Islands as called for
by the AMA House of Delegates), extending CHIP reauthorization for an additional four years
(through 2027) and addressing the so-called Medicare extenders, including repealing Medicare
outpatient therapy caps.

As a result of the work of our AMA and numerous state and national specialty medical
associations, a number of improvements to the QPP program were included in the final bill. These
included additional flexibility on the establishment of performance thresholds and the application
of cost measures, both of which will allow the Centers for Medicare & Medicaid Services to
continue to work with the physician community on implementation issues rather than having to
proceed immediately to more stringent requirements. Provisions of MACRA that applied the Merit-
based Incentive Payment System (MIPS) payment adjustments to Part B drugs were also repealed
and the authority of the Physician-focused Payment Model Technical Advisory Committee (PTAC)
to provide technical assistance to physicians developing alternative payment models was clarified
and broadened. Additionally, the requirement that the Advancing Care Information requirements
for physicians under MIPS become more stringent each year was repealed.

REPEAL AND REPLACE THE INDEPENDENT PAYMENT ADVISORY BOARD (IPAB)

The Bipartisan Budget Act of 2018 also repealed the IPAB which had been put into place by the
ACA. Prior to its repeal, no appointments had ever been made to IPAB and the requirement for
recommendations for Medicare cuts by the board was never triggered.

SUPPORT FOR MEDICAL SAVINGS ACCOUNTS, FLEXIBLE SPENDING ACCOUNTS,
AND THE MEDICARE PATIENT EMPOWERMENT ACT

While the AMA continues to support efforts to expand access to health savings accounts and
expand the use of flexible spending accounts, including support of the “Restoring Access to
Medication Act,” no new developments have occurred since the last meeting of the HOD.

The Medicare Patient Empowerment Act has not been reintroduced in the 115th Congress. The
AMA will continue to seek opportunities, however, to increase private contacting opportunities
under the Medicare program without penalty to the patient or physician.

STEPS TO LOWER HEALTH CARE COSTS

Policymakers continue to explore legislative and regulatory options to reduce the cost of care,
particularly as it relates to the costs of pharmaceuticals. While dozens of bills have been introduced
and multiple Congressional hearings have been held, no action on these proposals has been
scheduled to date. Our AMA continues to engage physicians and the public through www.TruthinRX.org, including collecting patient stories.

On February 28, 2018, a bipartisan group of U.S. Senators, including Sen. Bill Cassidy, MD, (R-LA) wrote to the AMA and other health care stakeholders regarding their efforts “to increase health care price and information transparency to empower patients, improve the quality of health care, and lower health care costs.” The letter requests stakeholder views on currently available information, what is not available, different methods to achieve price transparency, and other “common-sense” policies to empower patients and lower health care costs. Our AMA will respond to the inquiry and looks forward to engaging with these Senators and others on ways to lower health care costs.

One way to lower costs that is not in dispute is to lower the tremendous amount of time, effort, and resources that go into complying with overly burdensome, duplicative, and unnecessary administrative and regulatory requirements that do not benefit patient care. Physicians and other providers are spending more and more time on paperwork and less time directly on patient care, driving up costs for everyone. Since last summer, the House Committee on Ways and Means has been collecting information from health care providers as part of its Medicare Red Tape Relief Project. In announcing the efforts, Ways and Means Chairman Kevin Brady (R-TX) stated “we will be doing outreach to health care providers, doctors, nurses, hospitals, clinicians on what red tape and regulation out of Washington is interfering with the doctor-patient relationship, driving up the cost of health care, or simply getting in the way of the highest quality health care possible. And so Chairman Tiberi is going to be the one leading that effort. It will include soliciting ideas on what the Administration and executive branch can do, as well, and ultimately leading – we hope – to some action legislatively, as well.” While Subcommittee Chairman Tiberi has left Congress, we are pleased that the new Subcommittee Chairman, Peter Roskam (R-IL), has taken up this mantle, and we will continue to work with him and the committee to identify regulatory changes that can reduce the burden of providing care to Medicare beneficiaries as well as lower health care costs for all.

REPEAL NON-PHYSICIAN PROVIDER NON-DISCRIMINATION PROVISIONS OF THE ACA

Guidance released by the Department of Health and Human Services in 2014 included a positive interpretation of health plan requirements under section 2706(a) of the ACA, specifically clarifying that the section does not require “that a group health plan or health insurance issuer contract with any provider willing to abide by the terms and conditions for participation.” Nevertheless, the AMA will continue to seek legislative opportunities to repeal this provision.

CONCLUSION

While much of the federal activity since the 2017 Interim Meeting of the House of Delegates has centered on tax cuts and budgetary issues, health care is never far from the center of the debate. As we have over the last several months, our AMA will continue to seek opportunities to advance the policies that are the subject of this report as well as others adopted by the HOD.
REPORT OF THE BOARD OF TRUSTEES

B of T Report 7-A-18

Subject: AMA Performance, Activities and Status in 2017

Presented by: Gerald E. Harmon, MD, Chair

Policy G-605.050, “Annual Reporting Responsibilities of the AMA Board of Trustees,” calls for the Board of Trustees to submit a report at the American Medical Association (AMA) Annual Meeting each year summarizing AMA performance, activities, and status for the prior year.

INTRODUCTION

The AMA’s mission is to promote the art and science of medicine and the betterment of public health. As the physician organization whose reach and depth extends across all physicians, as well as policymakers, thought leaders and medical schools, the AMA is uniquely positioned to deliver results-focused initiatives that enable physicians to answer a national imperative to measurably improve the health of the nation.

Creating Thriving Physician Practices: Tools For The Field

PS2 Research: The AMA and KPMG surveyed 1,000 practicing physicians in the U.S. who had some awareness of the Medicare and Chip Reauthorization Act of 2015 (MACRA) and are involved in practice decisions related to the Quality Payment Program (QPP). This research aimed to better understand physician preparation and positioning for the QPP in 2017, which was the first reporting year under the program. Key findings of this research have helped the AMA develop educational and training resources for physicians, and have helped carve a path forward for practices participating or planning to participate in alternative payment models and the Merit-based Incentive Payment System (MIPS) through the QPP. The findings of this research were published in June 2017.

In a special report co-authored by senior AMA staff and published in The New England Journal of Medicine, relevant policy trends were identified and key recommendations made to grow the body of evidence on telehealth care delivery. This will have the potential to accelerate telehealth adoption, allowing physicians to enhance their delivery of clinical care.

Digital Health: The AMA formally launched the AMA Physician Innovation Network. Since launch in October, more than 2,070 users (companies and physicians) have joined the site. More than 1,100 of the users are physicians. There have been 1,000+ connection requests sent through the site, approximately 100 opportunities created thus far and numerous collaborators that have signed on to cross promote our efforts (e.g., MATTER, TMCx, Healthbox, and the Society of Physician Entrepreneurs).

More than 1.7 million clinical documents were shared in October 2017 among health care organizations through the Carequality Interoperability Framework. The rate of exchange has been rapidly accelerating each month as 2 million documents were exchanged in total for the first 12

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months. With existing users continuing to onboard clients, and more than a half dozen users expected to go live in the first quarter of 2018, there will be continued growth.

Xcertia, an mHealth app collaborative effort pioneered by the AMA, the American Heart Association (AHA), the DHX Group, and the Healthcare Information and Management Systems Society (HIMSS), builds on each organization’s ongoing efforts to foster safe, effective, and reputable health technologies. Initial content for Xcertia has been completed covering four areas: operability, security, privacy, and clinical evidence, and was released for public comment. The feedback will inform where to focus 2018 work group efforts.

**Physician Payment and Quality:** The AMA is working diligently so that practicing physicians are integral partners in the movement toward a thriving value-based health care system. AMA has created resources and tools for physicians and practice leaders that provide strategic guidance and education, implementation and decision support, and practice financial forecasting, among others.

By providing doctors with tools such as the AMA MIPS Action Plan ([https://apps.ama-assn.org/pme/#/actionplan](https://apps.ama-assn.org/pme/#/actionplan)), we assisted physician decision-making and participation in Medicare’s QPP, and in their making the larger move to value-based reimbursement.

**Practice Transformation:** The Professional Satisfaction and Sustainability unit’s (PS2) efforts in measuring physician burnout expanded with the addition of residency programs. We have worked closely with our partners in adapting the Mini-Z to measure burnout amongst residents and fellows. PS2 partnered with AMA Membership in designing and piloting this tool. We confirmed burnout assessments with 11 residency programs across the country. This is an excellent opportunity to further understand the resident and fellow experience, as well as opportunities to identify solutions to enhance the practice of medicine for the next generation of clinicians.

The AMA developed seven new modules in 2017 for STEPS Forward™:

- Creating the organizational foundation for Joy in Medicine
- Adopting OpenNotes: Partnering with patients
- Adult vaccinations: Team-based immunization
- Building a patient experience program
- EHR in-basket restructuring for improved efficiency
- Embedding pharmacists into the practice
- Managing type 2 diabetes: A team-based approach

**Guiding Professional Development:** A Commitment To Physician Growth

In collaboration with IHO, the ACE consortium created and piloted educational programing within the chronic disease prevention and management curriculum at four medical schools. The consortium, also in conjunction with IHO, developed a unique history and physical tool emphasizing biopsychosocial factors. This tool is being piloted at two medical schools.

Osteopathic residencies are now being accredited by ACGME, and staffers have been rapidly adding these newly accredited residencies to FREIDA Online, the AMA Residency & Fellowship Database. Searches for osteopathic residencies increased 95 percent in 2017 compared to 2016. There are now 455 programs on FREIDA that have osteopathic recognition or are formerly American Osteopathic Association accredited programs.
The Regenstrief EHR Clinical Learning Platform, an EHR specifically created for educational settings by Indiana University School of Medicine and the Regenstrief Institute with financial support from the ACE consortium, launched and is now used by five schools.

Innovations emerging from the ACE consortium continued to spread. Health systems science is increasingly recognized as the third pillar of medical education and taught alongside the other two pillars, basic and clinical science. The *Health Systems Science* textbook, published by Elsevier in December 2016, sold thousands of copies around the world and was adopted by 12 schools across the United States.

**Chronic Care: Improving Health Outcomes**

The AMA and American Heart Association launched a national “Health Care Provider High Blood Pressure Education” campaign that has garnered more than 500K acts of engagement via our various platforms. These platforms include Target: BP, a web platform that offers physician practices and health systems access to the new Target: BP Improvement Program (based on the 2017 Hypertension Guideline), which includes self-measured blood pressure as a key component to drive improved health outcomes.

In the fourth quarter of 2017 IHO co-led the successful launch of a new “National High Blood Pressure Awareness Consumer” campaign in collaboration with the AHA and the Ad Council that has already yielded more than 400K visitors to the campaign website (loweryourhbp.org) and garnered $747M in donated media placements across the country.

To date IHO is actively engaged with 11 state medical societies that will serve as models to help scale type 2 diabetes efforts nationwide. The list of states includes:

- Maryland State Medical Society
- Pennsylvania Medical Society
- Mississippi State Medical Association
- Nebraska Medical Association
- Ohio State Medical Association
- Oregon Medical Association
- Massachusetts Medical Society
- Minnesota Medical Association
- Michigan State Medical Society
- South Carolina State Medical Association
- Medical Society of the State of New York

The AMA and American Diabetes Association (ADA) collaborated with Samsung, one of the world’s leading electronics companies, to create a first-of-its-kind “mobile public awareness experience” during National Diabetes Awareness month in November 2017. Aimed at type 2 diabetes prevention, the goal of the collaboration was to help increase awareness among U.S. adults ages 18 to 60 about prediabetes as a condition, and to drive more individuals within this target population to assess their prediabetes risk via Samsung’s “S-Health App” for monitoring physical and other health activities. During the month more than 340K adults completed the prediabetes risk assessment. Our public awareness campaign with the Ad Council, CDC and ADA through television, radio, and print has to date yielded another 560,000 risk test completions.
Advocacy

The AMA took a leading role in the successful fight to preserve access to affordable health care coverage for millions of Americans. Through our site patientsbeforepolitics.org, the AMA generated more than 7 million actions, including calls, emails, and social interactions that helped shape the debate on Capitol Hill.

The AMA blocked two insurance mega-mergers that effectively protected over $500 million in annual physicians’ payments. The U.S. Court of Appeals in Washington, D.C., upheld the lower court’s decision to block the Anthem-Cigna merger. The AMA filed an amicus brief in that case, in which the AMA argued (among many other key points) that the trial court properly found that Anthem's reimbursement cuts, rather than enhancing consumer welfare, could cause quality to degrade and consumers to be deprived of choice. Also, at the AMA’s suggestion, the nation’s experts on antitrust and competition submitted their own amicus brief that supported AMA’s contention. On May 12, 2017, Anthem abandoned the Cigna merger.

The AMA secured retroactive changes to the Medicare legacy reporting requirements that will help physicians avoid $22 million in penalties in 2018, and addressed the biggest regulatory and administrative hurdles for physicians, including prior authorization, electronic health records, and insurer payment practices, such as new federal guidance that stops hidden transaction fees that could cost physician practices thousands of dollars per year.

The AMA secured more than 130 state legislative and regulatory victories on issues related to halting unfair health insurer practices, reversing the opioid epidemic, promoting medical liability reform, protecting Medicaid, and promoting team-based care/opposing inappropriate scope of practice expansions by non-physicians, as well as secured coverage for the Medicare Diabetes Prevention Program and for remote patient monitoring.

Health and Science

The AMA made progress on reversing the opioid epidemic. In 2017 the AMA was able to report fewer opioids being prescribed and an increase in prescription drug monitoring program use. The AMA continues its efforts to address the opioid epidemic by developing resources and advocating for policies intended to reduce opioid-related harm, increase access to effective treatment for pain, and broaden the base for accessing medication-assisted treatment for those suffering from opioid use disorder. A new opioid microsite was developed that contains a multitude of AMA and Federation-based resources addressing the intersection of pain, opioids, and addiction. Physicians are learning/following best practices for opioid prescribing. They continue, in increasing numbers, to access educational resources, register with and check patient information in prescription drug monitoring programs, obtain waivers for offering office-based treatment with buprenorphine, and co-prescribe naloxone for patients at risk of opioid overdose. Naloxone is now widely available for overdose interventions. Additionally, new partnerships were formed with hospitals, payers, government, and others in the public and private sector to work collaboratively to advance a public health solution to this enduring problem.

Health Solutions Group

In 2017 the AMA launched the Integrated Health Model Initiative (IHMI), a collaborative effort across health care and technology stakeholders that will unleash a new era of better, more effective patient care. IHMI supports a continuous learning environment to enable interoperable technology solutions and care models that will evolve with real-world use and feedback. IHMI uses the best
available science to incorporate essential data elements around function, state, and patient goals.

Key components of IHMI are: digital communities around costly and burdensome clinical areas, a physician-led validation process to review clinical applicability, and a data model for organizing and exchanging information. Since the public release in mid-October 2017, 1,000 individuals from 47 states and 33 countries have joined the IHMI platform, in addition to 17 collaborating organizations resulting in wide representation across external stakeholders.

In 2017 AMA Business Solutions, a subsidiary of the American Medical Association, collaborated with LexisNexis® Risk Solutions to create VerifyHCP™, a pre-populated physician data solution that aims to address the issue of inaccurate provider directories by streamlining verification and updates across participating health plans. VerifyHCP allows physicians to focus their resources on patient care and gives patients access to the credible information they need to make important health care decisions. A single interface with highly accurate pre-populated physician profile data allows for updates to all participating payer directories at one time. The solution reduces the administrative burden on physicians and helps patients access more accurate directories when selecting physicians.

The AMA in 2017 also established the Digital Medicine Payment Advisory Group, a collective of clinical and technical subject matter experts with years of hands-on experience integrating digital medicine services and tools into clinical practice to provide leadership in digital medicine adoption. This initiative will help open access to high-quality and safe clinical care for patients and their physicians that promote improved health outcomes. The group has identified payment and coverage strategies—with an initial emphasis on coding, coverage, and payment for remote patient monitoring services—to help overcome existing barriers to adoption. This group of 14 experts has been working as a cohesive group for more than a year with clear goals and objectives set for 2018 and beyond.

JAMA/JAMA Network

JAMA and the JAMA Network continue to expand the amount of content produced, the formats for distribution, the audiences they engage, and the impact their content has on research and practice. In 2017, JAMA users viewed full-text content over 31 million times and downloaded and listened to over 2 million podcasts. Downloads across the JAMA Network are up significantly as well, with over 70 million full-text views in 2017. JAMA’s impact factor rose to 44.4, and JAMA Oncology debuted with an impact factor of 16.6. Finally, in October, the JAMA Network announced the launch of JAMA Network Open, an open access journal that launched in 2018.

Communications

The AMA played a central role in health system reform by clearly and firmly articulating a positive vision for bipartisan reform, and by calling attention to the deficiencies in the various proposals that came through Congress. The AMA commanded attention as demonstrated by a nearly 50 percent share of voice of media coverage among its advocacy peers. The AMA was referenced more often—and by more media publications, broadcasts, and blogs—than any other health care organization in 2017, earning nearly 33 billion media impressions, which is more than on any other single issue in AMA history.

The AMA unveiled a bold brand campaign, the first in more than a decade, that in a brief timeframe helped change perceptions of the AMA among students, residents, and physicians and paved the way for the introduction of an ambitious membership campaign.
Physician Engagement

Physician Engagement: AMA launched the new “Membership Moves Medicine™” campaign, a multi-channel effort to educate prospective and existing members about AMA’s activities and accomplishments on behalf of patients and physicians—and provide tangible and compelling reasons to join the AMA. It also launched a digital communities pilot program (with nearly 4,000 initial participants across three main communities: IMGs, Medical Students, Physician—Reinventing Medical Practice) and the initial version of the Ambassador Program that leverages nearly 1,000 AMA council and section leaders to represent the AMA online, in social forums, and at live events.

Digital Transformation: The AMA launched more than 15 new areas on the AMA website, including a new House of Delegates/Annual Meeting site. The AMA revised the digital marketing platform with new landing pages, sign-up process, and account management center, greatly improving membership conversion rates. The website updates include five new thematically driven destinations that combine news storytelling and aggregated high-value content on subjects that connect with audiences for impact and engagement (i.e., compelling stories, research, tools, and resources to show the AMA’s impact and how members move medicine).

Membership: In 2017 the AMA saw its seventh consecutive year of membership growth, a 1.8 percent increase in dues paying members over 2016, and maintained a strong retention rate of nearly 82 percent.

Resident Program: The AMA launched the new GCEP Resident Education Platform (formerly known as the “Introduction to the Practice of Medicine”). By converging the strategic goals of Physician Engagement, the Education Center (EC), and ACE, the AMA was able to improve significantly on the former program’s appeal and performance. The new platform advances AMA content offerings and encourages frequent engagement; it provides opportunity to extend and expand programming at the UME, GME, and CME levels; and it drives lifelong affiliation and membership with the AMA.

EVP Compensation

During 2017, pursuant to his employment agreement, total cash compensation paid to James L. Madara, MD, as AMA Executive Vice President was $1,053,515 in salary and $987,735 in incentive compensation, reduced by $5,114 in pre-tax deductions. Other taxable amounts per the contract are as follows: $14,478 imputed costs for life insurance, $7,620 imputed costs for executive life insurance, $2,500 paid for health club fees, $2,880 paid for parking and $3,500 paid for a physical. An $81,000 contribution to a deferred compensation account was also made by the AMA. This will not be taxable until vested and paid pursuant to provisions in the deferred compensation agreement.

For additional information about AMA activities and accomplishments, please see the “AMA 2017 Annual Report.”
REPORT OF THE BOARD OF TRUSTEES

B of T Report 8-A-18

Subject: Annual Update on Activities and Progress in Tobacco Control: March 2017 through February 2018

Presented by: Gerald E. Harmon, MD, Chair

This report summarizes American Medical Association (AMA) activities and progress in tobacco control from March 2017 through February 2018 and is written pursuant to AMA Policy D-490.983, “Annual Tobacco Report.”

TOBACCO USE IN THE UNITED STATES: CDC MORBIDITY AND MORTALITY WEEKLY REPORTS (MMWR)

According to the Centers for Disease Control and Prevention (CDC) tobacco use remains the leading preventable cause of disease and death in the United States with an estimated 480,000 premature deaths annually, including more than 41,000 deaths resulting from secondhand smoke exposure. These data translate to about one in five deaths related to tobacco use annually, or 1,300 deaths every day. From March 2017 through February 2018, the CDC released 13 MMWRs related to tobacco use. These reports provide useful data that researchers, health departments, community organizations and others use to assess and develop ongoing evidence-based programs, policies and interventions to eliminate and/or prevent the economic and social costs of tobacco use.


Youth Smoking Rates and Trends

According to the June 16, 2017 MMWR, which was an analysis of data from the 2011-2016 National Youth Tobacco Surveys (NYTS), there were substantial increases in electronic cigarette (e-cigarette) and hookah use among high school and middle school students, whereas significant decreases were observed in the use of cigarettes, cigars, smokeless tobacco, pipe tobacco, and bidis. The NYTS is a cross-sectional, voluntary, school-based, pencil-and-paper questionnaire self-administered to U.S. middle and high school students. A three-stage cluster sampling procedure was used to generate a nationally representative sample of U.S. students attending public and private schools in grades 6–12.

Specifically among all high school students, current use of any tobacco product did not change significantly from 2011 (24.2%) to 2016 (20.2%); however, there was a significant decrease in current use of any combustible tobacco product (21.8% to 13.8%). The use of e-cigarettes increased from 1.5% to 11.3% during this same period.

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In 2016, among youth tobacco products users, 47.2% of high school students and 42.4% of middle school students used 2 or more tobacco products. E-cigarettes were the most commonly used tobacco product among high school (11.3%) and middle school (4.3%) students.

The authors highlight the need for sustained efforts to implement proven tobacco control policies and strategies that are critical to preventing youth use of all tobacco products. There is concern about the rising popularity of e-cigarettes. The FDA deeming rule that went into effect in August 2016, gives FDA jurisdiction over products made or derived from tobacco, including e-cigarettes, cigars, pipe tobacco and hookah tobacco. This oversight could reduce youth tobacco product initiation and use if combined with other environmental strategies such as taxes and raising the purchase age to 21.

**Adult Smoking Rates**

To assess progress toward the Healthy People 2020 target of reducing the proportion of U.S. adults aged 18 years and older who smoke cigarettes to 12.0% or lower, the January 19, 2018 MMWR analyzed data from the 2016 National Health Interview Survey (NHIS). The NHIS is an annual, nationally representative in-person survey of the noninstitutionalized U.S. civilian population. The NHIS core questionnaire is administered to a randomly selected adult in the household (the sample adult).

In 2016, the prevalence of current cigarette smoking among adults was 15.5%, which was a significant decline from 2005 (20.9%); however, no significant change has occurred since 2015 (15.1%). Current cigarette smoking prevalence was higher among males (17.5%) than among females (13.5%). By age group, prevalence was higher among adults aged 25–44 years (17.6%) and lower in adults 65 and older (8.8%).

**Veterans Smoke at Higher Rates**

The January 12, 2018 MMWR looked at tobacco use among military veterans in the U.S. from 2010-2015. An estimated 30% of veterans reported tobacco use and among those, 7% reported use of two or more tobacco products. Cigarettes were the most commonly used tobacco product (21.6%), followed by cigars (6.2%), smokeless tobacco (5.2%), roll-your-own tobacco (3.0%), and pipes (1.5%). Within subgroups of veterans, current use of any of the assessed tobacco products was higher among persons aged 18–25 years (56.8%), Hispanics (34.0%), or persons with less than a high school diploma (37.9%).

The authors highlighted the significant impact of tobacco use among veterans on healthcare costs. During 2010, the Veterans Health Administration (VHA) spent an estimated $2.7 billion on smoking-related ambulatory care, prescription drugs, hospitalization, and home health care for the segment of the veteran population receiving VHA services. Tobacco use among active military personnel can eventually contribute to VHA expenditures. Reducing tobacco use among both active duty military and veterans can therefore result in a substantial reduction in tobacco-related morbidity and mortality and billions of dollars in savings from averted medical costs.

Recommendations to address the high rates of tobacco use in veterans include promoting cessation to current military personnel and veterans, implementing tobacco-free policies at military installations and Veterans Affairs medical centers and clinics, increasing the age requirement to buy tobacco on military bases to 21 years, and eliminating tobacco product discounts through military retailers.
AMA TOBACCO CONTROL ACTIVITIES

AMA Calls on Walgreens to Stop Selling Cigarettes

According to an online survey, 82% of Walgreens’ shoppers surveyed agreed that “the primary focus of stores with pharmacies should be to sell products that help people get and stay healthy” and 73% reported that they favor a ban on tobacco sales at Walgreens. The survey was conducted by the Truth Initiative, a national nonprofit focused on eliminating tobacco use through youth engagement research and education.

The survey results were highlighted in a joint letter (January 2018) signed by the AMA and other medical and health groups calling on Walgreens to discontinue sales of tobacco products. The letter to the Walgreens Chief Medical Officer cited research that confirms that retail marketing, in-store advertising, and displays are associated with compromising quit attempts and cause the initiation and progression of tobacco use among young people. The letter also called on Walgreens to:

- refrain from opposing policies that reduce tobacco use including those that require tobacco-free retailers and regulate retail licensing and density;
- eliminate sales of tobacco products while continuing to sell FDA approved nicotine therapies; and
- employ pharmacy-based plans to assist smokers with quit attempts including cessation counseling.

The AMA opposed sales of tobacco products in pharmacies as early as 2003. As stated in the Board of Trustees Report 02-I-03, “Opposition to Sales of Tobacco in Pharmacies”, the sale of tobacco products in pharmacies presents an ethical conflict for pharmacists; sends unhealthy, mixed messages to consumers about the role of pharmacies in the community; is not a clear economic necessity; and negatively affects the health of our patients. By selling and promoting tobacco, pharmacies undermine the tobacco control efforts of the rest of the health community.

AMA first adopted its policy calling for a ban on sales of tobacco products in pharmacies in 2009 and reaffirmed Policy D-495.994, in 2013.

Declines in Smoking in Movies Stalled since 2010

In response to the July 7, 2017, MMWR, Tobacco Use in Top-Grossing Movies - United States, 2010–2016, the AMA signed on to a letter to film industry leaders demanding that movie producers, distributors and exhibitors apply an R-rating to all films that include depictions of smoking or tobacco. According to the MMWR, the average number of tobacco incidents increased 55% in youth-rated movies with any tobacco depiction from 22 incidents in 2010 to 34 incidents in 2016. Previous studies had shown a steady decline, and if that trend had continued, all youth-rated films would have been smoke-free by 2015.

The AMA was one of several organizations, including the American Academy of Pediatrics, American College of Physicians, American Heart Association, American Lung Association, American Public Health Association and others, who signed the letter citing the report. The medical and public health groups set a deadline of June 1, 2018 for the industry to end its practice of using tobacco depictions in youth-rated movies because research has shown these images have a direct impact on children.
In a press statement, AMA President Dr. David O. Barbe said “We urge the motion picture industry to listen to the collective plea of the nation's physicians and once and for all apply an 'R' rating to films depicting cigarette smoking to help keep lethal, addictive tobacco products out of the hands of young people. We will continue to advocate for more stringent policies and support efforts to protect our nation's youth from the dangers caused by tobacco use.”

AMA House of Delegates Continues to Support Strong Tobacco Control Policies

The AMA House of Delegates adopted new or modified existing tobacco control policies at its 2017 Annual Meeting and 2017 Interim Meeting. Among the policies adopted was H-490.905, “Use of Tobacco Industry-Sponsored Cessation and Prevention Materials,” which called on physicians to use smoking cessation materials from credible sources when talking with their patients. Physicians and health organizations are urged to avoid providing to patients and consumers information or materials on tobacco cessation that come from tobacco companies or other groups aligned with the tobacco industry.

The AMA also adopted D-490.974, “Corrective Statements Ordered to be Published by Tobacco Companies for the Violation of the Racketeer Influenced and Corrupt Organizations Act,” that calls for educating the public and policymakers about the organized conspiracy of several tobacco companies to commit fraud and mislead consumers about the negative health effects of tobacco use. In 2006, several tobacco companies were found in violation of the U.S. Racketeer Influenced and Corrupt Organizations (RICO) Act. Ten years after that decision, the U.S. Court of Appeals finalized the content of the corrective statements the companies are required to make public.

Under this policy, the AMA will work with state and medical specialty societies as well as public health organizations to increase public awareness of the tobacco companies that were found in violation of the RICO Act and the corrective statements that they are being required to publish. The policy also encourages state and medical specialty societies to work with appropriate public health organizations in their states to help identify public policies that may have been directly or indirectly influenced by tobacco companies, and encourage lawmakers to reject any potential tobacco industry influences on future policy.

AMA Fights for Tobacco Provisions in Appropriations Bill

The AMA joined with medical groups and health organizations to oppose the House Agriculture, Rural Development, Food and Drug Administration (FDA), and Related Agencies appropriations bill. The bill called for weakening the FDA’s authority over certain tobacco products and would exempt the Agency’s oversight over large and premium cigars entirely. This bill was of particular concern because it would have created a loophole that would enable manufacturers of some cheap, fruit- and candy-flavored cigars to escape from FDA oversight and prevent FDA from implementing common sense rules for all cigars.

A 2009 law requires FDA review of new or changed tobacco products and applies to new products introduced after February 15, 2007. This review is critical to stop tobacco companies from introducing products that are more appealing to children, more addictive and even more harmful.

The House appropriations language would completely exempt from this requirement any e-cigarettes or cigars that are already on the market. Exempted products would include cigars and e-cigarettes in an array of candy and fruit flavors that clearly appeal to children. The proposed language would allow these products to stay on the market without any FDA review to determine whether they attract children or otherwise harm public health.
The advocacy efforts by the medical and health groups were successful. In March 2018, the House policy riders to exempt “large and premium cigars” from FDA oversight and to change the “grandfather date” in order to exempt e-cigarettes, cigars, and other tobacco products from an FDA product review requirement were not included in the final bill.
Subject: Ownership of Patient Data

Presented by: Gerald E. Harmon, MD, Chair

At the 2017 Annual Meeting the House of Delegates adopted Policy D-315.976, “Ownership of Patient Data,” which asks that our American Medical Association undertake a study on the misuse of patient information by hospitals, corporations, insurance companies, and big pharma, including the impact on patient safety, quality of care, and access to care when a patient’s data is withheld from his or her physician.

The testimony on this resolution was unanimously in favor of adoption. Those who spoke discussed the many challenges related to accessing patient data and medical records by physicians, and agreed that a study is needed to better identify these obstacles and begin exploring solutions to the use and misuse of patient information.

This informational report provides an overview of the current laws and regulations at the state and federal levels that address ownership, access and use of patient data including under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its implementing regulations. It also looks at controls and processes in place to address physician and healthcare industry access and use of patient information.

LEGAL AND REGULATORY OVERVIEW

Ownership of, and access to, patient data contained in a medical record are distinct concepts under the law. State laws vary on the topic of who owns a patient’s medical record. As depicted in the following graphic from Health Information & the Law¹ the majority of state legislatures either grant ownership of the medical record to the clinician or institution, or remain silent on medical

¹ Provider ownership of medical record is referenced in language of law
2 Ownership is of the physical conveyance for the medical information
3 Ownership is of the information contained in the record

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Ownership of patient data is not specified under HIPAA. Patients, however, have broad access rights to their protected health information (PHI). Patients can also exercise control over whether and how their health information is used and disclosed for certain purposes, including marketing. The following points are highlighted for patients by the U.S. Department of Health & Human Services Office of Civil Rights document titled “Your Health Information Privacy Rights”:

(1) Generally, patient health information cannot be used for purposes not directly related to care without permission. For example, a doctor cannot give it to a patient’s employer, or share it for things like marketing and advertising, without written patient authorization and (2) patients can ask that their health information not be shared with certain people, groups, or companies.

The Office for Civil Rights (OCR) has an online complaint portal in which anyone can file a complaint against covered entities and their business associates if there is a potential violation of an individual’s health information privacy rights or other violation of the Privacy, Security, or Breach Notification Rules. A “Covered Entity” is defined as either a health plan, health care clearinghouse, or health care provider who transmits PHI in electronic form. “Business Associate” is defined in part as a person that provides data transmission services with respect to PHI to a covered entity and that requires access on a routine basis to such PHI. Additionally, a Business Associate may also be a subcontractor that creates, receives, maintains, or transmits PHI on behalf of the business associate. If OCR determines that a covered entity or business associate may have violated the HIPAA Rules, that entity or business associate must either voluntarily comply with the HIPAA Rules, take corrective action, or agree to a settlement with the injured party. Additionally, a civil monetary penalty (CMP) may be imposed on the covered entity if the corrective action is not viewed as satisfactory.

PHYSICIAN ACCESS TO PATIENT RECORDS

Much of the discussion on this resolution centered on the obstacles in accessing patient and medical record data by physicians. This can be a symptom of the physician’s contract with the hospital or healthcare entity they are employed by or contracted for services with, or the electronic healthcare record vendor that they or their employer has contracted with.

Contractual Considerations – Employment Agreements

In cases where a physician is an employee of a hospital or other healthcare entity, access to patient and medical record data both during and following employment is often addressed by the employment agreement. The AMA, as well as many state medical societies, provides physicians resources to assist in navigating various issues and ensuring a fair and comprehensive employment agreement. This is especially important during separation.

Depending on its terms, an employment or independent contractor (IC) arrangement between a physician and a hospital or health system should specify who owns the patient records and patient data, and which parties have access rights to the data, including after termination. The parties will negotiate their rights with respect to ownership of and access to the records for specified purposes, including upon patient request.

The “AMA Annotated Model Physician-Hospital Employment Agreement” addresses access to patient records and confidentiality in Section 8.7. While continuity of care is a high priority upon the termination of the contractual employment relationship between a hospital and a physician,
equally important is contractual language that acknowledges the physician’s entitlement to copies
of patient charts and records. “The employer may wish to specify that, upon termination, the
physician will not be entitled to keep or copy charts, files, or patient lists;” however, it is common
practice to negotiate a provision that allows the physician to obtain the patient records after
termination for situations such as a malpractice action, administrative investigation or proceeding
against the physician, as they would be necessary to the physician’s defense.

AMA Advocacy Efforts and Resources

The AMA model state bill titled “Physician Employment Patient Notification and Records Act”
states that, in order to ensure that the termination of their physicians’ employment does not disrupt
their care; patients must be timely provided with information enabling them to obtain care from
alternative physicians or continue to receive care from their physicians post-termination. The
model bill also states that access to medical records should be addressed in the employment
agreement and should state that the physician is entitled to copies of patient charts and records
relating to the physician’s provision of physician services: (1) upon written request from the
patient, or (2) when records are necessary to address any current or future legal, professional,
administrative, regulatory, or other issues, claims, allegations, proceedings, or investigations
against, involving or in connection with those services.

The AMA Advocacy Resource Center (ARC) has developed a legislative campaign with the goal
of assisting physicians with issues throughout the employment spectrum including negotiating
employment contracts, maintaining autonomy during employment, and terminating the
relationship.

Federal Regulation and Guidance

The U.S. Department of Health and Human Services (HHS) has also weighed in on the related
matter of charging for access to patient or medical records. In March of 2016, OCR issued new
guidance including the stipulation that in the case of a request for an electronic copy of PHI
maintained electronically, covered entities may charge a flat fee not to exceed $6.50 (inclusive of
all labor, supplies, and postage).

Accessing Data through an Electronic Health Record (EHR) Vendor

The second party with which a physician can encounter issues regarding access to patient and
medical record data is with their electronic health records vendor. Concerns over ensuring data are
readily available to physicians and patients, prompted HHS and the Office of the National
Coordinator (ONC) to release a Health IT Playbook to help clinicians navigate the EHR market.
HHS and ONC also have developed an EHR contracting guide, “EHR Contracts Untangled:
Selecting Wisely, Negotiating Terms, and Understanding the Fine Print.” The Health IT Playbook
and contracting guide are meant to assist clinicians and healthcare institutions in negotiating
contract terms with EHR vendors. The publication includes guidance and sample contract terms
addressing compliance with HIPAA and the control and access to EHR data - including the
avoidance of data blocking.

Contractual Considerations – EHR Vendor Agreement

The use of an EHR contract, including a Business Associate Agreement (BAA), can provide a
covered entity, such as a physician, the legal protection necessary to use and disclose patient PHI
with a health information exchange (HIE) or third party subcontractor for various purposes. These
activities may include health care activities, including but not limited to, claims processing, data analysis, or quality assurance.

Physicians are encouraged to ensure the contract with the EHR vendor clearly defines data rights. Failing to clearly address data access rights in the BAA and any other vendor contract can severely impact the physician’s ability to share data with patient registries and HIEs as well as easily transition to a new EHR vendor in the future.

The EHR vendor contract and BAA should also clearly identify what the EHR can and cannot do with the data that is created and used by the physician. The vendor agreement or BAA should address whether or not the vendor is permitted to aggregate de-identified data across different covered entities for medical research, population health management, or other purposes.

**AMA Tools and Resources**

The AMA’s Steps Forward™ module titled “Electronic Records Software Selection and Purchase” provides guidance on negotiating favorable contract terms. The AMA also has model legislation created in response to Policy D-478.972 that required the AMA to develop model state legislation to eliminate pricing barriers to EHR interfaces and connections to HIEs. The bill, titled “An Act to Improve the Transparency of Electronic Health Record Systems Costs and Promote Data Sharing,” identifies appropriate disclosures including data sharing capabilities and detailed fees.

**Federal Regulations and Guidance**

There are cases where it may be challenging to implement this guidance in today’s environment. Because of unequal bargaining power and the fact that a hospital or health system, and not an individual physician, often contracts with an EHR vendor, it can be difficult for a physician, practice, or institution to obtain favorable contract provisions. The 21st Century Cures Act (the Act) directs the Secretary of HHS to develop a strategy to reduce EHR regulatory and administrative burdens while placing new requirements upon developers as a condition of certification and maintenance of certification. These requirements address many of the AMA’s long-standing concerns with EHRs, including prohibiting vendor data blocking; improving the usability, interoperability, and security of EHRs; and testing certified EHR technology in real-world settings.

The Act provides for penalties of up to $1.0 million per instance for any developers, networks, or exchanges that the Office of Inspector General (OIG) of HHS finds to have committed information blocking.

The AMA has actively provided feedback to ONC, OIG, and HHS on what should and should not be considered blocking and publically, through numerous comment letters, supports the operationalization of the Act’s information blocking requirements for health IT vendors. The AMA is expecting the release of the proposed rule around the implementation of the Act’s requirements in April of 2018.

**USE OF PATIENT RECORDS BY THE HEALTHCARE INDUSTRY**

A search on use of EHR records reveals instances where health systems and EHR vendors are entering data agreements to provide de-identified, anonymized data to organizations including medical device manufacturers, technology providers, health information aggregators and clinical researchers. Two recent examples include a partnership between Mercy Health System and Medtronic to share de-identified data from approximately 80,000 patients with heart failure to
focus on how patients respond to Cardiac Resynchronization Therapy (CRT). In another recent example Google9 partnered with academic medical centers to explore how machine learning can be used to mine EHR data for improved outcomes.

EHR vendors also use de-identified patient data gathered through use of their products in population health tools. In a less common scenario, some EHR vendors are providing de-identified, anonymized patient data to health information organizations (HIO) who in turn merge the data with other available datasets and license the combination to government agencies, academia, and businesses for a range of medical research and commercial purposes. This includes pharmaceutical manufacturers who use this information in various aspects of clinical development and commercialization. HIOs also use anonymized patient data to deliver evidenced-based insights about drug safety issues as well as the quality and cost of care.

The search on use of anonymized EHR records also revealed a number of white papers and opinions on the promise of using EHR data for clinical research and improving outcomes stating, however, that there are a number of challenges yet to be overcome to make this effective.

A LOOK FORWARD

A scan of the health technology market shows that data continues to grow in importance. Several companies have announced initiatives and platforms that provide patients access and control of their information. These organizations include a Virginia-based Health IT company, Health Wizz10, who has created a patient-data platform that allows patients pull their data into the Health Wizz app via EHR patient portals and then use the DirectTrust framework to send their data to providers and other organizations. Apple11 is giving iPhone users a means to download their health records from a patient portal, store them safely, and share them with others. The Apple feature, Health Records, is currently in a beta release which includes integration with twelve participating hospital systems. Most recently, CMS Administrator Seema Verma announced the launch of the MyHealthEData Initiative. “MyHealthEData is a government-wide initiative that will break down the barriers that contribute to preventing patients from being able to access and control their medical records. MyHealthEData makes it clear that patients should have access and control to share their data with whomever they want, making the patient the center of our health care system. Patients need to be able to control their information and know that it’s secure and private. Having access to their medical information will help them make decisions about their care, and have a better understanding of their health.”12

AMA POLICY

The AMA has several policies related to this topic (see Appendix). Policy H-315.973, “Guiding Principles for the Collection, Use and Warehousing of Electronic Medical Records and Claims Data,” which was last updated and reaffirmed in 2013, establishes principles around the use of these data that include compliance with HIPAA, requires physician consent for analysis of the data, and requires data to remain accessible to authorized users for purposes of treatment, public health, patient safety, quality improvement, medical liability defense, and research.

In addition, Policy H-315.975, “Police, Payer, and Government Access to Patient Health Information,” and Policy H-315.987, “Limiting Access to Medical Records,” look to further define who should and should not have access to this information. Finally, Ethical Opinions E-3.2.4, “Access to Medical Records by Data Collection Companies,” E-3.2.1 “Confidentiality”, and E-3.3.2, “Confidentiality and Electronic Medical Records,” are also relevant to this discussion.
CONCLUSION

This is an issue that will become more complicated as the healthcare industry looks to further connect disparate patient information in an effort to map the patient journey and improve health outcomes. Throughout the progression it is important that patients have appropriate access to their data and physicians have the tools and controls they need to be good stewards of their patients’ information while at the same time have the ability to share information to seamlessly coordinate the best care. In support of these initiatives, the AMA has actively engaged with HHS, OIG, and ONC and has broad policy in place covering all aspects of patient record maintenance, access and control.

Physicians and healthcare institutions have the ability to control use and access to the patient data they create within an EHR through agreements with the EHR vendor and business associate agreements. Additionally all PHI contained in the EHR is protected under HIPAA.

Our AMA has taken a leadership role in ensuring appropriate use and access of these data by (1) working with ONC and HHS to encourage operational implementation of provisions in the 21st Century Cures Act to prohibit EHR vendors from blocking access to data and limiting a physician’s ability to effectively utilize their EHR system; (2) providing physicians and practices with resources on negotiating employment and independent contractor agreements to assist in clarifying ownership of and access to patient information upon termination of employment or contracting; (3) supplying physicians and practices with educational tools about favorable EHR vendor contract terms covering ownership of, access to, and use of patient information; (4) educating physicians and practices on how to file a HIPAA complaint with the OCR; and (5) providing the Federation of Medicine with model legislation that ensures appropriate handling and access to patient data.

Lastly, technologies are emerging every day that are focused on putting patient data in the patient’s hands with the capability of providing access and control to the patient with a mechanism of doing so in a systematic way.
REFERENCES

4. “Individuals’ Right under HIPAA to Access their Health Information 45 CFR § 164.524” [https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/#newlyreleasedfaqs]

APPENDIX – AMA POLICIES RELATED TO THIS REPORT

AMA Code of Medical Ethics

Code of Medical Ethics Opinion E-3.2.4, “Access to Medical Records by Data Collection Companies”
Disclosureing information to third parties for commercial purposes without consent undermines trust, violates principles of informed consent and confidentiality.

Information contained in patients’ medical records about physicians’ prescribing practices or other treatment decisions can serve many valuable purposes, such as improving quality of care. However, ethical concerns arise when access to such information is sought for marketing purposes on behalf of commercial entities that have financial interests in physicians’ treatment recommendations, such as pharmaceutical or medical device companies.

Information gathered and recorded in association with the care of a patient is confidential. Patients are entitled to expect that the sensitive personal information they divulge will be used solely to
enable their physician to most effectively provide needed services. Disclosing information to third parties for commercial purposes without consent undermines trust, violates principles of informed consent and confidentiality, and may harm the integrity of the patient-physician relationship.

Physicians who propose to permit third-party access to specific patient information for commercial purposes should:
(a) Only provide data that has been de-identified.
(b) Fully inform each patient whose record would be involved (or the patient’s authorized surrogate when the individual lacks decision-making capacity) about the purpose(s) for which access would be granted.

Physicians who propose to permit third parties to access the patient’s full medical record should:
(a) Obtain the consent of the patient (or authorized surrogate) to permit access to the patient’s medical record.
(b) Prohibit access to or decline to provide information from individual medical records for which consent has not been given.
(c) Decline incentives that constitute ethically inappropriate gifts, in keeping with ethics guidance.

Code of Medical Ethics Opinion E-3.3.1, “Management of Medical Records”
Physicians have an ethical obligation to manage medical records appropriately.

Medical records serve important patient interests for present health care and future needs, as well as insurance, employment, and other purposes.

In keeping with the professional responsibility to safeguard the confidentiality of patients’ personal information, physicians have an ethical obligation to manage medical records appropriately.

This obligation encompasses not only managing the records of current patients, but also retaining old records against possible future need, and providing copies or transferring records to a third party as requested by the patient or the patient’s authorized representative when the physician leaves a practice, sells his or her practice, retires, or dies.

To manage medical records responsibly, physicians (or the individual responsible for the practice’s medical records) should:

(a) Ensure that the practice or institution has and enforces clear policy prohibiting access to patients’ medical records by unauthorized staff.

(b) Use medical considerations to determine how long to keep records, retaining information that another physician seeing the patient for the first time could reasonably be expected to need or want to know unless otherwise required by law, including:
1. Immunization records, which should be kept indefinitely
2. Records of significant health events or conditions and interventions that could be expected to have a bearing on the patient’s future health care needs, such as records of chemotherapy

(c) Make the medical record available:
1. As requested or authorized by the patient (or the patient’s authorized representative)
2. To the succeeding physician or other authorized person when the physician discontinues his or her practice (whether through departure, sale of the practice, retirement, or death)
3. As otherwise required by law
(d) Never refuse to transfer the record on request by the patient or the patient’s authorized representative, for any reason.

(e) Charge a reasonable fee (if any) for the cost of transferring the record.

(f) Appropriately store records not transferred to the patient’s current physician.

(g) Notify the patient about how to access the stored record and for how long the record will be available.

(h) Ensure that records that are to be discarded are destroyed to protect confidentiality.

**Code of Medical Ethics Opinion 3.3.2, “Confidentiality and Electronic Medical Records”**

Information gathered and recorded in association with the care of a patient is confidential, regardless of the form in which it is collected or stored.

Physicians who collect or store patient information electronically, whether on stand-alone systems in their own practice or through contracts with service providers, must:

(a) Choose a system that conforms to acceptable industry practices and standards with respect to:
   1. Restriction of data entry and access to authorized personnel
   2. Capacity to routinely monitor/audit access to records
   3. Measures to ensure data security and integrity
   4. Policies and practices to address record retrieval, data sharing, third-party access and release of information, and disposition of records (when outdated or on termination of the service relationship) in keeping with ethics guidance

(b) Describe how the confidentiality and integrity of information is protected if the patient requests.

(c) Release patient information only in keeping with ethics guidance for confidentiality.

**Code of Medical Ethics Opinion 3.2.1, “Confidentiality”**

Medical records serve important patient interests for present health care and future needs, as well as insurance, employment, and other purposes.

In keeping with the professional responsibility to safeguard the confidentiality of patients’ personal information, physicians have an ethical obligation to manage medical records appropriately.

This obligation encompasses not only managing the records of current patients, but also retaining old records against possible future need, and providing copies or transferring records to a third party as requested by the patient or the patient’s authorized representative when the physician leaves a practice, sells his or her practice, retires, or dies.

To manage medical records responsibly, physicians (or the individual responsible for the practice’s medical records) should:

(a) Ensure that the practice or institution has and enforces clear policy prohibiting access to patients’ medical records by unauthorized staff.
(b) Use medical considerations to determine how long to keep records, retaining information that another physician seeing the patient for the first time could reasonably be expected to need or want to know unless otherwise required by law, including:
1. Immunization records, which should be kept indefinitely
2. Records of significant health events or conditions and interventions that could be expected to have a bearing on the patient’s future health care needs, such as records of chemotherapy

(c) Make the medical record available:
1. As requested or authorized by the patient (or the patient’s authorized representative)
2. To the succeeding physician or other authorized person when the physician discontinues his or her practice (whether through departure, sale of the practice, retirement, or death)
3. As otherwise required by law

(d) Never refuse to transfer the record on request by the patient or the patient’s authorized representative, for any reason.

(e) Charge a reasonable fee (if any) for the cost of transferring the record.

(f) Appropriately store records not transferred to the patient’s current physician.

(g) Notify the patient about how to access the stored record and for how long the record will be available.

(h) Ensure that records that are to be discarded are destroyed to protect confidentiality.

AMA Policy

H-315.973, “Guiding Principles for the Collection, Use and Warehousing of Electronic Medical Records and Claims Data”
1. It is AMA policy that any payer, clearinghouse, vendor, or other entity that collects and uses electronic medical records and claims data adhere to the following principles:

a. Electronic medical records and claims data transmitted for any given purpose to a third party must be the minimum necessary needed to accomplish the intended purpose.
b. All covered entities involved in the collection and use of electronic medical records and claims data must comply with the HIPAA Privacy and Security Rules.
c. The physician must be informed and provide permission for any analysis undertaken with his/her electronic medical records and claims data, including the data being studied and how the results will be used.
d. Any additional work required by the physician practice to collect data beyond the average data collection for the submission of transactions (e.g., claims, eligibility) must be compensated by the entity requesting the data.
e. Criteria developed for the analysis of physician claims or medical record data must be open for review and input by relevant outside entities.
f. Methods and criteria for analyzing the electronic medical records and claims data must be provided to the physician or an independent third party so re-analysis of the data can be performed.
g. An appeals process must be in place for a physician to appeal, prior to public release, any adverse decision derived from an analysis of his/her electronic medical records and claims data.
h. Clinical data collected by a data exchange network and searchable by a record locator service must be accessible only for payment and health care operations.
2. It is AMA policy that any physician, payer, clearinghouse, vendor, or other entity that warehouses electronic medical records and claims data adhere to the following principles:

a. The warehouse vendor must take the necessary steps to ensure the confidentiality, integrity, and availability of electronic medical records and claims data while protecting against threats to the security or integrity and unauthorized uses or disclosure of the information.
b. Electronic medical records data must remain accessible to authorized users for purposes of treatment, public health, patient safety, quality improvement, medical liability defense, and research.
c. Physician and patient permission must be obtained for any person or entity other than the physician or patient to access and use individually identifiable clinical data, when the physician is specifically identified.
d. Following the request from a physician to transfer his/her data to another data warehouse, the current vendor must transfer the electronic medical records and claims data and must delete/destroy the data from its data warehouse once the transfer has been completed and confirmed.

Our AMA: (1) will pursue the adoption of federal legislation and regulations that will: limit third party payers' random access to patient records unrelated to required quality assurance activities; limit third party payers' access to medical records to only that portion of the record (or only an abstract of the patient's records) necessary to evaluate for reimbursement purposes; require that requests for information and completion of forms be delineated and case specific; allow a summary of pertinent information relative to any inquiry into a patient's medical record be provided in lieu of a full copy of the records (except in instances of litigation where the records would be discoverable); and provide proper compensation for the time and skill spent by physicians and others in preparing and completing forms or summaries pertaining to patient records; and (2) supports the policy that copies of medical records of service no longer be required to be sent to insurance companies, Medicaid or Medicare with medical bills.

H-315.975, “Police, Payer, and Government Access to Patient Health Information”
(1) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, to define “health care operations” narrowly to include only those activities and functions that are routine and critical for general business operations and that cannot reasonably be undertaken with de-identified information.

(2) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, that the Centers for Medicare & Medicaid Services (CMMS) and other payers shall have access to medical records and individually identifiable health information solely for billing and payment purposes, and routine and critical health care operations that cannot reasonably be undertaken with de-identified health information.

(3) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, that CMMS and other payers may access and use medical records and individually identifiable health information for non-billing, non-payment purposes and non-routine, non-critical health care operations that cannot reasonably be undertaken with de-identified health information, only with the express written consent of the patient or the patient's authorized representative, each and every time, separate and apart from blanket consent at time of enrollment.

(4) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation that no government agency, including law enforcement agencies, be permitted access to medical records or individually identifiable health information (except for any discretionary or
mandatory disclosures made by physicians and other health care providers pursuant to ethical guidelines or to comply with applicable state or federal reporting laws) without the express written consent of the patient, or a court order or warrant permitting such access.

(5) Our AMA continues to strongly support and advocate a minimum necessary standard of disclosure of individually identifiable health information requested by payers, so that the information necessary to accomplish the intended purpose of the request be determined by physicians and other health care providers, as permitted under the final privacy rule.

H-315.979, “Electronic Data Interchange Status Report”
Our AMA will: (1) work to establish consensus on industry security guidelines for electronic storage and transmission of medical records as an important means of protecting patient privacy in a manner that avoids undue and non-productive burdens on physician practices; and (2) develop relevant educational tools or models in accordance with industry electronic security guidelines to assist physicians in compliance with state and federal regulations.

H-155.994, “Sharing of Diagnostic Findings”
The AMA (1) urges all physicians, when admitting patients to hospitals, to send pertinent abstracts of the patients' medical records, including histories and diagnostic procedures, so that the hospital physicians sharing in the care of those patients can practice more cost-effective and better medical care; (2) urges the hospital to return all information on in-hospital care to the attending physician upon patient discharge; and (3) encourages providers, working at the local level, to develop mechanisms for the sharing of diagnostic findings for a given patient in order to avoid duplication of expensive diagnostic tests and procedures.

H-315.977, “Abuse of the Medical Record for Regulation or Financing the Practice of Medicine”
1) Our AMA continues to oppose the use of the physician office medical record as a tool of CMS, as well as any other agency or third party, to regulate the financing and practice of medicine. (2) The medical record shall be the property of the physician and the information contained therein, the property of the patient. (3) The physician's office medical record should be used solely to document the delivery of health care.

H-315.971, “Patient Information in the Electronic Medical Record”
AMA Guidelines for Patient Access to Physicians' Electronic Medical Record Systems:

(1) Online interactions are best conducted over a secure network, with provisions for privacy and security, including encryption.

(2) Physicians should take reasonable steps to authenticate the identity of correspondent(s) in electronic communication and to ensure that recipients of information are authorized to receive it. Physicians are encouraged to follow the following guidelines for patient authentication: (a) Have a written patient authentication protocol for all practice personnel and require all members of the physician's staff to understand and adhere to the protocol. (b) Establish minimum standards for patient authentication when a patient is new to a practice or not well known. (c) Keep a written record, electronic or paper, of each patient authenticated.

(3) Prior to granting a patient access to his or her EMR, informed consent should be obtained regarding the appropriate use of and limitations to access of personal health information contained in the EMR. Physicians should develop and adhere to specific guidelines and protocols for online communications and/or patient access to the EMR for all patients, and make these guidelines known to the patient as part of the informed consent process. Such guidelines should specify
mechanisms for emergency access to the EMR and protection for and limitation of access to, highly sensitive medical information.

(4) If the patient is allowed to make annotations to his or her EMR (i.e., over-the-counter drug treatments, family medical history, other health information), the annotation should be indicated as authored by the patient with sourcing information (i.e., date and time stamp, login and IP address if applicable). A permanent record of all allowed annotations and communications relevant to the ongoing medical care of the patient should be maintained as part of the patient's medical record.

(5) Physicians retain the right to determine which information they do and/or do not import from a PHR into their EHR/EMR and to set parameters based on the clinical relevance of data contained within personal health records.

(6) Any data imported into a physician's EMR/EHR from a patient's personal health record (PHR) must preserve the source information of the original data and be further identified as to the PHR from which it was imported as additional source information to preserve an accurate audit trail.

(7) In order to maintain the legitimate recording of clinical events, patients should not be able to delete any health information in the record. Rather, in order to maintain the forensic nature of the record, patients should only be able to add notations when appropriate.

(8) Disclosures of Personal Health Information should comply with all applicable federal and state laws, privileges recognized in federal or state law, including common law, and the ethical requirements of physicians.

D-478.972, “EHR Interoperability”
Our AMA: (1) will enhance efforts to accelerate development and adoption of universal, enforceable electronic health record (EHR) interoperability standards for all vendors before the implementation of penalties associated with the Medicare Incentive Based Payment System; (2) supports and encourages Congress to introduce legislation to eliminate unjustified information blocking and excessive costs which prevent data exchange; (3) will develop model state legislation to eliminate pricing barriers to EHR interfaces and connections to Health Information Exchanges; (4) will continue efforts to promote interoperability of EHRs and clinical registries; (5) will seek ways to facilitate physician choice in selecting or migrating between EHR systems that are independent from hospital or health system mandates; and (6) will seek exemptions from Meaningful Use penalties due to the lack of interoperability or decertified EHRs and seek suspension of all Meaningful Use penalties by insurers, both public and private.
REPORT OF THE BOARD OF TRUSTEES

B of T Report 32-A-18

Subject: Studying Healthcare Institutions that Provide Child Care Services

Presented by: Gerald E. Harmon, MD, Chair

INTRODUCTION

At the 2017 Annual Meeting, Policy D-215.987, “Studying Healthcare Institutions that Provide Child Care Services,” was adopted by the House of Delegates. This policy directs the American Medical Association (AMA) to work with relevant entities to study healthcare institutions to determine whether they provide childcare services and report on those findings at the 2018 Annual Meeting. This report, which is presented for the information of the House, provides background on child care services in health care and the implications of access to child care for physicians, as well as results of a study conducted by the AMA and other relevant research.

BACKGROUND

Physicians and residents often work irregular, long and overnight hours. Those with young children, specifically pre-school age and younger, face significant challenges in ensuring their children are cared for during work hours. This is especially true for dual-physician couples, physicians with spouses or partners that work full time, and single parent physicians. According to a 2017 AMA study of women physicians, 56 percent of respondents indicated onsite child care is either somewhat or strongly important in helping them balance work and family responsibilities. Some challenges physicians encounter in trying to secure care for their children include accessibility, affordability, and flexibility in hours. Many child care centers are full to capacity and have wait lists that keep parents waiting for months or even years before their child can be accepted.

Parents often experience stress and anxiety in dealing with family responsibilities that may affect their work. Contending with the task of obtaining care for young children can increase stress, which contributes to higher rates of burnout. Burnout can lead to diminished concentration, medical errors or misdiagnoses, lack of empathy, and lower professional satisfaction. Implementing tactics to reduce personal and professional stress is associated with decreased rates of burnout and having access to child care services, either onsite or near their workplace, can help alleviate stress and anxiety for parents. Research also demonstrates that employees report improved productivity while using quality child care. Despite the correlations between parental stress and burnout and between access to child care and improved productivity, access to onsite child care is limited for most employees.

AMA POLICY

AMA Policy H-215.985, “Child Care in Hospitals,” states that the AMA: (1) strongly encourages hospitals to establish and support child care facilities; (2) encourages that priority be given to children of those in training and that services be structured to take their needs into consideration; (3) supports informing the AHA, hospital medical staffs, and residency program directors of these
policies; and (4) supports studying the elements of quality child care and availability of child care on a 24-hour basis.

AMA Policy H-525.998, “Women in Organized Medicine,” states that the “AMA (3) (a) supports the concept of proper child care for families of working parents; (b) reaffirms its position on child care facilities in or near medical centers and hospitals; (c) encourages business and industry to establish employee child care centers on or near their premises when possible; and (d) encourages local medical societies to survey physicians to determine the interest in clearinghouse activities and in child care services during medical society meetings.”

DISCUSSION

Although there is evidence to show that reducing burnout and stress can lead to higher rates of job satisfaction and productivity, there is limited research showing a direct relationship between access to employer-sponsored child care services and employee productivity or job satisfaction, and what research is available is not consistent. An evaluation of existing research, published in Personnel Psychology, concluded there is not a credible evidence base to support the claims that employer-sponsored child care increases productivity and job satisfaction, or that it reduces absenteeism. However, another more recent review demonstrates that offering onsite child care improves employee recruitment and productivity, and reduces turnover and absenteeism. Notwithstanding evidence for or against its perceived or actual benefits, access to employer-sponsored child care is an important consideration for physicians when making major decisions about their practices and their families.

Only seven percent of employers in the U.S. report offering onsite child care as a benefit to their employees. Employers are most likely to provide Dependent Care Assistance Plans (56 percent) which help employees pay for child care with pre-tax dollars, or Child Care Resource and Referral (41 percent), which is simply access to information about child care in the area. These options are easier to implement and less costly than offering child care at or near the worksite. Employers that provide onsite child care are eligible for a federal tax credit and a state tax credit in many states. The tax credit is not applicable for funds provided to employees to assist with the cost of outside child care.

In the health care industry, access to employer-provided child care assistance is more prevalent than in other industries. According to the Bureau of Labor Statistics, 17 percent of civilian workers in the health care/social assistance sector have access to an employer-sponsored child care benefit. Thirty-seven percent of civilian workers in hospitals have access to a workplace program that provides for either the full or partial cost of child care in a nursery, day care center, or a babysitter in facilities either on or off the employer's premises. According to the AMA women physician study, one in ten physicians indicated their employer offers onsite child care services, and of those, 19 percent have access to a subsidy, allowance, or discount to help cover the cost of the onsite care. The majority of respondents (57 percent) who report that their employer offers onsite care work in large practices with 26 or more physicians.

Residency and fellowship programs may also provide access to onsite or subsidized child care services. According to the AMA Residency & Fellowship Database® (FREIDA), which comprises information about more than 10,000 ACGME-accredited programs, 35 percent of the programs provide access to some type of child care service assistance, 3,344 offer onsite child care, 771 offer subsidies to assist with cost, and 528 offer both onsite care and subsidies. Users of the FREIDA database can find details about residency programs nationwide, including whether or not they offer...
onsite child care or subsidies to assist with the cost of offsite child care. FREIDA is free for anyone to access and has enhanced features for AMA members.

The AMA sought collaboration from relevant stakeholders to conduct a census and capture specific data on employer-provided child care resources and assistance in the health care industry. However, since none of the organizations contacted expressed interest in pursuing the research topic, the AMA Professional Satisfaction and Practice Sustainability and Market Research groups developed and deployed the survey in-house.

The brief two-minute survey was distributed in an email invitation to 264 chief operating officers and human resource decision-makers in health care organizations. Only seven of the individuals invited to participate in the survey responded. The very small response rate could be due to a few factors: (1) the AMA does not have an established relationship with the professionals that make employee benefit decisions, so these individuals may not feel compelled to respond to an inquiry from the AMA, implying that the AMA may not be the most appropriate organization to effectively acquire this information; (2) employee benefit information may be confidential or leadership may be otherwise hesitant to share the information even on an anonymous basis; and (3) the initial target population was small due to the AMA’s lack of email contact information for the designated audience, resulting in a relatively low response rate. Given the extremely small response rate it is difficult and not advisable to draw any significant conclusions from this research. Additional research is needed to understand the prevalence of employer-provided or -assisted child care; however, it is not clear that the AMA is the appropriate organization to pursue such research, given our limited access to the relevant health care human resource decision-makers and leaders who are knowledgeable about the subject.

CONCLUSION

Access to child care can help physicians and physicians in training alleviate stress and focus on their patients while at work. Reducing stress can help physicians’ combat burnout and increase satisfaction in practice. Given the information available, it is apparent only a small portion of employers, including health care organizations, offers onsite child care services. However, determining how many health care organizations offer these benefits is difficult. Some employers provide subsidies to help employees pay for child care, and others provide access to resources to help employees locate and arrange child care.

Physicians seeking employment or medical students applying for residency or fellowship may be interested in obtaining information about child care options provided by potential employers or programs. Physicians seeking employment should always ask prospective employers about child care during exploration of compensation and benefits packages. Additionally, the AMA’s FREIDA database provides this information for many of the residency and fellowship programs listed. A comprehensive list of health care organizations and employers that provides employment benefit information such as availability of employer-sponsored child care could not be identified. Creating and maintaining such a list would be challenging due to limited availability of the information, limited access to the individuals that could disclose the information, the scale of the effort that would be required to collect and maintain it, and the frequency at which the information could change over time.
REFERENCES

Subject: Management of Physician and Medical Student Stress

Presented by: Gerald E. Harmon, MD, Chair

INTRODUCTION

At the 2017 Annual Meeting, Policy D-405.982, “Management of Physician and Medical Student Stress,” was adopted by the House of Delegates. This policy directs the American Medical Association (AMA) to produce a report on administrative and regulatory burdens placed on physicians, residents and fellows, and medical students, and pursue strategies to reduce these burdens. This report, which is presented for the information of the House, outlines various administrative and regulatory processes that adversely affect medical students, residents, and physicians. It also discusses AMA’s efforts, including existing policies, to reduce administrative burdens and address physician stress and burnout, one of the major effects of overwhelming and burdensome mandates, tasks and processes.

BACKGROUND

Physicians, residents and medical students face work-related stresses at high rates.\(^1\,{}^2\,{}^3\) Rates of stress and resulting burnout have increased in recent years, with more than 54 percent of physicians reporting at least one symptom of burnout in 2015 compared to 45 percent in 2011.\(^4\) Forty nine percent of physicians often or always experience symptoms of burnout.\(^5\) There are many influences, both internal and external, that contribute to stress and burnout among health professionals. Many of the external factors are imposed by administrative and regulatory factors outside of the physicians’ control.

AMA POLICY

The AMA maintains numerous policies supporting physician wellness and the importance of reducing and preventing physician stress and burnout, as well as the reduction in administrative/regulatory burdens associated with medical practice that can cause stress and lead to burnout.

The AMA recognizes burnout and stress, and their effects, as serious issues that affect physicians and medical students (Policy D-310.968, “Physician and Medical Student Burnout”). AMA places great importance on physician health and wellness and the need for continued education on its importance (Policy H-405.961, “Physician Health Programs”). AMA policy and the Code of Ethics recognize that when physician health and wellness is compromised the safety and care of the patient can be as well (Code of Ethics 9.3.1). The AMA supports programs to assist physicians in early identification and management of stress, and is committed to helping physicians, practices, and health systems identify and manage stress-related burnout (Policy H-405.957, “Programs on Managing Physician Stress and Burnout”). The AMA developed principles to guide residency programs in the supervision of residents and the avoidance of the harmful effects of excessive fatigue and stress (Policy H-310.979, “Resident Physician Working Hours and Supervision”). The
AMA encourages research on the type and impact of external factors adversely affecting physicians, including workplace stress, litigation issues, and restructuring of the health care delivery systems (Policy H-95.955, “Physician Impairment”).


In addition, the AMA recognizes the unique stress medical students face with student debt and career choices, and has prioritized reducing medical student debt for legislative and other action (Policy H 305.928, “Proposed Revisions to AMA Policy on Medical Student Debt”). The prospect of finishing medical school without matching to a residency program is an added stress for medical students. Due to an increase in medical students and funding caps for graduate medical education (GME) programs, this has become increasingly burdensome. The AMA has also worked with CMS and other key organizations to increase the number of GME positions in order to accommodate the increase in medical students and accommodate the projected need for more physicians (Policy D-305.958, “Increasing Graduate Medical Education Positions as a Component to any Federal Health Care Reform Policy”).

DISCUSSION

Physicians report better professional satisfaction when they perceive that they are providing high-quality care, and obstacles to providing such care are major sources of professional dissatisfaction. Potential effects of physician stress and burnout include reduced empathy toward patients, poorer interactions during a visit, and medical errors, all which have the potential to decrease the quality of care. Burnout can lead to lower professional satisfaction and a desire to
reduce clinical hours or leave the practice of medicine.5, 6 There is evidence that stress and burnout affect medical students, residents and physicians at higher rates than the general U.S. population12, 13 and burnout has been connected to higher rates of suicidal ideation among physicians.14-17

In accord with the amplified attention on the effects of burnout, identifying the causes of stress and burnout has increasingly become the focus of research. Sources of stress and burnout among medical students and residents often include personal stressors, adjustment to a new work environment, ethical conflicts, financial issues, long hours, and exposure to human suffering.12, 18 While the practicing physician can be adversely impacted with the same stressors as medical students and residents, there are additional factors that are often tied to administrative and regulatory burdens experienced in practice. These factors affect physicians in multiple aspects of their work, including those related to the business of medicine, such as dealing with insurance companies and complying with regulatory requirements, as well as those related to the practice of medicine, such as licensing, credentialing, privileging, and maintenance of certification.

For physicians in practice, increased clerical burdens, including bureaucratic tasks and productivity requirements, are often cited as the top reasons physicians experience burnout.5, 19-21 The amount of time physicians spend doing administrative work includes more than half their day spent completing tasks in the electronic health record (EHR) system and almost 90 minutes of EHR work at home after hours.22 External factors detract from the quality of care physicians feel they can provide: nearly 40 percent of physicians report patient care is adversely impacted to a great degree by external factors such as third party authorizations, treatment protocols, and EHR design.5 Physicians also report that their EHRs have reduced or detracted from the quality of care, efficiency of practice, and interaction with patients.5

Prior authorizations required by payers are another source of dissatisfaction and burden for physicians.23 In a 2016 AMA study, 75 percent of physicians reported that burdens associated with prior authorization are high or extremely high in their practice, and 90 percent indicated that prior authorizations can delay patients’ access to necessary care. On average, physicians or their staff complete 37 prior authorizations per week, with almost a quarter of physicians completing more than 40 per week.24 Obtaining prior authorizations involves inefficient and sometimes difficult processes that cost practices time and money, and often create stress and add pressure on physicians.

Increasing documentation requirements from Medicare and commercial payers have also added to physicians’ administrative workload. Dated documentation requirements for Evaluation and Management (E/M) services are considered to be over burdensome and no longer aligned with the modern practice of medicine.25 A 2013 survey indicated 92 percent of medical residents and fellows reported that documentation requirements were excessive.26 Clinical documentation requirements have increased over time with the mandated use of EHRs, increased quality reporting and other factors,27 contributing significantly to the administrative overload.

Regulatory requirements can be an additional source of time-consuming tasks that lead to stress and burnout for physicians. The QPP, a new Medicare physician payment system created by MACRA, comprises two tracks through which physicians and practices can participate: the Merit-based Incentive Payment System (MIPS) or Advanced Alternative Payment Models (APMs). Participation in either track of the QPP requires specific uses of EHRs as well as recording, tracking and submitting quality and clinical practice improvement data to CMS in order to receive payment incentives and/or avoid payment penalties. While the changes implemented through the QPP represent an improvement over legacy Medicare pay-for-reporting programs, time and education are needed for physicians to feel prepared and comfortable conforming to new
requirements. A recent KPMG-AMA survey demonstrated that more than half of physicians are just somewhat knowledgeable about MACRA or QPP, and 41 percent have heard of MACRA or QPP but do not consider themselves knowledgeable. Additionally, 90 percent of the physicians participating in MIPS felt that the requirements are slightly or very burdensome, and the time required to report the required metrics is the most significant challenge.

In addition to the strains created by tasks involved in day to day business of medicine, there are other processes that require time away from patient care and/or add stressful tasks to the physician workload. MOC, which is in some states a prerequisite for credentialing or insurance network participation, involves costly fees and lengthy tests which more than 80 percent of physicians feel are over burdensome. After years of advocating for change, physician groups, including the AMA, have prompted the American Board of Internal Medicine to relax its MOC requirements with the introduction of simplified open-book exams starting in 2018. There is also evidence that requests for information about mental illness and medical conditions on state medical license applications may deter physicians from seeking needed health care, for fear of the impact on licensure or employment. Leaving mental health issues or conditions untreated can result in further exacerbation of stress or depression that can lead to burnout, and can even lead to other illnesses and effects on job stability.

The AMA has dedicated numerous resources to reduce administrative burdens that cause stress and excessive workloads, assist physicians in navigating complex processes that come with new regulations, and combat the burnout epidemic.

Through ongoing advocacy, the AMA works to address administrative burdens such as utilization management programs, prior authorization requirements, complex claim processes and other nonclinical activities that contribute to increased complexity and expense for physicians in practice. In addition, the AMA provides practical interpretation of legislation and regulations to help the practicing physician understand changes that may impact their practice. These are done via the AMA website, webinars, podcasts, STEPS Forward™ modules and live presentations to organized medicine. The AMA sections’ governing councils also continue their respective efforts to provide strategies and recommendations to address payment reform, prior authorization, and other issues that affect the practice of medicine.

In addition to advocacy, the AMA is working to provide useful tools for physicians to learn about and navigate new payment models, including MIPS and APMs. The “Navigating the Payment Process” topic page within the AMA website is a continuously growing wealth of information, resources and actionable tools to assist physicians in these complex administrative functions.

For physicians, residents, medical students and practices, AMA offers free access to its STEPS Forward online educational platform. The modules in the STEPS Forward platform provide simple, meaningful step-based strategies for addressing stress and burnout. Relevant modules include “Preventing Physician Distress and Suicide,” “Physician Wellness: Preventing Resident and Fellow Burnout,” “Improving Physician Resiliency,” “Preventing Physician Burnout,” and “Creating the Organizational Foundation for Joy in Medicine™.” Through the STEPS Forward site the AMA also provides access to the Mini-Z Burnout Survey, which enables organizational leaders, including residency program administrators, to periodically measure burnout levels among their staff and residents. The Mini-Z survey also affords the AMA an opportunity to create a robust data set to aid in the understanding of unique drivers of burnout and inform the AMA’s continued work in this area.
The Professional Satisfaction and Practice Sustainability strategy group, one of the AMA’s three strategic focus areas, continues to study and publish findings on burnout, its causes and effects, and strategies for addressing it. Currently in progress is a collaboration with Stanford Medicine WellMD Center and the Mayo Clinic to produce a follow-up study to the 2011 and 2014 burnout and satisfaction research. The AMA has collaborated with the Canadian and British Medical Associations for decades to co-host the International Conference on Physician Health, and will continue this long-standing partnership in 2018. The AMA will also co-host with Stanford University School of Medicine and the Mayo Clinic the second American Conference on Physician Health in 2019. Both of these highly attended conferences offer programming to educate and engage physicians, residents and medical students in organizational and individual level solutions to promote and improve physician and trainee health and wellness.

The AMA’s Accelerating Change in Medical Education strategy group is dedicated to fostering innovations in medical education that will create a learning environment and culture that ensures the psychological, emotional and physical wellbeing of medical students and residents. One example of the programming being put forth by this initiative is an online webinar that discusses national and local efforts to prevent burnout and promote wellness throughout the physician education continuum. The AMA also hosts a “Succeeding in Medical School” topic hub in which a variety of relevant resources cover issues such as easing stressors, managing medical school stress, and alleviating anxiety over exams.

CONCLUSION

The AMA recognizes the significant stressors and burdens that face medical students, residents and physicians throughout their careers, and the effects those tolls have on physician well-being and patient care. It is part of AMA’s strategic focus to help physicians create thriving, sustainable practices and improve professional satisfaction with the practice of medicine. The AMA is demonstrably committed to this work and continues to study the prevalence and severity of burnout among physicians and trainees, identify factors that contribute to burnout, and develop solutions to address the issue. The AMA will also persist in its efforts to advocate for better legislation and regulations that do not overburden physicians with excessive administrative tasks and requirements.
REFERENCES


Subject: Demographic Report of the House of Delegates and AMA Membership

Presented by: Gerald E. Harmon, MD, Chair

INTRODUCTION

This informational report, “Demographic Report of the House of Delegates and AMA Membership,” is prepared pursuant to Policy G-600.035, “House of Delegates Demographic Report,” which states:

A report on the demographics of our AMA House of Delegates will be issued annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty.

In addition, this report includes information pursuant to Policy G-635.125, “AMA Membership Demographics,” which states:

Stratified demographics of our AMA membership will be reported annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty.

This document compares the House of Delegates (HOD) with the entire American Medical Association (AMA) membership and with the overall United States physician and medical student population. Medical students are included in all references to the total physician population throughout this report to remain consistent with the bi-annual Council on Long Range Planning and Development report. In addition, residents and fellows endorsed by their states to serve as sectional delegates and alternate delegates are included in the appropriate comparisons for the state and specialty societies. For the purposes of this report, AMA-HOD includes both delegates and alternate delegates.

DATA SOURCES

Lists of delegates and alternate delegates are maintained in the Office of House of Delegates Affairs and are based on official rosters provided by the relevant society. The lists used in this report reflect 2017 year-end delegation rosters.

Data on individual demographic characteristics are taken from the AMA Physician Masterfile, which provides comprehensive demographic, medical education, and other information on all United States and international medical graduates (IMGs) who have undertaken residency training in the United States. Data on AMA membership and the total physician and medical student population are taken from the Masterfile and are based on 2017 year-end information.

Some key considerations must be kept in mind regarding the information captured in this report. Vacancies in delegation rosters mean that the total number of delegates is less than the 556 allotted
at the 2017 Interim Meeting, and the number of alternate delegates is nearly always less than the full allotment. As such, the total number of delegates and alternate delegates is 985 rather than the 1,112 allotted. Race and ethnicity information, which is provided directly by physicians, is missing for approximately 18% of AMA members and approximately 20.6% of the total United States physician and medical student population, limiting the ability to draw firm conclusions. Efforts to improve AMA data on race and ethnicity are part of Policy D-630.972. Improvements have been made in collecting data on race and ethnicity, resulting in a decline in reporting race/ethnicity as unknown in the HOD and the overall AMA membership.

CHARACTERISTICS OF AMA MEMBERSHIP AND DELEGATES

Table 1 presents basic demographic characteristics of AMA membership and delegates along with corresponding figures for the entire physician and medical student population. Data on physicians’ and students’ current activities appear in Table 2. This includes life stage as well as present employment and self-designated specialty.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>2017 AMA Members</th>
<th>All Physicians and Medical Students</th>
<th>AMA Delegates &amp; Alternate Delegates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>243,449</td>
<td>1,306,770</td>
<td>985</td>
</tr>
<tr>
<td>Mean age (years)</td>
<td>46.9</td>
<td>51.9</td>
<td>55.2</td>
</tr>
<tr>
<td><strong>Age distribution (percent)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under age 40</td>
<td>51.00%</td>
<td>29.37%</td>
<td>18.07%</td>
</tr>
<tr>
<td>40-49 years</td>
<td>9.93%</td>
<td>18.88%</td>
<td>12.59%</td>
</tr>
<tr>
<td>50-59 years</td>
<td>10.47%</td>
<td>17.80%</td>
<td>22.03%</td>
</tr>
<tr>
<td>60-69 years</td>
<td>10.88%</td>
<td>16.98%</td>
<td>31.78%</td>
</tr>
<tr>
<td>70 or more</td>
<td>17.72%</td>
<td>16.98%</td>
<td>15.53%</td>
</tr>
<tr>
<td><strong>Gender (percent)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>64.94%</td>
<td>65.55%</td>
<td>71.57%</td>
</tr>
<tr>
<td>Female</td>
<td>35.03%</td>
<td>34.36%</td>
<td>28.43%</td>
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<tr>
<td>Unknown</td>
<td>0.03%</td>
<td>0.09%</td>
<td>0.00%</td>
</tr>
<tr>
<td><strong>Race/ethnicity (percent)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White non-Hispanic</td>
<td>54.26%</td>
<td>51.74%</td>
<td>69.24%</td>
</tr>
<tr>
<td>Black non-Hispanic</td>
<td>4.61%</td>
<td>4.20%</td>
<td>3.96%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>5.41%</td>
<td>5.44%</td>
<td>3.35%</td>
</tr>
<tr>
<td>Asian/Asian American</td>
<td>14.74%</td>
<td>15.24%</td>
<td>10.66%</td>
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<tr>
<td>Native American</td>
<td>0.35%</td>
<td>0.26%</td>
<td>0.10%</td>
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<tr>
<td>Other¹</td>
<td>2.64%</td>
<td>2.52%</td>
<td>1.42%</td>
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<tr>
<td>Unknown</td>
<td>17.99%</td>
<td>20.62%</td>
<td>11.27%</td>
</tr>
<tr>
<td><strong>Education (percent)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>US or Canada</td>
<td>83.06%</td>
<td>76.98%</td>
<td>91.88%</td>
</tr>
<tr>
<td>IMG</td>
<td>16.94%</td>
<td>23.02%</td>
<td>8.12%</td>
</tr>
</tbody>
</table>

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¹ There were 127 vacancies as of year’s end, most of which are unfilled alternate delegate slots.
² Numbers include medical students and residents endorsed by their states for delegate and alternate delegate positions.
³ Age as of December 31. Mean age is the arithmetic average.
⁴ Includes other self-reported racial and ethnic groups.
Table 2. Life Stage, Present Employment and Self-Designated Specialty\(^5\), December 2017

<table>
<thead>
<tr>
<th>Life Stage (percent)</th>
<th>2017 AMA Members</th>
<th>All Physicians and Medical Students</th>
<th>AMA Delegates &amp; Alternate Delegates (^1,2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student(^6)</td>
<td>23.46%</td>
<td>7.68%</td>
<td>7.21%</td>
</tr>
<tr>
<td>Resident(^6)</td>
<td>23.61%</td>
<td>10.31%</td>
<td>5.38%</td>
</tr>
<tr>
<td>Young (under 40 or first 8 years in practice)</td>
<td>7.44%</td>
<td>15.86%</td>
<td>7.51%</td>
</tr>
<tr>
<td>Established (40-64)</td>
<td>22.90%</td>
<td>41.45%</td>
<td>50.36%</td>
</tr>
<tr>
<td>Senior (65+)</td>
<td>22.59%</td>
<td>24.71%</td>
<td>29.54%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Present Employment (percent)</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-employed solo practice</td>
<td>8.22%</td>
<td>8.96%</td>
<td>13.60%</td>
</tr>
<tr>
<td>Two physician practice</td>
<td>1.57%</td>
<td>1.72%</td>
<td>1.93%</td>
</tr>
<tr>
<td>Group practice</td>
<td>22.53%</td>
<td>41.14%</td>
<td>39.49%</td>
</tr>
<tr>
<td>HMO</td>
<td>0.09%</td>
<td>0.17%</td>
<td>0.71%</td>
</tr>
<tr>
<td>Medical school</td>
<td>1.22%</td>
<td>1.68%</td>
<td>4.47%</td>
</tr>
<tr>
<td>Non-government hospital</td>
<td>2.33%</td>
<td>2.84%</td>
<td>5.79%</td>
</tr>
<tr>
<td>State or local government hospital</td>
<td>4.59%</td>
<td>6.96%</td>
<td>10.46%</td>
</tr>
<tr>
<td>US government</td>
<td>1.09%</td>
<td>2.03%</td>
<td>4.06%</td>
</tr>
<tr>
<td>Locum Tenens</td>
<td>0.19%</td>
<td>0.21%</td>
<td>0.10%</td>
</tr>
<tr>
<td>Retired/Inactive</td>
<td>10.21%</td>
<td>11.44%</td>
<td>5.79%</td>
</tr>
<tr>
<td>Resident/Intern/Fellow</td>
<td>23.61%</td>
<td>10.31%</td>
<td>5.38%</td>
</tr>
<tr>
<td>Student</td>
<td>23.46%</td>
<td>7.68%</td>
<td>7.21%</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>0.89%</td>
<td>4.87%</td>
<td>1.02%</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Specialty (percent)</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Medicine</td>
<td>8.61%</td>
<td>11.74%</td>
<td>10.76%</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>19.17%</td>
<td>23.08%</td>
<td>20.20%</td>
</tr>
<tr>
<td>Surgery</td>
<td>13.93%</td>
<td>13.49%</td>
<td>21.52%</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>4.93%</td>
<td>8.77%</td>
<td>3.65%</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>5.22%</td>
<td>4.73%</td>
<td>5.48%</td>
</tr>
<tr>
<td>Radiology</td>
<td>3.57%</td>
<td>4.53%</td>
<td>5.08%</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>3.92%</td>
<td>5.28%</td>
<td>5.18%</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>3.69%</td>
<td>4.66%</td>
<td>3.86%</td>
</tr>
<tr>
<td>Pathology</td>
<td>1.77%</td>
<td>2.24%</td>
<td>2.13%</td>
</tr>
<tr>
<td>Other specialty</td>
<td>11.75%</td>
<td>13.82%</td>
<td>14.92%</td>
</tr>
<tr>
<td>Students</td>
<td>23.46%</td>
<td>7.68%</td>
<td>7.21%</td>
</tr>
</tbody>
</table>

\(^5\) See Appendix for a listing of specialty classifications.
\(^6\) Students and residents are categorized without regard to age.
# Appendix

Specialty classification using physician’s self-designated specialties.

<table>
<thead>
<tr>
<th>Major Specialty Classification</th>
<th>AMA Physician Masterfile Classification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Practice</td>
<td>General Practice, Family Practice</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>Internal Medicine, Allergy, Allergy and Immunology, Cardiovascular Diseases, Diabetes, Diagnostic Laboratory Immunology, Endocrinology, Gastroenterology, Geriatrics, Hematology, Immunology, Infectious Diseases, Nephrology, Nutrition, Medical Oncology, Pulmonary Disease, Rheumatology</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>Pediatrics, Pediatric Allergy, Pediatric Cardiology</td>
</tr>
<tr>
<td>Obstetrics/Gynecology</td>
<td>Obstetrics and Gynecology</td>
</tr>
<tr>
<td>Radiology</td>
<td>Diagnostic Radiology, Radiology, Radiation Oncology</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>Psychiatry, Child Psychiatry</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>Anesthesiology</td>
</tr>
<tr>
<td>Pathology</td>
<td>Forensic Pathology, Pathology</td>
</tr>
<tr>
<td>Other Specialty</td>
<td>Aerospace Medicine, Dermatology, Emergency Medicine, General Preventive Medicine, Neurology, Nuclear Medicine, Occupational Medicine, Physical Medicine and Rehabilitation, Public Health, Other Specialty, Unspecified</td>
</tr>
</tbody>
</table>
Subject: Ethical Physician Conduct in the Media

Presented by: Dennis S. Agliano, MD, Chair

INTRODUCTION

At the 2017 Interim Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 2-I-17, “Ethical Physician Conduct in the Media.” The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the next print edition of the *Code of Medical Ethics*.

Physicians who participate in the media can offer effective and accessible medical perspectives leading to a healthier and better informed society. However, ethical challenges present themselves when the worlds of medicine, journalism, and entertainment intersect. In the context of the media marketplace, understanding the role as a physician being distinct from a journalist, commentator, or media personality is imperative.

Physicians involved in the media environment should be aware of their ethical obligations to patients, the public, and the medical profession; and that their conduct can affect their medical colleagues, other health care professionals, as well as institutions with which they are affiliated. They should also recognize that members of the audience might not understand the unidirectional nature of the relationship and might think of themselves as patients. Physicians should:

(a) Always remember that they are physicians first and foremost, and must uphold the values, norms, and integrity of the medical profession.

(b) Encourage audience members to seek out qualified physicians to address the unique questions and concerns they have about their respective care when providing general medical advice.

(c) Be aware of how their medical training, qualifications, experience, and advice are being used by media forums and how this information is being communicated to the viewing public.

*Opinions of the Council on Ethical and Judicial Affairs will be placed on the Consent Calendar for informational reports, but may be withdrawn from the Consent Calendar on motion of any member of the House of Delegates and referred to a Reference Committee. The members of the House may discuss an Opinion fully in Reference Committee and on the floor of the House. After concluding its discussion, the House shall file the Opinion. The House may adopt a resolution requesting the Council on Ethical and Judicial Affairs to reconsider or withdraw the Opinion.*
(d) Understand that as physicians, they will be taken as authorities when they engage with the media and therefore should ensure that the medical information they provide is:

(i) accurate;
(ii) inclusive of known risks and benefits;
(iii) commensurate with their medical expertise;
(iv) based on valid scientific evidence and insight gained from professional experience.

(e) Confine their medical advice to their area(s) of expertise, and should clearly distinguish the limits of their medical knowledge where appropriate.

(f) Refrain from making clinical diagnoses about individuals (e.g., public officials, celebrities, persons in the news) they have not had the opportunity to personally examine.

(g) Protect patient privacy and confidentiality by refraining from the discussion of identifiable information, unless given specific permission by the patient to do so.

(h) Fully disclose any conflicts of interest and avoid situations that may lead to potential conflicts. (II, V, VII)
At the 2003 Annual Meeting, the Council on Ethical and Judicial Affairs (CEJA) presented a detailed explanation of its judicial function. This undertaking was motivated in part by the considerable attention professionalism has received in many areas of medicine, including the concept of professional self-regulation.

CEJA has authority under the Bylaws of the American Medical Association (AMA) to disapprove a membership application or to take action against a member. The disciplinary process begins when a possible violation of the Principles of Medical Ethics or illegal or other unethical conduct by an applicant or member is reported to the AMA. This information most often comes from statements made in the membership application form, a report of disciplinary action taken by state licensing authorities or other membership organizations, or a report of action taken by a government tribunal.

The Council rarely re-examines determinations of liability or sanctions imposed by other entities. However, it also does not impose its own sanctions without first offering a hearing to the physician. CEJA can impose the following sanctions: applicants can be accepted into membership without any condition, placed under monitoring, or placed on probation. They also may be accepted, but be the object of an admonishment, a reprimand, or censure. In some cases, their application can be rejected. Existing members similarly may be placed under monitoring or on probation, and can be admonished, reprimanded or censured. Additionally, their membership may be suspended or they may be expelled. Updated rules for review of membership can be found at https://www.ama-assn.org/governing-rules.

Beginning with the 2003 report, the Council has provided an annual tabulation of its judicial activities to the House of Delegates. In the appendix to this report, a tabulation of CEJA’s activities during the most recent reporting period is presented.
APPENDIX

CEJA
Judicial Function
Statistics

APRIL 1, 2017 – MARCH 31, 2018

<table>
<thead>
<tr>
<th>Physicians Reviewed</th>
<th>SUMMARY OF CEJA ACTIVITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Determinations of no probable cause</td>
</tr>
<tr>
<td>37</td>
<td>Determinations following a plenary hearing</td>
</tr>
<tr>
<td>11</td>
<td>Determinations after a finding of probable cause, based only on the written record, after the physician waived their plenary hearing right</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physicians Reviewed</th>
<th>FINAL DETERMINATIONS FOLLOWING INITIAL REVIEWS</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>No sanction or other type of action</td>
</tr>
<tr>
<td>8</td>
<td>Monitoring</td>
</tr>
<tr>
<td>12</td>
<td>Probation</td>
</tr>
<tr>
<td>6</td>
<td>Revocation</td>
</tr>
<tr>
<td>12</td>
<td>Suspension</td>
</tr>
<tr>
<td>2</td>
<td>Application denied</td>
</tr>
<tr>
<td>11</td>
<td>Censure</td>
</tr>
<tr>
<td>1</td>
<td>Reprimand</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physicians Reviewed</th>
<th>PROBATION/MONITORING STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>Members placed on Probation/Monitoring during reporting interval</td>
</tr>
<tr>
<td>8</td>
<td>Members placed on Probation without reporting to Data Bank</td>
</tr>
<tr>
<td>4</td>
<td>Probation/Monitoring concluded satisfactorily during reporting interval</td>
</tr>
<tr>
<td>1</td>
<td>Memberships revoked due to non-compliance with the terms of probation</td>
</tr>
<tr>
<td>46</td>
<td>Physicians on Probation/Monitoring at any time during reporting interval who paid their AMA membership dues</td>
</tr>
<tr>
<td>26</td>
<td>Physicians on Probation/Monitoring at any time during reporting interval who did not pay their AMA membership dues</td>
</tr>
</tbody>
</table>
REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRDPD Report 1-A-18

Subject: A Primer on Artificial and Augmented Intelligence

Presented by: Glenn Loomis, MD, Chair

Last year, the Council on Long Range Planning and Development (CLRPD) created the educational module, Health Care Trends: Scientific Innovation,¹ which accelerated its interest in artificial and augmented intelligence (AI), and prompted a series of discussions on these topics and their influences on the practice of medicine. Due to the complexity of the field, the Council developed this primer, which provides a history, definitions and components, and the status of AI in health care. Additionally, CLRPD postulated ways the field may progress, including the identification of opportunities and challenges for physicians. The Council feels it essential to provide a high-level look at this emerging issue that could dramatically affect medicine.

HISTORY OF AI

The most influential ideas underpinning computer science came from Alan Turing in 1950, who proposed a formal model of computing. Turing’s classic essay, Computing Machinery and Intelligence,² imagines the possibility of computers created for simulating intelligence and explores many of the components now associated with artificial intelligence, including how intelligence might be tested, and how machines might automatically learn. Though these ideas inspired AI, Turing did not have access to the computing resources needed to translate his ideas into action.

In 1956, the field of AI came to the forefront with the Dartmouth Summer Research Project on Artificial Intelligence. The goal was to investigate ways in which machines could be made to simulate aspects of intelligence—the essential idea that has continued to drive the field forward. Subsequently, experts in the field of computer science research pioneered the foray into heuristic search—a method that produces a solution in a reasonable timeframe that is sufficient for solving a given problem. In the area of computer vision, early work in character recognition laid the basis for more complex applications such as face recognition. By the late sixties, work had also begun on natural language processing (NLP).

In the nineties, technological progress made the task of building systems driven by real-world data more feasible. Cheaper and more reliable hardware for sensing and actuation made robots easier to build. Further, the Internet’s capacity for gathering large amounts of data, and the availability of computing power and storage to process those data enabled statistical techniques that, by design, derive solutions from data. These developments have allowed AI to emerge in the past two decades as a profound influence on our daily lives.³

DEFINITIONS AND COMPONENTS OF AI

The concepts of AI and machine learning have quickly become attractive to health care organizations; however, the related terminologies are not well understood. While many in the health care industry foresee their technological goals hovering just over the horizon, plotting a course to get there can be a difficult proposition, especially when the landscape is clouded by
marketing hyperbole, confusing vocabulary, technical terminology, and as-yet-undeliverable promises of truly automated insights.

Algorithms are a sequence of instructions used to solve a problem. Developed by programmers to instruct computers in new tasks, algorithms are the building blocks of the advanced digital world. Computer algorithms organize enormous amounts of data into information and services, based on certain instructions and rules.

Artificial Intelligence is the ability of a computer to complete tasks in a manner typically associated with a rational human being—a quality that enables an entity to function appropriately and with foresight in its environment. True AI is widely regarded as a program or algorithm that can beat the Turing Test, which states that an artificial intelligence must be able to exhibit intelligent behavior that is indistinguishable from that of a human.

Augmented Intelligence is an alternative conceptualization that focuses on AI's assistive role, emphasizing the fact that its design enhances human intelligence rather than replaces it.

Machine Learning is a part of the discipline of artificial intelligence and refers to constructing algorithms that can make accurate predictions about future outcomes. Machine learning can be supervised or unsupervised. In supervised learning, algorithms are presented with “training data” that contain examples with their desired conclusions, such as pathology slides that contain cancerous cells as well as slides that do not. Unsupervised learning does not typically leverage labeled training data. Instead, algorithms are tasked with identifying patterns in data sets on their own by defining signals and potential abnormalities based on the frequency or clustering of certain data.

Deep Learning is a subset of machine learning that employs artificial neural networks (ANNs) and algorithms structured to mimic biological brains with neurons and synapses. ANNs are often constructed in layers, each of which performs a slightly different function that contributes to the result. Deep learning is the study of how these layers interact and the practice of applying these principles to data.

Cognitive Computing, a term coined by IBM, is often used interchangeably with machine learning and artificial intelligence. However, cognitive computing systems do not necessarily aspire to imitate intelligent human behavior, but instead to supplement human decision-making power by identifying potentially useful insights with a high degree of certainty. Clinical decision support and augmented intelligence come to mind when considering this definition.

Natural Language Processing (NLP) forms the foundation for many cognitive computing exercises. The ingestion of source materials, such as medical literature, clinical notes, or audio dictation records requires a computer to understand what is written, spoken or otherwise being communicated. One commonly used application of NLP is optical character recognition (OCR) technology that can turn static text, such as a PDF of a lab report or a scan of a handwritten clinical note, into machine readable data. Once the data are in a workable format, the algorithm parses the meaning of each element to complete a task such as translating into a different language, querying a database, summarizing information or supplying a response to a conversation partner. In the health care field, where acronyms and abbreviations are common, accurately parsing through this “incomplete” data can be challenging.

On a basic level, classical computer programming takes rules and data as inputs, and generates an output or answer. Conversely, machine learning algorithms take data and answers as inputs, and
generate rules or insights as an output. For example, a computer may be given two sets of MRI images: one set that clearly shows a variety of brain tumors, and one that does not. By breaking down these images into machine-readable patterns, the computer can understand which patterns are likely to indicate a brain tumor and which represent healthy patients. When fed a new batch of images that may or may not contain tumors, the computer should be able to use that initial reference data to identify patterns that are similar to known positive diagnoses. Every time it makes an incorrect diagnosis, validated by a human clinician, it “learns” to adjust its criteria a little bit more by using the previous experience to inform its future decision-making. With enough training, it can become accurate enough to present reliable results to the user.

Humans complete these types of tasks almost without thought every moment of every day, but few algorithms are sophisticated enough to effectively mimic our natural capacity to process external input, extrapolate unspoken information from a query, consider complex ethical issues, use logic and reason to make a decision, and predict the likely outcomes of each action before they occur. When comparing the common definition of AI as the capability of a machine to imitate intelligent human behavior with the Turing Test challenge of creating an algorithm that performs a task indistinguishably from a human counterpart, it becomes clear that machines are still in the process of evolving. However, there are a few examples of use cases in health care that are coming closer to realizing the Turing Test.

STATUS OF HEALTH CARE AI

Some of the most promising use cases for health care AI tools include predictive analytics, precision medicine, and clinical decision support. Development in all of these areas is already well underway. The private sector has acknowledged these opportunities, and investments in AI have grown over the past several years. A recent report from Markets and Markets pins the health care AI sector at nearly $8 billion in 2022, accelerating at a compound annual growth rate of 52.68 percent over the forecast period.

In 2011, IBM got an early start in the health care AI space by using Watson’s NLP and cognitive computing abilities to train in clinical decision support at some of the top medical institutions in the country. IBM has also committed extensive resources, such as its $2.6 billion acquisition of Truven, to imaging analytics, genomics, pharmaceuticals, and population health management. Their efforts are not without roadblocks—a multiyear project to apply IBM Watson to cancer diagnostics with MD Anderson ended in failure. Other industry leaders, Google and Microsoft, are ramping up their efforts to apply advanced machine learning algorithms to the mysteries of human biology. Microsoft is tackling genomics, cancer, myopia and blindness, transplants, and imaging analytics, while Google recently published research on the role of machine learning in pathology and breast cancer, and diabetic retinopathy. Additionally, Google is the first of the titans to establish a formal program, Launchpad Studio, for working with startups specific to the industry, such as Augmedix, BrainQ, Byteflies, and Cytovale.

Currently, machine learning has started to prove its value in the realm of pattern recognition, NLP, and deep learning. At the Stanford University School of Medicine, a machine-learning algorithm out-performed pathologists at predicting patient survival times for two types of lung cancer. In the United Kingdom, a NLP tool applied to free-text peer assessments of physician performance, derived by human raters, agreed with the content of the documents 98 percent of the time. At Indiana University-Purdue University Indianapolis, machine learning correctly predicted relapse rates for a type of leukemia 90 percent of the time. It identified patients who would experience remission with 100 percent accuracy. Engineers at Boston University are working with Brigham and Women’s Hospital, and Boston Medical center to manage heart diseases and diabetes using...
algorithms that have the ability to predict hospitalizations up to a year in advance with 82 percent accuracy. However, current algorithms do not result in autonomous decisions. Instead, they play an assistive role to augment human intelligence rather than replace it.

FUTURE OF AI IN MEDICINE

What does the future of AI hold in medicine? AI technology could change the world for the better by making care delivery safer, improving diagnostic accuracy, increasing physician productivity and scale, or contributing to applications that improve quality of life. As the technology of AI continues to develop, physicians and medical associations must ensure that AI-enabled systems are governable; are open, transparent, and understandable; can work effectively with people; are included in medical education for students and practicing physicians; and remain consistent with human and medical ethics. Physician involvement with the evolution of this active field may help them to chart a better and wiser path forward for themselves, their patients, and the health care system.

Opportunities and challenges of AI in health care are equally profound for physicians:

*Opportunities*

- Office and hospital automation – patient scheduling, order entry, chat bots, voice recognition, etc.
- Data mining to surface the right data at the right time, and improve EHRs
- Diagnosis – analyze all the known data about the patient and produce insights
- Treatment – analyze the diagnosis and all other known data and produce best practice treatments, perhaps even comparing to “patients like me” data
- Additional time for physicians to spend with patients to focus on their health
- Improve patient experience, and aid behavioral change and treatment compliance
- Medical education – personal assistant for students and residents to surface information (less memorization), automated continuous assessment of competencies, and coaching

*Challenges*

- Data structure, integrity and security
- Technological mistrust – transparency is key
- Demonstrate that AI can reduce costs, deliver the quadruple aim, support the patient-physician relationship, and/or alleviate administrative burden
- Implement and integrate AI into clinical practices and patient care
- Uncertain long term employment outlook for health care professionals
- Susceptibility to training bias, malfeasance, and other possible technical problems
- Questions as to who will benefit and who may lose—what is best for an individual is not always best for public health, especially when limited resources are available

Additionally, AI opportunities and challenges lead to questions physicians will need to confront:

- What evidence is needed to demonstrate value, utility, and trust?
- How does AI intersect with other emerging health care capabilities, such as genomic medicine?
- How will regulatory bodies and professional organizations provide proper oversight for AI benefits and risks, and communicate these to the public?
- How can public and systemic expectations be managed, and concerns allayed?
- What education and training will health care professionals need to acquire in order to understand how AI solutions might help them, and their patients in clinical settings?
- What can health systems considering AI opportunities do now to maximize their chances of success for gaining efficiencies, improving care, and integrating into clinical workflows?
- How will risk be allocated, given the “black box” nature of AI systems?
- How will legal, policy, and regulatory implications, including standards for professional services, intellectual property rights, and FDA oversight be monitored and addressed?

Beyond the potential to dramatically affect the economy and society in the near future, AI has moved to the forefront of many policy debates around the world. These debates range from the governance of AI, such as ensuring accountability of algorithmic decisions, to mitigating the impact of AI on employment. Clear challenges must be addressed to support AI’s future in medicine. Therefore, it is up to all stakeholders, be they health care professionals, medical associations, policymakers, businesses, the technology industry, or civil society to ensure that AI’s impact is a positive one by proactively tackling the challenges, while ensuring the opportunities remain available.

REFERENCES

5. MarketsandMarkets. Artificial Intelligence in Healthcare Market by Offering (Hardware, Software and Services), Technology (Deep Learning, Querying Method, NLP, and Context Aware Processing), Application, End-User Industry, and Geography – Global Forecast to 2022. https://www.marketsandmarkets.com/Market-Reports/artificial-intelligence-healthcare-market-54679303.html?gclid=CjwKCAiAr_TQBRB5EiwACQCq3mViD0-a0Lo3XVAutWQC4nH5xUrizq9BSmKYT2JWIPwNLAVoC6vQQAxD_BwE.
Subject: Study of Declining Native American Medical Student Enrollment

Presented by: Lynne Kirk, MD, Chair

American Medical Association (AMA) Policy D-200.985 (5), “Strategies for Enhancing Diversity in the Physician Workforce,” reads as follows:

5. Our AMA will partner with key stakeholders (including but not limited to the Association of American Medical Colleges, Association of American Indian Physicians, Association of Native American Medical Students, We Are Healers, and the Indian Health Service) to study and report back by July 2018 on why enrollment in medical school for Native Americans is declining in spite of an overall substantial increase in medical school enrollment, and lastly to propose remedies to solve the problems identified in the AMA study.

This section of the policy was appended through Resolution 313-A-17, “Study of Declining Native American Medical Student Enrollment,” which was introduced by the AMA Minority Affairs Section at the 2017 Annual Meeting of the AMA House of Delegates (HOD).

Testimony before Reference Committee C during the meeting reflected limited but supportive testimony on this item focused on the need for increased diversity of the physician workforce to support access to patient care among underserved populations. It was noted that existing AMA policy on diversity dovetails with the intent of this resolution, and that the decline in the number of Native Americans entering medical school is worrisome and may hold future negative ramifications for access to care. Accordingly, Reference Committee C recommended adoption of Resolution 313 to the HOD, and the HOD accepted this recommendation. This report is in response to this policy.

BACKGROUND

The concern regarding Native American student enrollment and the Native American physician workforce is supported by Native American population health outcomes data, Native American health care accessibility data, student enrollment data, workforce data, and the quest for a culturally diverse and culturally competent physician workforce able to meet the health care needs of people from all ethnic backgrounds. The estimated 5.2 million American Indians and Alaska Natives (AI/ANs) living in the U.S. have long experienced lower health status when compared with other Americans. Between 1999 and 2014, premature mortality rates increased for AI/AN populations, while decreasing for blacks, Hispanics, Asians, and Pacific Islanders during the same period. The rates are particularly high for young adult AI/AN individuals. Lack of access to health care and mental health resources is believed to be a causative factor. Lower life expectancy and a disproportionate disease burden exist for a variety of reasons, including inadequate education, lack of economic development and investment, disproportionate poverty, discrimination in the delivery of health services, and cultural differences. These are broad quality of life issues rooted in economic adversity and poor social conditions. Diseases of the heart, malignant neoplasm, unintentional injuries, and diabetes are leading causes of AI/AN deaths (2008-2010). AI/AN
individuals born today have a life expectancy 4.4 years shorter than the U.S. population as a whole\textsuperscript{2} and seven years shorter than non-Hispanic whites.\textsuperscript{3} In a 2016 U.S. Government Accountability Office report to Congress, difficulties in filling health care provider vacancies and long wait times for primary care appointments were noted to be contributing factors to the health care disparities facing AI/ANs.\textsuperscript{4} A survey by the Harvard School of Public Health found that 23% of AI/ANs surveyed experienced discrimination when seeking health care, and 15% avoided seeking healthcare for themselves or their family because of concern that they would be discriminated against.\textsuperscript{5}

The Indian Health Service (IHS), an agency within the U.S. Department of Health and Human Services, states there is “ample opportunity—and pressing need—for physicians practicing a wide range of specializations.” The IHS website lists numerous job openings across multiple medical specialties and geographic locations.\textsuperscript{6} Federal law requires that absolute preference be given to AI/AN applicants. Out of the total active MD workforce (approximately 850,000) in the U.S., 0.4% (3,400) are self-identified as AI/AN.\textsuperscript{7}

In addition to the positive impact on the educational environment through, for example—(1) cultural competence in care delivery; (2) intellectual benefits; and (3) interpersonal benefits for patients, learners and faculty— increasing AI/AN medical school enrollment would translate into an increase in the AI/AN physician workforce. A workforce increase of this nature could positively impact AI/AN population health and improve access to physician services. A report from the Health Resources and Services Administration on physician workforce characteristics found that minority physicians have a greater propensity to practice in physician shortage areas (although the report did not specifically address AI/AN physicians or the AI/AN population).\textsuperscript{9} Another review on this subject concluded that underrepresented minority health professionals have been consistently more likely to deliver health care to the underserved; this study did include AI/AN providers but did not specifically address AI/AN physicians in the findings or conclusions.\textsuperscript{10} There are few conclusive data demonstrating that increasing the number of AI/AN medical students (and ultimately AI/AN physicians) would result in increased numbers of physicians who serve AI/AN communities. A literature search uncovered only one study, published in 1989, which concluded that most AI/AN physicians, while residing in areas with significant AI/AN populations, were primarily serving non-AI/AN patient populations.\textsuperscript{11} Collecting data on AI/AN physician practice patterns has proven difficult for a number of reasons, including the organization of providers to serve AI/AN needs. The Indian Self Determination and Education Assistance Act, also known as Public Law 93-638, allows the IHS to provide funds directly to tribes for administration and delivery of health services.\textsuperscript{12} An unintended consequence of this law has been to make collection of provider data difficult. A comprehensive study is currently underway to determine the practice setting and populations served by AI/AN physicians (personal communication with the study author, Siobhan Wescott, February 22, 2018).

When considering the available information on this topic, it is important to note that most data on AI/AN medical student enrollment and the physician workforce rely on an individual’s self-identification as American Indian, Native American, or Alaska Native. There is no established definition of AI/AN. The U.S. government relies on each of the 567 recognized tribes to set the standards for inclusion as a member of the tribe and official status of AI/AN or Native American.\textsuperscript{13} Inconsistency in criteria for recognition of AI/AN status may result in inaccuracies and inconsistencies in data. Some data sources also allow individuals to self-identify as “multiple race/ethnicity,” which may lead to underreporting of AI/AN data.
Among the ethnic groups traditionally considered to be underrepresented in medicine, AI/AN ethnicity is the least represented among U.S. allopathic medical students. Data from the Association of American Medical Colleges (AAMC) show that in 2016 a total of 20 schools reported at least one applicant who self-identified as AI/AN. The percentage of AI/AN applicants to these schools ranged from 0.9% to 3.8% of the total applicant pool. AAMC enrollment data for academic year 2016-17 show that 223 students, or 0.25% of the total allopathic medical school enrollees, self-identified as AI/AN. The majority of these students were enrolled in medical schools in Oklahoma (20), New Mexico (17), Minnesota (17), Texas (16), North Dakota (15), and Arizona (10). For the allopathic medical school graduating class of 2016, 31 individuals, or 0.16%, self-identified as AI/AN. Since 2002, the number of AI/AN applicants and matriculants to allopathic medical schools has been relatively consistent, despite the increase in the overall number of applicants and enrollees.

Data for osteopathic medical schools show that in 2016, a total of 51 applicants, or 0.3%, self-identified as AI/AN. Over the last 15 years, the number of AI/AN applicants to osteopathic schools has remained relatively constant (between 38 to 69 annually). Nine AI/AN students, or 0.1% of the total enrollee pool, matriculated into osteopathic schools in 2016. Data were not available for AI/AN enrollment in individual osteopathic medical schools in 2016, but the greatest numbers of applications were to schools located in Arizona (31), Pennsylvania (32) and Oklahoma (29). These data likely include students who applied to multiple programs.

Although the absolute numbers of applicants and matriculants, albeit small, have remained relatively constant over the last 15 years, the growth in total medical school applications and enrollment has resulted in a declining percentage of AI/AN applicants and matriculating students. This has occurred despite the emphasis on increasing diversity in matriculants to medical school and the physician workforce; an acceptance rate for AI/AN (44.9%) that exceeds all other racial and ethnic groups, including whites; and increases in the applicant and matriculation rates for other groups traditionally identified as underrepresented in medicine. These data indicate that efforts to recruit AI/AN students to enter health professions education are inadequate.

The relative decline in AI/AN applicants and matriculants has occurred despite focused efforts by institutions in states with large AI/AN populations. Several medical schools, alone or in collaboration with other schools, have implemented programs to encourage and support AI/AN students into the health professions. For example, the North Dakota School of Medicine and Health Sciences has developed the Indians Into Medicine Program (INMED™), a comprehensive program designed to assist American Indian students who aspire to be health professionals and to meet the needs of tribal communities.
Established in 1973, the program aims to address three major problems: 1) too few health professionals in AI communities, 2) too few AI health professionals, and 3) the substandard level of health and health care in AI communities. INMED support services include academic and personal counseling for students, assistance with financial aid applications, and summer enrichment sessions at the junior high through professional school levels. Each year, more than 100 AI students attend INMED’s annual summer enrichment sessions at the junior high, high school, and medical preparatory levels. These summer programs bolster participants’ math and science backgrounds and introduce them to health careers.

The state of Oklahoma is home to two medical schools as well as a significant AI population. The University of Oklahoma supports a summer enrichment program which aims to identify and support minority students, including AI students, who aspire to enter medical school. In 2014 the Oklahoma State University Center for Health Sciences, which houses the Oklahoma State University College of Osteopathic Medicine (OSUCOM), launched an Office for the Advancement of American Indians in Medicine and Science (OAAIMS) to recruit more American Indian high school and college students into medicine and science careers. Through mentoring and targeted programs, the initiative aims to increase the number of American Indians practicing medicine and working in the science fields. Ultimately, efforts made by the OAAIMS are intended to provide Native American students the means to be successful in these fields by offering hands-on experiences that combine Native culture, medicine, and science. Programs include a culturally-based scientific expedition experience for high school students, residential camps with simulation exercises, and a number of outreach programs on-site with tribal partnerships. These focused efforts have been effective, as OSUCOM’s latest incoming class of 2017 included 17 students who self-identified as AI/AN.

The University of Minnesota Medical School (UMMS) founded its Duluth campus in 1972 specifically for the purpose of serving the needs of rural Minnesota and Native American communities and to be a national leader in improving health care access and outcomes in rural Minnesota and AI/AN communities. The UMMS also launched the Center for American Indian and Minority Health in 1987. The purpose of the Center is to raise the health status of American Indians and Alaska Natives by: 1) recruiting and educating Native American medical students, 2) increasing awareness of American Indian health care issues, and 3) conducting research that serves the health interests of Native American communities.

Five medical schools in the southwest—the Universities of Arizona (Phoenix and Tucson), Colorado, New Mexico, and Utah—identified a collective need to increase student diversity, particularly with regard to AI/AN students. These five schools created the “4 Corners Alliance,” and, in collaboration with the Association of American Indian Physicians, invite pre-med/health American Indian students to a free two-day Pre-Admissions Workshop (PAW) annually. The PAW aims to provide students with the information and skills necessary to succeed in the medical and health professions school admission process.

Medical schools also have developed programs to address AI/AN health. For example, the University of Washington School of Medicine offers an Indian Health Pathways Certificate Program for medical students. The program’s goals are to: 1) prepare both native and non-native medical students for careers in AI/AN health, 2) encourage research on AI/AN health issues, and 3) enhance curriculum on AI/AN health issues at the University of Washington School of Medicine.

On a national level, the IHS supports AI/AN entry into the health professions and opportunities to explore career paths in AI/AN health care. Scholarships are available through the IHS Scholarship program, which has awarded more than 7,000 health professions scholarships since 1978. The IHS
website provides links to allow potential students to arrange IHS externships (with salary), and to coordinate AI/AN clerkship opportunities for medical students. In addition, post-graduation financial support is available through the IHS, with a loan repayment program of $20,000 per year of commitment (maximum $40,000) for health professions education loans, as well as a supplemental loan repayment program. The IHS also participates in the National Health Service Corps loan repayment program, with awards up to $50,000 for a two-year commitment.26

The University of Wisconsin, in collaboration with tribal organizations in Wisconsin and the Great Lakes Region, supports an outreach program, We are Healers, which aims to inspire AI youth to envision themselves as health professionals through stories of Native role models.27

Two organizations specifically provide support for AI/AN students aspiring to become physicians: the Association of American Indian Physicians (AAIP) and the Association of Native American Medical Students (ANAMS). The AAIP, whose mission includes promoting education in the medical disciplines, supports workshops, summer programs, scholarship programs, internships, and fellowships aimed at increasing the number of AI/AN students entering the health professions.28 The ANAMS, whose mission is to assist with the recruitment, retention, and support of AI/AN students into medicine and other health careers, provides information on a number of scholarship opportunities available to AI/AN students.29

The causes of the declining percentages of applicants and matriculants are not clear, but in part may be explained by the pre-secondary education success of and college education opportunities for AI/AN students. AI/AN students have the highest high school dropout rates among all racial and ethnic groups tracked by the National Center for Educational Statistics (NCES).30 Additionally, the college enrollment rate (23%) for AI/AN 18- to 24-year-olds is the lowest of all ethnic and racial groups tracked by the NCES.31 A recent survey of AI/ANs found that for almost half of respondents, college attendance was never discussed during adolescence and young adulthood.3

Overall, the AI/AN college graduation rate of 9.3% is well below the national average of 20.3%. The relative ineffectiveness of health professions pipeline programs for AI/AN has been described in the literature, possibly attributable to less rigor in primary and secondary education in science and mathematics.32

RELEVANT AMA POLICY AND ACTIVITIES

A list of relevant AMA policies on this issue is shown in the appendix. These include:

- D-200.985, “Strategies for Enhancing Diversity in the Physician Workforce”
- H-350.970, “Diversity in Medical Education”
- H-350.979, “Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession”
- H-350.960, “Underrepresented Student Access to US Medical Schools”

Aside from policy, since 2002 the AMA has supported the Doctors Back to School™ (DBTS), designed by the AMA Minority Affairs Consortium (today the Minority Affairs Section, or MAS) to highlight the need to expand the pipeline of underrepresented minorities (i.e., black, Latino, Native American) in medicine and eliminate minority health disparities. Through DBTS, physicians and medical students return to their communities to 1) pique young minority students’ interest in medicine by introducing them to “real-life” role models and 2) raise awareness of the need for more underrepresented minorities in the physician workforce. To date, DBTS has engaged more than 100,000 underrepresented minority youth. To expand the reach of the program and
number of volunteers, the MAS has developed partnerships with other AMA sections (e.g.,
Medical Student Section); medical societies/associations (e.g., American Society of
Anesthesiologists; Association of American Medical Colleges); coalitions (e.g., Commission to
End Health Care Disparities); nonprofit organizations (e.g., National Minority Quality Forum), and
diversity pipeline programs in medicine (e.g., Tour for Diversity; Mentoring in Medicine).

Each year, the MAS also partners with the AMA Foundation’s Physicians of Tomorrow
scholarship program to offer the Minority Scholars Award to underrepresented minority medical
students, with $10,000 awards toward their tuition expenses. Up to two students can be nominated
by each medical school dean. In recent years, awards have been disbursed to 20-25 recipients
annually. Since the inception of the program in 2004, 11 recipients have self-identified as Native
Alaskans.

SUMMARY

Despite the current level of support, outreach, and pipeline programs as noted above, the number of
AI/AN applicants/matriculants to medical schools remains quite low and essentially unchanged
over the last 15 years, even as the total enrollment in U.S. medical schools has markedly increased.

Although AI/AN students who are able to succeed in pre-medical training have ample opportunity
and high rates of success in gaining entry into medical schools, the current primary and secondary
education infrastructure and socioeconomic factors for AI/AN students may be inadequate to
promote successful entry in larger numbers into college-level education. While health professions
pipeline programs to promote AI/AN entry are in place at a number of institutions, and these
programs are showing success at the local level to promote medicine as a career path for AI/AN
students, they are limited in size and scope and have not been successful to date in increasing
AI/AN diversity in overall medical school enrollment or the physician workforce. Future initiatives
might benefit from focused efforts to improve preparation of AI/AN students for entry into post-
secondary education, particularly in the areas of science and mathematics.
TABLE: AI/AN APPLICANTS AND ENROLLMENT AT U.S. ALLOPATHIC AND OSTEOPATHIC MEDICAL SCHOOLS

<table>
<thead>
<tr>
<th>Year</th>
<th>Allopathic medical schools</th>
<th>Osteopathic medical schools</th>
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<tbody>
<tr>
<td></td>
<td>AI/AN applicants</td>
<td>AI/AN matriculants</td>
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<tr>
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<tr>
<td>02-03</td>
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</tr>
</tbody>
</table>

Allopathic data extracted from data tables found on the AAMC website, unless otherwise noted.

Osteopathic data extracted from data tables found on the AACOM website.

* Data from Barzansky B, Etzel S. Medical Schools in the United States, JAMA annual data publications. Data are for first year enrollment, not matriculants.
APPENDIX: RELEVANT AMA POLICY

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. Our AMA will partner with key stakeholders (including but not limited to the Association of American Medical Colleges, Association of American Indian Physicians, Association of Native American Medical Students, We Are Healers, and the Indian Health Service) to study and report back by July 2018 on why enrollment in medical school for Native Americans is declining in spite of an overall substantial increase in medical school enrollment, and lastly to propose remedies to solve the problems identified in the AMA study.
6. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
7. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
8. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
9. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
10. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.
11. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
12. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.

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.


**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 pre-collegiate 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.


**H-350.960, “Underrepresented Student Access to US Medical Schools”**

Our AMA: (1) recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population; and (2) supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students.

(Res. 908, I-08 Reaffirmed in lieu of Res. 311, A-15)
REFERENCES

22 Shrum K, Vuong A. Summary of American Indian Physician Pipeline Program at OSU-COM. Report distributed at Oklahoma State University Center for Health Sciences. September 18, 2017; Tulsa, OK.
At the 2017 Interim Meeting, the House of Delegates referred Resolution 817, “Addressing the Site of Service Differential,” which was introduced by the New Mexico Delegation and assigned to the Council on Medical Service for a report back to the House of Delegates at the 2018 Annual Meeting. Resolution 817-I-17 asked:

That our American Medical Association (AMA) study the site-of-service differential with a report back no later than the 2018 Interim Meeting, including: a) the rising gap between independent practice expenses and Medicare reimbursement, taking into account the costs of the regulatory requirements; b) the increased cost of medical personnel and equipment, including electronic health record (EHR/EMR) purchase, software requirements, and ongoing support and maintenance; c) the expense of maintaining hospital based facilities not common to independent practices, such as burn units and emergency departments, and determine what payment should be provided to cover those explicit costs; and d) the methodology by which hospitals report their uncompensated care, and the extent to which this is based on actual costs, not charges; and

That our AMA advocate for a combined Health Care Payment System for patients who receive care that is paid for by the Centers for Medicare & Medicaid Services, that: a) follows the recommendation of MedPAC to pay “site-neutral” reimbursement that sufficiently covers practice expenses without regard to whether services are performed under the Hospital Outpatient Prospective Payment System (HOPPS) or the Physician Fee Schedule (PFS); b) pays appropriate facility fees for both hospital owned facilities and independently owned non-hospital facilities, computed using the real costs of a facility based on its fair market value; and c) provides independent practices with the same opportunity to receive reimbursement for uncompensated care as is provided to hospital owned practices.

Resolution 817-I-17 raised a number of complex cost and payment issues spanning several subject matter areas in need of extensive study. These issues are further complicated by the Medicare program’s use of separate payment methodologies for each outpatient setting (ie, physician offices, hospital outpatient facilities, and ambulatory surgical centers). A current AMA Issue Brief provides an overview of these payment variations. The Council supports payment policies that are site-neutral to the extent possible without lowering payments overall and that fairly reflect the actual costs of providing services. AMA policy supporting equitable payments across outpatient sites of service, including policy established via Council reports, is appended. The Council recognizes the need for further study, and its deliberations of options for achieving payment parity under the Medicare program are ongoing. Accordingly, the Council intends to submit its final report with recommendations addressing the site-of-service differential at the 2018 Interim Meeting.
Appendix

H-240.979 Intrusion by Hospitals into the Private Practice of Medicine
The AMA urges private third party payers to implement coverage policies that do not unfairly discriminate between hospital-owned and independently-owned outpatient facilities with respect to payment of “facility” costs. (CMS Rep. H, I-87; Modified: Sunset Report, I-97; Reaffirmed: CMS Rep. 9, A-07; Reaffirmed: Res. 116, A-14; Reaffirmation A-14; Reaffirmation A-15)

H-240.993 Discontinuance of Federal Funding for Ambulatory Care Centers
The AMA strongly urges more aggressive implementation by HHS of existing provisions in federal legislation calling for equity of reimbursement between services provided by hospitals on an outpatient basis and similar services in physicians’ offices. (CMS Rep. B, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmation I-98; Reaffirmation I-03; Reaffirmation I-07; Reaffirmed: CMS Rep. 3, A-13; Reaffirmation A-15)

D-240.994 Payment Variations Across Outpatient Sites of Service
Our AMA will work with states to advocate that third party payers be required to: a. Assess equal or lower facility coinsurance for lower-cost sites of service (hospital outpatient department, ambulatory surgical center, or office-based facility); b. Publish and routinely update pertinent information related to patient cost-sharing; and c. Allow their plan’s participating physicians to perform outpatient procedures at an appropriate site of service as chosen by the physician and the patient. (CMS Rep. 3, A-13; Reaffirmation I-17)

H-330.925 Appropriate Payment Level Differences by Place and Type of Service
Our AMA (1) encourages CMS to adopt policy and establish mechanisms to fairly reimburse physicians for office-based procedures; (2) encourages CMS to adopt a site neutral payment policy for hospital outpatient departments and ambulatory surgical centers; (3) advocates for the use of valid and reliable data in the development of any payment methodology for the provision of ambulatory services; (4) advocates that in place of the Consumer Price Index for all Urban Consumers (CPI-U), CMS use the hospital market basket index to annually update ambulatory surgical center payment rates; (5) encourages the use of CPT codes across all sites-of-service as the only acceptable approach to payment methodology; and (6) will join other interested organizations and lobby for any needed changes in existing and proposed regulations affecting payment for ambulatory surgical centers to assure a fair rate of reimbursement for ambulatory surgery. (Sub. Res. 104, A-98; Reaffirmation I-98; Appended: CMS Rep. 7, A-99; Reaffirmation A-00; Reaffirmation I-03; Reaffirmation A-11; Reaffirmed: CMS Rep. 3, A-13; Reaffirmed: Sub. Res. 104, A-14; Reaffirmed: Res. 116, A-14; Modified: CMS Rep. 3, A-14; Reaffirmation A-14; Reaffirmation A-15; Reaffirmation I-17)

D-330.997 Appropriate Payment Level Differences by Place and Type of Service
1. Our AMA encourages CMS to: (A) define Medicare services consistently across settings and, in particular, to avoid the use of diagnosis codes in determining Medicare payments to hospital outpatient departments and other ambulatory settings; and (B) adopt payment methodology for hospital outpatient departments and ambulatory surgical centers that will assist in leveling the playing field across all sites-of-service. If necessary, the AMA should consider seeking a legislative remedy to the payment disparities between hospital outpatient departments and ambulatory surgical centers. 2. Our AMA will continue to encourage the CMS to collect data on the frequency, type and cost of services furnished in off-campus, provider-based departments. (CMS Rep. 7, A-99; Reaffirmation I-03; Reaffirmed: CMS Rep. 3, A-13; Reaffirmed: CMS Rep. 4, A-13; Appended: CMS Rep. 3, A-14; Reaffirmed: Sub. Res. 104, A-14; Reaffirmation A-14; Reaffirmation A-15; Reaffirmation I-17)
**D-390.997 CMS Practice Expense Formula**
Our AMA will seek from Congress legislation directing CMS that it include in the RBRVS practice expense allocation all costs incurred by physicians, including those costs incurred in hospitals and ambulatory surgical centers. (Sub. Res. 819, I-99 Reaffirmed: CMS Rep. 5, A-09)

**H-400.957 Medicare Reimbursement of Office-Based Procedures**
Our AMA will: (1) encourage CMS to expand the extent and amount of reimbursement for procedures performed in the physician's office, to shift more procedures from the hospital to the office setting, which is more cost effective; (2) seek to have the RBRVS practice expense RVUs reflect the true cost of performing office procedures; and (3) work with CMS to develop consistent regulations to be followed by carriers that include reimbursement for the costs of disposable supplies and surgical tray fees incurred with office-based procedures and surgery. (Sub. Res. 103, I-93 Reaffirmed by Rules & Credentials Cmt., A-96 Reaffirmation A-04 Reaffirmation I-04 Reaffirmed: CMS Rep. 1, A-14 Reaffirmed: CMS Rep. 3, A-14)

**H-400.966 Medicare Payment Schedule Conversion Factor**
(1) The AMA will aggressively promote the compilation of accurate data on all components of physician practice costs and the changes in such costs over time, as the basis for informed and effective advocacy with Congress and the Administration concerning physician payment under Medicare. (2) The AMA will work aggressively with CMS, the Bureau of Labor Statistics, and other appropriate federal agencies to improve the accuracy of such indices of market activity as the Medicare Economic Index and the medical component of the Consumer Price Index. (CMS Rep. B, I-92 Reaffirmed: CMS Rep. 10, A-03 Reaffirmed: CMS Rep. 6, I-08 Reaffirmed: CMS Rep. 1, I11 Reaffirmation: I-12 Reaffirmed in lieu of Res. 113, A-13 Reaffirmation I-13 Reaffirmed: CMS Rep. 3, A-14)

**H-400.956 RBRVS Development**
(1) That the AMA strongly advocate CMS adoption and implementation of all the RUC's recommendations for the five-year review; (2) That the AMA closely monitor all phases in the development of resource-based practice expense relative values to ensure that studies are methodologically sound and produce valid data, that practicing physicians and organized medicine have meaningful opportunities to participate, and that any implementation plans are consistent with AMA policies; (3) That the AMA work to ensure that the integrity of the physician work relative values is not compromised by annual budget neutrality or other adjustments that are unrelated to physician work; (4) That the AMA encourage payers using the relative work values of the Medicare RBRVS to also incorporate the key assumptions underlying these values, such as the Medicare global periods; and (5) That the AMA continue to pursue a favorable advisory opinion from the Federal Trade Commission regarding AMA provision of a valid RBRVS as developed by the RUC process to private payers and physicians. (BOT Rep. 16, A-95 BOT Rep. 11, A-96 Reaffirmed: CMS Rep. 4, I-02 Reaffirmed: BOT Rep. 14, A-08 Reaffirmed: Sub. Res. 104, A-14 Reaffirmation A-15)

**H-400.969 RVS Updating**
Status Report and Future Plans: The AMA/Specialty Society RVS Update Committee (RUC) represents an important opportunity for the medical profession to maintain professional control of the clinical practice of medicine. The AMA urges each and every organization represented in its House of Delegates to become an advocate for the RUC process in its interactions with the federal government and with its physician members. The AMA (1) will continue to urge CMS to adopt the recommendations of the AMA/Specialty Society RVS Update Committee for physician work relative values for new and revised CPT codes; (2) supports strongly use of this AMA/Specialty Society process as the principal method of refining and maintaining the Medicare RVS; (3)

D-478.996 Information Technology Standards and Costs
1. Our AMA will: (a) encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems; (b) work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices; (c) review the following issues when participating in or commenting on initiatives to create a NHII: (i) cost to physicians at the office-based level; (ii) security of electronic records; and (iii) the standardization of electronic systems; (d) continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records; and (e) continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems. 2. Our AMA advocates that physicians: (a) are offered flexibility related to the adoption and use of new certified Electronic Health Records (EHRs) versions or editions when there is not a sufficient choice of EHR products that meet the specified certification standards; and (b) not be financially penalized for certified EHR technology not meeting current standards. (Res. 717, A-04; Reaffirmation, A-05; Appended: Sub. Res. 707, A-06; Reaffirmation A-07; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation I-08; Reaffirmation I-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmed: Res. 205, A-11; Reaffirmed in lieu of Res. 714, A-12; Reaffirmed in lieu of Res. 715, A-12; Reaffirmed in lieu of Res. 724, A-13; Reaffirmation I-13; Reaffirmation A-14; Reaffirmed: BOT Rep. 03, I-16; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 204, I-17; Reaffirmation I-17)
REPORT OF THE SPEAKERS

Speakers’ Report 1-A-18

Subject: Recommendations for Policy Reconciliation

Presented by: Susan R. Bailey, MD, Speaker
Bruce A. Scott, MD, Vice Speaker

Policy G-600.111, “Consolidation and Reconciliation of AMA Policy,” calls on your Speakers to “present one or more reconciliation reports for action by the House of Delegates relating to newly passed policies from recent meetings that caused one or more existing policies to be redundant and/or obsolete.”

Your Speakers present this report to deal with policies, or portions of policies, that are no longer relevant or that were affected by actions taken in 2017. Suggestions on other policy statements that your Speakers might address should be sent to hod@ama-assn.org for possible action. Where changes to language will be made, additions are shown with underscore and deletions are shown with red strikethrough.

RECOMMENDED RECONCILIATIONS

Policy to be modified in light of later House of Delegates action


This policy requires a minor change in the first paragraph given that the House amended the bylaws and adopted policy to implement the new procedure for apportioning delegates to national medical specialty societies. The change is a modest deletion from the policy and includes an appropriate capitalization in the first sentence. No other change to the policy is necessary.

1. The current specialty society delegation allocation system (using a formula that incorporates the ballot) will be discontinued; and s Specialty society delegate allocation in the House of Delegates will be determined so that the total number of national specialty society delegates shall be equal to the total number of delegates apportioned to constituent societies under section 2.1.1 (and subsections thereof) of AMA bylaws, and will be distributed based on the latest available membership data for each society, which is generally from the society's most recent five year review, but may be determined annually at the society's request.…

Policy to be modified for clarification and consistency with practice

II. G-600.061, “Guidelines for Drafting a Resolution or Report”

The title of Policy G-600.061, “Guidelines for Drafting a Resolution or Report,” suggests that it applies to both resolutions and reports, and in fact several parts of the policy refer specifically to both resolutions and reports. However, some subparagraphs of Paragraph 1 do not reference reports, despite the fact that practice has enforced the guidelines with respect to all reports submitted to the House, and the House of Delegates Reference Manual plainly states (page 30) that
a fiscal note “indicating the financial implications of the report’s recommendations” will be included. To ensure correspondence between the policy title and actual practice, the policy should explicitly address reports in Paragraphs 1, 1b, 1c and 1d.

G-600.061, Guidelines for Drafting a Resolution or Report

Resolutions or reports with recommendations to the AMA House of Delegates shall meet the following guidelines:

1. When proposing new AMA policy or modification of existing policy, the resolution or report should meet the following criteria:

   a. The proposed policy should be stated as a broad guiding principle that sets forth the general philosophy of the Association on specific issues of concern to the medical profession;

   b. The proposed policy should be clearly identified at the end of the resolution or report;

   c. Recommendations for new or modified policy should include existing policy related to the subject as an appendix provided by the sponsor and supplemented as necessary byAMA staff. If a modification of existing policy is being proposed, the resolution or report should set out the pertinent text of the existing policy, citing the policy number from the AMA policy database, and clearly identify the proposed modification. Modifications should be indicated by underlining proposed new text and lining through any proposed text deletions. If adoption of the new or modified policy would render obsolete or supersede one or more existing policies, those existing policies as set out in the AMA policy database should be identified and recommended for rescission. Reminders of this requirement should be sent to all organizations represented in the House prior to the resolution submission deadline;

   d. A fiscal note setting forth the estimated resource implications (expense increase, expense reduction, or change in revenue) of the proposed policy, program, or action shall be generated by AMA staff in consultation with the sponsor. Estimated changes in expenses will include direct outlays by the AMA as well as the value of the time of AMA’s elected leaders and staff. A succinct description of the assumptions used to estimate the resource implications must be included in each fiscal note. When the resolution or report is estimated to have a resource implication of $50,000 or more, the AMA shall publish and distribute a document explaining the major financial components or cost centers (such as travel, consulting fees, meeting costs, or mailing). No resolution or report that proposes policies, programs, or actions that require financial support by the AMA shall be considered without a fiscal note that meets the criteria set forth in this policy.

2. When proposing to reaffirm existing policy, the resolution or report should contain a clear restatement of existing policy, citing the policy number from the AMA policy database.

3. When proposing to establish a directive, the resolution or report should include all elements required for establishing new policy as well as a clear statement of existing policy, citing the policy number from the AMA policy database, underlying the directive.

4. Reports responding to a referred resolution should include the resolves of that resolution in its original form or as last amended prior to the referral. Such reports should include a
recommendation specific to the referred resolution. When a report is written in response to a directive, the report should sunset the directive calling for the report.

5. The House’s action is limited to recommendations, conclusions, and policy statements at the end of report. While the supporting text of reports is filed and does not become policy, the House may correct factual errors in AMA reports, reword portions of a report that are objectionable, and rewrite portions that could be misinterpreted or misconstrued, so that the “revised” or “corrected” report can be presented for House action at the same meeting whenever possible. The supporting texts of reports are filed.

6. All resolutions and reports should be written to include both “MD and DO,” unless specifically applicable to one or the other.

7. Reports or resolutions should include, whenever possible or applicable, appropriate reference citations to facilitate independent review by delegates prior to policy development.

8. Each resolution resolve clause or report recommendation must be followed by a phrase, in parentheses, that indicates the nature and purpose of the resolve. These phrases are the following:
   a. New HOD Policy;
   b. Modify Current HOD Policy;
   c. Consolidate Existing HOD Policy;
   d. Modify Bylaws;
   e. Rescind HOD Policy;
   f. Reaffirm HOD Policy; or
   g. Directive to Take Action.

9. Our AMA’s Board of Trustees, AMA councils, House of Delegates reference committees, and sponsors of resolutions will try, whenever possible, to make adjustments, additions, or elaborations of AMA policy positions by recommending modifications to existing AMA policy statements rather than creating new policy.

References to completed reports to be deleted from policies

The following policies will be modified by deleting references to requested reports that have been sent to and considered by the House of Delegates. Other, substantive portions of these directives are unchanged.

III. H-95.990, “Drug Abuse Related to Prescribing Practices”

The policy includes a request for a study that has been completed, so that section of the policy will be stricken. The remainder of the policy remains intact.

1. Our AMA recommends the following series of actions for implementation by state medical societies concerning drug abuse related to prescribing practices:
   A. institution of comprehensive statewide programs to curtail prescription drug abuse and to promote appropriate prescribing practices, a program that reflects drug abuse problems currently within the state, and takes into account the fact that practices, laws and regulations differ from state to state. The program should incorporate these elements: (1) Determination of the nature and extent of the prescription drug abuse
(2) Cooperative relationships with law enforcement, regulatory agencies, pharmacists and other professional groups to identify "script doctors" and bring them to justice, and to prevent forgeries, thefts and other unlawful activities related to prescription drugs; (3) Cooperative relationships with such bodies to provide education to "duped doctors" and "dated doctors" so their prescribing practices can be improved in the future; (4) Educational materials on appropriate prescribing of controlled substances for all physicians and for medical students.

B. placement of the prescription drug abuse programs within the context of other drug abuse control efforts by law enforcement, regulating agencies and the health professions, in recognition of the fact that even optimal prescribing practices will not eliminate the availability of drugs for abuse purposes, nor appreciably affect the root causes of drug abuse. State medical societies should, in this regard, emphasize in particular: (1) Education of patients and the public on the appropriate medical uses of controlled drugs, and the deleterious effects of the abuse of these substances; (2) Instruction and consultation to practicing physicians on the treatment of drug abuse and drug dependence in its various forms.

2. Our AMA:
   A. promotes physician training and competence on the proper use of controlled substances;
   B. encourages physicians to use screening tools (such as NIDAMED) for drug use in their patients;
   C. will provide references and resources for physicians so they identify and promote treatment for unhealthy behaviors before they become life-threatening; and
   D. encourages physicians to query a state's controlled substances databases for information on their patients on controlled substances.

3. The Council on Science and Public Health will report at the 2012 Annual Meeting on the effectiveness of current drug policies, ways to prevent fraudulent prescriptions, and additional reporting requirements for state-based prescription drug monitoring programs for veterinarians, hospitals, opioid treatment programs, and Department of Veterans Affairs facilities.

4. Our AMA opposes any federal legislation that would require physicians to check a prescription drug monitoring program (PDMP) prior to prescribing controlled substances.

Council on Science and Public Health Report 2-I-13, “A Contemporary View of National Drug Control Policy,” reviewed the material and addressed the elements of paragraph 3 within the Council’s expertise. For that reason, paragraph 3 will be deleted.

IV. D-160.927, “Risk Adjustment Refinement in ACO Settings and Medicare Shared Savings Programs”

Our AMA will continue seeking the even application of risk-adjustment in ACO settings to allow Hierarchical Condition Category risk scores to increase year-over-year within an agreement period for the continuously assigned Medicare Shared Savings Program beneficiaries and report progress back to this House at the 2017 Annual Meeting.

At the 2017 Annual Meeting, the Board of Trustees offered Report 21, “Risk Adjustment Refinement in Accountable Care Organization (ACO) Settings and Medicare Shared Savings Programs (MSSP),” which described efforts that had been undertaken to address the CMS policies
and noted that our AMA would continue to urge CMS to improve risk adjustment methodology in ACOs.

V. D-165.935, “Protecting Patient Access to Health Insurance Coverage, Physicians, and Quality Health Care”

+ Our AMA will: (a) actively engage the new Administration and Congress in discussions about the future of health care reform, in collaboration with state and specialty medical societies, emphasizing our AMA’s extensive body of policy on health system reform; and (b) craft a strong public statement for immediate and broad release, articulating the priorities and firm commitment to our current AMA policies and our dedication in the development of comprehensive health care reform that continues and improves access to care for all patients.

2. Our AMA Board of Trustees will report back to our AMA House of Delegates at the 2017 Annual Meeting.

BOT Report 24-A-17, “Protecting Patient Access to Health Insurance Coverage, Physicians, and Quality Health Care,” characterized the efforts that had been undertaken to that point, including engagement with the Federation, collaborations with various patient advocacy groups and letters to congressional leadership as well as the White House.

VI. D-478.970, Physician-Patient Text Messaging and Non-HIPAA Compliant Electronic Messaging

Our AMA: (1) will study the medicolegal implications of text messaging and other non-HIPAA-compliant electronic messaging between physicians, patients, and members of the health care team, with report back at the 2017 Annual Meeting; and 2) will develop patient-oriented educational materials about text messaging and other non-HIPAA-compliant electronic messaging communication between physicians, patients, and members of the health care team.


Policy with a title change

VII. D-478.964, “High Cost to Authors for Open Source Peer Reviewed Publications”

Following usual practice, Board of Trustees Report 10-I-17 took its title from the underlying referred resolution. While the body of the report correctly referred to open access journals, the title, taken directly from the resolution, employed the term “open source.” As “open access” is the preferred terminology, the title of Policy D-478.964 will be changed to “High Cost to Authors for Open Access Peer Reviewed Publications.”

Directives to be rescinded in full

The following directives will be rescinded in full, as the requested studies have been completed, with reports presented to the House of Delegates several years ago.
VIII. D-160.930, “Studying Physician Access to ACO Participation”

Our AMA will study: (a) the criteria and processes by which various types of accountable care organizations (ACOs) determine which physicians will be selected to join vs. excluded from the ACO; (b) the criteria and processes by which physicians can be de-selected once they are members of an ACO; (c) the implications of such criteria and processes for patient access to care outside the ACO; and (d) the effect of evolving system alignments and integration on physician recruitment and retention. The results of this study will be reported back to the HOD and to our AMA membership at large by the 2015 Annual Meeting.

The directive was fulfilled by Council on Medical Service Report 7-A-15, “Physician Access to ACO Participation,” which noted that efforts to identify and support current and emerging payment and care delivery models that work best for physicians across a variety of practice settings are ongoing.

IX. D-165.940, “Monitoring the Affordable Care Act”

Our AMA will assess the progress of implementation of the Patient Protection and Affordable Care Act based on AMA policy, as well as the estimated budgetary, coverage and physician-practice impacts of the law, and report back to the House of Delegates at the 2013 Interim Meeting.

Council on Medical Service Report 5-I-13, “Monitoring the Affordable Care Act,” was prepared in response to this directive.

The changes outlined above do not reset the sunset clock and will be implemented when this report is filed.

Fiscal note: $250 to edit policy database.